House Bill 3093

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

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 pharmaceutical manufacturers to report to Department of Consumer and Business Services total cost of patient assistance programs and information on financial assistance provided to pharmacies, government agencies and advocacy organizations. Excludes proprietary information from disclosure on department's website.

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 to insurer's website. Requires 60-day advance notice to enrollees adversely affected by change in formulary.

Requires insurer and allows pharmacy to notify insured that if cash price for drug is less than insured's cost-share for drug, insured may pay cash price and expense must be counted toward deductible or out-of-pocket maximum.

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.

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 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 drug advertisement to disclose wholesale price of drug.

A BILL FOR AN ACT

Relating to the cost of prescription drugs; creating new provisions; and amending ORS 243.135, 414.312, 414.361, 414.625, 442.466, 743B.013, 743B.105 and 743B.125 and section 2, chapter 7, Oregon Laws 2018.

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

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

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

Whereas the Legislative Assembly charged the Task Force on the Fair Pricing of Prescription Drugs, consisting of representatives of pharmaceutical manufacturers, insurers, pharmacy benefit managers, prescription drug wholesalers, consumers, independent pharmacies, large retail pharmacy

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.

chains, hospitals, biopharmaceutical companies, coordinated care organizations and medical providers, with developing a strategy to create transparency for drug prices across the entire supply chain of pharmaceutical products; and

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

Whereas the Legislative Assembly, by this 2019 Act, intends to implement some of the recommendations of the task force in order help reduce the cost of prescription drugs for residents and businesses in this state; now, therefore,

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

DISCLOSURE OF TOTAL SPENDING ON PATIENT ASSISTANCE PROGRAMS

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

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

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

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

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

(d)(A) "Manufacture" means:

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

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

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

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

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

(iii) By a health care service contractor for dispensing to a subscriber or delivery to a health care facility or outpatient clinic owned or operated by the health care service contractor or an affiliate of the health care service contractor;

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

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

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

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

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

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

(A) Under federal law, be labeled "Caution: Federal law prohibits dispensing without prescription" prior to being dispensed or delivered; or

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

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

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

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

(b) There was a net increase of 10 percent or more in the price of the prescription drug described in paragraph (a) of this subsection over the course of the previous calendar year.

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

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

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

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

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

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

(f) The direct costs incurred by the manufacturer:

(A) To manufacture the prescription drug;

(B) To market the prescription drug;

(C) To distribute the prescription drug; and

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

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

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

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

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

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

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

(4) The department may use any prescription drug price information the department deems appropriate to verify that manufacturers have properly reported price increases as required by subsections (2) and (3) of this section.

(5) A manufacturer shall accompany the report provided under subsection (2) of this section with**:**

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

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

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

(C) The total cost of the program to the manufacturer;

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

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

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

(b) Information, as prescribed by the department by rule, regarding any financial assistance, other than rebates, incentives and discounts, provided by the manufacturer to pharmacies, government agencies or patient advocacy organizations.

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

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

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

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

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

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

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

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

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

(B) Following a request by the department for additional information during which a manufacturer may respond to the request.

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

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

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

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

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

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

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

(a) A list of the prescription drugs reported under subsection (2) of this section and the manufacturers of those prescription drugs;

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

and

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

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

(A) The information is conditionally exempt from disclosure under ORS 192.345 as a trade secret **or is proprietary**; and

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

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

(c) A person may petition the Attorney General, as provided in ORS 192.411, to review a decision by the department to withhold information pursuant to paragraph (a) of this subsection.

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

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

(13) No later than December 15 of each year, the department shall compile and report the information collected by the department under this section to the interim committees of the Legislative Assembly related to health. The report shall include recommendations for legislative changes, if any, to contain the cost of prescription drugs and reduce the impact of price increases on consumers, the Department of Corrections, the Public Employees' Benefit Board, the Oregon Health Authority, the Department of Human Services, the Oregon Educators Benefit Board and health insurance premiums in the commercial market.

