Vermont Department of Banking, Insurance, Securities and Health Care Administration
Bulletin HCA 134
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Clarification of the effect on Member Payments when an Exception to a Pharmacy Benefit Management Program has occurred under Regulation H-09-03 §4.3 (B)

The purpose of this Bulletin is to clarify the Department's position on the effect on member payments when an exception to a pharmacy benefit program ("PBMP") has occurred.

The Commissioner is authorized to issue this Bulletin pursuant to 8 V.S.A. § 15.

Regulation H-09-03 §1.4 (RR) provides:

"'Pharmaceutical benefit management program' ("PBMP") means any mechanisms or procedures used to manage prescription drug benefits, including but not limited to formularies, dose restrictions, prior or other authorization requirements, step therapy and/or substitution requirements."

It is the Department's position that mechanisms or procedures used to manage prescription drug benefits, including but not limited to "formularies" as referenced in § 1.4 (RR), include the list of the costs and the cost sharing requirements for prescription drugs.

Regulation H-09-03 §4.3(B) provides:

"A managed care organization shall grant an exception to a PBMP requirement and shall provide coverage on the same terms as it would have for the PBMP requirement if the member's prescribing health care provider certifies, based on relevant clinical information about the particular member and sound medical or scientific evidence or the known characteristics of the drug, that the PBMP requirement:

1. has been ineffective or is reasonably expected to be ineffective or significantly less effective in treating this member's condition such that an exception is medically necessary; or

2. has caused or is reasonably expected to cause adverse or harmful reactions in this member."

It has been brought to the Department's attention that there may be confusion as to the meaning of "on the same terms". Regulation H-09-03§4.3(B) should be read as follows:

> "A managed care organization shall grant an exception to a PBMP requirement and shall provide coverage on the same terms as it would have **but** for the PBMP requirement...."

Therefore, when an exception to a PBMP requirement has been granted, a member's coverage must be at the same level as it would have been if the member could have taken the generic drug.

By way of example:

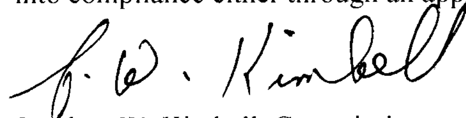
1) If the member's prescribing health care provider certifies that the member should not take a generic drug (lowest tier drug) the member's payment responsibility for a brand drug, formulary or non-

formulary, can be no greater than the amount that the member would have paid for the lowest tier copayment or co-insurance.

2) If the member's prescribing health care provider certifies that the member should not take a generic drug (lowest tier drug) in a step-therapy program, the member does not have to satisfy the step therapy program requirements and the member's payment responsibility for a brand drug, formulary or non-formulary, can be no greater than the amount that the member would have paid for the lowest tier copayment or co-insurance.

Filing Requirements

Policies that are not currently in compliance with Vermont law as described in this Bulletin must come into compliance either through an approved rider or amended policy form within 60 days.



Stephen W. Kimbell, Commissioner