State PBM Reform Inventory

Updated October 2026

Tennessee

Issue	Summary	Citation
Licensing/Registration	No person or entity shall administer the medication or device portion of pharmacy benefits coverage provided by a covered entity or otherwise act as a PBM in this state unless the person or entity has obtained licensure through the Department of Commerce and Insurance. A PBM's license shall be renewed biennially. An applicant shall pay a $100 fee for an initial application and $50 to renew a license.	Tenn. Code Ann. § 56-7-3113
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM shall allow patients, participants, and beneficiaries of the pharmacy benefits plans and programs that the PBM serves to utilize any pharmacy within this state that is licensed to dispense the prescription pharmaceutical product that the patient, participant, or beneficiary seeks to fill, as long as the pharmacy is willing to accept the same terms and conditions that the PBM has established for at least 1 of the networks of pharmacies that the PBM has established to serve patients, participants, and beneficiaries within this state. A PBM shall not charge a patient, participant, or beneficiary of a pharmacy benefits plan or program that the PBM serves a different copayment obligation or additional fee, or provide any inducement or financial incentive, for using any pharmacy within a given network of pharmacies established by the PBM to serve patients, participants, and beneficiaries within this state. **MAC Pricing:** Before a PBM or covered entity may place a drug on a MAC list, the PBM or covered entity must find that the drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler. The drug shall be removed from the MAC list by the PBM or covered entity within 5 business days after the date that the PBM or covered entity	Tenn. Code Ann. § 56-7-3121; Tenn. Code Ann. § 56-7-3106; Tenn. Code Ann. § 56-7-3107; Tenn. Code Ann. § 56-7-3108; Tenn. Code Ann. § 56-7-3206

	becomes aware that the drug no longer meets the requirements. A PBM or covered entity shall make available to each pharmacy with which the PBM or covered entity has a contract and to each pharmacy included in a network of pharmacies served by a PSAO with which the PBM or covered entity has a contract, at the beginning of the term of a contract and upon renewal of a contract: • The sources used to determine the MACs for the drugs and medical products and devices on each MAC list; • Every MAC for individual drugs used by that PBM or covered entity for patients served by that contracted pharmacy; and • Upon request, every MAC list used by that PBM or covered entity for patients served by that contracted pharmacy. A PBM or covered entity shall: • Update each MAC list at least every 3 business days; • Make the updated lists available to every pharmacy with which the PBM or covered entity has a contract and to every pharmacy included in a network of pharmacies served by a PSAO with which the PBM or covered entity has a contract, in a readily accessible, secure, and usable web-based format or other comparable format or process; and • Utilize the updated MACs to calculate the payments made to the contracted pharmacies within 5 business days. A PBM or covered entity shall establish a clearly defined process through which a pharmacy may contest the listed MAC for a particular drug or medical product or device. A PBM or covered entity shall make available on its secure web site information about the appeals process, including, but not limited to, a telephone number or process that a pharmacy may use to submit MAC appeals. • The pharmacy must file its appeal within 7 business days of its submission of the initial claim for reimbursement for the drug or medical product or device. The PBM or covered entity must make a final determination resolving the pharmacy's appeal within 7 business days of the PBM or covered entity's receipt of the appeal;	

	• If the final determination is a denial of the pharmacy's appeal, the PBM or covered entity must state the reason for the denial and provide the NDC 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 MAC for that drug; • If a pharmacy's appeal is determined to be valid by the PBM or covered entity, the PBM or covered entity shall adjust the MAC of the drug or medical product or device for the appealing pharmacy. The adjustment for the appealing pharmacy shall be effective from the date the pharmacy's appeal was filed, and the PBM or covered entity shall provide reimbursement to the appealing pharmacy and may require the appealing pharmacy to reverse and rebill the claim in question in order to receive the corrected reimbursement; • Once an appealing pharmacy's appeal is determined to be valid by the PBM or covered entity, the PBM or covered entity shall adjust the MAC of the drug or medical product or device to which the MAC applies for all similar pharmacies in the network as determined by the PBM within 3 business days for claims submitted in the next payment cycle. **Minimum Reimbursement:** A PBM shall not reimburse a contracted pharmacy for a prescription drug or device an amount that is less than the actual cost to that pharmacy for the prescription drug or device. A PBM shall establish a process for a pharmacy to appeal a reimbursement for failing to pay at least the actual cost to the pharmacy for the prescription drug or device. This requirement does not apply to a PBM when utilizing a reimbursement methodology that is identical to the methodology provided for in the state plan for medical assistance. A PBM shall pay a professional dispensing fee at a rate that is not less than the amount paid by the TennCare program to a pharmacy, if: • The pharmacy dispenses a prescription drug or device pursuant to an agreement with the PBM or a covered entity; and	

	• The pharmacy's annual prescription volume is at a level that, if the pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the pharmacy for the enhanced amount of professional dispensing fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual.	
Patient Cost-Sharing	**Copay Adjustment Programs:** When calculating an enrollee's contribution to an applicable cost- sharing requirement, an insurer shall include cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. This requirement does not apply to a prescription drug for which there is a generic alternative, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process	Tenn. Code Ann. § 56-7-3205
Vertical Integration	Beginning July 1, 2028, state law prohibits a PBM from directly or indirectly acquiring, holding, controlling, or otherwise possessing ownership of or a beneficial interest in a pharmacy license or a pharmacy license holder, including through contract. The prohibition applies regardless of the percentage of ownership interest. Compliance is made as a condition of the issuance, renewal, and validity of the pharmacy license. Exceptions are made for customary payer-pharmacy network contracts or minority ownership interests that do not convey managerial control or exclusive dispensing authority. Until September 1, 2028, the board is authorized to issue a limited-use pharmacy license solely for certain rare,	TN Code § 63-10-3 (2025)