STATE OF TENNESSEE
OFFICE OF THE ATTORNEY GENERAL

July 16, 2014

Opinion No. 14-71

Application of "Any Willing Pharmacy" Statute

QUESTIONS

1. Does Tenn. Code Ann. § 56-7-2359, the "any willing pharmacy statute," apply to Tennessee's Medicaid program, TennCare?

2. Does Tenn. Code Ann. § 56-7-2359 apply to state-run programs for children, such as CoverKids, the State Children's Health Insurance Program?

3. Does Tenn. Code Ann. § 56-7-2359, which applies to health-insurance issuers and managed-health-insurance issuers, apply to all insurance companies, health plans, and pharmacy benefit managers?

4. May insurers or their intermediaries impose standards or requirements beyond those imposed by Tennessee law in order for pharmacy-services providers to participate in their networks, such as a requirement that the provider maintain a license in every American state?

OPINIONS

1. No.

2. Tenn. Code Ann. § 56-7-2359 applies to CoverKids, the State Children's Health Insurance Program for uninsured children.

3. No.

4. The "terms and conditions" of a pharmacy-benefit policy, contract, or plan may specify the pharmacy's obligations to the insurer, the plan sponsor, and the plan members/enrollees and thus may include such items as rate and fee schedules, approved drug formularies, provisions regarding coinsurance, co-payments, deductibles, and quantity limits, so long as the insurer's provider lists are open to any licensed pharmacy or pharmacist on the same terms and conditions. Terms and conditions may not be used by insurers or their intermediaries to disqualify or exclude any willing pharmacy or pharmacist from participating in the network. The point at which an acceptable term and condition becomes an unacceptable qualification or exclusion would typically depend on the particular facts and circumstances

presented, but a requirement that pharmacy network participants be licensed in every American state would likely be prohibited under the statute.

ANALYSIS

1. Tenn. Code Ann. § 56-7-2359, the "any willing pharmacy act,"[1] generally requires health-insurance issuers and managed-health-insurance issuers to open their networks for participation by any licensed pharmacy or pharmacist on the same terms and conditions offered to any other provider of pharmacy services under their policies, contracts, or plans. But the statute does not apply to TennCare, Tennessee's Medicaid program; § 56-7-2359(c) expressly provides that "[n]othing contained in this section shall be construed or interpreted as applying to the TennCare programs administered pursuant to the waivers approved by the federal department of health and human services." Although this provision appears in subsection (c) of the statute, it nevertheless applies to "this section," i.e., all of § 56-7-2359, and not just to subsection (c). By contrast, the immediately preceding sentence of the statute sets forth the circumstances in which "[t]his subsection (c)" does not apply.[2]

2. CoverKids is the State Children's Health Insurance Program; it is a "program to provide health care coverage for uninsured children who are not eligible for health care services under any part of Tennessee's medicaid program, either pursuant to the medicaid state plan or pursuant to any medicaid waivers secured by the bureau of TennCare." Tenn. Code Ann. § 71-3-1103. In creating CoverKids, it was the intent of the legislature "to create and fund a program *separate from* the Tennessee medicaid program." *Id.* (emphasis added). Thus, Tenn. Code Ann. § 56-7-2359's express exemption for TennCare does not include CoverKids.

In Tenn. Att'y Gen. Op. 04-01 (Jan. 6, 2004), this Office opined that § 56-7-2359 did not apply to the State insurance committees that administer health plans for State and local employees, based in part on the fact that the plans were self-funded governmental plans. But in *Gray v. City of Memphis*, No. W2004-00976-COA-R3-CV, 2005 WL 652786 (Tenn. Ct. App. Mar. 22, 2005), the Tennessee Court of Appeals held that the legislature intended Title 56 to regulate the State and its political subdivisions unless otherwise provided and that the self-funded health-benefit plans issued by the City of Memphis were governed by § 56-7-2359. 2005 WL 652786, at *6, *7. In light of *Gray*, the answer to the question whether § 56-7-2359 applies to a State health-insurance program for children like CoverKids depends on whether the

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[1] *See Reeves-Sain Med., Inc. v. BlueCross BlueShield of Tenn.*, 40 S.W.3d. 503, 505 (Tenn. Ct. App. 2000).

[2] The same contrast in language appeared in the enacting legislation, 1998 Tenn. Pub. Acts, ch. 1033, § 9, which stated that "[t]he provisions of *this paragraph* shall not apply to any drug removed from a previously approved formulary" and that "[n]othing contained in *this section* shall be construed or interpreted as applying to the TennCare programs." (emphases added).

program is a health-insurance issuer or a managed-health-insurance issuer, as those terms are used in the statute.

