

A-Engrossed Senate Bill 872

Ordered by the Senate June 21
Including Senate Amendments dated June 21

Sponsored by Senators STEINER HAYWARD, LINTHICUM, Representatives NOBLE, ALONSO LEON; Senators BENTZ, BEYER, BURDICK, COURTNEY, DEMBROW, FAGAN, FREDERICK, GELSER, GOLDEN, HANSELL, HASS, HEARD, JOHNSON, MANNING JR, MONNES ANDERSON, PROZANSKI, RILEY, ROBLAN, WAGNER, WINTERS, Representatives BYNUM, CLEM, FINDLEY, HELM, KENY-GUYER, MARSH, MEEK, NOSSE, RESCHKE, SALINAS, SMITH G, SOLLMAN, WILDE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires pharmaceutical manufacturers to report to Department of Consumer and Business Services total *[cost of]* **amount of money spent on** patient assistance programs, *[and]* information on financial assistance provided to pharmacies, government agencies and advocacy organizations **and total amount of financial incentives paid to each pharmacy benefit manager.** *[Excludes proprietary information from disclosure on department's website.] Exempts from public disclosure information reported to department until department posts to website all information reported by manufacturer.*

Requires state-sponsored programs that use pharmacy benefit managers to use fee-only pharmacy benefit managers.

Requires insurers to post specified information regarding formulary, tiers and costs **for small employer and individual health benefit plans** to insurer's website. Requires 60-day advance notice to **department and to enrollees** adversely affected by change in formulary.

Requires insurer and allows pharmacy to notify insured that if *[cash]* **retail** price for drug is less than insured's *[cost-share]* **out-of-pocket cost** for drug **using pharmacy benefit**, insured may pay *[cash]* **retail** price and *[expense must be counted]* **if requested by enrollee, insurer must count cost** toward deductible or out-of-pocket maximum. **Requires State Board of Pharmacy to prescribe by rule notice of enrollee's rights for distribution to pharmacy customers and to translate notice into multiple languages.**

Requires hospitals and other medical providers to *[disclose in patient billing information regarding mark-up on price of drug. Also requires billing to disclose price of drug charged to specified state agencies and insurers]* **report to Oregon Health Authority information regarding 50 most prescribed drugs and 50 most expensive drugs prescribed by provider.**

Requires specified state agencies to report to Legislative Assembly on high-cost drugs. Requires Oregon Health Authority to refer to Pharmacy and Therapeutics Committee any drug exceeding specified cost.

Requires patient advocacy organization with *[budget]* **annual gross receipts** exceeding \$50,000 that has registered lobbyist in this state to report to Oregon Government Ethics Commission *[and Oregon Health Authority]* specified information regarding funding received from participants in pharmaceutical supply chain.

Requires pharmacy benefit managers to report to Department of Consumer and Business Services and plan sponsors specified information regarding rebates, reimbursements, fees and incentives paid for drugs by manufacturers, insurers and pharmacies. **Requires insurers to include with rate filing certified statement regarding insurers' use of rebates.**

[Requires drug advertisement to disclose wholesale price of drug.]

Modifies responsibilities of Task Force on Fair Pricing of Prescription Drugs and requires report of findings, by September 15, 2020, to interim committees of Legislative Assembly related to health.

Modifies reporting to department by insurers about costly drugs reimbursed by health benefit plans.

Requires pharmaceutical manufacturers that register with State Board of Pharmacy to also register with department. Requires department to adopt registration fee based on reasonable cost to department to administer specified provisions.

1

A BILL FOR AN ACT

2 Relating to the cost of prescription drugs; creating new provisions; and amending ORS 243.135,

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 414.312, 414.361, 414.625, 442.466, 735.533, 743.018, 743.020, 743B.013, 743B.105 and 743B.125 and
2 sections 2, 3, 5, 11 and 12, chapter 7, Oregon Laws 2018.

3 Whereas the state has a substantial public interest in the price and cost of prescription drugs;
4 and

5 Whereas the state is a major purchaser of prescription drugs through the Public Employees'
6 Benefit Board, the Oregon Health Authority, the Department of Human Services, the Department
7 of Corrections and the Oregon Youth Authority; and

8 Whereas the state also provides major tax expenditures for health care through the tax exclu-
9 sion of employer-sponsored health insurance coverage and the deductibility of the excess medical
10 costs of individuals and families; and

11 Whereas the Legislative Assembly charged the Task Force on the Fair Pricing of Prescription
12 Drugs, consisting of representatives of pharmaceutical manufacturers, insurers, pharmacy benefit
13 managers, prescription drug wholesalers, consumers, independent pharmacies, large retail pharmacy
14 chains, hospitals, biopharmaceutical companies, coordinated care organizations and medical provid-
15 ers, with developing a strategy to create transparency for drug prices across the entire supply chain
16 of pharmaceutical products; and

17 Whereas the task force provided a final report containing 14 recommendations; and

18 Whereas the Legislative Assembly, by this 2019 Act, intends to implement some of the recom-
19 mendations of the task force in order help reduce the cost of prescription drugs for residents and
20 businesses in this state while preserving the exemption of trade secrets from disclosure under
21 Oregon laws requiring the disclosure of public records and reports; now, therefore,

22 **Be It Enacted by the People of the State of Oregon:**

23
24 **DISCLOSURE OF TOTAL SPENDING ON PATIENT ASSISTANCE PROGRAMS**

25
26 **SECTION 1.** Section 2, chapter 7, Oregon Laws 2018, as amended by sections 6 and 7, chapter
27 7, Oregon Laws 2018, is amended to read:

28 **Sec. 2.** (1) As used in this section:

29 (a) "Drug" has the meaning given that term in ORS 689.005.

30 (b) "Health care facility" has the meaning given that term in ORS 442.015.

31 (c) "Health care service contractor" has the meaning given that term in ORS 750.005.

32 (d)(A) "Manufacture" means:

33 (i) The production, preparation, propagation, compounding, conversion or processing of a drug,
34 either directly or indirectly by extraction from substances of natural origin or independently by
35 means of chemical synthesis, or by a combination of extraction and chemical synthesis; and

36 (ii) The packaging or repackaging of a drug or labeling or relabeling of a drug container.

37 (B) "Manufacture" does not include the preparation or compounding of a drug by an individual
38 for the individual's own use or the preparation, compounding, packaging or labeling of a drug:

39 (i) By a health care practitioner incidental to administering or dispensing a drug in the course
40 of professional practice;

41 (ii) By a health care practitioner or at the practitioner's authorization and supervision for the
42 purpose of or incidental to research, teaching or chemical analysis activities and not for sale;

43 (iii) By a health care service contractor for dispensing to a subscriber or delivery to a health
44 care facility or outpatient clinic owned or operated by the health care service contractor or an af-
45 filiate of the health care service contractor;

1 (iv) By a centralized repackaging operation for distribution to subscribers of health care service
2 contractors or to pharmacies, health care facilities or outpatient clinics operated by or affiliated
3 with a health care service contractor; or

4 (v) By a health care facility for dispensing to a patient or other person.

5 (e) "Manufacturer" means a person that manufactures a prescription drug that is sold in this
6 state.

7 (f) "New prescription drug" has the meaning prescribed by the Department of Consumer and
8 Business Services by rule.

9 (g) "Patient assistance program" means a program that a manufacturer offers to the general
10 public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs
11 by using coupons or discount cards, receiving copayment assistance or by other means.

12 (h) "Prescription drug" means a drug that must:

13 (A) Under federal law, be labeled "Caution: Federal law prohibits dispensing without pre-
14 scription" prior to being dispensed or delivered; or

15 (B) Under any applicable federal or state law or regulation, be dispensed only by prescription
16 or restricted to use only by health care practitioners.

17 (i) "Price" means the wholesale acquisition cost as defined in 42 U.S.C. 1395w-3a(c)(6)(B).

18 (j) **"Rebate" means a retroactive abatement, credit, discount or refund usually provided
19 as consideration for a specified volume of business.**

20 (2) No later than March 15 of each year, a manufacturer shall report the information described
21 in subsection (3) of this section to the department regarding each prescription drug for which:

22 (a) The price was \$100 or more for a one-month supply or for a course of treatment lasting less
23 than one month; and

24 (b)(A) There was a [*net*] **cumulative** increase of 10 percent or more in the price of the pre-
25 scription drug [*described in paragraph (a) of this subsection*] over the course of the previous calendar
26 year; **or**

27 **(B) During the previous calendar year, one or more increases in the price of the drug
28 resulted in the price being at least 10 percent higher than the price of the drug at any other
29 time during the calendar year.**

30 (3) For each prescription drug described in subsection (2) of this section, a manufacturer shall
31 report to the department, in the form and manner prescribed by the department:

32 (a) The name and price of the prescription drug and the [*net*] **cumulative** increase, expressed
33 as a percentage, in the price of the drug over the course of the previous calendar year;

34 (b) The length of time the prescription drug has been on the market;

35 (c) The factors that contributed to the price increase;

36 (d) The name of any generic version of the prescription drug available on the market;

37 (e) The research and development costs associated with the prescription drug that were paid
38 using public funds;

39 (f) The direct costs incurred by the manufacturer:

40 (A) To manufacture the prescription drug;

41 (B) To market the prescription drug;

42 (C) To distribute the prescription drug; and

43 (D) For ongoing safety and effectiveness research associated with the prescription drug;

44 (g) The total sales revenue for the prescription drug during the previous calendar year;

45 (h) The manufacturer's profit attributable to the prescription drug during the previous calendar

1 year;

2 (i) The introductory price of the prescription drug when it was approved for marketing by the
3 United States Food and Drug Administration and the net yearly increase, by calendar year, in the
4 price of the prescription drug during the previous five years;

5 (j) The 10 highest prices paid for the prescription drug during the previous calendar year in any
6 country other than the United States;

7 (k) Any other information that the manufacturer deems relevant to the price increase described
8 in subsection (2)(b) of this section; and

9 (L) The documentation necessary to support the information reported under this subsection.

10 (4) The department may use any prescription drug price information the department deems ap-
11 propriate to verify that manufacturers have properly reported price increases as required by sub-
12 sections (2) and (3) of this section.

13 (5) A manufacturer shall accompany the *[report]* **reports** provided under *[subsection (2)]* **sub-**
14 **sections (2) and (6)** of this section with:

15 (a) The following information about each patient assistance program offered by the manufac-
16 turer to consumers residing in this state for the prescription drugs described in subsection (2) of this
17 section:

18 [(a)] (A) The number of consumers who participated in the program;

19 [(b)] (B) The total value of the coupons, discounts, copayment assistance or other reduction in
20 costs provided to consumers in this state who participated in the program;

21 (C) **The total amount of money spent on the program by the manufacturer;**

22 [(c)] (D) For each drug, the number of refills that qualify for the program, if applicable;

23 [(d)] (E) If the program expires after a specified period of time, the period of time that the
24 program is available to each consumer; and

25 [(e)] (F) The eligibility criteria for the program and how eligibility is verified for accuracy[.];

26 (b) **Information, as prescribed by the department by rule, regarding any financial assist-**
27 **ance, other than rebates, incentives and discounts, provided by the manufacturer to phar-**
28 **macies, government agencies or patient advocacy organizations; and**

29 (c) **The total amount of financial incentives, as defined by the department by rule, paid**
30 **to each pharmacy benefit manager, as defined in ORS 735.530, that administers a pharmacy**
31 **benefit for residents of this state. The report shall include but is not limited to financial in-**
32 **centives based on:**

33 (A) **The percentage of enrollees whose benefits are administered by the pharmacy benefit**
34 **manager who are prescribed the manufacturer's drugs; and**

35 (B) **The extent to which a manufacturer's drugs have a preferred or exclusive status on**
36 **the prescription drug formulary administered by the pharmacy benefit manager.**

37 (6) No later than 30 days after a manufacturer introduces a new prescription drug for sale in
38 the United States at a price that exceeds the threshold established by the Centers for Medicare and
39 Medicaid Services for specialty drugs in the Medicare Part D program, the manufacturer shall notify
40 the department, in the form and manner prescribed by the department, of all the following informa-
41 tion:

42 (a) A description of the marketing used in the introduction of the new prescription drug;

43 (b) The methodology used to establish the price of the new prescription drug;

44 (c) Whether the United States Food and Drug Administration granted the new prescription drug
45 a breakthrough therapy designation or a priority review;

1 (d) If the new prescription drug was not developed by the manufacturer, the date of and the
2 price paid for acquisition of the new prescription drug by the manufacturer;

3 (e) The manufacturer's estimate of the average number of patients who will be prescribed the
4 new prescription drug each month; and

5 (f) The research and development costs associated with the new prescription drug that were paid
6 using public funds.

