

TO: All Pharmacy Benefits Managers and Affiliated Health Insurers

FROM: Julie Mix McPeak, Commissioner *Julie Mix McPeak*

RE: Violations of Tennessee Law by Pharmacy Benefits Managers

DATE: July 27, 2015

The Tennessee Department of Commerce and Insurance ("Department") has been notified that various Pharmacy Benefits Managers ("PBMs") may have engaged in numerous violations of Tennessee law governing PBMs since the laws' January 1, 2015 effective date. Tenn. Code Ann. § 56-7-3101 *et seq.* governs the operation of PBMs by the Department and requires PBMs to update the nationally recognized reference prices or amounts used for reimbursement no less than every three (3) days, provide the sources used to determine the maximum allowable costs at the beginning of each contract term, and utilize the updated costs to calculate payments to pharmacies within five (5) days. Specifically, Tenn. Code Ann. 56-7-3107 provides:

(a) A pharmacy benefits manager or covered entity shall make available to each pharmacy with which the pharmacy benefits manager or covered entity has a contract and to each pharmacy included in a network of pharmacies served by a pharmacy services administrative organization with which the pharmacy benefits manager or covered entity has a contract, at the beginning of the term of a contract and upon renewal of a contract:

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

....

(b) A pharmacy benefits manager or covered entity shall:

(1) Update each maximum allowable cost list at least every three (3) business days, as required by § 56-7-3104(b);

....

(3) Utilize the updated maximum allowable costs to calculate the payments made to the contracted pharmacies within five (5) business days [Emphasis added].

In addition, a PBM must provide an appeal process for a pharmacist to contest the PBMs' listed maximum allowable costs within seven (7) days of submission of its initial claim. A PBM has seven (7) days to make a final determination which must include, if denied, a reason for the denial and the national drug code of an equivalent drug available for that price. Specifically, Tenn. Code Ann. § 56-7-3108 provides:

....

(c) The pharmacy must file its appeal within seven (7) business days of its submission of the initial claim for reimbursement for the drug or medical product or device. ***The pharmacy benefits manager or covered entity must make a final determination resolving the pharmacy's appeal within seven (7) business days*** of the pharmacy benefits manager or covered entity's 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 of an equivalent drug that is generally available*** for purchase by pharmacies in this state from national or regional wholesalers at a price which is equal to or less than the maximum allowable cost for that drug [Emphasis added].

Any violations of this statute will be strictly enforced by the Department and penalties will be pursued under the authority of Tenn. Code Ann. § 56-2-305.

Any questions regarding the intent of this Memorandum should be directed to the Insurance Division's Consumer Insurance Services Section, 6th Floor, Davy Crockett Tower, 500 James Robertson Parkway, Nashville, Tennessee, 37243, and/or (615) 741-2218.