What does SB 872 do? (-1 amendment changes in blue)

Section 1 (pg 2, line 10): DISCLOSURE OF TOTAL SPENDING ON PATIENT ASSISTANCE PROGRAMS

1. Disclosure of total and average spending on patient assistance programs from manufacturers.
2. Any financial assistance provided to pharmacies, government agencies, and patient groups (other than rebates or discounts) for the purchase of pharmaceuticals reported separately.
3. Exempts information that is proprietary or considered a trade secret.

-1 amendment will:

- *Clarify that for any annual reporting, the timeline shall be for **the preceding 12 months**, not the most recent full calendar year.*
- *Clarify language regarding information that is "proprietary" or considered a "trade secret" in accordance with feedback from Dept of Justice, Dept of Consumer and Business Services, and relevant supply chain entities.*

Sections 2 - 6 (pg 5, line 27): FEE-ONLY PHARMACY BENEFIT MANAGERS FOR STATE-SPONSORED PROGRAMS

1. Requires state-sponsored health plans (e.g., Public Employees' Benefit Board/Oregon Educators Benefit Board, CCOs) to evaluate fee-only contracts with PBM vendors.

-1 amendment will:

- *Clarify that "evaluate" means: "...including but not limited to evaluating contracting with a pharmacy benefit manager or third party administrator on a fee-only basis.*
- *Require PEBB, OEBB, and the CCOs to report back to the legislature on this evaluation process and the results no later than May of 2020. Each individual CCO shall report to OHA and OHA shall report to the legislature on their behalf.*

2. Requires the pharmacy benefit manager or third party administrator to ~~evaluate~~ pass through any rebates, incentives or discounts offered by pharmaceutical manufacturers.

-1 amendment will:

- *Clarify that all PBMs are required to pass through any rebate, incentive or discount offered by manufacturers.*

Sections 7 - 9 (pg 15, line 16): PUBLISHING INFORMATION REGARDING INSURERS' FORMULARIES; NOTICE TO INSUREDS REGARDING CHANGES TO FORMULARIES

1. Requires commercial insurers (small, group, and individual plans) to provide notice to insurance enrollees about a change in formulary, utilization management rules, or formulary tier placement with increased transparency on availability of brand and generic drugs, grievance and appeals processes, rates, and appeal denials.
2. Information is to include the following:
    - Alphabetical list of drugs by brand name and generics should include:
        - Whether a generic alternative is available, whether step therapy or prior authorization requires generic substitution for the product;
        - If there are quantity limits, prior authorization or step therapy required for the drug;
        - Index of formulary tier levels, definitions, and associated fee structure for each level of a formulary tier; and
        - Member's cost share amounts pursuant to their health plan benefits that include information on when enrollees will be charged the lesser of pharmacy usual and customary price (cash price) pursuant to their health plan.
    - Additional required information insurers are to provide enrollees:
        - 60-day notice to each enrollee who will be affected by a negative change in the formulary - new utilization management rules, new or modified tier placement, or coverage only of a forthcoming generic.
        - Grievance and appeals requirements and processes.

-1 amendment currently will not make any changes to this section.

Sections 10 - 11 (pg 25, line 40): DISCLOSURE OF LESSER OF CASH PRICE OR COST-SHARE AND PROHIBITION ON GAG CLAUSES

1. Declares that consumers have the right to be educated by a pharmacist or pharmacy about all available means to reduce the cost of a prescribed drug, including but not limited to:
    a. Receiving information about the cost and efficacy of any less expensive drug;
    b. Being informed that the consumer may pay the cash price for a prescription drug if the cash price is less than the consumer's out-of-pocket costs for the drug under the consumer's insurance plan; and
    c. Being informed that if the consumer pays the cash for the drug, the price paid must be applied toward the consumer's deductible or out-of-pocket maximum.

-1 amendment will:

- *Require that the "Board of Pharmacy shall establish by rule language for mandatory postings in all pharmacies informing consumers of these rights."*

2. Prohibits PBMs from interfering with this right by issuing penalties or other consequences.
3. Requires any price paid for a drug, regardless of whether the drug was accessed through a PBM or health benefit plan or not, be applied consumer's deductible or out-of-pocket maximum.

-1 amendment will:

- *Clarify that in the event a consumer pays cash for a drug rather than through their health plan, they shall be responsible for pursuing that the cost be applied towards their deductible or out-of-pocket maximum.*

Sections 12 - 14 (pg 26, line 28): DISCLOSURE OF HOSPITAL AND MEDICAL PROVIDER MARK-UPS FOR PRESCRIPTION DRUGS

1. Requires hospitals and medical providers to disclose markups on an itemized bill to patients that shall include:
    a. The patient's charge for the prescription drug;
    b. The price paid for the drug by the medical provider;
    c. Each fee charged for the preparation, dispensing or administration of the drug; and
    d. The charge for the drug the medical provider bills to OHA, PEBB or OEBB for state-sponsored plans
2. Requires that this information also be reported to OHA for display on health care costs on the agency's website.

-1 amendment currently will not make any changes to this section.