7 (7)(a) After receiving the report or information described in subsections (2), (3), (5) or (6) of this
8 section, the department may make a written request to the manufacturer for supporting documen-
9 tation or additional information concerning the report. The department shall prescribe by rule the
10 periods:

11 (A) Following the receipt of the report or information during which the department may request
12 additional information; and

13 (B) Following a request by the department for additional information during which a manufac-
14 turer may respond to the request.

15 (b) The department may extend the period prescribed under paragraph (a)(B) of this subsection,
16 as necessary, on a case-by-case basis.

17 (8) A manufacturer may be subject to a civil penalty, as provided in section 3 [*of this 2018*
18 *Act*], **chapter 7, Oregon Laws 2018**, for:

19 (a) Failing to submit timely reports or notices as required by this section;

20 (b) Failing to provide information required under this section;

21 (c) Failing to respond in a timely manner to a written request by the department for additional
22 information under subsection (7) of this section; or

23 (d) Providing inaccurate or incomplete information under this section.

24 (9) Except as provided in subsection (10) of this section, the department shall post to its website
25 all of the following information:

26 (a) A list of the prescription drugs reported under subsection (2) of this section and the man-
27 ufacturers of those prescription drugs;

28 (b) Information reported to the department under subsections (3) and (5) to (7) of this section;
29 and

30 (c) Written requests by the department for additional information under subsection (7) of this
31 section.

32 (10)(a) The department may not post to its website any information described in subsection (9)
33 of this section if:

34 (A) The information is conditionally exempt from disclosure under ORS 192.345 as a trade secret;
35 and

36 (B) The public interest does not require disclosure of the information.

37 (b) If the department withholds any information from public disclosure pursuant to this sub-
38 section, the department shall post to its website a report describing the nature of the information
39 and the department's basis for withholding the information from disclosure.

40 [(c)] (11)(a) A person may petition the Attorney General, as provided in ORS 192.411, to review
41 a decision by the department to withhold information pursuant to [paragraph (a)] **subsection (10)(a)**
42 of this [subsection] **section**.

43 **(b) Notwithstanding ORS 192.311 to 192.478, information reported by a manufacturer un-**
44 **der this section is exempt from public disclosure until the department posts to its website**
45 **all of the information required by subsection (9) of this section.**

1 **(12) The department and its officers, employees and agents are immune from any claim**
2 **or action based on the disclosure of a trade secret made:**

3 **(a) In compliance with this section;**

4 **(b) In good faith reliance on any order of disclosure issued pursuant to ORS 192.311 to**
5 **192.478; or**

6 **(c) On the advice of an attorney authorized to advise the department, its officers, em-**
7 **ployees or agents.**

8 [(11)] **(13)(a)** The department shall make available to consumers, online and by telephone, a
9 process for consumers to notify the department about an increase in the price of a prescription drug.

10 **(b) The department may, upon request, disclose information about consumer notifications**
11 **of increases in prices of prescription drugs, under this subsection, but may not disclose**
12 **personally identifiable information about a consumer including the consumer's name, ad-**
13 **dress, telephone number or electronic mail address.**

14 [(12)] **(14)** The department may adopt rules as necessary for carrying out the provisions of this
15 section, including but not limited to rules establishing fees to be paid by manufacturers to be used
16 solely to pay the costs of the department in carrying out the provisions of this section.

17 [(13)] **(15)** No later than December 15 of each year, the department shall compile and report the
18 information collected by the department under this section to the interim committees of the Legis-
19 lative Assembly related to health. The report shall include recommendations for legislative changes,
20 if any, to contain the cost of prescription drugs and reduce the impact of price increases on con-
21 sumers, the Department of Corrections, the Public Employees' Benefit Board, the Oregon Health
22 Authority, the Department of Human Services, the Oregon Educators Benefit Board and health in-
23 surance premiums in the commercial market.

24
25 **FEE-ONLY PHARMACY BENEFIT MANAGERS FOR STATE-SPONSORED PROGRAMS**

26
27 **SECTION 2.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is
28 amended to read:

29 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
30 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
31 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
32 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
33 on:

34 (a) Employee choice among high quality plans;

35 (b) A competitive marketplace;

36 (c) Plan performance and information;

37 (d) Employer flexibility in plan design and contracting;

38 (e) Quality customer service;

39 (f) Creativity and innovation;

40 (g) Plan benefits as part of total employee compensation;

41 (h) The improvement of employee health; and

42 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
43 plan.

44 (2) The board may approve more than one carrier for each type of plan contracted for and of-
45 fered but the number of carriers shall be held to a number consistent with adequate service to eli-

1 gible employees and their family members.

2 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
3 options under which an eligible employee may arrange coverage for family members who are not
4 enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.
5 An eligible employee who declines coverage in a health benefit plan offered by the Public
6 Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse
7 or family member in another health benefit plan offered by the Public Employees' Benefit Board or
8 the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that
9 was declined.

10 (4) Payroll deductions for costs that are not payable by the state or a local government may be
11 made upon receipt of a signed authorization from the employee indicating an election to participate
12 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

13 (5) In developing any health benefit plan, the board may provide an option of additional cover-
14 age for eligible employees and their family members at an additional cost or premium.

15 (6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
16 their family members under rules adopted by the board. Because of the special problems that may
17 arise in individual instances under comprehensive group practice plan coverage involving acceptable
18 provider-patient relations between a particular panel of providers and particular eligible employees
19 and their family members, the board shall provide a procedure under which any eligible employee
20 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
21 sive group practice benefit plan.

22 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this state
23 according to the criteria described in subsection (1) of this section.

24 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
25 the board that are designed to limit the growth in per-member expenditures for health services to
26 no more than 3.4 percent per year, **including but not limited to contracting with a pharmacy**
27 **benefit manager or third party administrator on a fee-only basis and requiring the pharmacy**
28 **benefit manager or third party administrator to pass through to the board rebates, incen-**
29 **tives or discounts offered by pharmaceutical manufacturers.**

30 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
31 mium amounts paid for contracted health benefit plans to 3.4 percent.

32 (9) A carrier or third party administrator that contracts with the board to provide or administer
33 a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan
34 enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would
35 affect the cost of the premium for the plan.

36 (10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
37 ditures in self-insured health benefit plans on payments for primary care.

38 (11) No later than February 1 of each year, the board shall report to the Legislative Assembly
39 on the board's progress toward achieving the target of spending at least 12 percent of total medical
40 expenditures in self-insured health benefit plans on payments for primary care.

41 **SECTION 3.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and sec-
42 tion 27, chapter 746, Oregon Laws 2017, is amended to read:

43 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
44 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
45 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-

1 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
2 on:

- 3 (a) Employee choice among high quality plans;
- 4 (b) A competitive marketplace;
- 5 (c) Plan performance and information;
- 6 (d) Employer flexibility in plan design and contracting;
- 7 (e) Quality customer service;
- 8 (f) Creativity and innovation;
- 9 (g) Plan benefits as part of total employee compensation;
- 10 (h) The improvement of employee health; and
- 11 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
12 plan.

13 (2) The board may approve more than one carrier for each type of plan contracted for and of-
14 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
15 gible employees and their family members.

16 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
17 options under which an eligible employee may arrange coverage for family members who are not
18 enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.
19 An eligible employee who declines coverage in a health benefit plan offered by the Public
20 Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse
21 or family member in another health benefit plan offered by the Public Employees' Benefit Board or
22 the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that
23 was declined.

24 (4) Payroll deductions for costs that are not payable by the state or a local government may be
25 made upon receipt of a signed authorization from the employee indicating an election to participate
26 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

27 (5) In developing any health benefit plan, the board may provide an option of additional cover-
28 age for eligible employees and their family members at an additional cost or premium.

29 (6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
30 their family members under rules adopted by the board. Because of the special problems that may
31 arise in individual instances under comprehensive group practice plan coverage involving acceptable
32 provider-patient relations between a particular panel of providers and particular eligible employees
33 and their family members, the board shall provide a procedure under which any eligible employee
34 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
35 sive group practice benefit plan.

36 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this state
37 according to the criteria described in subsection (1) of this section.

38 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
39 the board that are designed to limit the growth in per-member expenditures for health services to
40 no more than 3.4 percent per year, **including but not limited to contracting with a pharmacy**
41 **benefit manager or third party administrator on a fee-only basis and requiring the pharmacy**
42 **benefit manager or third party administrator to pass through to the board rebates, incen-**
43 **tives or discounts offered by pharmaceutical manufacturers.**

44 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
45 mium amounts paid for contracted health benefit plans to 3.4 percent.

1 (9) A carrier or third party administrator that contracts with the board to provide or administer
2 a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan
3 enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would
4 affect the cost of the premium for the plan.

5 (10) If the board spends less than 12 percent of its total medical expenditures in self-insured
6 health benefit plans on payments for primary care, the board shall implement a plan for increasing
7 the percentage of total medical expenditures spent on payments for primary care by at least one
8 percent each year.

9 (11) No later than February 1 of each year, the board shall report to the Legislative Assembly
10 on any plan implemented under subsection (10) of this section and on the board's progress toward
11 achieving the target of spending at least 12 percent of total medical expenditures in self-insured
12 health benefit plans on payments for primary care.

13 **SECTION 4.** ORS 414.312 is amended to read:

14 414.312. (1) As used in ORS 414.312 to 414.318:

15 (a) "Pharmacy benefit manager" means an entity that negotiates and executes contracts with
16 pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers
17 and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug
18 manufacturers and pharmacies.

19 (b) "Prescription drug claims processor" means an entity that processes and pays prescription
20 drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data be-
21 tween pharmacies and the Oregon Prescription Drug Program and processes related payments to
22 pharmacies.

23 (c) "Program price" means the reimbursement rates and prescription drug prices established by
24 the administrator of the Oregon Prescription Drug Program.

25 (2) The Oregon Prescription Drug Program is established in the Oregon Health Authority. The
26 purpose of the program is to:

27 (a) Purchase prescription drugs, replenish prescription drugs dispensed or reimburse pharmacies
28 for prescription drugs in order to receive discounted prices and rebates;

29 (b) Make prescription drugs available at the lowest possible cost to participants in the program
30 as a means to promote health;

31 (c) Maintain a list of prescription drugs recommended as the most effective prescription drugs
32 available at the best possible prices; and

33 (d) Promote health through the purchase and provision of discount prescription drugs and co-
34 ordination of comprehensive prescription benefit services for eligible entities and members.

35 (3) The Director of the Oregon Health Authority shall appoint an administrator of the Oregon
36 Prescription Drug Program. The administrator may:

37 (a) Negotiate price discounts and rebates on prescription drugs with prescription drug man-
38 ufacturers or group purchasing organizations;

39 (b) Purchase prescription drugs on behalf of individuals and entities that participate in the
40 program;

41 (c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and
42 transmit program prices to pharmacies;

43 (d) Determine program prices and reimburse or replenish pharmacies for prescription drugs
44 dispensed or transferred;

45 (e) Adopt and implement a preferred drug list for the program;

1 (f) Develop a system for allocating and distributing the operational costs of the program and any
2 rebates obtained to participants of the program; and

3 (g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

4 (4) The following individuals or entities may participate in the program:

5 (a) Public Employees' Benefit Board, Oregon Educators Benefit Board and Public Employees
6 Retirement System;

7 (b) Local governments as defined in ORS 174.116 and special government bodies as defined in
8 ORS 174.117 that directly or indirectly purchase prescription drugs;

9 (c) Oregon Health and Science University established under ORS 353.020;

10 (d) State agencies that directly or indirectly purchase prescription drugs, including agencies that
11 dispense prescription drugs directly to persons in state-operated facilities;

12 (e) Residents of this state who lack or are underinsured for prescription drug coverage;

13 (f) Private entities; and

14 (g) Labor organizations.

15 (5) The administrator may establish different program prices for pharmacies in rural areas to
16 maintain statewide access to the program.

17 (6) The administrator may establish the terms and conditions for a pharmacy to enroll in the
18 program. A licensed pharmacy that is willing to accept the terms and conditions established by the
19 administrator may apply to enroll in the program.

20 (7) Except as provided in subsection (8) of this section, the administrator may not:

21 (a) Contract with a pharmacy benefit manager;

22 (b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

23 (c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dis-
24 pensed through the program.

25 (8) The administrator shall contract with one or more entities to perform any of the functions
26 of the program, including but not limited to:

27 (a) Contracting with a pharmacy benefit manager **on a fee-only basis and requiring the**
28 **pharmacy benefit manager to pass through to participants in the program rebates, incentives**
29 **or discounts offered by prescription drug manufacturers.** *[and]*

30 (b) **Contracting** directly or indirectly with such pharmacy networks as the administrator con-
31 siders necessary to maintain statewide access to the program.

32 *[(b)]* (c) Negotiating with prescription drug manufacturers on behalf of the administrator.

33 (9) Notwithstanding subsection (4)(e) of this section, individuals who are eligible for Medicare
34 Part D prescription drug coverage may participate in the program.