FEE-ONLY PHARMACY BENEFIT MANAGERS FOR STATE-SPONSORED PROGRAMS

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

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

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) The improvement of employee health; and

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public

Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) The improvement of employee health; and

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. ORS 414.312 is amended to read:

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

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

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

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

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

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

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

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

(d) Promote health through the purchase and provision of discount prescription drugs and coordination of comprehensive prescription benefit services for eligible entities and members.

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

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers or group purchasing organizations;

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

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

(d) Determine program prices and reimburse or replenish pharmacies for prescription drugs

dispensed or transferred;

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

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

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

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

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

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

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

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

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

(f) Private entities; and

(g) Labor organizations.

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

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

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

(a) Contract with a pharmacy benefit manager;

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

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

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

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

(b) Contracting directly or indirectly with such pharmacy networks as the administrator considers necessary to maintain statewide access to the program.

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

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

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

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

414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be

local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

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

(b) Meet the following minimum financial requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

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

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

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

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

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

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

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

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

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

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

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

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

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

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

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

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

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

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

(b) Meet the following minimum financial requirements:

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

(B) Maintain a net worth in an amount equal to at least five percent of the average combined

revenue in the prior two quarters of the participating health care entities.

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

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

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

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

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

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

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

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

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

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

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

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

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

(i) Each coordinated care organization convenes a community advisory council that meets the

criteria specified in ORS 414.627.

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

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

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

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

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

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

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

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

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

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

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

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

(3) The authority shall consider the participation of area agencies and other nonprofit agencies

in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

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

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

PUBLISHING INFORMATION REGARDING INSURERS' FORMULARIES; NOTICE TO INSUREDS REGARDING CHANGES TO FORMULARIES

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

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

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

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

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

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

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

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

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

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

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

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

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

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a

specified service area, except that:

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

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

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

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

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

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

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

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

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

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

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

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

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

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

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

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

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

(L) In the case of a health benefit plan that is offered in the small employer market only to one

or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

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

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

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

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

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

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

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

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

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

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

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

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

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

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

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

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

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

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers must be based solely on the factors specified in subparagraph (B) of this

paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

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

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

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

(iii) Adjustments to reflect differences in family composition.

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

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

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

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

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

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

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

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

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

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

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

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification must

be in a uniform form and manner and must contain such information as specified by the department. The carrier shall retain a copy of each certification at the carrier's principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

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

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

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

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

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

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

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

(a) Publish to the carrier's website:

(A) The tiers in the carrier's prescription drug formulary, definitions of each tier and the fee structure for each tier;

(B) The carrier's prescription drug formulary, sorted alphabetically by the brand name and the generic name;

(C) For each drug in the prescription drug formulary:

(i) That is a brand name drug, whether:

(I) A generic alternative is available; and

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

(ii) Quantity limits imposed on the drug, if any; and

(iii) The applicable cost-sharing; and

(D) Notification that an enrollee, as provided in section 11 of this 2019 Act, may ask a pharmacist if the cash price for a prescription drug is lower than the enrollee's out-of-pocket costs under the plan and, if it is, that the enrollee may pay the cash price and have the price paid applied to the enrollee's deductible or out-of-pocket maximum.

(b)(A) Provide written notice to an enrollee at least 60 days in advance of a change to the prescription drug formulary that will adversely affect the enrollee. Changes that adversely affect an enrollee include but are not limited to:

(i) Imposition of new utilization management requirements;

(ii) Modification of tiers in the formulary or a change to the placement of a drug on a tier that results in a higher out-of-pocket cost to the enrollee; or

(iii) Required substitution of a brand name drug with a generic alternative.

(B) Include in the notice required by this paragraph information for enrollees about how to file grievances and about appeals and the appeals process.

