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HOUSE OF REPRESENTATIVES

HB 2799: Copay Transparency

The Problem: Prescription drugs, and especially specialty prescription drugs, can pose a significant cost to Oregon's working families. Between high deductibles, premiums, and coinsurance costs, patients living with cancer, hemophilia, leukemia, lymphoma, multiple sclerosis, HIV/AIDS, and other health conditions that necessitate expensive drug regimens struggle to meet the rising costs of the care they rely on to live a healthy, dignified life. Even as consumers budget for their health care costs, they also face difficulties associated with drug formulary changes that can increase the cost of their prescriptions, or completely remove them from their benefit plan midyear—often adding new challenges to maintaining their health at an affordable cost. Consumers in Oregon need increased transparency in their out of pocket health care costs to help plan and budget, and more information about changes to drug formularies.

The Solution: HB 2799 requires carriers to offer, in at least 25% of their benefit plans, flat dollar copayments for prescription drug coverage. In addition, it requires carriers to report annually to the Department of Consumer and Business Services (DCBS) specified information about changes to the formulary, cost sharing, and utilization controls for prescription drugs.

Plan Choice:

- Each carrier shall ensure that at least 25% of individual, small, and group plans shall apply a flat dollar copayment structure to the entire drug benefit, including all tiers.
    - These plans are prohibited from including a deductible or other cost-sharing requirement.
- Requires the flat dollar copayment structure for prescription drugs be reasonably graduated and proportionately related in all tier levels.

*Exceptions: Catastrophic plans or high deductible health plan with a corresponding qualified health savings account that covers the essential health benefits.

Reporting Requirement:

Carriers that offer individual, small, and group plans must report the following information annually to DCBS:

- The number of times the carrier removed a prescription drug from the drug formulary in the prior 12month period, other than in response to an alert issued by the United States Food and Drug Administration., and why each drug was removed from the formulary;
- The number of times the carrier increased the deductible, copayment, coinsurance, or other cost sharing applicable to a prescription drug in the prior 12-month period, except when an A-rated generic for the drug was added to the formulary before the increase became effective, and why the cost-sharing was increased; and
- The number of times the carrier imposed new utilization controls on a prescription drug in the prior 12month period, including but not limited to prior authorization or step therapy, and why the new utilization control was imposed on each drug.

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