35 (10) The program may contract with vendors as necessary to utilize discount purchasing pro-
36 grams, including but not limited to group purchasing organizations established to meet the criteria
37 of the Nonprofit Institutions Act, 15 U.S.C. 13c, or that are exempt under the Robinson-Patman Act,
38 15 U.S.C. 13.

39 **SECTION 5.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended
40 to read:

41 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
42 quirements for a coordinated care organization and shall integrate the criteria and requirements
43 into each contract with a coordinated care organization. Coordinated care organizations may be
44 local, community-based organizations or statewide organizations with community-based participation
45 in governance or any combination of the two. Coordinated care organizations may contract with

1 counties or with other public or private entities to provide services to members. The authority may
2 not contract with only one statewide organization. A coordinated care organization may be a single
3 corporate structure or a network of providers organized through contractual relationships. The cri-
4 teria and requirements adopted by the authority under this section must include, but are not limited
5 to, a requirement that the coordinated care organization:

6 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
7 financial reserves.

8 (b) Meet the following minimum financial requirements:

9 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
10 nated care organization's total actual or projected liabilities above \$250,000.

11 (B) Maintain a net worth in an amount equal to at least five percent of the average combined
12 revenue in the prior two quarters of the participating health care entities.

13 (C) Expend a portion of the annual net income or reserves of the coordinated care organization
14 that exceed the financial requirements specified in this paragraph on services designed to address
15 health disparities and the social determinants of health consistent with the coordinated care
16 organization's community health improvement plan and transformation plan and the terms and con-
17 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
18 U.S.C. 1315).

19 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-
20 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care
21 organization's total expenditures for physical and mental health care provided to members, except
22 for expenditures on prescription drugs, vision care and dental care.

23 (d) Develop and implement alternative payment methodologies that are based on health care
24 quality and improved health outcomes.

25 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
26 services, oral health care and covered long-term care services.

27 (f) Engage community members and health care providers in improving the health of the com-
28 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
29 exist among the coordinated care organization's members and in the coordinated care organization's
30 community.

31 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
32 authority must adopt by rule requirements for coordinated care organizations contracting with the
33 authority so that:

34 (a) Each member of the coordinated care organization receives integrated person centered care
35 and services designed to provide choice, independence and dignity.

36 (b) Each member has a consistent and stable relationship with a care team that is responsible
37 for comprehensive care management and service delivery.

38 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
39 using patient centered primary care homes, behavioral health homes or other models that support
40 patient centered primary care and behavioral health care and individualized care plans to the extent
41 feasible.

42 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
43 tering and leaving an acute care facility or a long term care setting.

44 (e) Members receive assistance in navigating the health care delivery system and in accessing
45 community and social support services and statewide resources, including through the use of certi-

1 fied health care interpreters and qualified health care interpreters, as those terms are defined in
2 ORS 413.550.

3 (f) Services and supports are geographically located as close to where members reside as possi-
4 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
5 communities and underserved populations.

6 (g) Each coordinated care organization uses health information technology to link services and
7 care providers across the continuum of care to the greatest extent practicable and if financially vi-
8 able.

9 (h) Each coordinated care organization complies with the safeguards for members described in
10 ORS 414.635.

11 (i) Each coordinated care organization convenes a community advisory council that meets the
12 criteria specified in ORS 414.627.

13 (j) Each coordinated care organization prioritizes working with members who have high health
14 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
15 members in accessing and managing appropriate preventive, health, remedial and supportive care
16 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
17 gency room visits and hospital admissions.

18 (k) Members have a choice of providers within the coordinated care organization's network and
19 that providers participating in a coordinated care organization:

20 (A) Work together to develop best practices for care and service delivery to reduce waste and
21 improve the health and well-being of members.

22 (B) Are educated about the integrated approach and how to access and communicate within the
23 integrated system about a patient's treatment plan and health history.

24 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
25 making and communication.

26 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

27 (E) Include providers of specialty care.

28 (F) Are selected by coordinated care organizations using universal application and credentialing
29 procedures and objective quality information and are removed if the providers fail to meet objective
30 quality standards.

31 (G) Work together to develop best practices for culturally appropriate care and service delivery
32 to reduce waste, reduce health disparities and improve the health and well-being of members.

33 (L) Each coordinated care organization reports on outcome and quality measures adopted under
34 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464
35 and 442.466.

36 (m) Each coordinated care organization uses best practices in the management of finances,
37 contracts, claims processing, payment functions and provider networks.

38 (n) Each coordinated care organization participates in the learning collaborative described in
39 ORS 413.259 (3).

40 (o) Each coordinated care organization has a governing body that complies with section 2,
41 chapter 49, Oregon Laws 2018, and that includes:

42 (A) At least one member representing persons that share in the financial risk of the organiza-
43 tion;

44 (B) A representative of a dental care organization selected by the coordinated care organization;

45 (C) The major components of the health care delivery system;

1 (D) At least two health care providers in active practice, including:

2 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
3 678.375, whose area of practice is primary care; and

4 (ii) A mental health or chemical dependency treatment provider;

5 (E) At least two members from the community at large, to ensure that the organization's
6 decision-making is consistent with the values of the members and the community; and

7 (F) At least one member of the community advisory council.

8 (p) Each coordinated care organization's governing body establishes standards for publicizing
9 the activities of the coordinated care organization and the organization's community advisory
10 councils, as necessary, to keep the community informed.

11 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
12 in the configuration of coordinated care organizations.

13 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
14 thority shall:

15 (a) For members and potential members, optimize access to care and choice of providers;

16 (b) For providers, optimize choice in contracting with coordinated care organizations; and

17 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
18 to optimize access and choice under this subsection.

19 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
20 relationship with any dental care organization that serves members of the coordinated care organ-
21 ization in the area where they reside.

22 **(6) If a coordinated care organization contracts with a pharmacy benefit manager, it**
23 **must be on a fee-only basis and must require the pharmacy benefit manager to pass through**
24 **to the coordinated care organization rebates, incentives or discounts offered by pharmaceu-**
25 **tical manufacturers.**

26 **SECTION 6.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and sec-
27 tion 4, chapter 49, Oregon Laws 2018, is amended to read:

28 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
29 quirements for a coordinated care organization and shall integrate the criteria and requirements
30 into each contract with a coordinated care organization. Coordinated care organizations may be
31 local, community-based organizations or statewide organizations with community-based participation
32 in governance or any combination of the two. Coordinated care organizations may contract with
33 counties or with other public or private entities to provide services to members. The authority may
34 not contract with only one statewide organization. A coordinated care organization may be a single
35 corporate structure or a network of providers organized through contractual relationships. The cri-
36 teria and requirements adopted by the authority under this section must include, but are not limited
37 to, a requirement that the coordinated care organization:

38 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
39 financial reserves.

40 (b) Meet the following minimum financial requirements:

41 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
42 nated care organization's total actual or projected liabilities above \$250,000.

43 (B) Maintain a net worth in an amount equal to at least five percent of the average combined
44 revenue in the prior two quarters of the participating health care entities.

45 (C) Expend a portion of the annual net income or reserves of the coordinated care organization

1 that exceed the financial requirements specified in this paragraph on services designed to address
2 health disparities and the social determinants of health consistent with the coordinated care
3 organization's community health improvement plan and transformation plan and the terms and con-
4 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
5 U.S.C. 1315).

6 (c) Operate within a fixed global budget and spend on primary care, as defined by the authority
7 by rule, at least 12 percent of the coordinated care organization's total expenditures for physical
8 and mental health care provided to members, except for expenditures on prescription drugs, vision
9 care and dental care.

10 (d) Develop and implement alternative payment methodologies that are based on health care
11 quality and improved health outcomes.

12 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
13 services, oral health care and covered long-term care services.

14 (f) Engage community members and health care providers in improving the health of the com-
15 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
16 exist among the coordinated care organization's members and in the coordinated care organization's
17 community.

18 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
19 authority must adopt by rule requirements for coordinated care organizations contracting with the
20 authority so that:

21 (a) Each member of the coordinated care organization receives integrated person centered care
22 and services designed to provide choice, independence and dignity.

23 (b) Each member has a consistent and stable relationship with a care team that is responsible
24 for comprehensive care management and service delivery.

25 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
26 using patient centered primary care homes, behavioral health homes or other models that support
27 patient centered primary care and behavioral health care and individualized care plans to the extent
28 feasible.

29 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
30 tering and leaving an acute care facility or a long term care setting.

31 (e) Members receive assistance in navigating the health care delivery system and in accessing
32 community and social support services and statewide resources, including through the use of certi-
33 fied health care interpreters and qualified health care interpreters, as those terms are defined in
34 ORS 413.550.

35 (f) Services and supports are geographically located as close to where members reside as possi-
36 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
37 communities and underserved populations.

38 (g) Each coordinated care organization uses health information technology to link services and
39 care providers across the continuum of care to the greatest extent practicable and if financially vi-
40 able.

41 (h) Each coordinated care organization complies with the safeguards for members described in
42 ORS 414.635.

43 (i) Each coordinated care organization convenes a community advisory council that meets the
44 criteria specified in ORS 414.627.

45 (j) Each coordinated care organization prioritizes working with members who have high health

1 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
2 members in accessing and managing appropriate preventive, health, remedial and supportive care
3 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
4 gency room visits and hospital admissions.

5 (k) Members have a choice of providers within the coordinated care organization's network and
6 that providers participating in a coordinated care organization:

7 (A) Work together to develop best practices for care and service delivery to reduce waste and
8 improve the health and well-being of members.

9 (B) Are educated about the integrated approach and how to access and communicate within the
10 integrated system about a patient's treatment plan and health history.

11 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
12 making and communication.

13 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

14 (E) Include providers of specialty care.

15 (F) Are selected by coordinated care organizations using universal application and credentialing
16 procedures and objective quality information and are removed if the providers fail to meet objective
17 quality standards.

18 (G) Work together to develop best practices for culturally appropriate care and service delivery
19 to reduce waste, reduce health disparities and improve the health and well-being of members.

20 (L) Each coordinated care organization reports on outcome and quality measures adopted under
21 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464
22 and 442.466.

23 (m) Each coordinated care organization uses best practices in the management of finances,
24 contracts, claims processing, payment functions and provider networks.

25 (n) Each coordinated care organization participates in the learning collaborative described in
26 ORS 413.259 (3).

27 (o) Each coordinated care organization has a governing body that complies with section 2,
28 chapter 49, Oregon Laws 2018, and that includes:

29 (A) At least one member representing persons that share in the financial risk of the organiza-
30 tion;

31 (B) A representative of a dental care organization selected by the coordinated care organization;

32 (C) The major components of the health care delivery system;

33 (D) At least two health care providers in active practice, including:

34 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
35 678.375, whose area of practice is primary care; and

36 (ii) A mental health or chemical dependency treatment provider;

37 (E) At least two members from the community at large, to ensure that the organization's
38 decision-making is consistent with the values of the members and the community; and

39 (F) At least one member of the community advisory council.

40 (p) Each coordinated care organization's governing body establishes standards for publicizing
41 the activities of the coordinated care organization and the organization's community advisory
42 councils, as necessary, to keep the community informed.

43 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
44 in the configuration of coordinated care organizations.

45 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-

1 thority shall:

2 (a) For members and potential members, optimize access to care and choice of providers;

3 (b) For providers, optimize choice in contracting with coordinated care organizations; and

4 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
5 to optimize access and choice under this subsection.

6 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
7 relationship with any dental care organization that serves members of the coordinated care organ-
8 ization in the area where they reside.

9 **(6) If a coordinated care organization contracts with a pharmacy benefit manager, it
10 must be on a fee-only basis and must require the pharmacy benefit manager to pass through
11 to the coordinated care organization rebates, incentives or discounts offered by pharmaceu-
12 tical manufacturers.**

13
14 **PUBLISHING INFORMATION REGARDING INSURERS’**
15 **FORMULARIES; NOTICE TO INSUREDS REGARDING**
16 **CHANGES TO FORMULARIES**
17

18 **SECTION 7.** ORS 743B.013 is amended to read:

19 743B.013. (1) A health benefit plan issued to a small employer:

20 (a) Other than a grandfathered health plan, must cover essential health benefits consistent with
21 42 U.S.C. 300gg-11.

22 (b) May require an affiliation period that does not exceed two months for an enrollee or 90 days
23 for a late enrollee.

24 (c) May not apply a preexisting condition exclusion to any enrollee.

25 (2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility
26 waiting period that does not exceed 90 days.

27 (3) Each small employer health benefit plan is renewable with respect to all eligible enrollees
28 at the option of the policyholder, small employer or contract holder unless:

29 (a) The policyholder, small employer or contract holder fails to pay the required premiums.

30 (b) The policyholder, small employer or contract holder or, with respect to coverage of individ-
31 ual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an inten-
32 tional misrepresentation of a material fact as prohibited by the terms of the plan.

