HB 3212-5
(LC 2723)
4/7/25 (EKJ/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO
HOUSE BILL 3212

On page 1 of the printed bill, line 2, after "ORS" delete the rest of line and insert "414.065, 735.534, 735.536, 743A.062 and 743B.505.".

Delete lines 4 through 28 and delete pages 2 through 5 and insert:

"SECTION 1. ORS 735.534, as amended by section 6, chapter 87, Oregon Laws 2024, is amended to read:

"735.534. (1) As used in this section:

"**(a) 'Contract' does not mean a pharmacy or provider manual.**

"(b) 'Coordinated care organization' means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

"[*(a)(A)*] **(c)(A)** 'Generally available for purchase' means a drug is available for purchase in this state by a pharmacy from a national or regional wholesaler at the time a claim for reimbursement is submitted by a network pharmacy.

"(B) A drug is not 'generally available for purchase' if the drug:

"(i) May be dispensed only in a hospital or inpatient care facility;

"(ii) Is unavailable due to a shortage of the product or an ingredient;

"(iii) Is available to a pharmacy at a price that is at or below the maximum allowable cost only if purchased in substantial quantities that are inconsistent with the business needs of a pharmacy;

"(iv) Is sold at a discount due to a short expiration date on the drug; or

"(v) Is the subject of an active or pending recall.

"[*(b)*] **(d)** 'List' means the list of drugs for which maximum allowable costs have been established.

"[*(c)*] **(e)** 'Maximum allowable cost' means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

"[*(d)*] **(f)** 'Multiple source drug' means a therapeutically equivalent drug that is available from at least two manufacturers.

"(g) 'Net acquisition cost' means the net amount the pharmacy paid for a prescription drug, including all actual or estimated discounts and price concessions.

"[*(e)*] **(h)** 'Therapeutically equivalent' has the meaning given that term in ORS 689.515.

"(2) A pharmacy benefit manager licensed under ORS 735.532:

"(a) May not place a drug on a list unless there are at least two multiple source drugs, or at least one generic drug generally available for purchase.

"(b) Shall ensure that all drugs on a list are generally available for purchase.

"(c) Shall ensure that no drug on a list is obsolete.

"(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the specific authoritative industry sources, other than proprietary sources, the pharmacy benefit manager uses to determine the maximum allowable cost set by the pharmacy benefit manager.

"(e) Shall make a list available to a network pharmacy upon request in a format that:

"(A) Is electronic;

"(B) Is computer accessible and searchable;

"(C) Identifies all drugs for which maximum allowable costs have been established; and

"(D) For each drug specifies:

"(i) The national drug code; and

"(ii) The maximum allowable cost.

"(f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in the format described in paragraph (e) of this subsection.

"(g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost.

"(h) May not reimburse a 340B pharmacy differently than any other network pharmacy based on its status as a 340B pharmacy.

"(i) Shall comply with the provisions of ORS 743A.062.

"(j) May not retroactively deny or reduce payment on a claim for reimbursement of the cost of services after the claim has been adjudicated by the pharmacy benefit manager unless the:

"(A) Adjudicated claim was submitted fraudulently;

"(B) Pharmacy benefit manager's payment on the adjudicated claim was incorrect because the pharmacy had already been paid for the services;

"(C) Services were improperly rendered by the pharmacy in violation of state or federal law; or

"(D) Payment was incorrect due to an error that the pharmacy and pharmacy benefit manager agree was a clerical error.

"(k) May not impose a fee on a pharmacy after the point of sale.

"(L) Shall provide notice to a pharmacy of any claim for reimbursement of the cost of a prescription drug that is denied or reduced. The notice shall identify the specific disaggregated claim that was denied or reduced and a detailed explanation for why the specific claim was denied or reduced.

"**(m) Shall offer a carrier, as defined in ORS 743B.005, or a coordinated care organization, an option to enter into a contract for pharmacy benefit services that does not include spread pricing.**

"(n) Shall pay a network critical access pharmacy, as defined by the Department of Consumer and Business Services consistent with the

definition adopted by the Oregon Health Authority in the Oregon Prescription Drug Program pursuant to ORS 414.320, a professional dispensing fee in an amount no less than 50 cents, adjusted annually by rule by the Department of Consumer and Business Services as described in subsection (10) of this section, for prescription drugs subject to the maximum allowable cost. This paragraph does not apply to value-based contracts entered into by a pharmacy benefit manager and a pharmacy or pharmacy services administrative organization, as defined in section 2, chapter 87, Oregon Laws 2024.

