House Insurance Subcommittee Am. #1

Amendment No._____

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Date _____
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Signature of Sponsor

AMEND Senate Bill No. 2458* House Bill No. 2661

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 56-7-3102 is amended by deleting the section and substituting:

As used in this part, unless the context otherwise requires:

(1) "Covered entity":

(A) Means an individual or entity, other than a patient, healthcare provider, or pharmacist, involved in the financing of a pharmacy benefits plan or program; and

(B) Does not include:

(i) The TennCare program administered pursuant to the waivers approved by the United States department of health and human services;

(ii) The sponsor of a plan subject to regulation under medicare part D (42 U.S.C. §§ 1395w–101, et seq.); or

(iii) A health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, or other long-term care;

(2) "Maximum allowable cost list" means a listing of pharmaceutical products or method for calculating reimbursement amounts used by a pharmacy benefits manager, directly or indirectly, setting the maximum allowable cost on which reimbursement payment to a pharmacy or pharmacist may be based for

dispensing a prescription pharmaceutical product and includes, but is not limited to:

(A) Average acquisition cost, including national average drug acquisition cost;

(B) Average manufacturer price;

(C) Average wholesale price;

(D) Brand effective rate or generic effective rate;

(E) Discount indexing;

(F) Federal upper limits;

(G) Wholesale acquisition cost; and

(H) Any other term that a pharmacy benefits manager or a third-party payor may use to establish reimbursement rates to a pharmacist or pharmacy for pharmaceutical products;

(3) "Pharmaceutical product" means a generic drug, brand-name drug, biologic, or other prescription drug, vaccine, or device;

(4) "Pharmaceutical wholesaler":

(A) Means an individual or entity that sells and distributes, directly or indirectly, prescription pharmaceutical products, including, but not limited to, brand-name, generic, and over-the-counter pharmaceuticals, and that offers regular or private delivery to a pharmacy; and

(B) Includes a prescription pharmaceutical product manufacturer that sells directly to a pharmacy or pharmacist;

(5) "Pharmacist" has the same meaning as defined in § 63-10-204;

(6) "Pharmacy" has the same meaning as defined in § 63-10-204;

(7) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice;

(8) "Pharmacy benefits manager" means an individual or entity that administers or manages a pharmacy benefits plan or program on behalf of a covered entity;

(9) "Pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager;

(10) "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmaceutical products to individuals who reside in or are employed in this state; and

(11) "Pharmacy services administrative organization" means an entity that provides contracting and other administrative services to a pharmacy to assist in the pharmacy's interaction with third-party payers, pharmacy benefits managers, drug wholesalers, and other entities.

SECTION 2. Tennessee Code Annotated, Section 56-7-3104, is amended by deleting the section and substituting:

(a) Notwithstanding another law to the contrary, a pharmacy benefits manager shall not place or continue to list a pharmaceutical product on a maximum allowable cost list unless the pharmaceutical product:

(1) Is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States food and drug administration's most recent version of the "Orange Book" or "Green Book," or has been given an NR or NA rating by Medi-span, a Gold Standard rating, or a similar rating by a nationally recognized reference;

(2) Is generally available for purchase by pharmacies in this state from national or regional wholesalers operating in this state; and

(3) Is not obsolete.

(b) Notwithstanding another law to the contrary, a pharmacy benefits manager shall:

(1) Provide access to its maximum allowable cost list to each pharmacy subject to the maximum allowable cost list;

(2) Update its maximum allowable cost list on a timely basis, but in no event more than three (3) calendar days after the date of:

(A) An increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in this state; or

(B) A change in the methodology on which the maximum allowable cost list is based or in the value of a variable involved in the methodology; and

(3) Provide a process for each pharmacy subject to the maximum allowable cost list to receive notification within three (3) calendar days of an update to the maximum allowable cost list.

(c)

(1) A pharmacy benefits manager shall provide a reasonable appeal procedure to allow a pharmacy to challenge maximum allowable costs and reimbursements made under a maximum allowable cost list for a specific pharmaceutical product or pharmaceutical products as:

(A) Violating this section; or

(B) Being less than the pharmacy acquisition cost.

(2) The reasonable appeal procedure required pursuant to this subsection (c) must include the following:

(A) A dedicated telephone number and email address or website for the purpose of submitting appeals;

(B) The ability to submit an appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and

(C) Provide no less than seven (7) business days to file an appeal.