33 (c) The number of enrollees covered under the plan is less than the number or percentage of
34 enrollees required by participation requirements under the plan.

35 (d) The small employer fails to comply with the contribution requirements under the health
36 benefit plan.

37 (e) The carrier discontinues both offering and renewing all of the carrier’s small employer health
38 benefit plans in this state or in a specified service area within this state. In order to discontinue
39 plans under this paragraph, the carrier:

40 (A) Must give notice of the decision to the Department of Consumer and Business Services and
41 to all policyholders covered by the plans;

42 (B) May not cancel coverage under the plans for 180 days after the date of the notice required
43 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a
44 specified service area, except that:

45 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if

1 the cancellation is for a specified service area in the circumstances described in subparagraph (C)
2 of this paragraph; and

3 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-
4 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to
5 a delinquency proceeding, as defined in ORS 734.014; and

6 (C) May not cancel coverage under the plans for 90 days after the date of the notice required
7 under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area
8 because of an inability to reach an agreement with the health care providers or organization of
9 health care providers to provide services under the plans within the service area.

10 (f) The carrier discontinues both offering and renewing a small employer health benefit plan in
11 a specified service area within this state because of an inability to reach an agreement with the
12 health care providers or organization of health care providers to provide services under the plan
13 within the service area. In order to discontinue a plan under this paragraph, the carrier:

14 (A) Must give notice to the department and to all policyholders covered by the plan;

15 (B) May not cancel coverage under the plan for 90 days after the date of the notice required
16 under subparagraph (A) of this paragraph; and

17 (C) Must offer in writing to each small employer covered by the plan, all other small employer
18 health benefit plans that the carrier offers to small employers in the specified service area. The
19 carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The
20 carrier shall offer the plans at least 90 days prior to discontinuation.

21 (g) The carrier discontinues both offering and renewing a health benefit plan, other than a
22 grandfathered health plan, for all small employers in this state or in a specified service area within
23 this state, other than a plan discontinued under paragraph (f) of this subsection.

24 (h) The carrier discontinues both offering and renewing a grandfathered health plan for all small
25 employers in this state or in a specified service area within this state, other than a plan discontin-
26 ued under paragraph (f) of this subsection.

27 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-
28 section, the carrier must:

29 (A) Offer in writing to each small employer covered by the plan, all other health benefit plans
30 that the carrier offers to small employers in the specified service area.

31 (B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

32 (C) Offer the plans at least 90 days prior to discontinuation.

33 (D) Act uniformly without regard to the claims experience of the affected policyholders or the
34 health status of any current or prospective enrollee.

35 (j) The Director of the Department of Consumer and Business Services orders the carrier to
36 discontinue coverage in accordance with procedures specified or approved by the director upon
37 finding that the continuation of the coverage would:

38 (A) Not be in the best interests of the enrollees; or

39 (B) Impair the carrier's ability to meet contractual obligations.

40 (k) In the case of a small employer health benefit plan that delivers covered services through
41 a specified network of health care providers, there is no longer any enrollee who lives, resides or
42 works in the service area of the provider network.

43 (L) In the case of a health benefit plan that is offered in the small employer market only to one
44 or more bona fide associations, the membership of an employer in the association ceases and the
45 termination of coverage is not related to the health status of any enrollee.

1 (4) A carrier may modify a small employer health benefit plan at the time of coverage renewal.
2 The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this sec-
3 tion.

4 (5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may
5 not rescind the coverage of an enrollee in a small employer health benefit plan unless:

6 (a) The enrollee or a person seeking coverage on behalf of the enrollee:

7 (A) Performs an act, practice or omission that constitutes fraud; or

8 (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
9 plan;

10 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-
11 scribed by the department, to the enrollee; and

12 (c) The carrier provides notice of the rescission to the department in the form, manner and time
13 frame prescribed by the department by rule.

14 (6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may
15 not rescind a small employer health benefit plan unless:

16 (a) The small employer or a representative of the small employer:

17 (A) Performs an act, practice or omission that constitutes fraud; or

18 (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
19 plan;

20 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-
21 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-
22 age; and

23 (c) The carrier provides notice of the rescission to the department in the form, manner and time
24 frame prescribed by the department by rule.

25 (7)(a) A carrier may continue to enforce reasonable employer participation and contribution re-
26 quirements on small employers. However, participation and contribution requirements shall be ap-
27 plied uniformly among all small employer groups with the same number of eligible employees
28 applying for coverage or receiving coverage from the carrier. In determining minimum participation
29 requirements, a carrier shall count only those employees who are not covered by an existing group
30 health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored
31 or subsidized health plan, including but not limited to the medical assistance program under ORS
32 chapter 414.

33 (b) A carrier may not deny a small employer's application for coverage under a health benefit
34 plan based on participation or contribution requirements but may require small employers that do
35 not meet participation or contribution requirements to enroll during the open enrollment period
36 beginning November 15 and ending December 15.

37 (8) Premium rates for small employer health benefit plans, except grandfathered health plans,
38 are subject to the following provisions:

39 (a) Each carrier must file with the department the initial geographic average rate and any
40 changes in the geographic average rate with respect to each health benefit plan issued by the car-
41 rier to small employers.

42 (b)(A) The variations in premium rates charged during a rating period for health benefit plans
43 issued to small employers must be based solely on the factors specified in subparagraph (B) of this
44 paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph
45 apply to premium rates for health benefit plans for small employers. All other factors must be ap-

1 plied in the same actuarially sound way to all small employer health benefit plans.

2 (B) The variations in premium rates described in subparagraph (A) of this paragraph may be
3 based only on one or more of the following factors as prescribed by the department by rule:

4 (i) The ages of enrolled employees and their dependents, except that the rate for adults may not
5 vary by more than three to one;

6 (ii) The level at which enrolled employees and dependents of enrolled employees engage in to-
7 bacco use, except that the rate may not vary by more than 1.5 to one; and

8 (iii) Adjustments to reflect differences in family composition.

9 (C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the
10 department and in accordance with this paragraph. Except as otherwise provided in this section, the
11 premium rate established by a carrier for a small employer health benefit plan applies uniformly to
12 all employees of the small employer enrolled in that plan.

13 (c) Except as provided in paragraph (b) of this subsection, the variation in premium rates be-
14 tween different health benefit plans offered by a carrier to small employers must be based solely on
15 objective differences in plan design or coverage, age, tobacco use and family composition and must
16 not include differences based on the risk characteristics of groups assumed to select a particular
17 health benefit plan.

18 (d) A carrier may not increase the rates of a health benefit plan issued to a small employer more
19 than once in a 12-month period. Annual rate increases are effective on the plan anniversary date
20 of the health benefit plan issued to a small employer. The percentage increase in the premium rate
21 charged to a small employer for a new rating period may not exceed the sum of the following:

22 (A) The percentage change in the geographic average rate measured from the first day of the
23 prior rating period to the first day of the new period; and

24 (B) Any adjustment attributable to changes in age and differences in family composition.

25 (9) Premium rates for grandfathered health plans are subject to requirements prescribed by the
26 department by rule.

27 (10) In connection with the offering for sale of any health benefit plan to a small employer, each
28 carrier shall make a reasonable disclosure as part of the carrier's solicitation and sales materials
29 of:

30 (a) The full array of health benefit plans that are offered to small employers by the carrier;

31 (b) The authority of the carrier to adjust rates and premiums, and the extent to which the car-
32 rier considers age, tobacco use, family composition and geographic factors in establishing and ad-
33 justing rates and premiums; and

34 (c) The benefits and premiums for all health insurance coverage for which the employer is
35 qualified.

36 (11)(a) Each carrier shall maintain at the carrier's principal place of business a complete and
37 detailed description of the carrier's rating practices and renewal underwriting practices relating to
38 the carrier's small employer health benefit plans, including information and documentation that
39 demonstrate that the carrier's rating methods and practices are based upon commonly accepted
40 actuarial practices and are in accordance with sound actuarial principles.

41 (b) A carrier offering a small employer health benefit plan shall file with the department at least
42 once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010
43 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification must
44 be in a uniform form and manner and must contain such information as specified by the department.
45 The carrier shall retain a copy of each certification at the carrier's principal place of business. A

1 carrier is not required to file the actuarial certification under this paragraph if the department has
2 approved the carrier's rate filing within the preceding 12-month period.

3 (c) A carrier shall make the information and documentation described in paragraph (a) of this
4 subsection available to the department upon request. Except as provided in ORS 743.018 and except
5 in cases of violations of ORS 743B.010 to 743B.013, the information is proprietary and trade secret
6 information and is not subject to disclosure to persons outside the department except as agreed to
7 by the carrier or as ordered by a court of competent jurisdiction.

8 (12) A carrier may not provide any financial or other incentive to any insurance producer that
9 would encourage the insurance producer to sell health benefit plans of the carrier to small employer
10 groups based on a small employer group's anticipated claims experience.

11 (13) For purposes of this section, the date a small employer health benefit plan is continued is
12 the anniversary date of the first issuance of the health benefit plan.

13 (14) A carrier shall include a provision that offers coverage to all eligible employees of a small
14 employer and to all dependents of the eligible employees to the extent the employer chooses to offer
15 coverage to dependents.

16 (15) All small employer health benefit plans must contain special enrollment periods during
17 which eligible employees and dependents may enroll for coverage, as provided by federal law and
18 rules adopted by the department.

19 (16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar
20 amount of essential health benefits.

21 **(17) A carrier that offers a small employer health benefit plan that reimburses the cost**
22 **of prescription drugs sold by a retail pharmacy or administered by a health care provider**
23 **shall:**

24 **(a) Submit a narrative report to the department describing how the carrier designed the**
25 **carrier's formulary and describing typical changes that the carrier makes to the formulary.**

26 **(b) Publish to the carrier's website:**

27 **(A) In a format that allows for easy comparison of the prescription drug coverage under**
28 **each small employer health benefit plan offered by the carrier:**

29 **(i) The carrier's prescription drug formulary;**

30 **(ii) The tiers in the carrier's prescription drug formulary; and**

31 **(iii) The range of copayments, coinsurance or other cost-sharing within each tier.**

32 **(B) For each drug in the prescription drug formulary that is a brand name drug, whether:**

33 **(i) A generic alternative is available;**

34 **(ii) Step therapy or prior authorization protocols are required and, if so, whether the**
35 **protocols require that a generic alternative be substituted; and**

36 **(iii) Quantity limits are imposed on the drug.**

37 **(C) Notification that an enrollee may purchase a drug from a pharmacy at the retail price**
38 **if the retail price is lower than the enrollee's out-of-pocket cost using the enrollee's phar-**
39 **macy benefit and, if the enrollee purchases the drug at the retail price, the price paid must**
40 **be applied to the enrollee's deductible or out-of-pocket maximum if requested by the enrollee.**

41 **(c) At least 60 days in advance of a change to the prescription drug formulary, provide**
42 **written notice of the change to the department and to each enrollee who will be adversely**
43 **affected by the change. A change that adversely affects an enrollee includes but is not lim-**
44 **ited to:**

45 **(A) Imposition of new utilization review requirements;**

1 **(B) Removal of a drug from the formulary for which a claim has been submitted for the**
2 **enrollee during the plan year; and**

3 **(C) A modification to the formulary tiers or a change in a drug's placement on a tier that**
4 **results in a higher out-of-pocket cost to an enrollee except when the modification is due to**
5 **the availability of a generic alternative.**

6 **(d) Include in the notice required by paragraph (c) of this subsection the information**
7 **described in ORS 743B.250 (1)(b) and (d) and information about how to request an internal**
8 **review and external appeal.**

9 **(e) Report to the department, in the form and manner prescribed by the department, the**
10 **information described in paragraph (b)(A) and (B) of this subsection.**

11 **(18) A carrier may provide the notice required by subsection (17)(c) of this section less**
12 **than 60 days prior to a change in a prescription drug formulary if the change is necessary**
13 **to ensure the safety of enrollees or in other emergency circumstances as prescribed by the**
14 **department by rule.**

15 **SECTION 8.** ORS 743B.105 is amended to read:

16 743B.105. The following requirements apply to all group health benefit plans other than small
17 employer health benefit plans covering two or more certificate holders:

18 (1) A carrier offering a group health benefit plan may not decline to offer coverage to any eli-
19 gible prospective enrollee and may not impose different terms or conditions on the coverage, pre-
20 miums or contributions of any enrollee in the group that are based on the actual or expected health
21 status of the enrollee.

22 (2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee
23 but may impose:

24 (a) An affiliation period that does not exceed two months for an enrollee or three months for a
25 late enrollee; or

26 (b) A group eligibility waiting period for late enrollees that does not exceed 90 days.