"(o) May not sign or enter into a contract with a pharmacy or pharmacy services administrative organization, as defined in section 2, chapter 87, Oregon Laws 2024, that:

"(A) Requires a pharmacy to participate in any other contract; or

"(B) Requires the pharmacy to provide pharmacy services to an individual who no longer has prescription drug benefit coverage.

"(3) Subsection (2)(j) of this section may not be construed to limit pharmacy claim audits under ORS 735.540 to 735.552.

"(4) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net [*amount*] **acquisition cost** that the network pharmacy paid to the supplier of the drug. The process must allow a network pharmacy a period of no less than 60 days after a claim is reimbursed in which to file the appeal. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.

"(5) A pharmacy benefit manager shall allow a network pharmacy to submit the documentation in support of its appeal on paper or electronically and may not:

"(a) Refuse to accept an appeal submitted by a person authorized to act

on behalf of the network pharmacy;

"(b) Refuse to adjudicate an appeal for the reason that the appeal is submitted along with other claims that are denied; or

"(c) Impose requirements or establish procedures that have the effect of unduly obstructing or delaying an appeal.

"(6) A pharmacy benefit manager must provide as part of the appeals process established under subsection (4) of this section:

"(a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals;

"(b) A final response to an appeal of the reimbursement for a drug within seven business days; and

"(c) If the appeal is denied, the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.

"(7)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall:

"(A) Make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward; and

"(B) Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any additional charges.

"(b) If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies.

"(8) A pharmacy may file a complaint with the Department of Consumer and Business Services to contest a finding of a pharmacy benefit manager in response to an appeal under subsection (4) of this section or a pharmacy benefit manager's failure to comply with the provisions of this section.

"**(9) This section does not apply to mail order pharmacies or specialty pharmacies.**

"[*(9)*] **(10)** The Department of Consumer and Business Services [*may adopt rules to carry out the provisions of this section.*] **shall:**

"(a) Define by rule 'critical access pharmacy' consistent with the definition adopted by the Oregon Health Authority under ORS 414.320, as in effect on January 1, 2025; and

"(b) No later than January 1 of each year:

"(A) Calculate the dispensing fee rate for critical access pharmacies based only on the increase by a percentage equal to the percentage change from the preceding year in the medical care component of the Consumer Price Index for All Urban Consumers, West Region (All Items), as published by the Bureau of Labor Statistics of the United States Department of Labor.

"(B) Publish on the Department of Consumer and Business Services website a list of critical access pharmacies and the dispensing fee for critical access pharmacies. The dispensing fee becomes effective 90 days after publication to the department's website.

"(11) This section does not apply to contracts entered into by a pharmacy benefit manager and a self-insured plan.

"**SECTION 2.** ORS 735.536, as amended by section 7, chapter 87, Oregon Laws 2024, is amended to read:

"735.536. (1) As used in this section, 'out-of-pocket cost' means the amount paid by an enrollee under the enrollee's coverage, including deductibles, copayments, coinsurance or other expenses as prescribed by the Department of Consumer and Business Services by rule.

"(2) A pharmacy benefit manager licensed under ORS 735.532:

"(a) May not require a prescription to be filled or refilled by a mail order pharmacy as a condition for reimbursing the cost of the drug**, unless the mail order pharmacy is a specialty pharmacy**.

"[*(b) Except as provided in paragraph (c) of this subsection, may require a prescription for a specialty drug to be filled or refilled at a specialty pharmacy as a condition for the reimbursement of the cost of a drug.*]

"[*(c)*] **(b)** Shall reimburse the cost of a specialty drug that is filled or refilled at a network pharmacy that is a long term care pharmacy.

"[*(d)(A)*] **(c)(A)** Shall allow a network pharmacy to mail, ship or deliver prescription drugs to its patients as an ancillary service.

"(B) Is not required to reimburse a delivery fee charged by a pharmacy for a delivery described in subparagraph (A) of this paragraph unless the fee is specified in the contract between the pharmacy benefit manager and the pharmacy.

