

State PBM Reform Inventory

Updated March 2026

Vermont

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Commissioner of Financial Regulation. Applicants for an initial PBM license shall submit an application form established by the department, a nonrefundable application fee of \$1,600, and an initial licensure fee of \$10,000. PBMs must renew their licenses each year and pay a renewal fee of \$12,000.	18 V.S.A. § 3611
Reporting Requirements	<p>For plans renewed or initiated after July 1, 2024, a PBM shall allow access by contracted health insurers to financial and contractual information necessary to conduct a complete and independent audit designed to verify the following:</p> <ul style="list-style-type: none"> • Full pass-through of negotiated drug prices and fees associated with all drugs dispensed to beneficiaries of the health benefit plan in both retail and mail-order settings or resulting from any of the pharmacy benefit management functions defined in the contract; • Full pass-through of all financial remuneration associated with all drugs dispensed to beneficiaries of the health benefit plan in both retail and mail-order settings or resulting from any of the pharmacy benefit management functions defined in the contract; and • Any other verifications relating to the pricing arrangements and activities of the PBM required by the contract, if required by the Commissioner. <p>A PBM shall disclose to a contracted health insurer all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer's health benefit plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees.</p>	18 V.S.A. § 3621 18 V.S.A. § 3622

<p>PBM Income</p>	<p>Spread Pricing: Effective July 1, 2024, a PBM shall not conduct or participate in spread pricing. A PBM must ensure that the total amount required to be paid by a health benefit plan and a covered person for a prescription drug covered under the plan does not exceed the amount paid to the pharmacy for dispensing the drug.</p> <p>Rebate Pass-Through: If the PBM derives any payment or benefit for the dispensation of prescription drugs based on volume of sales for certain prescription drugs or classes or brands of drugs, that PBM shall pass that payment or benefit on in full to the health insurer.</p>	<p>18 V.S.A. § 3612</p> <p>18 V.S.A. § 3622</p>
<p>Pharmacy Contracting</p>	<p>MAC Pricing: In order to be subject to MAC, a drug must be widely available for purchase by all pharmacies in the State, without limitations, from national or regional wholesalers and must not be obsolete or temporarily unavailable.</p> <p>For each drug for which a PBM establishes a MAC to determine the reimbursement rate, the PBM shall do all of the following:</p> <ul style="list-style-type: none"> • Make available, in a format that is readily accessible and understandable by a pharmacist, the actual MAC for each drug and the source used to determine the MAC, which shall not be dependent upon individual beneficiary identification or benefit stage; • Update the MAC at least once every 7 calendar days; • Establish or maintain a reasonable administrative appeals process to allow a dispensing pharmacy provider to contest a listed MAC; • Respond in writing to any appealing pharmacy within 10 calendar days after receipt of an appeal, provided that the dispensing pharmacy shall file any appeal within 10 calendar days from the date its claim for reimbursement is adjudicated; <ul style="list-style-type: none"> ○ A PBM shall allow a pharmacy to appeal after the 10-day period if a claim is subject to an audit by the PBM or its auditing agent. • For a denied appeal, provide the reason for the denial and identify the NDC and a Vermont-licensed wholesaler of an 	<p>18 V.S.A. § 3631</p> <p>8 V.S.A. § 4093c (2)</p>

	<p>equivalent drug product that may be purchased by contracted pharmacies at or below the MAC;</p> <ul style="list-style-type: none"> • For a successful appeal: <ul style="list-style-type: none"> ○ Make the change in the MAC within 30 business days after the redetermination; and ○ Allow the appealing pharmacy or pharmacist to reverse and rebill the claim in question. <p>Patient Steering: A PBM shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount the PBM reimburses a PBM affiliate for providing the same pharmacist services.</p> <p>A health insurer or PBM shall not do any of the following:</p> <ul style="list-style-type: none"> • Require a covered individual, as a condition of payment or reimbursement, to purchase pharmacist services, including prescription drugs, exclusively through a mail-order pharmacy or a PBM affiliate; • Offer or implement plan designs that require a covered individual to use a mail-order pharmacy or a PBM affiliate; • Order a covered individual, orally or in writing, including through online messaging, to use a mail-order pharmacy or a PBM affiliate; or • Offer or implement plan designs that increase plan or patient costs if the covered individual chooses not to use a mail-order pharmacy or a PBM affiliate. 	
Patient Cost-Sharing	<p>Maximum Cost-Sharing Levels: Patient cost-sharing at the point of sale may not exceed the lesser of the contracted cost-share amount or the amount an individual would pay for a prescription if that individual were paying without insurance. This does not apply to self-funded health benefit plans governed by ERISA.</p> <p>Copay Cap: A health benefit plan that provides coverage for prescription insulin drugs shall cap the total amount of any cost-sharing or co-pay that an insured or beneficiary is required to pay under the plan for a covered prescription insulin drug at an amount not to exceed one hundred dollars (\$100) per 30-day supply of the insulin drug, without regard to the policy deductible, regardless of the amount or type of insulin needed to fill the</p>	<p>AL Code § 27-45A-8 (2023); AL Code § 27-63-1 (2023)</p>

	<p>insured's or beneficiary's prescription. On January 1 of each year, the limit on the amount that an insured is required to pay for a 30-day supply of a covered prescription insulin drug shall increase by a percentage equal to the percentage change from the preceding year in the prescription drug component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor. This requirement does not apply to a health benefit plan if implementing the cost-sharing or co-pay cap would necessitate increasing the health benefit plan's cost-sharing for other services to comply with federally mandated actuarial values for non-grandfathered individual and small group plans.</p>	
--	---	--