Testimony on SB 608 -A2 Amendment: Co-Pay Accumulator Legislation

May 8, 2023

Chair Nosse and Members of the Committee,

My name is Mary Anne Cooper, and I'm the Oregon Director of Government Relations at Cambia Health Solutions, which operates Regence Blue Cross Blue Shield of Oregon. Thank you for the opportunity to submit testimony on SB 608 -A2 Amendment. We are concerned that SB 608 -A2 Amendment, while offered as a measure to help patients, will increase already significant profit margins for drug manufacturers, increase health insurance costs, and keep patients on expensive drugs even if lower cost, equally effective treatments are available on the market. We believe there are several more patient-focused solutions to drug affordability that we encourage the committee to consider in place of SB 608 -A2 Amendment.

As one of the state's largest health insurers, Regence is committed to addressing both persistent and emerging health needs for the nearly one million Oregonians we serve. In keeping with our values as a tax paying nonprofit, 85% of every premium dollar goes to pay our members' medical claims and expenses. In Oregon, prescription drugs account for 20-30% of all plan spending.[1] These costs are largely driven by specialty drug spending, where manufacturer coupons are often directed. Within Regence, specialty drugs account for only 1.2% of claims, but over 55% of the total costs of prescription drugs.

Today our members can and do use manufacturer coupons to help offset their obligation at the pharmacy counter, but only the member's own out-of-pocket costs "count" toward their cost share obligation under their policy. This wouldn't be a problem if manufacturers consistently provided coupons throughout the calendar year, but some manufacturers have limits that appear to be more focused on incentivizing use of their drug, such as only making them available for a limited

[1] Department of Consumer and Business Services. (2022, November 30). Prescription Drug Price Transparency Results and Recommendations – 2022. Retrieved March 9, 2023, from https://dfr.oregon.gov/drugtransparency/Documents/Prescription-Drug-Price-Transparency-Annual-Report-2021.pdf

number of fills. SB 608 -A2 Amendment's requirement for insurers to count those coupons toward the members' cost-share obligations limits the value of coupon assistance manufacturers would provide before the plan picks up 100% of the cost and incentivizes patients to stay on high-cost drugs, even if equally effective alternative therapies are available or introduced to the market.

Of note, people in the United States pay twice as much for their prescriptions compared to thirty-two other developed countries.[2] We know that many people cannot afford the high costs of their medications without insurance. The skyrocketing price of prescription drugs is one of the main reasons the state has created the Prescription Drug Affordability Board and the Prescription Drug Price Transparency Board, neither of which have endorsed this approach to improve drug affordability.

Over the years, manufacturers have aggressively raised prices on existing drugs and have continuously raised the price of new drugs. The Congressional Oversight Committee Investigation on Drug Pricing found that manufacturers raised the price of 12 drugs over 250 times with the median price of those drugs being almost 500% higher than when it was originally brought to market.[3] In 2008, the average cost of a new drug entering the market was $2,000 annually, today it is $220,000 annually.[4]

Manufacturers use copay coupons to mask these high prices. Coupons are given to patients to help them afford the unjustified cost of the medications that Americans pay more for than any other part of the world. Manufacturers are now asking for the state's help to circumvent health plan tools that lower prescription drug spending and steer patients toward more expensive drugs.

Yet, these coupons have been associated with drug cost increases. According to a study done by researchers from Harvard, UCLA, and Northwestern, "coupons are associated with faster branded price growth. Drugs without coupons experience real price growth of 7–8 percent per year, while drugs with coupons experience price growth of 12–13 percent per year."[5] Notably, government health plans such as Medicare and Medicaid have banned copay coupons as a form of an illegal kickback.

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[2] Drug pricing investigation : majority staff report. (2021). Committee on Oversight and Reform, U.S. House of Representatives.

[3] Drug pricing investigation : majority staff report. (2021). Committee on Oversight and Reform, U.S. House of Representatives.

[4] https://www.reuters.com/business/healthcare-pharmaceuticals/us-new-drug-price-exceeds-200000-median-2022-2023-01-05/#:~:text=The%20median%20annual%20price%20of,2022%2C%20the%20median%20was%20%24222%2C003

[5] Dafny, L., Ody, C., & Schmitt, M. (2017). When discounts raise costs: the effect of copay coupons on generic utilization. *American Economic Journal: Economic Policy*, *9*(2), 91-123.