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

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

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of this paragraph; and

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

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

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

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

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

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

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

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

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

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

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

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

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

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

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

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

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

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may

not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

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

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

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

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

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

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

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

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

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

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

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

(10) A carrier that offers a group health benefit plan that reimburses the costs of prescription drugs sold by a retail pharmacy or administered by a health care provider shall:

(a) Publish to the carrier's website:

(A) The tiers in the carrier's prescription drug formulary, definitions of each tier and the fee structure for each tier;

(B) The carrier's prescription drug formulary, sorted alphabetically by the brand name and the generic name;

(C) For each drug in the prescription drug formulary:

(i) That is a brand name drug, whether:

(I) A generic alternative is available; and

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

(ii) Quantity limits imposed on the drug, if any; and

(iii) The applicable cost-sharing; and

(D) Notification that an enrollee, as provided in section 11 of this 2019 Act, may ask a pharmacist if the cash price for a prescription drug is lower than the enrollee's out-of-pocket costs under the plan and, if it is, that the enrollee may pay the cash price and have the price paid applied to the enrollee's deductible or out-of-pocket maximum.

(b)(A) Provide written notice to an enrollee at least 60 days in advance of a change to the prescription drug formulary that will adversely affect the enrollee. Changes that adversely affect an enrollee include but are not limited to:

(i) Imposition of new utilization management requirements;

(ii) Modification of tiers in the formulary or a change to the placement of a drug on a

tier that results in a higher out-of-pocket cost to the enrollee; or

(iii) Required substitution of a brand name drug with a generic alternative.

(B) Include in the notice required by this paragraph information for enrollees about how to file grievances and appeals and about the appeals process.

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

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

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

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

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

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

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

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

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

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

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

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

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

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

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

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

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

(d) The carrier discontinues both offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the

service area. In order to discontinue a plan under this paragraph, the carrier:

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

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

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

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

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

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier shall:

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

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

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

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

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

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

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

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

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

(6) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

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

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

(7) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in the carrier's other individual health benefit plans, the coverage for all existing

policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

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

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

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

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

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

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

(a) Publish to the carrier's website:

(A) The tiers in the carrier's prescription drug formulary, definitions of each tier and the fee structure for each tier;

(B) The carrier's prescription drug formulary, sorted alphabetically by the brand name and the generic name;

(C) For each drug in the prescription drug formulary:

(i) That is a brand name drug, whether:

(I) A generic alternative is available; and

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

(ii) Quantity limits imposed on the drug, if any; and

(iii) The applicable cost-sharing; and

(D) Notification that an enrollee, as provided in section 11 of this 2019 Act, may ask a pharmacist if the cash price for a prescription drug is lower than the enrollee's out-of-pocket costs under the plan and, if it is, that the enrollee may pay the cash price and have the price paid applied to the enrollee's deductible or out-of-pocket maximum.

(b)(A) Provide written notice to an enrollee at least 60 days in advance of a change to the prescription drug formulary that will adversely affect the enrollee. Changes that adversely affect an enrollee include but are not limited to:

(i) Imposition of new utilization management requirements;

(ii) Modification of tiers in the formulary or a change to the placement of a drug on a tier that results in a higher out-of-pocket cost to the enrollee; or

(iii) Required substitution of a brand name drug with a generic alternative.

(B) Include in the notice required by this paragraph information for enrollees about how to file grievances and appeals and about the appeals process.

DISCLOSURE OF LESSER OF CASH PRICE OR COST-SHARE AND PROHIBITION ON GAG CLAUSES

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

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

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

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

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

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

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

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

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

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

(b) Being informed that the consumer may pay the cash price for a prescription drug if the cash price is less than the consumer's out-of-pocket costs for the drug under the consumer's pharmacy benefit; and

(c) Being informed that if the consumer pays the cash price as described in paragraph (b) of this subsection, the price paid must be applied toward the consumer's deductible or out-of-pocket maximum as provided in subsection (4) of this section.

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

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

DISCLOSURE OF HOSPITAL AND MEDICAL PROVIDER MARK-UPS FOR PRESCRIPTION DRUGS

SECTION 12. (1) As used in this section:

(a) "Insurer" has the meaning given that term in ORS 731.106.

(b) "Medical provider" means:

(A) A hospital licensed under ORS 441.020.