(3) A pharmacy benefits manager shall respond to an appeal under this subsection (c) within seven (7) business days after notice of the appeal is received by the pharmacy benefits manager.

(4)

(A) If a pharmacy benefits manager grants an appeal under this subsection (c) by finding that this section has been violated or the pharmacy or pharmacist was reimbursed less than the pharmacy acquisition cost, then within seven (7) business days after notice of the appeal is received by the pharmacy benefits manager, the pharmacy benefits manager shall:

(i) Make the necessary change to the challenged maximum allowable cost;

(ii) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim upon which the appeal is based;

(iii) If the pharmaceutical product involved in the appeal is a drug, then provide to the pharmacy or pharmacist the national drug code number for the drug on which the increase or change is based; and

(iv) Make the change effective for each similarly situated pharmacy that is subject to the maximum allowable cost list.

(B) If a pharmacy benefits manager denies an appeal under this subsection (c), then within seven (7) business days after notice of the

appeal is received by the pharmacy benefits manager, the pharmacy benefits manager shall provide the appealing pharmacy or pharmacist with:

(i) The name of the national or regional pharmaceutical wholesalers operating in this state that have the pharmaceutical product currently in stock at a price that is less than the cost listed on the maximum allowable cost list; and

(ii) If the pharmaceutical product involved in the appeal is a drug, then the national drug code number for the drug. If the pharmaceutical product involved is a medical device, then the unique device identifier for the device.

(C) If the pharmaceutical product associated with the national drug code number or unique device identifier is not available at a cost that is less than the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription pharmaceutical products for resale, then the pharmacy benefits manager shall adjust the maximum allowable cost to an amount greater than the appealing pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the pharmaceutical product at a cost that is equal to or less than the previously challenged maximum allowable cost.

(d) It is the intent of this section that each pharmacy or pharmacist in this state be reimbursed an amount by a pharmacy benefits manager that is not in violation of this section or below the pharmacy or pharmacist's pharmacy acquisition cost. The commissioner of commerce and insurance is authorized to promulgate rules to effectuate the purposes of this section, including, but not limited to, an external appeals process for any claim denied by a pharmacy benefits manager. The rules must be

promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(e) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmaceutical product. The amount must be calculated on a per unit basis based on the same generic product identifier or generic code number.

(f) A pharmacy or pharmacist may decline to provide a pharmaceutical product to a patient or pharmacy benefits manager if, as a result of a maximum allowable cost list, the pharmacy or pharmacist would be paid less than the pharmacy acquisition cost of the pharmacy providing the pharmaceutical product.

SECTION 3. Tennessee Code Annotated, Section 56-7-3106, is amended by deleting the section and substituting:

A pharmacy benefits manager shall pay a pharmacy dispensing a pharmaceutical product pursuant to a pharmacy benefits agreement a professional dispensing fee at a rate not less than the amount paid by the TennCare programs administered pursuant to the waivers approved by the United States department of health and human services, as set forth in the operative edition of the Division of TennCare Pharmacy Provider Manual, or successor publication, for each prescription pharmaceutical product that is dispensed to the patient by the pharmacy. The dispensing fee required to be paid pursuant to this section must be calculated on a per unit basis based on the same generic product identifier or generic code number. The dispensing fee is in addition to the amount that the pharmacy benefits manager reimburses a pharmacy, consistent with this part, for the cost of the pharmaceutical product that the pharmacy dispenses to the patient.

SECTION 4. Tennessee Code Annotated, Section 56-7-3107, is amended by deleting the section and substituting:

A pharmacy benefits manager shall not assess, charge, or collect any form of remuneration that passes from a pharmacy or pharmacist to the pharmacy benefits manager, including, but not limited to, claim-processing fees, performance-based fees, network-participation fees, or accreditation fees.

SECTION 5. Tennessee Code Annotated, Section 56-7-3108, is amended by deleting the section and substituting:

A pharmacy benefits manager shall not directly or indirectly deny or reduce a claim after the claim has been processed, unless one (1) of the following applies:

(1) The original claim was submitted fraudulently; or

(2) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmaceutical product.

SECTION 6. Tennessee Code Annotated, Section 56-7-3115, is amended by deleting the section and substituting:

(a) A pharmacy benefits manager shall allow participants and beneficiaries of the pharmacy benefits plans and programs that the pharmacy benefits manager serves to utilize any pharmacy within this state that is licensed to dispense the prescription pharmaceutical product that the participant or beneficiary seeks to fill, as long as the pharmacy is willing to accept the same terms and conditions that the pharmacy benefits manager has established for at least one (1) of the networks of pharmacies that the pharmacy benefits manager has established to serve patients within this state.