Medicare's ban on copay coupons saved the Part D program an estimated $18 billion over the last ten years.[6]

Manufacturers have the power to lower drug prices and alleviate patient cost burden. We saw that recently when Eli Lily significantly lowered the price of their insulin by 70%. Yet manufacturers continue to tout coupons as the solution. Why? Because the coupons bolster ever-increasing revenue targets and incentivize patients to use expensive treatments. Copay coupons are not charity. Rather, they are a key part of drug manufacturers' shell games that distract from unreasonable and constant price increases. Nationally the continued use of copay coupons will raise overall drug spending by $32 billion for employers, unions and other plan sponsors while earning drug manufacturers a 4:1 to 6:1 return on investment.[7]

Utah's government-run Public Employee Health Plan recently completed a fiscal analysis of how a bill similar to SB 608 -A2 Amendment would impact that state's benefit plan. They concluded that state healthcare spending would rise by more than $2.7 million, with about 85% of the added cost directly benefiting drug manufacturers (because available assistance would no longer be maximized) and only 15% benefiting patients (who would hit their deductibles faster). We are working on getting specific numbers for Regence in Oregon.

As health plans continue to pay for increasingly costly drugs, the unwanted but necessary effect is rising health insurance costs. Of note, plans and employers must grapple with prohibitive costs of newer emerging drug therapies with list prices in the $2-3 million dollar range. Indeed, Regence has seen its drug spending rise in recent years, from $90 PMPM in January 2022 to $110 PMPM in February 2023, with a total increase in our fully insured business of $29 million during that time period. SB 608 - A2 Amendment would exacerbate this trend. If the legislature's concern is a patient's inability to afford their insurance cost share obligation for expensive specialty drugs, there are several solutions that would address that concern without incentivizing excessive drug prices from manufacturers. We are happy to work with the committee on those solutions.

[6] Visante Copay Coupon Study. "How Copay Coupons Could Raise Prescription Drug Costs by $32 Billion Over the Next Decade." October 2011.

[7] Wickersham, P. (2013). Sorting out the truth about copay coupons. Employee Benefit Plan Review, 67(10), 26.

We also note that pharmaceutical companies have figured how to bypass laws that disallow them from providing financial assistance directly to patients. By aggressively donating money to patient advocacy groups, manufacturers have financially motivated these charity groups to push pro-pharmaceutical legislation even though some of the legislative outcomes actually harm patients. Current federal regulations allow drug manufacturers to make tax deductible donations to patient assistance charities which do not have to be publicly reported.[8]

The Oregon Prescription Drug Affordability Board has recommended that all manufacturers report annually on all patient assistance programs that they maintain or fund. We support this approach, as it will provide more information on the roles pharmaceutical manufacturers play in shaping policies such as SB 608 -A2 Amendment.

We would love to work with this committee to find a solution that primarily benefits patients, not drug manufacturers. We have several solutions we have identified that help solve the problem of untenable drug prices impacting consumers' ability to afford their medications without incentivizing drug cost increases, that we are happy to share with the committee.

As drafted, we oppose SB 608 -A2 Amendment, as the benefits would flow overwhelmingly to drug manufacturers and fails to address unjustified high drug prices. We share the goal of the committee of easing the burden of skyrocketing drug prices on consumers and look forward to working with the committee on solutions.

Thank you for the opportunity to submit testimony, and please let me know if you have any questions.

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[8] Dafny, Leemore, Christopher Ody, and Teresa Rokos. "Giving a Buck or Making a Buck? Donations by Pharmaceutical Manufacturers to Independent Patient Assistance Charities." Health Affairs 41, no. 9 (September 2022).

Co-Pay Accumulator Amendments – Cambia (drafted as amendment to -A2 Amendment to SB 608)

SECTION 3. Section 4 of this 2023 Act is added to and made a part of the Insurance Code.

SECTION 4. (1) As used in this section:

"Qualified prescription drug" means a prescription drug that is not readily available in all pharmacies, including an injectable medication, that is covered under a health plan and for which:

(i)(A) there is no generic equivalent, biosimilar as defined in 42 U.S. Code § 262, or interchangeable biological product; or

(B) there is no covered drug in the same therapeutic category used to treat the insured's condition that is preferred under a formulary for the insured's health benefit plan; or

(ii) the insured has:

(A)(1) received preauthorization from the health benefit plan for the prescription drug; and

(2) completed the health benefit plan's step therapy protocol or other utilization management requirements for the prescription drug; or

(B) received authorization for the prescription drug as the result of an internal or external review.