27 (3) Each group health benefit plan shall contain a special enrollment period during which eligi-
28 ble employees and dependents may enroll for coverage, as provided by federal law and rules adopted
29 by the Department of Consumer and Business Services.

30 (4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by
31 the carrier for which the group is eligible, if the group applies for the plan, agrees to make the re-
32 quired premium payments and agrees to satisfy the other requirements of the plan.

33 (b) The department may waive the requirements of this subsection if the department finds that
34 issuing a plan to a group or groups would endanger the carrier's ability to fulfill the carrier's con-
35 tractual obligations or result in financial impairment of the carrier.

36 (5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at
37 the option of the policyholder unless:

38 (a) The policyholder fails to pay the required premiums.

39 (b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a rep-
40 resentative of an enrollee engages in fraud or makes an intentional misrepresentation of a material
41 fact as prohibited by the terms of the plan.

42 (c) The number of enrollees covered under the plan is less than the number or percentage of
43 enrollees required by participation requirements under the plan.

44 (d) The policyholder fails to comply with the contribution requirements under the plan.

45 (e) The carrier discontinues both offering and renewing, all of the carrier's group health benefit

1 plans in this state or in a specified service area within this state. In order to discontinue plans un-
2 der this paragraph, the carrier:

3 (A) Must give notice of the decision to the department and to all policyholders covered by the
4 plans;

5 (B) May not cancel coverage under the plans for 180 days after the date of the notice required
6 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a
7 specified service area, except that:

8 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if
9 the cancellation is for a specified service area in the circumstances described in subparagraph (C)
10 of this paragraph; and

11 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-
12 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to
13 a delinquency proceeding, as defined in ORS 734.014; and

14 (C) May not cancel coverage under the plans for 90 days after the date of the notice required
15 under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area
16 because of an inability to reach an agreement with the health care providers or organization of
17 health care providers to provide services under the plans within the service area.

18 (f) The carrier discontinues both offering and renewing a group health benefit plan in a specified
19 service area within this state because of an inability to reach an agreement with the health care
20 providers or organization of health care providers to provide services under the plan within the
21 service area. In order to discontinue a plan under this paragraph, the carrier:

22 (A) Must give notice of the decision to the department and to all policyholders covered by the
23 plan;

24 (B) May not cancel coverage under the plan for 90 days after the date of the notice required
25 under subparagraph (A) of this paragraph; and

26 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit
27 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least
28 90 days prior to discontinuation.

29 (g) The carrier discontinues both offering and renewing a group health benefit plan, other than
30 a grandfathered health plan, for all groups in this state or in a specified service area within this
31 state, other than a plan discontinued under paragraph (f) of this subsection.

32 (h) The carrier discontinues both offering and renewing a grandfathered health plan for all
33 groups in this state or in a specified service area within this state, other than a plan discontinued
34 under paragraph (f) of this subsection.

35 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-
36 section, the carrier must:

37 (A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans
38 that the carrier offers to groups in the specified service area.

39 (B) Offer the plans at least 90 days prior to discontinuation.

40 (C) Act uniformly without regard to the claims experience of the affected policyholders or the
41 health status of any current or prospective enrollee.

42 (j) The director orders the carrier to discontinue coverage in accordance with procedures spec-
43 ified or approved by the director upon finding that the continuation of the coverage would:

44 (A) Not be in the best interests of the enrollees; or

45 (B) Impair the carrier's ability to meet contractual obligations.

1 (k) In the case of a group health benefit plan that delivers covered services through a specified
2 network of health care providers, there is no longer any enrollee who lives, resides or works in the
3 service area of the provider network.

4 (L) In the case of a health benefit plan that is offered in the group market only to one or more
5 bona fide associations, the membership of an employer in the association ceases and the termination
6 of coverage is not related to the health status of any enrollee.

7 (6) A carrier may modify a group health benefit plan at the time of coverage renewal. The
8 modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

9 (7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may
10 not rescind the coverage of an enrollee under a group health benefit plan unless:

11 (a) The enrollee:

12 (A) Performs an act, practice or omission that constitutes fraud; or

13 (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
14 plan;

15 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-
16 scribed by the department, to the enrollee; and

17 (c) The carrier provides notice of the rescission to the department in the form, manner and time
18 frame prescribed by the department by rule.

19 (8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may
20 not rescind a group health benefit plan unless:

21 (a) The plan sponsor or a representative of the plan sponsor:

22 (A) Performs an act, practice or omission that constitutes fraud; or

23 (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
24 plan;

25 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-
26 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-
27 age; and

28 (c) The carrier provides notice of the rescission to the department in the form, manner and time
29 frame prescribed by the department by rule.

30 (9) A group health benefit plan may not impose annual or lifetime limits on the dollar amount
31 of essential health benefits.

32 **(10) A carrier that offers a group health benefit plan that reimburses the costs of pre-**
33 **scription drugs sold by a retail pharmacy or administered by a health care provider shall:**

34 **(a) Submit a narrative report to the department describing how the carrier designed the**
35 **carrier's formulary and describing typical changes that the carrier makes to the formulary.**

36 **(b) Publish to the carrier's website notification that an enrollee may purchase a drug**
37 **from a pharmacy at the retail price if the retail price is lower than the enrollee's out-of-**
38 **pocket cost using the enrollee's pharmacy benefit and, if the enrollee purchases the drug at**
39 **the retail price, the price paid must be applied to the enrollee's deductible or out-of-pocket**
40 **maximum if requested by the enrollee.**

41 **(c) At least 60 days in advance of a change to the prescription drug formulary, provide**
42 **written notice of the change to the department and to each enrollee who will be adversely**
43 **affected by the change. A change that adversely affects an enrollee includes but is not lim-**
44 **ited to:**

45 **(A) Imposition of new utilization review requirements;**

1 **(B) Removal of a drug from the formulary for which a claim has been submitted for the**
2 **enrollee during the plan year; and**

3 **(C) A modification to the formulary tiers or a change in a drug's placement on a tier that**
4 **results in a higher out-of-pocket cost to an enrollee.**

5 **(d) Include in the notice required by paragraph (c) of this subsection the information**
6 **described in ORS 743B.250 (1)(b) and (d) and information about how to request an internal**
7 **review and external appeal.**

8 **(e) Report to the department, in the form and manner prescribed by the department, the**
9 **information described in paragraph (b)(A) and (B) of this subsection.**

10 **(11) A carrier may provide the notice required by subsection (10)(c) of this section less**
11 **than 60 days prior to a change in a prescription drug formulary if the change is necessary**
12 **to ensure the safety of enrollees or in other emergency circumstances as prescribed by the**
13 **department by rule.**

14 **SECTION 9.** ORS 743B.125 is amended to read:

15 743B.125. (1) With respect to coverage under an individual health benefit plan, a carrier may
16 not impose an individual coverage waiting period.

17 (2) With respect to individual coverage under a grandfathered health plan, a carrier:

18 (a) May impose an exclusion period for specified covered services applicable to all individuals
19 enrolling for the first time in the individual health benefit plan.

20 (b) May not impose a preexisting condition exclusion unless the exclusion complies with the
21 following requirements:

22 (A) The exclusion applies only to a condition for which medical advice, diagnosis, care or
23 treatment was recommended or received during the six-month period immediately preceding the
24 individual's effective date of coverage.

25 (B) The exclusion expires no later than six months after the individual's effective date of cov-
26 erage.

27 (3) An individual health benefit plan other than a grandfathered health plan must cover, at a
28 minimum, all essential health benefits.

29 (4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued
30 through a bona fide association, unless:

31 (a) The policyholder fails to pay the required premiums.

32 (b) The policyholder or a representative of the policyholder engages in fraud or makes an in-
33 tentional misrepresentation of a material fact as prohibited by the terms of the policy.

34 (c) The carrier discontinues both offering and renewing all of the carrier's individual health
35 benefit plans in this state or in a specified service area within this state. In order to discontinue the
36 plans under this paragraph, the carrier:

37 (A) Shall give notice of the decision to the Department of Consumer and Business Services and
38 to all policyholders covered by the plans;

39 (B) May not cancel coverage under the plans for 180 days after the date of the notice required
40 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a
41 specified service area, except that:

42 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if
43 the cancellation is for a specified service area in the circumstances described in subparagraph (C)
44 of this paragraph; and

45 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-

1 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to
2 a delinquency proceeding, as defined in ORS 734.014; and

3 (C) May not cancel coverage under the plans for 90 days after the date of the notice required
4 under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area
5 because of an inability to reach an agreement with the health care providers or organization of
6 health care providers to provide services under the plans within the service area.

7 (d) The carrier discontinues both offering and renewing an individual health benefit plan in a
8 specified service area within this state because of an inability to reach an agreement with the health
9 care providers or organization of health care providers to provide services under the plan within the
10 service area. In order to discontinue a plan under this paragraph, the carrier:

11 (A) Shall give notice of the decision to the department and to all policyholders covered by the
12 plan;

13 (B) May not cancel coverage under the plan for 90 days after the date of the notice required
14 under subparagraph (A) of this paragraph; and

15 (C) Shall offer in writing to each policyholder covered by the plan, all other individual health
16 benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans
17 at least 90 days prior to discontinuation.

18 (e) The carrier discontinues both offering and renewing an individual health benefit plan, other
19 than a grandfathered health plan, for all individuals in this state or in a specified service area
20 within this state, other than a plan discontinued under paragraph (d) of this subsection.

21 (f) The carrier discontinues both offering and renewing a grandfathered health plan for all in-
22 dividuals in this state or in a specified service area within this state, other than a plan discontinued
23 under paragraph (d) of this subsection.

24 (g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-
25 section, the carrier shall:

26 (A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the
27 carrier offers to individuals in the specified service area.

28 (B) Offer the plans at least 90 days prior to discontinuation.

29 (C) Act uniformly without regard to the claims experience of the affected policyholders or the
30 health status of any current or prospective enrollee.

31 (h) The Director of the Department of Consumer and Business Services orders the carrier to
32 discontinue coverage in accordance with procedures specified or approved by the director upon
33 finding that the continuation of the coverage would:

34 (A) Not be in the best interests of the enrollee; or

35 (B) Impair the carrier's ability to meet the carrier's contractual obligations.

36 (i) In the case of an individual health benefit plan that delivers covered services through a
37 specified network of health care providers, the enrollee no longer lives, resides or works in the
38 service area of the provider network and the termination of coverage is not related to the health
39 status of any enrollee.

40 (j) In the case of a health benefit plan that is offered in the individual market only through one
41 or more bona fide associations, the membership of an individual in the association ceases and the
42 termination of coverage is not related to the health status of any enrollee.

43 (5) A carrier may modify an individual health benefit plan at the time of coverage renewal. The
44 modification is not a discontinuation of the plan under subsection (4)(c), (e) and (f) of this section.

45 (6) Notwithstanding any other provision of this section, and subject to the provisions of ORS

1 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or
2 a representative of the policyholder:

3 (a) Performs an act, practice or omission that constitutes fraud; or

4 (b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
5 policy.

6 (7) A carrier that continues to offer coverage in the individual market in this state is not re-
7 quired to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier
8 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-
9 tive coverage in the carrier's other individual health benefit plans, the coverage for all existing
10 policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

11 (8) An individual health benefit plan may not impose annual or lifetime limits on the dollar
12 amount of essential health benefits.

13 (9) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential
14 health benefits.

15 (10) This section does not require a carrier to actively market, offer, issue or accept applications
16 for:

17 (a) A bona fide association health benefit plan from individuals who are not members of the bona
18 fide association; or

19 (b) A grandfathered health plan from individuals who are not eligible for coverage under the
20 plan.

21 **(11) A carrier that offers an individual health benefit plan that reimburses the costs of**
22 **prescription drugs sold by a retail pharmacy or administered by a health care provider shall:**

23 **(a) Submit a narrative report to the department describing how the carrier designed the**
24 **carrier's formulary and describing typical changes that the carrier makes to the formulary.**

25 **(b) Publish to the carrier's website:**

26 **(A) In a format that allows for easy comparison of the prescription drug coverage under**
27 **each individual health benefit plan offered by the carrier:**

28 **(i) The carrier's prescription drug formulary;**

29 **(ii) The tiers in the carrier's prescription drug formulary; and**

30 **(iii) The range of copayments, coinsurance or other cost-sharing within each tier.**

31 **(B) For each drug in the prescription drug formulary that is a brand name drug, whether:**

32 **(i) A generic alternative is available;**

33 **(ii) Step therapy or prior authorization protocols are required and, if so, whether the**
34 **protocols require that a generic alternative be substituted; and**

35 **(iii) Quantity limits are imposed on the drug.**

36 **(C) Notification that an enrollee may purchase a drug from a pharmacy at the retail price**
37 **if the retail price is lower than the enrollee's out-of-pocket cost using the enrollee's phar-**
38 **macy benefit and, if the enrollee purchases the drug at the retail price, the price paid must**
39 **be applied to the enrollee's deductible or out-of-pocket maximum if requested by the enrollee.**

40 **(c) At least 60 days in advance of a change to the prescription drug formulary, provide**
41 **written notice of the change to the department and to each enrollee who will be adversely**
42 **affected by the change. A change that adversely affects an enrollee includes but is not lim-**
43 **ited to:**

44 **(A) Imposition of new utilization review requirements;**

45 **(B) Removal of a drug prescribed for the enrollee from the formulary; and**

1 (C) A modification to the formulary tiers or a change in a drug's placement on a tier that
2 results in a higher out-of-pocket cost to an enrollee.

