Amendment No. 1 to SB2008

Bailey
Signature of Sponsor

AMEND Senate Bill No. 2008* House Bill No. 2170

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 56-7-3201, is amended by adding the following new subdivisions:

( ) "Health insurance coverage" has the same meaning as defined in § 56-7-109;

( ) "Health insurance entity" has the same meaning as defined in § 56-7-109;

( ) "Healthcare service" means an item or service furnished to an individual for the purpose of preventing, diagnosing, alleviating, curing, or healing human illness, injury, or physical disability;

( ) "Third-party administrator" means a third-party administrator as defined in § 56-7-2902.

SECTION 2. Tennessee Code Annotated, Section 56-7-3205, is amended by deleting the section and substituting:

(a)

(1) When calculating an enrollee's contribution to an applicable cost sharing requirement, a health insurance entity shall include cost sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If, under federal law, application of this requirement would result in health savings account ineligibility under § 223 of the federal internal revenue code (26 U.S.C. § 223), this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has

satisfied the minimum deductible under § 223 of the federal internal revenue code (26 U.S.C. § 223), except for items or services that are preventive care pursuant to § 223(c)(2)(C) of the federal internal revenue code (26 U.S.C. § 223(c)(2)(C)), in which case the requirements of this subsection (a) apply regardless of whether such minimum deductible has been satisfied.

(2) Subdivision (a)(1):

(A) Applies to contracts for health insurance coverage entered into, amended, extended, or renewed on or after July 1, 2021; and

(B) Does not create any liability by an enrollee to a health insurance entity based on cost-sharing amounts paid on behalf of the enrollee by another person prior to the effective date of this act that were applied toward the enrollee's minimum deductible.

(b)

(1) Subsection (a) does not apply to a prescription drug for which there is a generic alternative or an interchangeable biological product, as defined in 42 U.S.C. § 262(i)(3), unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the health insurance entity's exceptions and appeals process, or as specified in § 53-10-204(a).

(2) Subdivision (b)(1):

(A) Applies to contracts for health insurance coverage entered into, amended, extended, or renewed on or after July 1, 2021; and

(B) Does not create any liability by an enrollee to a health insurance entity based on cost-sharing amounts paid on behalf of the enrollee by another person prior to the effective date of this act that were applied toward the enrollee's minimum deductible.

(c) The annual limitation on cost sharing provided for under 42 U.S.C. § 18022(c)(1) applies to all healthcare services covered under health insurance coverage offered or issued by a health insurance entity in this state.

(d) A health insurance entity, pharmacy benefits manager, or third-party administrator shall not directly or indirectly set, alter, implement, or condition the terms of health insurance coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug; or

(e) In implementing the requirements of this section, this state shall only regulate a health insurance entity, pharmacy benefits manager, or third-party administrator to the extent permissible under applicable law.

SECTION 3. Tennessee Code Annotated, Section 56-7-3207, is amended by deleting the section and substituting:

(a) A pharmacy benefits manager shall report to a health insurance entity and to a patient any benefit percentage that either are entitled to as a benefit of a covered person.

(b) Prior to entering into an agreement with a patient for the purpose of obtaining financial or product assistance from a patient assistance program administered by a pharmaceutical manufacturer, charitable organization, or governmental entity to assist in the payment or procurement of prescription drugs for a patient, a health insurance entity, pharmacy benefits manager, or third-party administrator shall disclose the following in writing to the patient:

(1) Any payment, commission, inducement, or any form of valuable consideration that the person or entity receives by procuring or obtaining discounted prescription drugs on behalf of the patient;

(2) That the patient may experience delays or disruptions if funds are unable to be received from a patient assistance program;

(3) That the prescription drugs may be obtained from a foreign source; and

(4) Whether any benefits offered by a health insurance entity are impacted from the receipt of the financial or product assistance.

SECTION 4. This act takes effect upon becoming a law, the public welfare requiring it, and, except as otherwise provided in subsections (a) and (b) of SECTION 2, this act applies only to contracts for health insurance coverage entered into, amended, extended, or renewed on or after January 1, 2025.