SENATE BILL 1249
By Reeves

HOUSE BILL 1530

By Hicks G

AN ACT to amend Tennessee Code Annotated, Title 4; Title 47, Chapter 18 and Title 56, relative to healthcare costs.

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Cost-sharing information" means the amount an enrollee is required to pay in order to receive a drug that is covered under an enrollee's health plan;

(2) "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or another benefit program providing payment, reimbursement, or indemnification for healthcare costs for the individual or the individual's eligible dependents;

(3) "Healthcare professional" means a person licensed, registered, certified, or permitted pursuant to title 63 and regulated under the authority of either the department of health or an agency, board, council, or committee attached to the department of health;

(4) "Healthcare provider" means:

(A) A healthcare professional; and

(B) A healthcare facility licensed under title 33 or 68; and

(5) "Health plan" means health insurance coverage as defined in § 56-7-109.

(b)

(1) A health plan or pharmacy benefits manager shall, upon request of an enrollee, enrollee's healthcare provider, or authorized representative of an enrollee, furnish the cost, benefit, and coverage data described in subsection (c) to the enrollee, enrollee's healthcare provider, or authorized representative of the enrollee and shall ensure that the data is:

(A) Accurate as of the most recent change to the data that was made prior to the date of request;

(B) Provided in real time; and

(C) Subject to subdivision (b)(2), provided in the format designated by the requesting party.

(2) The format of the request and data must use established industry content and transport standards published by:

(A) A standards development organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, ASC X12, and Health Level 7; or

(B) A relevant federal or state governing body, including the federal centers for medicare and medicaid services and the office of the national coordinator for health information technology.

(3) A facsimile, proprietary payor or patient portal, or other electronic form is not an acceptable electronic data request or delivery format under this section.

(c) A health plan or pharmacy benefits manager that receives a request for data that complies with subsection (b) shall provide the following data for each drug covered under the enrollee's health plan:

(1) The enrollee's eligibility information for the drug;

(2) A list of any clinically appropriate alternatives to drugs covered under the enrollee's health plan;

(3) Cost-sharing information for the drugs and the clinically appropriate alternatives, including a description of any variance in cost-sharing based on pharmacy, whether retail or mail order, or healthcare provider dispensing or administering the drug or alternatives; and

(4) Applicable utilization management requirements for the drugs or clinically appropriate alternatives, including prior authorization, step therapy, quantity limits, and site-of-service restrictions.

(d) A health plan or pharmacy benefits manager:

(1) Shall furnish the data set forth in subsection (c), regardless of whether the request is made using the drug's unique billing code, such as a national drug code number or Healthcare Common Procedure Coding System (HCPCS) code, or using a descriptive term, such as the drug's brand name or generic name; and

(2) Shall not deny or delay a request based on the method used to make the request as a means to avoid sharing the data set forth in subsection (c).

(e) A health plan or pharmacy benefits manager that furnishes data as provided in subsection (c) shall not:

(1) Restrict, prohibit, or otherwise hinder a healthcare provider from communicating or sharing:

(A) The data set forth in subsection (c);

(B) Additional information on lower-cost or clinically appropriate alternative drugs, whether or not the drugs are covered under the enrollee's plan; or

(C) Additional payment or cost-sharing information that may reduce the patient's out-of-pocket costs, such as cash price or patient assistance, and support programs sponsored by a manufacturer, foundation, or other entity;

(2) Except as may be required by law, interfere with, prevent, or materially discourage access to, exchange of, or the use of the data set forth in subsection (c), including:

(A) Charging fees;

(B) Failing to respond to a request at the time made when such a response is reasonably possible;

(C) Implementing technology in nonstandard ways; or

(D) Instituting enrollee consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using the data; or

(3) Penalize a healthcare provider for:

(A) Disclosing the information described in subdivision (e)(1) to an enrollee; or

(B) Prescribing, administering, or ordering a clinically appropriate or lower-cost alternative drug.

(f) A health plan or pharmacy benefits manager shall treat an enrollee's authorized representative in the same manner as the enrollee for purposes of this

section as long as the person has legal authority to act on behalf of the enrollee in making decisions related to health care.

SECTION 2. 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 July 1, 2021, the public welfare requiring it.