SENATE BILL 2008
By Reeves

HOUSE BILL 2170

By Williams

AN ACT to amend Tennessee Code Annotated, Title 4; Title 8; Title 10; Title 53; Title 56; Title 63; Title 68 and Title 71, relative to pharmacy benefits.

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

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

( ) "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;

( ) "Health plan" means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services;

( ) "Insurer" means an entity subject to the insurance laws and rules of insurance in this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services under a health plan in this state; and

( ) "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) When calculating an enrollee's contribution to an applicable cost sharing requirement, an insurer 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.

(b) Subsection (a) does not apply to a prescription drug for which there is a generic alternative, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in § 53-10-204(a).

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

(d) An insurer, pharmacy benefits manager, or third-party administrator shall not directly or indirectly set, alter, implement, or condition the terms of health plan 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.

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

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it, and applies only to health plans entered into, amended, extended, or renewed on or after January 1, 2025.