~~**(a)(A) "Generic equivalent" means a drug that meets applicable standards of strength, quality and purity according to the United States Pharmacopoeia or other nationally recognized compendium and that, compared to a brand name drug:**~~

~~**(i) Has an identical amount of the same active chemical ingredients and the same dosage form; and**~~

~~**(ii) If administered in the same amounts, will provide comparable therapeutic effects.**~~

~~**(B) "Generic equivalent" does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.**~~

(b)(A) "Health plan" means:

(i) An individual or group health benefit plan, as defined in ORS 743B.005;

(ii) A plan providing coverage for a specific disease or condition only;

(iii) A medical services contract;

(iv) A health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board; or

(v) Other similar certificate, policy, contract or arrangement or any endorsement or rider that covers all or a portion of the cost of an individual's health care and that is subject to regulation by the Department of Consumer and Business Services.

(B) "Health plan" does not include coverages provided by:

(i) Medicare;

(ii) The state medical assistance program;

(iii) The federal government to federal employees;

(iv) TRICARE;

(v) Workers' compensation;

(vi) Limited benefit coverage; or

(vii) Accident only, credit, disability or long term care insurance.

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(c) "High deductible health plan" means a health plan described in 26 U.S.C. 223.

(d) "Person" includes:

(A) An individual;

(B) A trust;

(C) An estate;

(D) A partnership; (E) A corporation;

(F) An association;

(G) A joint stock company;

(H) An insurance company;

(I) A state;

(J) A political subdivision, instrumentality or municipal corporation of a state; or (K) A nonprofit organization.

(e) "Pharmacy benefit manager" means a pharmacy benefit manager, as defined in ORS 735.530, that manages pharmacy benefits for a health plan.

(f) "Preventive services" has the meaning given that term in 42 U.S.C. 1395x.

~~(2) To the extent permitted by federal law, an insurer offering a health plan that provides pharmacy benefits and a pharmacy benefit manager shall include all amounts paid by an enrollee or paid by another person on behalf of an enrollee toward the cost of a covered~~ qualified prescription drug when calculating the enrollee's contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement ~~applied to the drug if:~~

~~(a) The drug does not have a generic equivalent; or~~

~~(b) The drug has a generic equivalent and the enrollee has:~~

~~(A) Obtained prior authorization from the insurer or pharmacy benefit manager;~~

~~(B) Complied with a step therapy protocol; or~~

~~(C) Received approval from the insurer or pharmacy benefit manager through the insurer's or the pharmacy benefit manager's exceptions, appeal or review process~~.

~~(3)~~ For high deductible health plans the provisions of subsection (2) of this section apply only to preventive services until the enrollee has satisfied the ~~minimum~~ deductible under ~~26 U.S.C. 223(c)(2)~~the plan.

(4) If a manufacturer pays an amount on behalf of an enrollee for a covered prescription drug, such manufacturer:

(a) must provide the full value of the assistance to the enrollee until the enrollee meets its cost sharing requirements, and to the enrollee's health benefit plan thereafter;

(b) may not discontinue a coupon during a calendar year;

(c) must notify the insured prior to November 1 if the financial assistance will be discontinued in a subsequent calendar year;

(d) must base its decision to pay an amount to reduce or eliminate an insured's cost sharing requirement solely on the insured's financial need;

(e) may not condition the assistance on enrollment in a specific health benefit plan, except to ensure compliance with 42 U.S.C. § 1320a-7b(b) and related federal anti-kickback statutes;

(f) must provide assistance to an individual without health insurance coverage on terms no less favorable than those offered to insureds;

(g) may not adjust the amount of assistance it provides to an insured if the insured's health benefit plan eliminates the insured's cost sharing requirements when payments are made on an insured's behalf for a qualified prescription drug; and

(h) may not provide assistance in the form of a post claim reimbursement to an insured.

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(5) A drug manufacturer may not offer a coupon for any drug where the manufacturer has triggered reporting obligations under ORS 646A.689(2)(b) in the prior year.

(6) On or before August 1, 2024, and on or before August 1 of each year thereafter, a manufacturer shall report the following information for the preceding calendar year for each prescription drug for which a discount, rebate, product voucher, or other reduction intended to lower an insured's cost sharing is offered:

(a) The number of patients in the state who received assistance;

(b) The total value of such assistance;

(c) The terms and conditions to qualify for assistance and how eligibility is verified for accuracy;

(d) The total sales of the prescription drug in the state, based on the prescription drug's wholesale acquisition cost; and

(e) The steps the manufacturer takes to comply with 42 U.S.C. § 1320a-7b(b).

