State PBM Reform Inventory

Updated October 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 non-refundable 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	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: • 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. 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.	18 V.S.A. § 3621; 18 V.S.A. § 3622

PBM Income	**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. **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.	18 V.S.A. § 3612; 18 V.S.A. § 3622
Pharmacy Contracting	**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. For each drug for which a PBM establishes a MAC to determine the reimbursement rate, the PBM shall do all the following: • 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; ○ 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	18 V.S.A. § 3631; 8 V.S.A. § 4093c (2)

	equivalent drug product that may be purchased by contracted pharmacies at or below the MAC;
	• For a successful appeal:
	  ○ 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.
	
	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.
	
	A health insurer or PBM shall not do any of the following:
	• 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	**Maximum Cost-Sharing Levels:** A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of: • The cost-sharing amount under the terms of the health benefit plan; • The MAC for the drug; or • The amount the covered person would pay for the drug, after application of any known discounts, if the covered person were paying the cash price. **Copay Adjustment Programs:** A PBM shall attribute any amount paid by or on behalf of a covered person, including any third-party payment, financial assistance, discount, coupon, or any other reduction in out-of-	18 V.S.A. § 3612; 8 V.S.A. § 4092g

	pocket expenses made by or on behalf of a covered person for prescription drugs, toward: • The out-of-pocket limits for prescription drug costs; • The covered person's deductible, if any; and • The annual out-of-pocket maximums applicable to the covered person's health benefit plan. This requirement shall only apply to prescription drugs for which there is no generic drug or interchangeable biological product, or drugs for which the covered person has obtained access through prior authorization, a step therapy protocol, or the PBM's or health benefit plan's exceptions and appeals process. For enrollers in high-deductible health plans, this requirement shall only apply after the individual meets their minimum deductible to remain eligible for an HSA. **Copay Cap:** A health insurance or other health benefit plan offered by a health insurer or PBM shall limit a beneficiary's total out-of-pocket responsibility for prescription insulin medications to not more than $100 per 30-day supply, regardless of the amount, type, or number of insulin medications prescribed for the beneficiary. The monthly limit shall apply regardless of whether the beneficiary has satisfied any applicable deductible requirement under the health insurance or health benefit plan.	