

**Tennessee Pharmacists Association
Position Statement**

**SB774 Overbey
HB1110 Shepard**

Patient's Right to Prescription Transparency Act of 2009

Pharmacy, Pharmacists – As introduced, imposes a methodology and disclosure duties on health insurance entities and pharmacy benefit managers concerning calculation of out-of-pocket costs for prescription drugs. – Amends TCA Title 56.

Position: **The Tennessee Pharmacists Association respectfully urges the members of the General Assembly to SUPPORT passage of SB774 and HB1110.**

Intent: This legislation:

Prohibits a covered entity (for example, insurance company) or pharmacy benefits manager from preventing any pharmacy from disclosing to the patient or authorized representative of the patient the actual reimbursement received by the pharmacy for a particular prescription or covered service.

Requires when a patient's out-of-pocket cost (co-pay) for a prescription or covered service is percentage-based, the out-of-pocket cost must be calculated using the actual reimbursement amount received by the pharmacy for the prescription or covered service.

Specifies when a covered entity or pharmacy benefits manager provides information to a patient about the cost of a covered prescription or covered service, the information will include the actual reimbursement amount paid to the pharmacy.

Background: Tennessee currently has no laws, rules or regulations defining what a percentage based out-of-pocket cost for a prescription is based on. This has resulted in variability of the calculation of the out-of-pocket cost for prescriptions and confusion for patients trying to understand their percentage based co-pays.

This situation and patient confusion has been further complicated by the fact in some cases, for some prescription benefit plans, pharmacy providers have been prohibited from disclosing to a patient what the pharmacy actually received in reimbursement for the patient's prescription or covered service.

The Center for Medicare and Medicaid Services (CMS) determined in 2008 there were similar problems with Medicare beneficiaries and calculation of their percentage based prescription co-pays and calculation of true out of pocket expenses for the Medicare prescription benefits. As a result, CMS has adopted rules requiring the entities and PBMs involved in delivery of Medicare prescription drug plan services to comply with the same provisions as are proposed for all Tennesseans in this legislation. These new requirements for Medicare prescription plan services are effective on January 1, 2010.

Bill Specifics:

- The bill would create law in Tennessee that provides the same requirements regarding calculation of patient percentage-based out-of-pocket costs and disclosure of prescription costs for prescriptions that will exist in the Federal Medicare Prescription Benefit Program.
- This bill does not require a change any contract arrangements for covered entities or pharmacy benefit managers regarding overall drug costs or rebates or administrative arrangements.
- This bill does not require any covered entity or pharmacy benefit manager to disclose or make transparent any of its business arrangements except to disclose to its enrolled patients the price actually paid to the pharmacy for a prescription or other covered service for that particular patient.
- The effective date of this law will be January 1, 2010 to coincide with the effective date of the Medicare prescription benefit requirement.

Fiscal Impact:

- The Fiscal note is not available at this time..