82nd OREGON LEGISLATIVE ASSEMBLY--2023 Regular Session

House Bill 2762

Sponsored by Representative NOSSE (Presession filed.)

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 insurers offering health benefit plans and pharmacy benefit managers to provide specified information regarding prescribed drug covered by plan or administered by manager, at time drug is prescribed.

1 **A BILL FOR AN ACT**

2 Relating to prescription drug costs.

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

4 **SECTION 1. Section 2 of this 2023 Act is added to and made a part of the Insurance Code.**

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

6 **(a) "Enrollee" includes:**

7 **(A)(i) An employee, dependent of the employee or an individual otherwise eligible for a**
8 **group or individual health benefit plan who has enrolled for coverage under the terms of the**
9 **plan; and**

10 **(ii) An individual who has enrolled for coverage in a health benefit plan for which a**
11 **pharmacy benefit manager has contracted with the insurer to reimburse claims submitted**
12 **by pharmacies or pharmacists for the costs of drugs prescribed for the individual; or**

13 **(B) A health care provider for, or other person authorized to act on behalf of, an indi-**
14 **vidual described in subparagraph (A) of this paragraph.**

15 **(b) "Health plan" includes:**

16 **(A) A health benefit plan as defined in ORS 743B.005, and the insurer offering the health**
17 **benefit plan; and**

18 **(B) The pharmacy benefit administered by a pharmacy benefit manager registered under**
19 **ORS 735.532, and the pharmacy benefit manager.**

20 **(2) Upon the request of an enrollee, a health plan must provide, in real time, the follow-**
21 **ing enrollee-specific information for any drug covered by the health plan:**

22 **(a) Eligibility information prescribed by the Department of Consumer and Business Ser-**
23 **vices by rule;**

24 **(b) The cost of the drug and any cost-sharing or other out-of-pocket expenses associated**
25 **with dispensing the drug;**

26 **(c) Formulary, benefit or coverage information applicable to the drug;**

27 **(d) Clinically appropriate alternative drugs, if applicable;**

28 **(e) Any variance in the cost of the drug or of any clinically appropriate alternative drug**
29 **based on the pharmacy that dispenses the drug;**

30 **(f) The cost of the drug in relation to any out-of-pocket maximum under the health plan;**

31 **(g) Utilization review requirements for the drug; and**

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.

(h) Other information prescribed by the department by rule.

(3) The information provided under subsection (2) of this section:

(a) Must be:

(A) Current and provided at the time that the drug is prescribed;

(B) In a format easily accessible to the enrollee;

(C) Provided whether the request is made using the drug's unique billing code or a descriptive term; and

(D) Made available using technology that meets the standards approved by the American National Standards Institute;

(b) If the requester is a health care provider, must be provided through an electronic health records system accessible by the provider on the digital platform that the provider uses to provide patients with real-time information about the patients' medication costs; and

(c) May not be:

(A) Made available solely through a facsimile; or

(B) Denied or unreasonably delayed based on how the drug is described.

(4) A health plan may not restrict, prohibit or otherwise hinder a prescriber from communicating to or sharing with a patient information about other options that may reduce the patient's cost, such as a cash price, lower cost clinically appropriate alternative drugs, whether or not the drug is covered by the health plan, patient assistance programs, the cost of the drug at the patient's pharmacy of choice or other prescription cost options.

(5) A health plan may not, except as required by law, interfere with, prevent or discourage an enrollee's access to, exchange or use of the information described in subsection (2) of this section such as by:

(a) Charging fees for the information;

(b) Failing to respond to a request for the information within a reasonable time period; or

(c) Penalizing a health care provider or other professional for disclosing the information to a patient or for prescribing, administering or ordering a clinically appropriate alternative or lower cost alternative.

(6) This section does not:

(a) Limit access to the most current, patient-specific eligibility or patient-specific prescription cost and benefit data of a health plan; or

(b) Restrict or interfere with a patient's choice of care or a health care provider's ability to convey to a patient the full range of prescription drug cost options available to the patient.

(7) The department may adopt rules to carry out the provisions of this section including, but not limited to, requirements for any electronic prescription decision tool that may be used by a health plan to comply with this section.