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BULLETIN 21-01

TO: All Pharmacy Benefits Managers

FROM: Carter Lawrence, Commissioner

RE: Department Guidance for Public Chapter 569

DATE: July 8th, 2021

The purpose of this bulletin is to provide guidance on the applicability of the recent changes to Pharmacy Benefits Manager ("PBM") laws found in Public Chapter ("Pub. Ch.") 569.

Specifically, this bulletin provides guidance with respect to the applicability of the changes to the PBM laws as they relate to ERISA plans, and where to file processes for PBM appeals for reimbursement as described in Pub. Ch. 569.

Per the language found throughout the PBM laws published in Pub. Ch. 569, the new requirements apply to "pharmacy benefits managers" and "covered entities." As defined in Title 56, Chapters 31 and 32, relating to Pharmacy Benefits Managers and Pharmacy Benefits, respectively, a "pharmacy benefits manager" means, per Tenn. Code Ann. § 56-7-3102(5):

> [A] person, business or other entity and any wholly or partially owned subsidiary of the entity, that administers the medication and/or device portion of pharmacy benefits coverage provided by a covered entity. "Pharmacy benefits manager" includes, but is not limited to, a health insurance issuer, managed health insurance issuer as defined in § 56-32-128(a), nonprofit hospital, medication service organization, insurer, health coverage plan, health maintenance organization licensed to practice pursuant to this title, a health program administered by the state or its political subdivisions, including the TennCare programs administered pursuant to the waivers approved by the United States department of health and human services, nonprofit insurance companies, prepaid plans, self-insured entities, and all other corporations, entities or persons acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity and includes, but is not limited to, a mail order pharmacy[.]

A "covered entity" means, per Tenn. Code Ann. § 56-7-3102(1):

> [A] health insurance issuer, managed health insurance issuer as defined in § 56-32-128(a), nonprofit hospital, medication service organization, insurer, health coverage plan, health maintenance organization licensed to practice pursuant to this title, a health program administered by the state or its political subdivisions, including the TennCare programs administered pursuant to the waivers approved by the United States department of health and human services, nonprofit insurance companies, prepaid plans, self-insured entities, and all other corporations, entities or persons, or an employer, labor union, or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state. "Covered entity" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, or other long-term care[.]

A review of the plain language of both definitions show that each includes "self-insured entities," which would include ERISA plans. No exclusions in the PBM laws are carved out to exclude plans currently regulated by ERISA. The Department interprets the new PBM laws according to the plain language provided and, therefore, believes it is the legislative intent for ERISA plans to be included in the requirements set forth in Pub. Ch. 569. The Department will enforce Pub. Ch. 569 accordingly.

Additionally, the new PBM laws as set forth in Pub. Ch. 569 allow for an appeal process regarding reimbursements. Appeals processes can be filed with the Department electronically at the following email address: PBM.Appeal@tn.gov.