3 (d) Include in the notice required by paragraph (c) of this subsection the information
4 described in ORS 743B.250 (1)(b) and (d) and information about how to request an internal
5 review and external appeal.

6 (e) Report to the department, in the form and manner prescribed by the department, the
7 information described in paragraph (b)(A) and (B) of this subsection.

8 (12) A carrier may provide the notice required by subsection (11)(c) of this section less
9 than 60 days prior to a change in a prescription drug formulary if the change is necessary
10 to ensure the safety of enrollees or in other emergency circumstances as prescribed by the
11 department by rule.

12
13 **DISCLOSURE OF LESSER OF CASH PRICE OR COST-SHARE**
14 **AND PROHIBITION ON GAG CLAUSES**
15

16 **SECTION 10.** Section 11 of this 2019 Act is added to and made a part of the Insurance
17 Code.

18 **SECTION 11.** (1) As used in this section:

19 (a) "Consumer" means an individual with a pharmacy benefit.

20 (b) "Pharmacist" has the meaning given that term in ORS 689.005.

21 (c) "Pharmacy" has the meaning given that term in ORS 689.005.

22 (d) "Pharmacy benefit" means the reimbursement of an individual's cost for prescription
23 drugs under a policy or certificate of health insurance or by a pharmacy benefit manager or
24 third party administrator.

25 (e) "Pharmacy benefit manager" has the meaning given that term in ORS 735.530.

26 (f) "Third party administrator" means a person licensed under ORS 744.702.

27 (2) A consumer has the right to be educated by a pharmacy or pharmacist about all
28 means available to the consumer to reduce the consumer's costs for a drug prescribed for
29 the consumer including, but not limited to:

30 (a) Receiving information about the cost and efficacy of any less costly alternative drug;

31 (b) Being informed that the consumer may purchase a prescription drug at the retail
32 price if the retail price is lower than the consumer's out-of-pocket cost for the drug using
33 the consumer's pharmacy benefit; and

34 (c) Being informed that if the consumer purchases a drug at the retail price as described
35 in paragraph (b) of this subsection, the consumer may request that the price paid be applied
36 toward the consumer's deductible or out-of-pocket maximum as provided in subsection (4)
37 of this section.

38 (3) An insurer, pharmacy benefit manager or third party administrator may not, by
39 contract with a pharmacy or pharmacist, by penalty imposed on a pharmacy or pharmacist
40 or by other means, interfere with the right of consumers established in subsection (2) of this
41 section.

42 (4) Upon the request of a consumer, an insurer, pharmacy benefit manager or third party
43 administrator shall apply toward any deductible or out-of-pocket maximum imposed under a
44 consumer's pharmacy benefit the price paid by a consumer to purchase a prescription drug
45 covered by the pharmacy benefit regardless of whether the consumer used the pharmacy

1 **benefit to purchase the drug.**

2 **(5) The State Board of Pharmacy shall prescribe by rule a notice explaining consumers'**
3 **rights under this section and a requirement for each pharmacy to prominently display the**
4 **notice as prescribed the board. The board shall translate the notice into multiple languages,**
5 **as determined by the board, and customers of each pharmacy must be provided the notice**
6 **in their primary language, if available.**

7 **SECTION 12.** ORS 735.533 is amended to read:

8 735.533. (1) In accordance with ORS chapter 183, the Department of Consumer and Business
9 Services may deny an application for registration as a pharmacy benefit manager or an application
10 for renewal of a registration as a pharmacy benefit manager, and may suspend or revoke a regis-
11 tration as a pharmacy benefit manager, if the department finds that an applicant or registrant:

12 (a) Falsified an application for registration or for the renewal of a registration or engaged in
13 any dishonest act in relation to the application;

14 (b) Engaged in dishonesty, fraud or gross negligence in the conduct of business as a pharmacy
15 benefit manager;

16 (c) Engaged in conduct that resulted in a conviction of a felony under the laws of any state or
17 of the United States, to the extent that such conduct may be considered under ORS 670.280;

18 (d) Was convicted under the laws of any state or of the United States of any crime of which an
19 essential element is dishonesty or fraud;

20 (e) Had a certificate of authority or authority to conduct business as a pharmacy benefit man-
21 ager denied, revoked or suspended in another state;

22 (f) Failed to pay a civil penalty imposed by final order of the department or to comply with the
23 terms of suspension set by the department;

24 (g) Failed to meet the terms of a consent decree approved by a court of competent jurisdiction
25 in this state, or a consent order made between the department and the pharmacy benefit manager;

26 (h) Refused to be examined or to produce accounts, records or files for examination, including
27 the refusal by any officer of the applicant or registrant to give information with respect to the af-
28 fairs of the pharmacy benefit manager, or refused to perform any other legal obligation with respect
29 to an examination by the department; or

30 (i) Violated any rule or order of the department or any provision of the Insurance Code.

31 (2) The department may prescribe by rule a procedure by which a pharmacy or an entity acting
32 on behalf of a pharmacy may file a complaint with the department alleging that a pharmacy benefit
33 manager has engaged in conduct described in this section **or has, by contract, penalty or other**
34 **means, interfered with the rights of consumers under section 11 of this 2019 Act.** The de-
35 partment may restrict the right of a pharmacy or entity to file a complaint only to the extent nec-
36 cessary to prevent abuse of the complaint process.

37
38 **DISCLOSURE OF HOSPITAL AND MEDICAL PROVIDER**

39 **MARK-UPS FOR PRESCRIPTION DRUGS**

40
41 **SECTION 13.** (1) **As used in this section:**

42 (a) **"Drug" means a prescription drug other than a:**

43 (A) **Drug prescribed for or administered during an inpatient procedure; or**

44 (B) **A 340B drug.**

45 (b) **"Insurer" has the meaning given that term in ORS 731.106.**

1 (c) "Medical provider" means:

2 (A) A hospital licensed under ORS 441.020.

3 (B) An ambulatory surgical center licensed under ORS 441.020.

4 (C) An outpatient renal dialysis facility licensed under ORS 441.020.

5 (D) A health professional, other than a primary care provider, who is in independent
6 practice and who receives more than 15 percent of the health professional's gross annual
7 revenue from the sale of prescription drugs other than vaccines or immunizations adminis-
8 tered for the purpose of preventing disease.

9 (d) "Primary care" means family medicine, general internal medicine, naturopathic
10 medicine, obstetrics and gynecology, pediatrics or general psychiatry.

11 (e) "340B drug" means a drug that is purchased at a discount under 42 U.S.C. 256b.

12 (2) A medical provider shall report to the Oregon Health Authority, in the form and
13 manner prescribed by the authority, the following information regarding the medical
14 provider's 50 most prescribed drugs and the 50 most expensive drugs prescribed by the
15 medical provider:

16 (a) The total amount spent on each drug in the preceding three-month period; and

17 (b) The total amount billed to insurers for each drug in the preceding three-month pe-
18 riod.

19 (3) The information reported under subsection (2) of this section shall be reported using
20 the National Drug Code or successor drug identification standard.

21 (4) The authority shall use the information reported under this section to display health
22 care price information on its website, as described in ORS 442.466.

23 (5) The reports required by this section are not intended to duplicate information re-
24 ported to the authority under ORS 442.466.

25 **SECTION 14.** ORS 442.466 is amended to read:

26 442.466. (1) The Oregon Health Authority shall establish and maintain a program that requires
27 reporting entities to report health care data for the following purposes:

28 (a) Determining the maximum capacity and distribution of existing resources allocated to health
29 care.

30 (b) Identifying the demands for health care.

31 (c) Allowing health care policymakers to make informed choices.

32 (d) Evaluating the effectiveness of intervention programs in improving health outcomes.

33 (e) Comparing the costs and effectiveness of various treatment settings and approaches.

34 (f) Providing information to consumers and purchasers of health care.

35 (g) Improving the quality and affordability of health care and health care coverage.

36 (h) Assisting the authority in furthering the health policies expressed by the Legislative As-
37 sembly in ORS 442.025.

38 (i) Evaluating health disparities, including but not limited to disparities related to race and
39 ethnicity.

40 (2) The authority shall prescribe by rule standards that are consistent with standards adopted
41 by the Accredited Standards Committee X12 of the American National Standards Institute, the
42 Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Pro-
43 grams that:

44 (a) Establish the time, place, form and manner of reporting data under this section, including
45 but not limited to:

- 1 (A) Requiring the use of unique patient and provider identifiers;
- 2 (B) Specifying a uniform coding system that reflects all health care utilization and costs for
3 health care services provided to Oregon residents in other states; and
- 4 (C) Establishing enrollment thresholds below which reporting will not be required.
- 5 (b) Establish the types of data to be reported under this section, including but not limited to:
- 6 (A) Health care claims and enrollment data used by reporting entities and paid health care
7 claims data;
- 8 (B) Reports, schedules, statistics or other data relating to health care costs, prices, quality,
9 utilization or resources determined by the authority to be necessary to carry out the purposes of
10 this section; and
- 11 (C) Data related to race, ethnicity and primary language collected in a manner consistent with
12 established national standards.
- 13 (3) Any third party administrator that is not required to obtain a license under ORS 744.702 and
14 that is legally responsible for payment of a claim for a health care item or service provided to an
15 Oregon resident may report to the authority the health care data described in subsection (2) of this
16 section.
- 17 (4) The authority shall adopt rules establishing requirements for reporting entities to train pro-
18 viders on protocols for collecting race, ethnicity and primary language data in a culturally compe-
19 tent manner.
- 20 (5)(a) The authority shall use data collected under this section to provide information to con-
21 sumers of health care to empower the consumers to make economically sound and medically appro-
22 priate decisions. The information must include, but not be limited to, the prices and quality of health
23 care services.
- 24 (b) The authority shall, using only data collected under this section from reporting entities de-
25 scribed in ORS 442.464 (1) to (3) **and data collected from medical providers under section 13 of**
26 **this 2019 Act**, post to its website health care price information including the median prices paid
27 by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most
28 common inpatient procedures and the 100 most common outpatient procedures.
- 29 (c) The health care price information posted to the website must be:
- 30 (A) Displayed in a consumer friendly format;
- 31 (B) Easily accessible by consumers; and
- 32 (C) Updated at least annually to reflect the most recent data available.
- 33 (d) The authority shall apply for and receive donations, gifts and grants from any public or
34 private source to pay the cost of posting health care price information to its website in accordance
35 with this subsection. Moneys received shall be deposited to the Oregon Health Authority Fund.
- 36 (e) The obligation of the authority to post health care price information to its website as re-
37 quired by this subsection is limited to the extent of any moneys specifically appropriated for that
38 purpose or available from donations, gifts and grants from private or public sources.
- 39 (6) The authority may contract with a third party to collect and process the health care data
40 reported under this section. The contract must prohibit the collection of Social Security numbers
41 and must prohibit the disclosure or use of the data for any purpose other than those specifically
42 authorized by the contract. The contract must require the third party to transmit all data collected
43 and processed under the contract to the authority.
- 44 (7) The authority shall facilitate a collaboration between the Department of Human Services, the
45 authority, the Department of Consumer and Business Services and interested stakeholders to de-

1 velop a comprehensive health care information system using the data reported under this section
2 and collected by the authority under ORS 442.120 and 442.400 to 442.463 **and section 13 of this 2019**
3 **Act**. The authority, in consultation with interested stakeholders, shall:

4 (a) Formulate the data sets that will be included in the system;

5 (b) Establish the criteria and procedures for the development of limited use data sets;

6 (c) Establish the criteria and procedures to ensure that limited use data sets are accessible and
7 compliant with federal and state privacy laws; and

8 (d) Establish a time frame for the creation of the comprehensive health care information system.

9 (8) Information disclosed through the comprehensive health care information system described
10 in subsection (7) of this section:

11 (a) Shall be available, when disclosed in a form and manner that ensures the privacy and secu-
12 rity of personal health information as required by state and federal laws, as a resource to insurers,
13 employers, providers, purchasers of health care and state agencies to allow for continuous review
14 of health care utilization, expenditures and performance in this state;

15 (b) Shall be available to Oregon programs for quality in health care for use in improving health
16 care in Oregon, subject to rules prescribed by the authority conforming to state and federal privacy
17 laws or limiting access to limited use data sets;

18 (c) Shall be presented to allow for comparisons of geographic, demographic and economic factors
19 and institutional size; and

20 (d) May not disclose trade secrets of reporting entities.

