# *Tennessee Strategies to*
# Curb Excess Costs in the System

## Premium Rate Review

States can limit excessive health insurance premium increases through rate review, in which regulators assess proposed hikes to ensure they reflect accurate data and reasonable cost projections. The Affordable Care Act (ACA) set federal standards for effective review, and states meeting these are recognized by the Centers for Medicare and Medicaid Services (CMS). States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. Strategies examined in this section include:

- Effective Rate Review Per CMS
- Authority to Modify or Reject Premium Rate Increases
- Affordability Criteria Included in Premium Rate Review

## Hospital Price Regulation

Some states have pursued hospital cost control through reference-based pricing or global budgets. Reference-based pricing sets payment at a fixed rate, typically a multiple of Medicare, while global budgets establish a prospective annual payment for defined services, shifting responsibility to providers and payers to manage costs within that limit. This section tracks states that utilize:

- Medicare Reference-Based Pricing
- Hospital Global Budgets

## Affordable Coverage

States can expand access to affordable coverage by offering state-funded premium subsidies for Marketplace plans or by operating subsidized health coverage such as a Public Option or Basic Health Plan. Public Options are state-administered insurance programs designed to increase competition and control costs through negotiated provider rates. These program designs vary across states, with differences in cost-containment strategies, network adequacy requirements, and reimbursement structures. Strategies examined in this section include:

- Whether the State has Implemented a Public Option
- Whether the Public Option Includes a Provider Participation Mandate
- If the state Operates a Basic Health Plan
- If the State Provides State-Based Premium Subsidies for Marketplace Coverage

## Prescription Drug Pricing

Rising prescription drug costs continue to strain households, employers, and state budgets, with specialty drugs driving a growing share of spending. Unlike most consumer goods, drug prices in the U.S. often increase year over year, even after launch, and lack of transparency across the supply chain enables sustained price escalation. Manufacturers and pharmacy benefit managers (PBMs) use rebates, coupons, and contracting practices that can obscure true costs and shift expenses to consumers.

States are adopting a range of strategies to improve transparency, promote generic utilization, and curb excessive pricing. These include regulating PBM practices such as spread pricing, restricting the use of manufacturer coupons, requiring rebate transparency, and establishing collaborative purchasing or rebate arrangements. This section examines whether states have implemented tools to lower drug prices, enhance accountability, and expand access to affordable medications through:

- Prescription Drug Pricing Consortiums
- Prohibitions on Drug Manufacturer Coupons for Specialty Drugs
- Prohibitions on Copay Accumulator Programs
- Biologic Substitution Laws to Increase Generic Utilization
    - Authorization Flexibilities
    - Notification Requirements
- Drug Carve Outs in Medicaid Managed Care
- FFS Policies to Promote Generic Utilization
    - Mandatory Generics
- Supplemental Rebate Programs or Arrangements
- Drug Rebate Transparency and Reporting Requirements
- Spread Pricing Restrictions
- Prohibitions on Retroactive Claims Reductions or “Clawbacks”
- Prohibitions on Cost-Disclosure and Gag Clause Restrictions

## Medicaid Costs

Medical Loss Ratio remittance ensures managed care organizations (MCOs) spend a minimum percentage of premium revenue on actual medical care and quality improvement rather than administrative costs or profit. If they fail to meet the threshold, excess funds are returned to the state. By enforcing MLR standards, states help guarantee that Medicaid beneficiaries receive value for the funds allocated to their care, improving transparency and trust in managed care systems. Returned funds can be reinvested into Medicaid programs, expanding coverage or enhancing benefits without increasing state budgets.

Site-neutral policies standardize reimbursement rates across care settings (e.g., hospital outpatient departments vs. physician offices), reducing incentives for providers to steer patients toward higher-cost settings. Aligning payments helps curb unnecessary spending and mitigates cost growth in Medicaid programs, which is critical for states managing tight budgets.

- States Utilize Medical Loss Ratio Remittance
- Medicaid Site Neutral Requirements

# Curb Excess Costs in the System

## Premium Rate Review

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Effective Rate Review per Centers for Medicare and Medicaid Services (CMS) | ⊗ Does not have an effective rate review process | |
| Authority to Modify or Reject Premium Rate Increases | ⊗ Does not have the authority to modify or reject premium rate increases | The federal government is responsible for reviewing rate filings in states without an effective rate review program. |
| Affordability Criteria Included in Premium Rate Review | ⊗ Does not incorporate affordability criteria into premium rate review | |

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program * No Source, or Limited Information Found

# Curb Excess Costs in the System

## Hospital Price Regulation

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Medicare Reference-Based Pricing | ⊗ State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing | |
| Hospital Global Budgets | ⊗ State has not implemented hospital global budgets | |

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

# Curb Excess Costs in the System

## Affordable Coverage

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Public Option | ⊗ State does not offer an active public option insurance plan | |
| Public Option Includes Provider Participation Mandate | ⊗ State does not does not offer a public option, with or without a participation mandate | |
| Basic Health Plan | ⊗ State does not operate a Basic Health Plan | |
| State-Based Premium Subsidies | ⊗ State does not offer supplementary state-funded premium subsidies | |

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program * No Source, or Limited Information Found

# Curb Excess Costs in the System

## Prescription Drug Pricing

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Biologic Substitution Laws: Prescriber Permission Requirements | State does not require express authorization for biologic substitution | |
| Biologic Substitution Laws: Prescriber Notification Requirements | Pharmacists are required to notify prescribers of biologic substitution | Pharmacists in Tennessee are required to notify the prescribing physician of a substitution within five business days. |
| Drug Purchasing Consortium | State does not participate in a drug purchasing consortium* | |
| Drug Coupon Prohibitions | State does not prohibit the use of drug manufacturer coupons* | |
| Medicaid Managed Care Organization (MCO) Carve Out | State Medicaid does not carve out any drug classes from their MCO benefits* | |
| Mandatory Generics in Medicaid Fee-for-Service (FFS) | Medicaid Fee-for-Service (FFS) programs and pharmacists are required to substitute a generic version of a drug | Tennessee has policies or tools to promote mandatory generics. |

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

# Curb Excess Costs in the System

## Prescription Drug Pricing

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Supplemental Rebate Programs | ● Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place | |
| Drug Rebate Transparency and Reporting Requirements | ⊗ Pharmacy benefit managers are not required to report rebate data to the state | |
| Spread Pricing Restrictions | ⊗ State does not prohibit pharmacy benefit managers from engaging in spread pricing* | |
| Pharmacy Benefit Manager Reimbursement and Clawbacks | ⊗ State does not prohibit PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”) | |
| Cost-Disclosure and Gag Clause Restrictions | ● State law prohibits gag clauses in pharmacy contracts | |
| Prohibits Copay Accumulator Programs | ● State prohibits copay accumulator programs | |

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program * No Source, or Limited Information Found

# Curb Excess Costs in the System

## Medicaid Costs

| Policy | Status as of June 2025 | Summary |
|---|---|---|
| Medical Loss Ratio Remittances (MLR) for Medicaid Managed Care Population | State requires MLR remittances for its Medicaid managed care population | |
| Medicaid Site Neutral Payments | State has not enacted Medicaid site neutral payment legislation* | |

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

November 2025

healthcarevaluehub.org

With support from Arnold Ventures, the Healthcare Value Hub provides free, timely information about the policies and practices that address high health care costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all by applying research-based and field-tested solutions that transform our systems of health and health care.