~~(7)~~ **(7) The report described in Subsection (6) shall be provided to the Division of Financial Regulation and each health benefit plan subject to this section.**

(8) The Department of Financial Regulation may make rules to implement this Section.

SECTION 5. ORS 243.144, as amended by section 2, chapter 72, Oregon Laws 2022, is amended to read:

243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in: (1) ORS 743A.058;

(2) ORS 743B.256;

(3) ORS 743B.420;

(4) ORS 743B.423;

(5) ORS 743B.601;

(6) ORS 743B.810; [*and*]

(7) ORS 743B.287 (4)**; and**

(8) **Section 4 of this 2023 Act**.

SECTION 6. ORS 243.877, as amended by section 3, chapter 72, Oregon Laws 2022, is amended to read:

243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743B.256;

(3) ORS 743B.420;

(4) ORS 743B.423;

(5) ORS 743B.601;

(6) ORS 743B.810; [*and*]

(7) ORS 743B.287 (4)**; and**

(8) Section 4 of this 2023 Act.

SECTION 7. ORS 743B.001 is amended to read:

743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550, 743B.555 and 743B.602 **and section 4 of this 2023 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

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(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

(f) Denial, in whole or in part, of a request for prior authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to other utilization review requirements.

(2) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Clinical review criteria" means screening procedures, decision rules, medical protocols and clinical guidance used by an insurer or other entity in conducting utilization review and evaluating: (a) Medical necessity;

(b) Appropriateness of an item or health service for which prior authorization is requested or for which an exception to step therapy has been requested as described in ORS 743B.602; or (c) Any other coverage that is subject to utilization review.

(4) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(5) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(6) "Enrollee" has the meaning given that term in ORS 743B.005.

(7) "Essential community provider" has the meaning given that term in rules adopted by theDepartment of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

(8) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(9) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(10) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

(11) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(12) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(13) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(14) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(15)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receivebenefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers byproviding an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(16) "Prior authorization" means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(17)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(18) "Step therapy" means a utilization review protocol, policy or program in which an insurer requires certain preferred drugs for treatment of a specific medical condition be proven ineffective or contraindicated before a prescribed drug may be reimbursed.

(19) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.

SECTION 8. ORS 750.055, as amended by section 11, chapter 37, Oregon Laws 2022, is amended to read:

750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.138 and 705.139.

(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS 734.014 to 734.440.

(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to742.542.

(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, **743.025,** 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.

(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170,

743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2, 7 chapter 771, Oregon Laws 2013, and sections 6 and 7, chapter 37, Oregon Laws 2022.

8 (i) ORS [*743.025,*] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197,

9 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 10 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,

11 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 12 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 13 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 **and section 4 of this 2023 Act**.

14 (j) The following provisions of ORS chapter 744:

15 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-

16 ers;

17 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and 18 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

19 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 20 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

21 (2) The following provisions of the Insurance Code apply to health care service contractors ex22 cept in the case of group practice health maintenance organizations that are federally qualified 23 pursuant to Title XIII of the Public Health Service Act:

24 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper25 ates an in-house drug outlet.

26 (b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse 27 practitioner associated with a group practice health maintenance organization.

28 (3) For the purposes of this section, health care service contractors are insurers.

29 (4) Any for-profit health care service contractor organized under the laws of any other state that 30 is not governed by the insurance laws of the other state is subject to all requirements of ORS 31 chapter 732.

32 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de33 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

34 (b) A health care service contractor's classification as a domestic insurance company under 35 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 36 to 734.710.

37 (6) The Director of the Department of Consumer and Business Services may, after notice and 38 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 39 and 750.045 that are necessary for the proper administration of these provisions.

SECTION 9. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws

2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, and section 12, chapter 37, Oregon Laws 2022, is amended to read:

750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.138 and 705.139.

(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS 734.014 to 734.440.

(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, **743.025,** 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.

(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and sections 6 and 7, chapter 37, Oregon Laws 2022.

(i) ORS [*743.025,*] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 **and section 4 of this 2023 Act**.

(j) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

(b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nursepractitioner associated with a group practice health maintenance organization.

(3) For the purposes of this section, health care service contractors are insurers.

(4) Any for-profit health care service contractor organized under the laws of any other state thatis not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

SECTION 10. Section 4 of this 2023 Act and the amendments to ORS 243.144, 243.877, 743B.001 and 750.055 by sections 3 to 7 of this 2023 Act apply to health plans, as defined in section 4 of this 2023 Act, and to health care service contracts offered by health care service contractors, as defined in ORS 750.005, issued, renewed or extended on or after the effective date of this 2023 Act.

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