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SENATE BILL 1280

By Reeves

AN ACT to amend Tennessee Code Annotated, Title 4; Title 56 and Title 71, relative to 340B entities.

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) A health insurance issuer, managed health insurance issuer as defined in § 56-32-128(a), pharmacy benefits manager, or other third-party payer shall not:

(1) Reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than the rate paid for the same drug by national drug code number to pharmacies that are not 340B entities;

(2) Assess a fee, chargeback, or adjustment upon a 340B entity that is not equally assessed on non-340B entities; or

(3) Exclude 340B entities from its network of participating pharmacies based on criteria that is not applied to non-340B entities.

(b) With respect to a patient eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, a pharmacy benefits manager, or third party that makes payment for those drugs, shall not discriminate against a 340B entity in a manner that prevents or interferes with the patient's choice to receive those drugs from the 340B entity.

(c) Notwithstanding § 56-7-1005, this section does not apply to:

(1) The TennCare program administered under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, or any successor Medicaid program;

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

(3) The prescription drug program described in chapter 57 of this title, or any successor program.

(d) As used in this section:

(1) "340B entity" means a covered entity participating in the federal 340B drug discount program, as defined in section 340B of the "Public Health Service Act", 42 U.S.C. § 256b, including the entity's pharmacy or pharmacies, or any pharmacy or pharmacies under contract with the 340B covered entity to dispense drugs on behalf of the 340B covered entity; and

(2) "National drug code number" means the unique national drug code number that identifies a specific approved drug, its manufacturer, and its package presentation.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following as a new section:

(a) A pharmacy benefits manager shall permit a person covered under a group medical benefit contract, or a pharmacy benefit contract, that provides coverage for prescription drugs to obtain prescription drugs, including specialty drugs, from a physician's office, hospital outpatient infusion center providing and administering the prescription drug, or pharmacy.

(b) A pharmacy benefits manager shall not impose coverage or benefits limitations, or require a person covered under a group medical benefit contract, or a pharmacy benefit contract, that provides coverage for prescription drugs, including specialty drugs, to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or other penalty when obtaining prescription drugs,

including specialty drugs, from a physician's office, hospital outpatient infusion center providing and administering the prescription drug, or pharmacy.

(c) A pharmacy benefits manager shall not interfere with the patient's right to choose the patient's pharmacy or provider of choice, including inducement, steering, or offering financial or other incentives.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

(a) Notwithstanding a law to the contrary, a pharmacy benefits manager or a covered entity shall base the calculation of any coinsurance for a prescription drug or device on the allowed amount of the drug or device.

(b) Notwithstanding a law to the contrary, a pharmacy benefits manager shall not charge a covered entity an amount greater than the reimbursement paid by a pharmacy benefits manager to a contracted pharmacy for the prescription drug or device.

(c) As used in this section, "allowed amount" means the cost of a prescription drug or device after applying all pharmacy benefits manager or covered entity discounts.

SECTION 4. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

A pharmacy benefits manager has a fiduciary responsibility to report to the plan and the patient any benefit percentage that either are entitled to as a benefit as a covered person.

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 7, Part 32, is amended by adding the following as a new section:

(a) A covered entity 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 (b) to the enrollee, enrollee's healthcare provider, or authorized representative of the enrollee and shall ensure that the data is:

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

(2) Provided in real time; and

(3) Provided in the format designated by the requesting party.

(b) A covered entity that receives a request for data that complies with subsection (a) 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; 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.

(c) A covered entity that furnishes data as provided in subsection (b) shall not:

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

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

(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 (b), 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 (c)(1) to an enrollee; or

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

SECTION 6. This act takes effect July 1, 2021, the public welfare requiring it, and applies to contracts entered into, executed, issued, amended, delivered, or renewed on or after that date.