21 (9) The collection, storage and release of health care data and other information under this
22 section is subject to the requirements of the federal Health Insurance Portability and Accountability
23 Act.

24 **(10)(a) Notwithstanding subsection (9) of this section, in addition to the comprehensive**
25 **health care information system described in subsection (7) of this section, the Department**
26 **of Consumer and Business Services shall be allowed to access, use and disclose data collected**
27 **under this section by certifying, in writing, that the data will only be used to carry out the**
28 **department's duties.**

29 **(b) Personally identifiable information disclosed to the department under paragraph (a)**
30 **of this subsection is confidential and not subject to further disclosure under ORS 192.311 to**
31 **192.478.**

32
33 **STATE AGENCY COST REPORTING FOR PRESCRIPTION DRUGS**

34
35 **SECTION 15.** (1) **The Oregon Health Authority, the Public Employees' Benefit Board, the**
36 **Oregon Educators Benefit Board, the Department of Corrections and the Oregon Youth Au-**
37 **thority shall annually report to the Legislative Assembly, in the manner provided in ORS**
38 **192.245, information about each agency's expenditures for prescription drugs in the preceding**
39 **12-month period, as described in subsection (2) of this section. The Oregon Health Authority**
40 **shall include in its report information about coordinated care organizations' expenditures for**
41 **prescription drugs.**

42 (2) **Each report required by subsection (1) of this section must include:**

43 (a) **The 10 most prescribed drugs and the total cost of the drugs;**

44 (b) **The name and manufacturer of the 10 highest cost drugs, both before and after any**
45 **rebates received from pharmaceutical manufacturers;**

1 (c) Of the drugs reported in paragraph (b) of this subsection, the drug with the greatest
2 total costs and the amount of the total costs;

3 (d) The 10 drugs for which there was the greatest increase in cost to the agency over a
4 12-month period; and

5 (e) Any drug for which the wholesale acquisition cost, as defined in 42 U.S.C.
6 1395w-3a(c)(6)(B), is \$10,000 or more for a one-month supply or for a course of treatment
7 lasting less than one month.

8 (3) The Oregon Health Authority shall notify the Pharmacy and Therapeutics Committee
9 established in ORS 414.353 of drugs described in subsection (2)(e) of this section. The com-
10 mittee shall evaluate the drugs and make recommendations to the authority as required by
11 ORS 414.361 (3) regarding the inclusion of the drugs on any preferred drug list adopted by
12 the authority and on the Practitioner-Managed Prescription Drug Plan.

13 **SECTION 16.** ORS 414.361 is amended to read:

14 414.361. (1) The Pharmacy and Therapeutics Committee shall advise the Oregon Health Author-
15 ity on:

16 (a) Adoption of rules to implement ORS 414.351 to 414.414 in accordance with ORS chapter 183.

17 (b) Implementation of the medical assistance program retrospective and prospective programs
18 as described in ORS 414.351 to 414.414, including the type of software programs to be used by the
19 pharmacist for prospective drug use review and the provisions of the contractual agreement between
20 the state and any entity involved in the retrospective program.

21 (c) Development of and application of the criteria and standards to be used in retrospective and
22 prospective drug use review in a manner that ensures that such criteria and standards are based
23 on compendia, relevant guidelines obtained from professional groups through consensus-driven pro-
24 cesses, the experience of practitioners with expertise in drug therapy, data and experience obtained
25 from drug utilization review program operations. The committee shall have an open professional
26 consensus process for establishing and revising criteria and standards. Criteria and standards shall
27 be available to the public. In developing recommendations for criteria and standards, the committee
28 shall establish an explicit ongoing process for soliciting and considering input from interested par-
29 ties. The committee shall make timely revisions to the criteria and standards based upon this input
30 in addition to revisions based upon scheduled review of the criteria and standards. Further, the drug
31 utilization review standards shall reflect the local practices of prescribers in order to monitor:

32 (A) Therapeutic appropriateness.

33 (B) Overutilization or underutilization.

34 (C) Therapeutic duplication.

35 (D) Drug-disease contraindications.

36 (E) Drug-drug interactions.

37 (F) Incorrect drug dosage or drug treatment duration.

38 (G) Clinical abuse or misuse.

39 (H) Drug allergies.

40 (d) Development, selection and application of and assessment for interventions that are educa-
41 tional and not punitive in nature for medical assistance program prescribers, dispensers and pa-
42 tients.

43 (2) In reviewing retrospective and prospective drug use, the committee may consider only drugs
44 that have received final approval from the federal Food and Drug Administration.

45 (3) The committee shall make recommendations to the authority, subject to approval by the Di-

1 rector of the Oregon Health Authority or the director's designee[,];

2 (a) For drugs to be included on any preferred drug list adopted by the authority and on the
3 Practitioner-Managed Prescription Drug Plan. [*The committee shall also recommend*]

4 (b) **Regarding the utilization of drugs described in section 15 (2)(e) of this 2019 Act and**
5 **the inclusion of the drugs on any preferred drug list adopted by the authority and on the**
6 **Practitioner-Managed Prescription Drug Plan.**

7 (c) All utilization controls, prior authorization requirements or other conditions for the inclu-
8 sion of a drug on a preferred drug list.

9 (4) In making recommendations under subsection (3) of this section, the committee may use any
10 information the committee deems appropriate. The recommendations must be based upon the fol-
11 lowing factors in order of priority:

12 (a) Safety and efficacy of the drug.

13 (b) The ability of Oregonians to access effective prescription drugs that are appropriate for their
14 clinical conditions.

15 (c) Substantial differences in the costs of drugs within the same therapeutic class.

16 (5) The committee shall post a recommendation to the website of the authority no later than 30
17 days after the date the committee approves the recommendation. The director shall approve, disap-
18 prove or modify any recommendation of the committee as soon as practicable, shall publish the de-
19 cision on the website and shall notify persons who have requested notification of the decision. A
20 recommendation adopted by the director, in whole or in part, with respect to the inclusion of a drug
21 on a preferred drug list or the Practitioner-Managed Prescription Drug Plan may not become effec-
22 tive less than 60 days after the date that the director's decision is published.

23 (6) The director shall reconsider any decision to adopt or modify a recommendation of the
24 committee with respect to the inclusion of a particular drug on a preferred drug list or the
25 Practitioner-Managed Prescription Drug Plan, upon the request of any interested person filed no
26 later than 30 days after the director's decision is published on the website. The decision on recon-
27 sideration shall be sent to the requester and posted to the website without undue delay.

28
29 **DISCLOSURE OF FUNDING OF PATIENT ADVOCACY**
30 **ORGANIZATIONS BY PHARMACEUTICAL SUPPLY CHAIN**

31
32 **SECTION 17. Section 18 of this 2019 Act is added to and made a part of ORS 171.725 to**
33 **171.785.**

34 **SECTION 18. (1) As used in this section:**

35 (a) **"Patient advocacy organization" means a nonprofit organization, including but not**
36 **limited to an organization that is exempt from taxation under section 501(c)(3) of the Inter-**
37 **nal Revenue Code:**

38 (A) **That advocates on behalf of patients' access to prescription drugs or pharmaceutical**
39 **treatment;**

40 (B) **On whose behalf a lobbyist was registered or was required to register with the**
41 **Oregon Government Ethics Commission; and**

42 (C) **That has annual gross receipts of more than \$50,000.**

43 (b) **"Pharmaceutical supply chain" means:**

44 (A) **A manufacturer, as defined in section 2, chapter 7, Oregon Laws 2018.**

45 (B) **A wholesale distributor of prescription drugs.**

1 (C) A pharmacy benefit manager, as defined in ORS 735.530.

2 (D) An insurer, as defined in ORS 731.106, that offers health insurance, as defined in ORS
3 731.162, that reimburses the cost of prescription drugs.

4 (E) A hospital, as defined in ORS 442.015.

5 (F) A health care professional that charges a patient for the cost of a prescription drug
6 administered by the health care professional.

7 (G) A coordinated care organization, as defined in ORS 414.025.

8 (H) A for-profit entity that provides health care.

9 (I) A trade association for any person described in this paragraph.

10 (c) "Prescription drug" has the meaning given that term in section 2, chapter 7, Oregon
11 Laws 2018.

12 (2) A patient advocacy organization that receives more than 10 percent of its annual
13 budget from payments, donations, subsidies or other consideration from persons in the
14 pharmaceutical supply chain shall file with the statement required by ORS 171.750 a state-
15 ment containing the following information:

16 (a) The total amount of the consideration received by the patient advocacy organization
17 from all persons in the pharmaceutical supply chain reported as a percentage of the
18 organization's annual budget; and

19 (b) For any payment, donation, subsidy or other consideration of \$1,000 or more received
20 from a person in the pharmaceutical supply chain, the person's name and the amount of the
21 consideration.

22 (3) The Oregon Government Ethics Commission shall provide to the Attorney General,
23 upon request, a copy of the statement containing the information described in subsection (2)
24 of this section.

25
26 **DISCLOSURE OF REBATES, FEES AND REIMBURSEMENTS BY**
27 **PHARMACY BENEFIT MANAGERS AND INSURERS**
28 **(To the Department of Consumer and Business Services)**
29

30 **SECTION 19.** Sections 20 and 21 of this 2019 Act are added to and made a part of the
31 Insurance Code.

32 **SECTION 20.** (1) As used in this section and section 21 of this 2019 Act:

33 (a) "Manufacturer" has the meaning given that term in section 2, chapter 7, Oregon
34 Laws 2018.

35 (b) "Rebate" means a retroactive abatement, credit, discount or refund usually as con-
36 sideration for a specified volume of business.

37 (2) A pharmacy benefit manager registered under ORS 735.532 shall submit an annual
38 report to the Department of Consumer and Business Services on prescription drugs for
39 which the:

40 (a) Wholesale acquisition cost, as defined in 42 U.S.C. 1395w-3a(c)(6)(B), is \$100 or more
41 for a one-month supply or for a course of treatment lasting less than one month; or

42 (b) Average reimbursement received from an insurer by the pharmacy benefit manager
43 for the prescription drug is 25 percent or more than the average reimbursement paid by re-
44 tail pharmacies.

45 (3) The pharmacy benefit manager shall submit the report in the form and manner pre-

1 scribed by the department and shall include the following information:

2 (a) The average rebate paid by the manufacturer of the prescription drug to the phar-
3 macy benefit manager;

4 (b) The average reimbursement paid by the pharmacy benefit manager to retail pharma-
5 cies; and

6 (c) The average reimbursement paid to the pharmacy benefit manager by insurers or
7 other clients of the pharmacy benefit manager.

8 (4) The information shall be reported using the national drug code number for the for-
9 mulation of the prescription drug as assigned by the United States Food and Drug Adminis-
10 tration.

11 (5) The department may increase the registration fee paid by pharmacy benefit managers
12 under ORS 735.532 if necessary to pay the expenses of the department in administering the
13 reporting functions required by this section.

14
15 (To Plan Sponsors)

16
17 **SECTION 21.** A pharmacy benefit manager registered under ORS 735.532 shall report to
18 a plan sponsor, following the end of each three-month period within a plan year:

19 (1) The total amount of rebates, incentives and fees received by the pharmacy benefit
20 manager from pharmaceutical manufacturers and the percentage of the rebates, incentives
21 and fees received by the pharmacy benefit manager from pharmaceutical manufacturers that
22 were paid to the plan sponsor during the three-month period;

23 (2) The fee paid by the pharmacy benefit manager to each retail pharmacy during the
24 three-month period for the dispensing of a prescription drug; and

25 (3) The fee charged to the plan sponsor during the three-month period to process a claim
26 for the dispensing of a prescription drug.

27 **SECTION 22.** ORS 743.020 is amended to read:

28 743.020. An insurer licensed by the Department of Consumer and Business Services shall include
29 in any rate filing under ORS 743.018 with respect to individual and small employer health insurance
30 policies:

31 (1) A statement of administrative expenses in the form and manner prescribed by the department
32 by rule[. *The statement must include*], **including** but [*is*] not limited to:

33 [(1)] (a) A statement of administrative expenses on a per member per month basis; and

34 [(2)] (b) An explanation of the basis for any proposed premium rate increases or decreases.

35 (2)(a) A certified statement of the percentage of rebates, as defined in section 2, chapter
36 7, Oregon Laws 2018, received by the insurer from manufacturers, as defined in section 2,
37 chapter 7, Oregon Laws 2018, that were applied to directly offset premiums or out-of-pocket
38 costs for enrollees or to otherwise directly benefit enrollees; and

39 (b) A certified statement of how the insurer spent the percentage of rebates received
40 from manufacturers that were not applied as described in paragraph (a) of this subsection.