(b) A pharmacy benefits manager may establish a preferred network of pharmacies and a non-preferred network of pharmacies, but the pharmacy benefits manager shall not prohibit a pharmacy from participating in either type of network within this state as long as the pharmacy is licensed by this state and the federal government and willing to accept the same terms and conditions that the pharmacy benefits manager has established for other pharmacies participating within the network that the pharmacy wishes to join.

(c) A pharmacy benefits manager shall not charge a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefits manager serves a different copayment obligation or additional fee, or provide any inducement or financial incentive, for using any pharmacy within a given network of pharmacies established by the pharmacy benefits manager to serve patients within this state.

SECTION 7. Tennessee Code Annotated, Section 56-7-3202, is amended by deleting the section and substituting:

A violation of this part may subject the pharmacy benefits manager or covered entity to the sanctions described in § 56-2-305.

SECTION 8. Tennessee Code Annotated, Section 56-7-3206, is amended by deleting the section.

SECTION 9. This act takes effect thirty days after becoming law, the public welfare requiring it, and applies to:

(1) All pharmacy benefits plan and program payments made on or after July 1, 2021, but prior to the effective date of this act, by a pharmacy benefits manager for the period in which the pharmacy benefits manager did not have an approved actual reimbursement appeals process;

(2) All pharmacy benefits plan and program payments made on or after the effective date of this act; and

(3) All other pharmacy benefits plans and programs entered into, renewed, or otherwise modified after the effective date of this act.

House Insurance Subcommittee Am. #1

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Signature of Sponsor

AMEND Senate Bill No. 1310 House Bill No. 677*

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-3501. Part definitions.

As used in this part:

(1) "Health benefit plan" has the same meaning as defined in § 56-61-102;

(2) "Health carrier" has the same meaning as defined in § 56-61-102;

(3) "Healthcare provider" has the same meaning as defined in § 56-61-102;

(4) "Interchangeable biological product" means a biological product licensed by the federal food and drug administration and determined to meet the safety standards for determining interchangeability pursuant to 42 U.S.C. § 262(k)(4);

(5) "Pharmaceutical sample" means a unit of a prescription drug that is not intended to be sold;

(6) "Prescription drug" means a drug that under federal or state law is required to be dispensed only pursuant to a prescription order or is restricted to use by individuals authorized by law to prescribe drugs;

(7) "Required prescription drug" means a medication that is required as part of a step therapy protocol;

(8) "Step therapy exception" occurs when a step therapy protocol is overridden in favor of immediate coverage of the healthcare provider's selected prescription drug;

(9) "Step therapy protocol" means a protocol, policy, or program that establishes a specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by a health carrier or health benefit plan; and

(10) "Utilization review organization" means an entity that conducts utilization review, as defined in § 56-6-703, other than a health carrier or health benefit plan performing utilization review for its own health plans.

56-7-3502. Exception process.

(a) If a health carrier, health benefit plan, or utilization review organization denies coverage of a prescription drug for the treatment of a medical condition through the use of a step therapy protocol, then the health carrier, health benefit plan, or utilization review organization must provide access to a clear, readily accessible, and convenient process for a patient or prescribing practitioner to request a step therapy exception. The process must be easily accessible on the website of the health carrier, health benefit plan, or utilization review organization. A health carrier, health benefit plan, or utilization review organization may use its existing medical exceptions process to satisfy this subsection (a).

(b) A health carrier, health benefit plan, or utilization review organization shall grant a step therapy exception if:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by, or physical or mental harm to, the patient due to a documented adverse event with a previous use of the required prescription drug or a documented medical condition, including a comorbid condition;

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) The patient, while under the current or a previous health insurance or health benefit plan, has previously tried the required prescription drug or another drug with the same mechanism of action as the required drug and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(4) The required prescription drug is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to:

(A) Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(B) Worsen a comorbid condition of the patient; or

(C) Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or

(5) The patient is currently receiving a positive therapeutic outcome on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan, and the patient's healthcare provider gives documentation to the health insurance, health benefit plan, or utilization review organization that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(c) Upon granting a step therapy exception, the health carrier, health benefit plan, or utilization review organization shall authorize coverage for the prescription drug

prescribed by the patient's treating healthcare provider if the prescription drug is covered under the current health insurance, health benefit plan, or utilization review organization.