"[*(e)*] **(d)** May not require a patient signature as proof of delivery of a mailed or shipped prescription drug if the network pharmacy:

"(A)(i) Maintains a mailing or shipping log signed by a representative of the pharmacy; or

"(ii) Maintains each notification of delivery provided by the United States Postal Service or a package delivery service; and

"(B) Is responsible for the cost of mailing, shipping or delivering a replacement for a drug that was mailed or shipped but not received by the enrollee.

"[*(f)*] **(e)** May not penalize a network pharmacy by imposing charges or fees, requiring contract amendments, canceling or terminating contracts or demanding recoupment or otherwise retaliate against a network pharmacy for:

"(A) Informing an enrollee of the difference between the out-of-pocket cost to the enrollee to purchase a prescription drug using the enrollee's pharmacy benefit and the pharmacy's usual and customary charge for the prescription drug;

"(B) Filing an appeal;

"(C) Filing a complaint against the pharmacy benefit manager with the

Department of Consumer and Business Services;

"(D) Engaging in the legislative process; or

"(E) Challenging the pharmacy benefit manager's practices or agreements.

"[*(g)*] **(f)** May not charge a fee to a pharmacy for submitting claims or for the adjudication of claims.

"(3) The Department of Consumer and Business Services may adopt rules to carry out the provisions of this section.

"**(4) This section does not apply to contracts entered into by a pharmacy benefit manager and a self-insured plan.**

"SECTION 3. ORS 743A.062, as amended by section 11, chapter 87, Oregon Laws 2024, is amended to read:

"743A.062. (1) As used in this section:

"(a) 'Medical assistance program' means the state program that provides medical assistance as defined in ORS 414.025.

"**(b) 'Net acquisition cost' has the meaning given that term in ORS 735.534.**

"[*(b)*] **(c)** '340B drug' means a covered drug dispensed by a covered entity, as those terms are defined in 42 U.S.C. 256b, that is subject to the cap on amounts required to be paid in 42 U.S.C. 256b(a)(1).

"(2) A policy or certificate of health insurance or other contract providing for the reimbursement of the cost of a prescription drug to a resident of this state may not:

"(a) Exclude coverage of the drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if the Health Evidence Review Commission established under ORS 414.688 or the Pharmacy and Therapeutics Committee established under ORS 414.353 determines that the drug is recognized as effective for the treatment of that indication:

"(A) In publications that the commission or the committee determines to be equivalent to:

"(i) The American Hospital Formulary Service drug information;

"(ii) 'Drug Facts and Comparisons' (Lippincott-Raven Publishers);

"(iii) The United States Pharmacopoeia drug information; or

"(iv) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;

"(B) In the majority of relevant peer-reviewed medical literature; or

"(C) By the United States Secretary of Health and Human Services;

"(b) For an insured who is enrolled in the medical assistance program:

"(A) Except as provided in subsection (3) of this section, require a prescription for the drug to be filled or refilled at a mail order pharmacy; or

"(B) Require a prescription for the drug to be filled or refilled at a pharmacy that is not a local pharmacy enrolled in the medical assistance program;

"(c) Discriminate in the reimbursement of a prescription for 340B drugs from other prescription drugs;

"(d) Assess a fee, chargeback, clawback or other adjustment for the dispensing of a 340B drug;

"(e) Exclude a pharmacy from a pharmacy network on the basis that the pharmacy dispenses a 340B drug;

"(f) Restrict the methods by which a 340B drug may be dispensed or delivered; [*or*]

"(g) Restrict the number of pharmacies within a pharmacy network that may dispense or deliver 340B drugs[.]**;**

"(h) Deny a pharmacy or pharmacist licensed in this state the opportunity to participate as a preferred provider if the pharmacy is willing to accept and comply with the same terms and conditions to participate in the network; or

"(i) Prevent a pharmacy from declining to dispense a covered drug to a patient if the amount of the reimbursement is less than the pharmacy's net acquisition cost for procuring the covered drug.

"(3) Subsection (2)(b)(A) of this section does not prohibit an insurer from requiring a medical assistance recipient to fill or refill a prescription for a specialty drug at a mail order pharmacy that is a specialty pharmacy.