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

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

(D) A health professional who is in independent practice and administers drugs to patients.

(2) A medical provider shall include in every billing that includes a charge for the dispensing or administration of a prescription drug, whether the charge is listed separately or is included in a bundle of services, an itemization showing:

(a) The charge for the prescription drug;

(b) The price paid for the drug by the medical provider;

(c) Each fee charged for the preparation, dispensing or administration of the drug; and

(d) The charge for the drug the medical provider bills to the Oregon Health Authority,

the Oregon Educators Benefit Board, the Public Employees' Benefit Board, Medicare and commercial insurers.

SECTION 13. Section 12 of this 2019 Act is amended to read:

Sec. 12. (1) As used in this section:

(a) "Insurer" has the meaning given that term in ORS 731.106.

(b) "Medical provider" means:

(A) A hospital licensed under ORS 441.020.

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

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

(D) A health professional who is in independent practice and administers drugs to patients.

(2) A medical provider shall include in every billing that includes a charge for the dispensing or administration of a prescription drug, whether the charge is listed separately or is included in a bundle of services, an itemization showing:

(a) The charge for the prescription drug;

(b) The price paid for the drug by the medical provider;

(c) Each fee charged for the preparation, dispensing or administration of the drug; and

(d) The charge for the drug the medical provider bills to the Oregon Health Authority, the Oregon Educators Benefit Board, the Public Employees' Benefit Board, Medicare and commercial insurers.

(3) A medical provider shall report the information described in subsection (2) of this section to the authority, in the form and manner prescribed by the authority, to be used by the authority to display health care price information on its website, as described in ORS 442.466.

SECTION 14. ORS 442.466 is amended to read:

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

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

(b) Identifying the demands for health care.

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

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

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

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

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

(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

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

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

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

(A) Requiring the use of unique patient and provider identifiers;

(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

(C) Establishing enrollment thresholds below which reporting will not be required.

(b) Establish the types of data to be reported under this section, including but not limited to:

(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section; and

(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the authority the health care data described in subsection (2) of this section.

(4) The authority shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

(5)(a) The authority shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(b) The authority shall, using only data collected under this section from reporting entities described in ORS 442.464 (1) to (3) **and data collected from medical providers under section 12 of this 2019 Act**, post to its website health care price information including the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most common inpatient procedures and the 100 most common outpatient procedures.

(c) The health care price information posted to the website must be:

(A) Displayed in a consumer friendly format;

(B) Easily accessible by consumers; and

(C) Updated at least annually to reflect the most recent data available.

(d) The authority shall apply for and receive donations, gifts and grants from any public or private source to pay the cost of posting health care price information to its website in accordance with this subsection. Moneys received shall be deposited to the Oregon Health Authority Fund.

(e) The obligation of the authority to post health care price information to its website as required by this subsection is limited to the extent of any moneys specifically appropriated for that purpose or available from donations, gifts and grants from private or public sources.

(6) The authority may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the authority.

(7) The authority shall facilitate a collaboration between the Department of Human Services, the authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section

and collected by the authority under ORS 442.120 and 442.400 to 442.463 **and section 12 of this 2019 Act**. The authority, in consultation with interested stakeholders, shall:

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

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

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

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

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

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

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

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

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

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

STATE AGENCY COST REPORTING FOR PRESCRIPTION DRUGS

SECTION 15. (1) The Oregon Health Authority, the Public Employees' Benefit Board, the Oregon Educators Benefit Board, the Department of Corrections and the Oregon Youth Authority shall annually report to the Legislative Assembly, in the manner provided in ORS 192.245, information about each agency's expenditures for prescription drugs, as described in subsection (2) of this section. The Oregon Health Authority shall include in its report information about coordinated care organizations' expenditures for prescription drugs.

