

HOUSE BILL 786

By Sexton C

AN ACT to amend Tennessee Code Annotated, Title 56,
Chapter 7, Part 31, relative to pharmacy benefits
managers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-3103(a)(3), is amended by deleting the subdivision and substituting the following:

(3) Any clerical or recordkeeping error identified during an audit, such as a typographical error, scrivener's error, omission, or computer error, is not prima facie evidence of fraud or intentional misrepresentation and must not be the basis of a recoupment unless the error results in an actual overpayment to the pharmacy or the wrong medication being dispensed to the patient. Notwithstanding any other law, no claim is subject to criminal penalties without proof of intent to commit fraud;

SECTION 2. Tennessee Code Annotated, Section 56-7-3103(a), is amended by adding the following as new subdivisions:

() A pharmacy has the right to submit amended claims within thirty (30) days of the discovery of a clerical or recordkeeping error if the prescription was dispensed according to the requirements of state and federal law;

() Any recoupment related to clerical or recordkeeping errors does not include the cost of the drug or dispensed product, except in cases of the following:

(A) Fraud or other intentional and willful misrepresentation;

(B) Dispensing in excess of the pharmacy benefits contract established

by the plan sponsor; or

(C) Prescriptions not filled in accordance with the prescriber's order.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following as new sections:

56-7-3115.

A covered entity or pharmacy benefits manager shall not, directly or indirectly, charge a pharmacist or a pharmacy a fee related to a claim:

- (1) That is not apparent at the time of claim processing;
- (2) That is not reported on the remittance advice of an adjudicated claim;

and

- (3) That is charged to the pharmacist after the initial claim has been adjudicated.

56-7-3116.

A covered entity or pharmacy benefits manager shall not include any term or condition in a contract with a pharmacy or pharmacist that requires a pharmacist to dispense a drug or other product to a patient.

56-7-3117.

A covered entity or pharmacy benefits manager shall not notify a person receiving benefits through the covered entity or pharmacy benefits manager that a pharmacy has been removed from the provider network of that covered entity or pharmacy benefits manager until notification of removal has been provided to the pharmacy.

56-7-3118.

A covered entity or pharmacy benefits manager shall disclose to a pharmacy or pharmacist in its network, at least thirty (30) days before the date that the change becomes effective, any material change to a contract provision that affects the terms of reimbursement, the process for verifying benefits and eligibility, the dispute resolution procedure, the procedure for verifying drugs included in the formulary, and the procedure for contract termination.

56-7-3119.

(a) The comptroller shall perform an annual audit of all pharmacy benefits managers providing services funded by this state. The comptroller's audit must address, at a minimum, the following:

(1) Wholesale acquisition costs of pharmaceuticals;

(2) Rebates obtained by the health insurance issuer or their contracted pharmacy benefits manager from pharmaceutical manufacturers;

(3) Any fees or payments made to the health insurance issuer or their contracted pharmacy benefits manager by this state;

(4) Payments to pharmacies, including any differential in payments to contracted pharmacies based on volume of prescriptions dispensed, ownership, or ownership interest by the pharmacy benefits manager; and

(5) Arrangements between pharmaceutical manufacturers and health insurance issuers or their contracted pharmacy benefits managers.

(b) By April 1 of each year, the comptroller shall provide a report containing the audit findings to the speaker of the house of representatives, the speaker of the senate, and the chairs of the senate commerce and labor committee, senate health and welfare committee, health committee of the house of representatives, and insurance committee of the house of representatives.

56-7-3120.

(a) Every contract between a covered entity or pharmacy benefits manager and a pharmacist or pharmacy must be mutually agreed upon and must outline the terms and conditions for the provision of pharmacy services.

(b) A covered entity or pharmacy benefits manager shall not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

(c) Removal of a pharmacy or a pharmacist from the network of a covered entity or pharmacy benefits manager does not release the covered entity or pharmacy benefits manager from the obligation to make any payment due to the pharmacy or pharmacist for services that have been properly rendered.

(d) A covered entity or pharmacy benefits manager shall not reimburse a pharmacy or pharmacist for a drug or dispensed product or service in an amount less than the covered entity or pharmacy benefits manager reimburses itself or an affiliate for providing the same drug or dispensed product or service.

(e) A covered entity or pharmacy benefits manager shall not designate a drug or dispensed product as a "specialty drug" based solely on the cost of the drug or dispensed product.

SECTION 4. This act shall take effect on July 1, 2019, the public welfare requiring it.