Senate Bill 237

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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 **as introduced.**

Requires at least 25 percent of carrier's individual and group health benefit plans within each metal level of coverage to have copayment-only cost sharing requirements.

A BILL FOR AN ACT

Relating to cost sharing for prescription drugs.

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

SECTION 1. Sections 2 and 3 of this 2017 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Copayment-only plan" means a plan that imposes a single flat copayment amount on all prescription drugs paid for or reimbursed by the plan.

(b) "Cost sharing" includes copayments, coinsurance or deductibles.

(c) "Metal level of coverage" means a bronze, silver, gold or platinum level as described in 42 U.S.C. 18022(d).

(d) "Plan" means a health benefit plan, as defined in ORS 743B.005, that pays for or reimburses the cost of prescription drugs.

(e) "Tier" means a group of prescription drugs, within a drug formulary, to which defined cost sharing requirements apply.

(2) At least 25 percent of a carrier's individual plans in each metal level of coverage offered in each geographic area served by the carrier must be copayment-only plans. If a carrier offers only one plan in a metal level of coverage in a geographic area, the plan must be a copayment-only plan.

(3) An individual plan that is not a copayment-only plan may have different cost sharing requirements for each tier if the cost sharing among all tiers is proportional.

(4) The Department of Consumer and Business Services shall adopt by rule a standard to evaluate whether a plan complies with subsection (3) of this section to ensure that:

(a) The cost sharing requirements among all tiers are proportional;

(b) The highest-cost prescription drugs are not assigned to only the highest-cost tier; and

(c) Not all prescription drugs that treat a specific condition are assigned to only the highest-cost tier.

SECTION 3. (1) As used in this section:

(a) "Copayment-only plan" means a plan that imposes a single flat copayment amount on all prescription drugs paid for or reimbursed by the plan.

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.

(b) "Cost sharing" includes copayments, coinsurance or deductibles.

(c) "Metal level of coverage" means a bronze, silver, gold or platinum level as described in 42 U.S.C. 18022(d).

(d) "Plan" means a health benefit plan, as defined in ORS 743B.005, that pays for or reimburses the cost of prescription drugs.

(e) "Tier" means a group of prescription drugs, within a drug formulary, to which defined cost sharing requirements apply.

(2) At least 25 percent of a carrier's group plans in each metal level of coverage offered in each geographic area served by the carrier must be copayment-only plans. If a carrier offers only one plan in a metal level of coverage in a geographic area, the plan must be a copayment-only plan.

(3) A group plan that is not a copayment-only plan may have different cost sharing requirements for each tier if the cost sharing among all tiers is proportional.

(4) The Department of Consumer and Business Services shall adopt by rule a standard to evaluate whether a plan complies with subsection (3) of this section to ensure that:

(a) The cost sharing requirements among all tiers are proportional;

(b) The highest-cost prescription drugs are not assigned to only the highest-cost tier; and

(c) Not all prescription drugs that treat a specific condition are assigned to the highest-cost tier.

SECTION 4. Sections 2 and 3 of this 2017 Act apply to health benefit plans delivered, issued for delivery, renewed, amended or continued by a carrier on or after January 1, 2018.