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

(a) The 10 most prescribed drugs;

(b) The 10 highest cost drugs, both before and after any rebates received from pharmaceutical manufacturers;

(c) The 10 drugs for which there was the greatest increase in cost to the agency from the prior 12-month period; and

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

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

SECTION 16. ORS 414.361 is amended to read:

414.361. (1) The Pharmacy and Therapeutics Committee shall advise the Oregon Health Authority on:

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

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

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

(A) Therapeutic appropriateness.

(B) Overutilization or underutilization.

(C) Therapeutic duplication.

(D) Drug-disease contraindications.

(E) Drug-drug interactions.

(F) Incorrect drug dosage or drug treatment duration.

(G) Clinical abuse or misuse.

(H) Drug allergies.

(d) Development, selection and application of and assessment for interventions that are educational and not punitive in nature for medical assistance program prescribers, dispensers and patients.

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

(3) The committee shall make recommendations to the authority, subject to approval by the Director of the Oregon Health Authority or the director's designee[*,*]**:**

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

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

(c) All utilization controls, prior authorization requirements or other conditions for the inclusion of a drug on a preferred drug list.

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

(a) Safety and efficacy of the drug.

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

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

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

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

DISCLOSURE OF FUNDING OF PATIENT ADVOCACY ORGANIZATIONS BY PHARMACEUTICAL SUPPLY CHAIN

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

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

(a) "Patient advocacy organization" means a nonprofit organization that is exempt from taxation under section 501(c)(3) of the Internal Revenue Code and:

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

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

(C) That has an annual budget of more than $50,000.

(b) "Pharmaceutical supply chain" means:

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

(B) A wholesale distributor of prescription drugs.

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

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

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

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

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

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

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

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

(2) A patient advocacy organization that receives more than 10 percent of its annual budget from payments, donations, subsidies or other consideration from persons in the

pharmaceutical supply chain shall file with the statement required by ORS 171.750 a statement containing the following information:

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

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

(3) A patient advocacy organization shall also report the information described in subsection (2) of this section to the Oregon Health Authority, in the form and manner prescribed by the authority.

DISCLOSURE OF REBATES, FEES AND REIMBURSEMENTS BY PHARMACY BENEFIT MANAGERS

(To the Department of Consumer and Business Services)

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

SECTION 20. (1) As used in this section and section 21 of this 2019 Act, "manufacturer" has the meaning given that term in section 2, chapter 7, Oregon Laws 2018.

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

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

(b) Average reimbursement received from an insurer by the pharmacy benefit manager for the prescription drug is 25 percent or more than the average reimbursement paid by retail pharmacies.

(3) The pharmacy benefit manager shall submit the report in the form and manner prescribed by the department and shall include the following information:

(a) The average rebate paid by the manufacturer of the prescription drug to the pharmacy benefit manager;

(b) The average fee paid by the manufacturer of the prescription drug to the pharmacy benefit manager;

(c) The average reimbursement paid by the pharmacy benefit manager to retail pharmacies; and

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

(4) The information shall be reported using the national drug code number for the formulation of the prescription drug as assigned by the United States Food and Drug Administration.

(To Plan Sponsors)

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

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

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

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

DISCLOSURE OF PRICE IN DRUG ADVERTISEMENT

SECTION 22. **(1) As used in this section:**

(a) "Advertise" means to communicate within this state by newspaper, radio, television or other print, broadcast or electronic medium information designed to create public interest.

(b) "Manufacturer," "prescription drug" and "price" have the meanings given those terms in section 2, chapter 7, Oregon Laws 2018.

(2) A manufacturer that advertises a prescription drug shall clearly and conspicuously disclose in the advertisement the wholesale price for the prescription drug paid by pharmacies located in this state.

OPERATIVE DATES AND APPLICABILITY DATES

SECTION 23. **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 24. **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 25. **(1) Section 12 of this 2019 Act becomes operative on July 1, 2020.**

(2) The amendments to section 12 of this 2019 Act by 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.

SECTION 26. **Section 22 of this 2019 Act applies to a prescription drug advertisement that is published or broadcast on or after the effective date of this 2019 Act.**

CAPTIONS

SECTION 27. **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.**