41 **SECTION 23.** Section 3, chapter 7, Oregon Laws 2018, is amended to read:

42 **Sec. 3.** (1) A manufacturer or pharmacy benefit manager that fails to report or provide in-
43 formation as required by section 2, [*of this 2018 Act*] **chapter 7, Oregon Laws 2018, or section 20**
44 **of this 2019 Act**, may be subject to a civil penalty as provided in this section.

45 (2) The Department of Consumer and Business Services shall adopt a schedule of penalties, not

1 to exceed \$10,000 per day of violation, based on the severity of each violation.

2 (3) The department shall impose civil penalties under this section as provided in ORS 183.745.

3 (4) The department may remit or mitigate civil penalties under this section upon terms and
4 conditions the department considers proper and consistent with the public health and safety.

5 (5) Civil penalties collected under this section shall be paid over to the State Treasurer and
6 deposited in the General Fund to be made available for general governmental expenses.

7
8 **TASK FORCE ON FAIR PRICING OF PRESCRIPTION DRUGS**

9
10 **SECTION 24.** Section 11, chapter 7, Oregon Laws 2018, is amended to read:

11 **Sec. 11.** (1) The Task Force on the Fair Pricing of Prescription Drugs is established.

12 (2) The task force consists of 18 members appointed as follows:

13 (a) The President of the Senate shall appoint:

14 (A) One member from the Senate who is a member of the majority party.

15 (B) One member from the Senate who is a member of the minority party.

16 (b) The Speaker of the House of Representatives shall appoint:

17 (A) One member from the House of Representatives who is a member of the majority party.

18 (B) One member from the House of Representatives who is a member of the minority party.

19 (c) The Governor shall appoint the following members:

20 (A) One representative from the Department of Consumer and Business Services;

21 (B) One representative from the Oregon Health Authority;

22 (C) One representative from the Oregon Health Policy Board; and

23 (D) Individuals representing:

24 (i) Pharmaceutical manufacturers;

25 (ii) Insurance companies offering health insurance in this state;

26 (iii) Pharmacy benefit managers;

27 (iv) Prescription drug wholesalers;

28 (v) Consumers;

29 (vi) Independent pharmacies;

30 (vii) Large retail pharmacy chains;

31 (viii) Hospitals;

32 (ix) Biopharmaceutical companies based in Oregon;

33 (x) Coordinated care organizations; and

34 (xi) Medical providers.

35 (3) The task force shall [*develop a strategy to create transparency for drug prices across the entire*
36 *supply chain of pharmaceutical products, including but not limited to manufacturers, insurers, phar-*
37 *macy benefit managers, distributors, wholesalers and retail pharmacies.]:*

38 (a) **Evaluate legislation enacted during the 2019 regular session of the Eightieth Legisla-**
39 **tive Assembly that was intended to address transparency in the cost of prescription drugs**
40 **and any similar legislation that has been enacted in other states; and**

41 (b) **Evaluate additional strategies that may be used to reduce the cost of prescription**
42 **drugs for Oregonians.**

43 (4) A majority of the voting members of the task force constitutes a quorum for the transaction
44 of business.

45 (5) Official action by the task force requires the approval of a majority of the voting members

1 of the task force.

2 (6) The task force shall elect one of its members to serve as chairperson.

3 (7) If there is a vacancy for any cause, the appointing authority shall make an appointment to
4 become immediately effective.

5 (8) The task force shall meet at times and places specified by the call of the chairperson or of
6 a majority of the voting members of the task force.

7 (9) The task force may adopt rules necessary for the operation of the task force.

8 (10) The task force shall submit a report **of its findings under subsection (3) of this section**
9 in the manner provided by ORS 192.245, and may include recommendations for legislation, to the
10 interim committees of the Legislative Assembly related to health no later than *[November 1, 2018]*
11 **September 15, 2020**. The report must contain a cost-effective and enforceable solution that exposes
12 the cost factors that negatively impact prices paid by Oregonians for pharmaceutical products.

13 (11) The Legislative Policy and Research Director shall provide staff support to the task force.

14 (12) Members of the Legislative Assembly appointed to the task force are nonvoting members
15 of the task force and may act in an advisory capacity only.

16 (13) Members of the task force who are not members of the Legislative Assembly are not enti-
17 tled to compensation or reimbursement for expenses and serve as volunteers on the task force.

18 (14) All agencies of state government, as defined in ORS 174.111, are directed to assist the task
19 force in the performance of the task force's duties and, to the extent permitted by laws relating to
20 confidentiality, to furnish information and advice the members of the task force consider necessary
21 to perform their duties.

22 **SECTION 25.** Section 12, chapter 7, Oregon Laws 2018, is amended to read:

23 **Sec. 12.** Section 11, *[of this 2018 Act]* **chapter 7, Oregon Laws 2018**, is repealed on December
24 31, *[2020]* **2021**.

25
26 **INSURER PRESCRIPTION DRUG PRICES**
27

28 **SECTION 26.** Section 5, chapter 7, Oregon Laws 2018, is amended to read:

29 **Sec. 5.** (1) An insurer shall *[include with any filing under ORS 743.018]* **annually report to the**
30 **Department of Consumer and Business Services, in the manner and format prescribed by the**
31 **department**, the following information regarding drugs reimbursed by *[the insurer under policies or*
32 *certificates]* **health benefit plans, as defined in ORS 743B.005, issued by the insurer** in this state:

33 (a) The *[25]* **50** most frequently prescribed drugs;

34 (b) The *[25]* **50** most costly drugs as a portion of total annual spending, **both before and after**
35 **any rebates received from manufacturers;**

36 (c) The *[25]* **50** drugs that have caused the greatest increase in total plan spending from one year
37 to the next; and

38 (d) **Any drug for which the price is \$10,000 or more for a one-month supply or for a**
39 **course of treatment lasting less than one month.**

40 (2) **For the drugs specified in subsection (1) of this section, the report must include:**

41 (a) **The average out-of-pocket cost to an enrollee for a one-month supply or a course of**
42 **treatment;**

43 (b) **The average cost paid by the insurer to a pharmacy benefit manager or third party**
44 **administrator; and**

45 *[(d)]* (c) **The impact of the costs of prescription drugs on premium rates.**

1 [(2)] (3) The Department of Consumer and Business Services shall conduct a public hearing an-
2 nually on:

3 (a) Prescription drug prices[,];

4 (b) Information reported to the department under section 2, [of this 2018 Act] **chapter 7,**
5 **Oregon Laws 2018;** [and]

6 (c) Information described in [subsection (1)] **subsections (1) and (2)** of this section;

7 (d) **Information reported by carriers under ORS 743B.013 (17), 743B.105 (10) and 743B.125**
8 **(11); and**

9 (e) **Information reported by pharmacy benefit managers under section 20 of this 2019**
10 **Act.**

11 [(3)] (4) The department shall regularly update the interim committees of the Legislative As-
12 sembly related to health on the information described in [subsection (1)] **subsections (1) and (2)** of
13 this section.

14 [(4) Subsection (1) of this section applies to an insurer that issues policies or certificates of health
15 insurance for sale in this state that include a prescription drug benefit.]

16 **SECTION 27.** ORS 743.018, as amended by section 8, chapter 7, Oregon Laws 2018, is amended
17 to read:

18 743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015,
19 every insurer shall file with the Director of the Department of Consumer and Business Services all
20 schedules and tables of premium rates for life and health insurance to be used on risks in this state,
21 and shall file any amendments to or corrections of such schedules and tables. Premium rates are
22 subject to approval, disapproval or withdrawal of approval by the director as provided in ORS
23 742.003, 742.005, 742.007 and 743.019.

24 (2) Except as provided in ORS 743B.013 and subsection (3) of this section, a rate filing by a
25 carrier for any of the following health benefit plans subject to ORS 743.004, 743.022, 743.535 and
26 743B.003 to 743B.127 shall be available for public inspection immediately upon submission of the
27 filing to the director:

28 (a) Health benefit plans for small employers.

29 (b) Individual health benefit plans.

30 (3) The director may by rule:

31 (a) Specify all information a carrier must submit as part of a rate filing under this section; and

32 (b) Identify the information submitted that will be exempt from disclosure under this section
33 because the information constitutes a trade secret and would, if disclosed, harm competition.

34 (4) The director, after conducting an actuarial review of the rate filing, may approve a proposed
35 premium rate for a health benefit plan for small employers or for an individual health benefit plan
36 if, in the director's discretion, the proposed rates are:

37 (a) Actuarially sound;

38 (b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

39 (c) Based upon reasonable administrative expenses.

40 (5) In order to determine whether the proposed premium rates for a health benefit plan for small
41 employers or for an individual health benefit plan are reasonable and not excessive, inadequate or
42 unfairly discriminatory, the director may consider:

43 (a) The insurer's financial position, including but not limited to profitability, surplus, reserves
44 and investment savings.

45 (b) Historical and projected administrative costs and medical and hospital expenses[, including

1 *expenses for drugs reported under section 5, chapter 7, Oregon Laws 2018].*

2 (c) Historical and projected loss ratio between the amounts spent on medical services and
3 earned premiums.

4 (d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

5 (e) Changes to covered benefits or health benefit plan design.

6 (f) Changes in the insurer's health care cost containment and quality improvement efforts since
7 the insurer's last rate filing for the same category of health benefit plan.

8 (g) Whether the proposed change in the premium rate is necessary to maintain the insurer's
9 solvency or to maintain rate stability and prevent excessive rate increases in the future.

10 (h) Any public comments received under ORS 743.019 pertaining to the standards set forth in
11 subsection (4) of this section and this subsection.

12 (6) The requirements of this section do not supersede other provisions of law that require
13 insurers, health care service contractors or multiple employer welfare arrangements providing
14 health insurance to file schedules or tables of premium rates or proposed premium rates with the
15 director or to seek the director's approval of rates or changes to rates.

16
17 **PHARMACEUTICAL MANUFACTURER REGISTRATION WITH**
18 **DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**
19

20 **SECTION 28. (1) As used in this section:**

21 (a) "Manufacturer" has the meaning given that term in section 2, chapter 7, Oregon
22 Laws 2018.

23 (b) "Wholesale acquisition cost" has the meaning given that term in 42 U.S.C.
24 1395w-3a(c)(6)(B).

25 (2) A manufacturer shall annually register with the Department of Consumer and Busi-
26 ness Services, as provided in this section, if the manufacturer:

27 (a) Is required to register with the State Board of Pharmacy as a manufacturing drug
28 outlet under ORS 689.305; and

29 (b) Has established or changed the wholesale acquisition cost for a drug that it manu-
30 factures.

31 (3) To register with the department, the manufacturer shall submit an application as
32 prescribed by the department by rule and pay the registration fee adopted by the department.

33 (4) A registration may be renewed upon payment of a registration fee.

34 (5) The department shall adopt by rule the fees required for registration and for the an-
35 nual renewal of a registration, based upon the department's reasonable costs in administer-
36 ing sections 2 and 3, chapter 7, Oregon Laws 2018, and this section.

37 (6) Moneys collected by the department under subsections (3) and (4) of this section shall
38 be deposited in the Consumer and Business Services Fund created in ORS 705.145.

39 **SECTION 29. The Department of Consumer and Business Services may request informa-**
40 **tion from any manufacturer, as defined in section 2, chapter 7, Oregon Laws 2018, regarding**
41 **any matter related to the administration of sections 2 and 3, chapter 7, Oregon Laws 2018,**
42 **and section 28 of this 2019 Act. The manufacturer must respond promptly and in the format**
43 **requested by the department. The department may require any response to be verified by an**
44 **officer of a manufacturer. A response from a manufacturer is subject to ORS 731.260.**
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OPERATIVE DATES AND APPLICABILITY DATES

SECTION 30. The amendments to ORS 743B.013, 743B.105 and 743B.125 by sections 7 to 9 of this 2019 Act apply to health benefit plans issued, extended or renewed on or after January 1, 2021.

SECTION 31. Section 11 of this 2019 Act applies to pharmacy benefits, as defined in section 11 of this 2019 Act, offered or administered by insurers, pharmacy benefit managers or third party administrators on and after the effective date of this 2019 Act.

SECTION 32. The report described in section 20 of this 2019 Act is first due on March 15, 2020.

SECTION 33. The amendments to ORS 243.135, 414.312 and 414.625 by sections 2 to 6 of this 2019 Act apply to plan years beginning on and after January 1, 2021.

SECTION 34. Section 13 of this 2019 Act and the amendments to ORS 442.466 by section 14 of this 2019 Act become operative on July 1, 2022.

APPROPRIATION

SECTION 35. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2019, out of the General Fund, the amount of \$390,534, which may be expended for carrying out the provisions of this 2019 Act.

CAPTIONS

SECTION 36. The unit captions used in this 2019 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2019 Act.