Sections 15 - 16 (pg 29, line 24): STATE AGENCY COST REPORTING FOR PRESCRIPTION DRUGS

1. Requires an annual report from state agencies (OHA, PEBB, OEBB, DOC, OYA) on the top ten most prescribed, top ten highest cost paid, and top ten highest increased cost over the prior year of state-purchased prescription drugs.
2. Requires OHA to identify any prescription drug under the Medicaid program for which the annual wholesale cost or the per-course cost of treatment of the drug is at least $10,000.
3. Directs OHA to notify the manufacturer that the manufacturer is required to prepare a report on the drug's cost to the Pharmacy and Therapeutics Committee.

-1 amendment currently will not make any changes to this section.

Section 17 - 18 (pg 31, line 17): DISCLOSURE OF FUNDING OF PATIENT ADVOCACY ORGANIZATIONS BY PHARMACEUTICAL SUPPLY CHAIN

1. Requires that "patient advocacy programs" that receive more than 10% of funding from entities in the pharmaceutical supply chain report annually on this giving to the Government Ethics Commission ~~and the Oregon Health Authority~~.
2. Defines "patient advocacy program" as a 501(c)~~(3)~~ that:
    - Has a registered lobbyist
    - Has an annual budget of more than ~~$50,000~~ TBD

-1 amendment will:

- *Add that: "Any reports filed under this Section shall also be provided to the Attorney General upon request."*
- *Expand the definition of Patient Advocacy Group to capture more organizations.*

Sections 19 - 21 (pg 32, line 13): DISCLOSURE OF REBATES, FEES AND REIMBURSEMENTS BY PHARMACY BENEFIT MANAGERS

1. Requires that PBMs report to DCBS information on prescription drugs that:
    a. Have a Wholesale Acquisition Cost of $100 or more per month/course of treatment; or
    b. For which the average insurer rebate is 25% or more than the average pharmacy reimbursement
2. For each applicable drug, the report shall include:
    a. Average manufacturer rebate received
    b. Average manufacturer fee received
    c. Average product reimbursement made to pharmacies
    d. Product reimbursement received from insurers/clients
3. Requires that every three months during the plan year, PBMs disclose to their health plans sponsors:
    a. The aggregate amount of manufacturer rebates;
    b. Fees, including any differences in what is paid to pharmacies and what is reported to health plans; and
    c. Other payments, gifts, or incentives received on behalf of the plan's enrollees, and the percentage of those funds retained by the PBM

-1 amendment currently will not make any changes to this section.

Section 22 (pg 33, line 12): DISCLOSURE OF PRICES IN DRUG ADVERTISEMENT

1. Requires pharmaceutical manufacturers to "clearly and conspicuously" include the WAC cost of the drug in any direct-to-consumer advertising in the State of Oregon.

-1 amendment will:

- *Add a disclaimer in any DTC advertising that any one consumer may pay less than this amount.*
- *Add that violations shall be subject to civil penalty (the penalty will mirror existing compliance language from a similar statute).*

Sections 23 - 26 (pg 33, line 24): OPERATIVE DATES AND APPLICABILITY DATES

1. Includes the following operative dates:
    a. Health plans/commercial insurers: Jan 1st, 2021
    b. PBMs: Jan 1st, 2020
    c. Hospitals/medical providers: July 1st, 2022
    d. Manufacturers (for advertising): Jan 1st, 2020

-1 amendment currently will not make any changes to this section.

ADDITIONAL EDITS TO BE ADDED IN THE -1 AMENDMENT

1. *For all relevant sections: Update language regarding information that is defined as "proprietary" or considered a "trade secret" in accordance with feedback from Dept of Justice, Dept of Consumer and Business Services, and relevant supply chain entities*
2. *Include a new section of reporting requirements for manufacturers:*
    a. *Manufacturers are required to disclose the total aggregate amount of financial incentives paid to each PBM serving the covered lives of health plans offered by carriers in Oregon. Disclosure should include financial incentives paid to PBMs related to market share including any remuneration for preferred or exclusive status on formularies.*
3. *Include two new sections of reporting requirements for commercial insurers:*
    a. *Commercial health insurers are required to certify through their annual filing documents the percentage of rebates that were applied to directly offset consumers' premiums, out-of-pocket costs, and/or directly benefit the consumer. Commercial health insurers are required to report where any percentage of rebates, not applied to minimize consumers' premiums, were spent.*
    b. *Commercial insurers are required to report the following information: Average price paid per prescription minus prescription dispensing fee; Average product reimbursement; Impact of rebates on premium expressed as a percentage.*
4. *Extend the Fair Pricing of Prescription Drugs Task Force and expand the mission to include:*
    a. *The ongoing evaluation of implementation and results of this year's bill (SB 872/HB 3093) and any Oregon statute looking to improve transparency in prescription drugs; review legislation passed in other states on applicability in Oregon; and evaluate strategies for reducing cost of drugs. Report due to the Legislature by September 1, 2020. Extend the sunset of the Taskforce to December 31st of 2021.*