(d) The health carrier, health benefit plan, or utilization review organization shall grant or deny a step therapy exception request or an appeal within the turnaround times established pursuant to § 56-6-705 for an expedited appeal. If a response by a health carrier, health benefit plan, or utilization review organization is not received within that time period, then the exception is granted.

(e) A step therapy exception is eligible for appeal by an insured.

(f) This section does not prevent:

(1) A health carrier, health benefit plan, or utilization review organization from requiring a patient to try an AB-rated generic equivalent or interchangeable biological product prior to providing coverage for the equivalent branded prescription drug;

(2) A health carrier, health benefit plan, or utilization review organization from requiring a pharmacist to substitute a prescription drug consistent with the laws of this state; or

(3) A healthcare provider from prescribing a prescription drug that is determined to be medically appropriate.

(g) The use of pharmaceutical samples of a required prescription drug is not considered a trial of the required prescription drug as part of a step therapy protocol.

56-7-3503. Rulemaking.

The commissioner of commerce and insurance shall promulgate rules to effectuate this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-7-3504. Applicability.

(a) This part applies to a group health benefit plan or health insurance coverage offered in connection with a group health benefit plan that provides coverage for a

prescription drug pursuant to a policy that meets the definition of a step therapy protocol, regardless of whether the policy is described as a step therapy protocol, and includes a state or local insurance program, under title 8, chapter 27.

(b) This part does not apply to:

(1) The TennCare program provided for in title 71, chapter 5, or a successor program;

(2) The CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; or

(3) The Access Tennessee Act of 2006, compiled in chapter 7, part 29 of this title.

SECTION 2. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 3. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2023, the public welfare requiring it, and applies to agreements for health insurance or health benefit plans issued, delivered, entered into, amended, or renewed on or after that date.

House Insurance Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 1949 House Bill No. 1941*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 55-12-141, is amended by deleting subsection (d) and substituting:

(d) The following automobile insurance requirements apply while a transportation network company driver is engaged in a prearranged ride:

(1) Primary automobile liability insurance that provides at least one million dollars ($1,000,000) for death, bodily injury, and property damage;

(2) Uninsured and underinsured motorist insurance that provides at least one million dollars ($1,000,000) for death, bodily injury, and property damage;

(3) The automobile liability insurance required under this section must comply with § 56-7-1201; and

(4) The coverage requirements of this subsection (d) may be satisfied by any of the following:

(A) Automobile insurance maintained by the transportation network company driver;

(B) Automobile insurance maintained by the transportation network company; or

(C) Any combination of subdivisions (d)(4)(A) and (B).

SECTION 2. This act takes effect July 1, 2022, the public welfare requiring it, and applies to policies entered into, issued, amended, or renewed on or after that date.

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AMEND Senate Bill No. 2386* **House Bill No. 2855**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 56-7-2355(a)(1), is amended by deleting the subdivision and substituting:

(1) "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, regardless of the final diagnosis of the symptoms, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

(A) Placing the person's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of a bodily organ or part;

SECTION 2. Tennessee Code Annotated, Section 56-7-2355(b)(1), is amended by deleting the subdivision and substituting:

(1) A health benefit plan shall not deny coverage or payment for emergency services if the symptoms presented by an enrollee of a health benefit plan and recorded by the attending provider indicate that an emergency medical condition could exist, regardless of:

(A) The final diagnosis of the symptoms;

(B) Whether prior authorization was obtained to provide those services; and

(C) Whether the provider furnishing the services has a contractual agreement with the health benefit plan for the provision of the services to the enrollee.

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it, and applies to plans delivered, issued, entered into, renewed, or amended on or after that date.

House Insurance Subcommittee Am. #1

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Signature of Sponsor

AMEND Senate Bill No. 2771 House Bill No. 2544*

by deleting subsection (b) in SECTION 1 and substituting:

(b) A health benefit plan that provides coverage for imaging services for screening mammography must provide coverage to a patient for low-dose mammography according to the following guidelines:

(1) A baseline mammogram for a woman thirty-five (35) to forty (40) years of age;

(2) A yearly mammogram for a woman thirty-five (35) to forty (40) years of age if the woman is at high risk based upon personal family medical history, dense breast tissue, or additional factors that may increase the individual's risk of breast cancer; and

(3) A yearly mammogram for a woman forty (40) years of age or older based on the recommendation of the woman's physician licensed under title 63, chapters 6 or 9.