HOUSE BILL 1554
By Shepard

SENATE BILL 1991

By Overbey

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

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

SECTION 1. Tennessee Code Annotated, Section 56-7-3102, is amended by adding the following definitions, appropriately numbered:

( ) "Maximum allowable cost list" means a list of multi-source generic drugs, medical products or devices, or both medical products and devices, for which a maximum allowable cost has been established by a pharmacy benefits manager or covered entity.

( ) "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager or covered entity will reimburse a pharmacy for the cost of a multi-source generic drug or a medical product or device.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following new sections to that part:

56-7-3106.

(a) Before a pharmacy benefits manager or covered entity may place a drug on a maximum allowable cost list, the pharmacy benefits manager or covered entity must find:

(1) That there are at least three (3) generically equivalent versions of that drug which are available for purchase by all pharmacies in this state from national or regional wholesalers; and

(2) That the drug is not obsolete or temporarily unavailable or listed on a drug shortage list.

(b) If a drug which has been placed on a maximum allowable cost list no longer meets the requirements of subsection (a), that drug shall be removed from the maximum allowable cost list by the pharmacy benefits manager or covered entity within three (3) business days after the date that the pharmacy benefits manager or covered entity becomes aware that the drug no longer meets the requirements of subsection (a).

56-7-3107.

(a) A pharmacy benefits manager or covered entity shall provide to each pharmacy with which the pharmacy benefits manager or covered entity has a contract, at the time of contracting and thereafter as described in (b):

(1) The methodology and sources used to determine the maximum allowable costs for the multi-source generic drugs and medical products and devices on each maximum allowable cost list; and

(2) Every maximum allowable cost list used by that pharmacy benefits manager or covered entity for that contracted pharmacy.

(b) A pharmacy benefits manager or covered entity shall update each maximum allowable cost list on its website at the same time it updates the list for its own use, shall make the updated lists, including all changes in the cost of the multi-source generic drugs and medical products and devices, available to every pharmacy with which the pharmacy benefits manager or covered entity has a contract in a readily accessible, secure and usable web-based format, and shall immediately utilize the updated maximum allowable costs in calculating the payments made to the contracted pharmacies.

56-7-3108.

(a) A pharmacy benefits manager or covered entity shall not set the maximum allowable cost for any multi-source generic drug or medical product or device it places on a maximum allowable cost list in an amount which is below the amount found in the source used by the pharmacy benefits manager or covered entity to set the cost.

(b) A pharmacy benefits manager or covered entity shall not include the pharmacist's dispensing fee, or any other professional fee not related to the product, in calculating the maximum allowable cost for any multi-source generic drug or medical product or device.

56-7-3109.

(a) A pharmacy benefits manager or covered entity shall establish a clearly defined process through which a pharmacy may contest the listed maximum allowable cost for a particular drug or medical product or device.

(b) A pharmacy may base its appeal on one (1) or more of the following:

(1) The maximum allowable cost established for a particular drug or medical product or device is below the cost at which the pharmacy can obtain the drug or medical product or device; or

(2) The pharmacy benefits manager or covered entity has placed a drug on the list without properly determining that the requirements of § 56-7-3106 have been met; or

(3) The maximum allowable cost calculated for a particular drug or medical product or device was established in violation of § 56-7-3108.

(c) The pharmacy benefits manager or covered entity must make a final determination resolving the pharmacy's appeal within seven (7) calendar days of its receipt of the appeal.

(d) If the final determination is a denial of the pharmacy's appeal, the pharmacy benefits manager or covered entity must state the reason for the denial and provide the national drug code and a source of a generically equivalent drug that may be purchased by similarly situated pharmacies at a price which is equal to or less than the maximum allowable cost for that drug,

(e) If a pharmacy's appeal is determined by the pharmacy benefits manager or covered entity to be valid, the pharmacy benefits manager or covered entity shall adjust the maximum allowable cost of the drug or medical product or device for the appealing pharmacy and for all other similarly situated pharmacies in the network of that pharmacy benefits manager or covered entity. The adjustment shall be effective from the date the pharmacy's appeal was filed, and the pharmacy benefits manager or covered entity shall provide retroactive reimbursement to the appealing pharmacy and all other similarly situated pharmacies in the network in the next payment cycle.

(f) A pharmacy benefits manager or covered entity shall make available on its website information about the appeals process, including but not limited to a telephone number that a pharmacy may use to contact the person responsible for processing appeals.

(g) If the pharmacy benefits manager or covered entity denies a pharmacy's appeal, the pharmacy shall have the right to an external review of the issues raised in its appeal, by a person or entity independent of the pharmacy benefits manager or covered entity. Each pharmacy benefits manager or covered entity shall establish an external review process which is substantially equivalent to the external review process described in §§ 56-61-112 – 56-61-125.

56-7-3110. A violation of this part may subject the pharmacy benefits manager or covered entity to any of the sanctions described in § 56-2-305.

SECTION 3. This act shall take effect on July 1, 2014, and shall apply to all contracts entered into or renewed after that date, the public welfare requiring it.