"(4) Required coverage of a prescription drug under this section shall include coverage for medically necessary services associated with the administration of that drug.

"(5) Nothing in this section requires coverage for any prescription drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

"(6) Nothing in this section requires coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration.

"(7) Notwithstanding ORS 750.055 (1)(h), this section does not apply to a health maintenance organization as defined in ORS 750.005.

"**(8) This section does not apply to mail order pharmacies or specialty pharmacies, as those terms are defined in ORS 735.530.**

"[*(8)*] **(9)** This section is exempt from ORS 743A.001.

"SECTION 4. ORS 743B.505 is amended to read:

"743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS 743B.005, through a specified network of health care providers shall:

"(a) Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees for initial and follow-up appointments without unreasonable delay.

"(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS 741.310, contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential

community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services;

"(B) If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; or

"(C) With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.

"(c) Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's network of providers for each health benefit plan.

"(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

"(b) This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

"(c) This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

"(d) Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on January 1, 2017.

"(3) The Department of Consumer and Business Services shall use one of the following methods in an annual evaluation of whether the network of providers available to enrollees in a health benefit plan meets the requirements of this section:

"(a) An approach by which an insurer submits evidence that the insurer is complying with at least one of the factors prescribed by the department by rule from each of the following categories:

"(A) Access to care consistent with the needs of the enrollees served by the network;

"(B) Consumer satisfaction;

"(C) Transparency; and

"(D) Quality of care and cost containment; or

"(b) A nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.

"(4) In evaluating an insurer's network of mental and behavioral health providers under subsection (3) of this section, the department shall ensure that the network includes:

"(a) An adequate number and geographic distribution, as prescribed by the department by rule, of licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, psychologists and psychiatrists who are accepting new patients, based on the needs of the insureds under the policy or certificate, including but not limited to providers who can address the needs of:

"(A) Children and adults;

"(B) Individuals with limited English proficiency or who are illiterate;

"(C) Individuals with diverse cultural or ethnic backgrounds;

"(D) Individuals with chronic or complex behavioral health conditions; and

"(E) Other groups specified by the department by rule; and

"(b) An adequate number of the providers described in paragraph (a) of this subsection in all geographic areas where the insurer offers plans.

"(5) This section does not require an insurer to contract with an essential community provider that refuses to accept the insurer's generally applicable payment rates for services covered by the plan.

"(6) This section does not require an insurer to submit provider contracts to the department for review.

"**(7) It shall not be considered a denial of access to a covered service under this section if, pursuant to ORS 743A.062 (2), a pharmacist declines to dispense a covered drug to a patient because the amount of reimbursement is less than the pharmacy's net acquisition cost for procuring the covered drug.**

"SECTION 5. ORS 414.065, as amended by section 1, chapter 18, Oregon Laws 2024, is amended to read:

"414.065. (1)(a) Consistent with ORS 414.690, 414.710, 414.712 and 414.766 and other statutes governing the provision of and payments for health services in medical assistance, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and to legislative funding:

"(A) The types and extent of health services to be provided to each eligible group of recipients of medical assistance.

"(B) Standards, including outcome and quality measures, to be observed in the provision of health services.

"(C) The number of days of health services toward the cost of which

medical assistance funds will be expended in the care of any person.

"(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

"(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

"(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health services.

"(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

"(2) In making the determinations under subsection (1) of this section and in the imposition of any utilization controls on access to health services, the authority may not consider a quality of life in general measure, either directly or by considering a source that relies on a quality of life in general measure.

"(3) The types and extent of health services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance, and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health services in meeting the costs thereof.

"(4) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health services for which such payments of medical assistance were made.

"(5) Notwithstanding subsection (1) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

"(6) In determining a global budget for a coordinated care organization:

"(a) The allocation of the payment, the risk and any cost savings shall

be determined by the governing body of the organization;

"(b) The authority shall consider the community health assessment conducted by the organization in accordance with ORS 414.577 and reviewed annually, [*and*] the organization's health care costs **and the dispensing fee required pursuant to ORS 735.534 (2)**; and

"(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

"(7) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

"(a) To support improved delivery of health care to recipients of medical assistance; and

"(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.".