The term "health insurance issuer" in Tenn. Code Ann. § 56-7-2359 is not defined by the statute.[3] But the meaning of "managed health insurance issuer" in Tenn. Code Ann. § 56-7-2359 is the same as in § 56-32-128(a). *See* Tenn. Code Ann. § 56-7-2359(d). Under § 56-32-128(a), a "'managed health insurance issuer' means an entity that: (1) Offers health insurance coverage or benefits under a contract that restricts reimbursement for covered services to a defined network of providers; and (2) Is regulated under this title or is an entity that accepts the financial risks associated with the provision of health care services by persons who do not own or control, or who are not employed by, the entity." CoverKids fits this definition. The program supplies coverage for prescription drugs obtained from network pharmacies and requires co-pays at differing levels based on family income. *See* Tenn. Comp. R. & Regs. 0620-05-01.-03; *id.* 0620-05-01-.06. And under the program, the State of Tennessee, with funding from the federal government, bears the financial risk associated with providing health-care services to persons not employed by the State, or the State contracts with other risk-bearing entities to provide such health care.[4] While CoverKids is a federally funded program, it has been approved as a state plan by the federal government as a condition for receipt of federal funds under Title XXI, and no federally authorized plan feature appears to exempt CoverKids from the law or necessarily entails a departure from the mandates of Tenn. Code Ann. § 56-7-2359.

3. Not all insurance companies, health plans, or pharmacy benefit managers are covered by § 56-7-2359, because drug benefits are furnished in a variety of contexts, some of which are not subject to insurance regulation at all or, if so subject, may be exempted from general health-insurance laws mandating benefits. Furthermore, as mentioned above, a federal statute could work to exclude a plan from the requirements of state law or to override the Tennessee mandate based on specific circumstances. Determining whether a particular insurer or plan is subject to the statute requires an examination of the particular facts and circumstances under a given contract, policy, or plan of drug coverage and is thus beyond the scope of this Opinion.[5]

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[3] In *Gray*, relying on other statutory definitions for the terms "insurer" and "health insurance coverage," the court held that Memphis was a health-insurance issuer; even though it was not an insurance *company*, it issued health-insurance coverage, including prescription-drug coverage, through a self-funded benefit plan to enrollees who paid a premium. 2005 WL 652786, at *6-7.

[4] Under Tenn. Code Ann. § 71-3-1108, the Department of Finance and Administration may contract directly with health-care providers to provide services to enrollees and may establish appropriate rates of payments for services, or the Department may contract with insurance companies, managed-care plans, or other entities to provide services to enrollees. Payments to such contracted entities may require the contractor to assume full or partial risk for the cost of services.

[5] For example, § 56-7-2359 does "not apply to health plans preempted from state regulation by the Employee Retirement Income Security Act of 1974 ("ERISA")." 2001 Tenn. Pub. Acts, ch. 236, § 9.

4. Tenn. Code Ann. § 56-7-2359(a) provides that "[n]o health insurance issuer and no managed health insurance issuer may . . . [d]eny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy, contract or plan." In other words, the statute "requires insurance companies to include all pharmacies on their lists of providers if the pharmacy agrees to the terms and conditions offered to others on the list." *Reeves-Sain Medic., Inc. v. BlueCross BlueShield of Tenn.*, 40 S.W3d. 503, 505 (Tenn. Ct. App. 2000).

An insurer may impose standard contract terms to specify the pharmacy's obligations to the insurer, the plan sponsor, and the plan members/enrollees. The "terms and conditions" of a policy, contract, or plan generally refers to an insurer's rate and fee schedules. *See id.* at 507 (legislative history of the bill giving rise to § 56-7-2359 indicates that pharmacists were included in the bill in order to provide "an option to participate in the networks if they choose to accept those prices"); *see also* Tenn. Code Ann. § 56-7-2359(a)(1) (making exception for when insurer may establish higher rates or fees). But the terms and conditions of a contract, policy, or plan may also include procedures for approving and revising drug formularies, as well as provisions regarding "coinsurance, co-payment, deductible and quantity limit factors." *Id.* § 56-7-2359(c), (e). *See also J.E. Pierce Apothecary, Inc. v. Harvard Pilgrim Health Care, Inc.*, 365 F. Supp. 2d 119, 130 (D. Mass. 2005) (referring to terms and conditions such as reimbursement-rate methodology, participation in utilization review and quality-assurance, online requirements for eligibility and claims determinations, and participation in surveys and complaint-resolution programs). Whatever the terms and conditions, though, the statute requires insurance companies "to open up their approved provider lists to any 'licensed' pharmacy or pharmacist providing 'pharmacy' or 'pharmaceutical' services *on the same* terms and conditions extended to all other licensed providers." *Reeves-Sain*, 40 S.W.3d at 506-07 (emphasis added).

But the "terms and conditions" imposed on pharmaceutical services by an insurer or its intermediary may not work to disqualify or exclude any willing pharmacy or pharmacist from participating in the network. While the point at which an acceptable term and condition becomes an unacceptable qualification or exclusion would typically depend on the particular facts and circumstances presented, a requirement that pharmacy network participants be licensed in every American state would likely be prohibited under the statute.

Applying this exception entails a complex, fact-based analysis of particular plans within a highly litigated framework of ERISA preemption.

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