The Oregon Division of Financial Regulation recently announced the following permanent rulemaking:

ID 6-2025: Updates to Pharmacy Benefit Manager Rules and DPT Insurer Reporting Rule

Rules: 836-053-1630, 836-200-0401, 836-200-0406, 836-200-0411, 836-200-0416, 836-200-0418, 836-200-0421, 836-200-0436, 836-200-0440

Summary: This rulemaking replaces references to registration throughout our current rules, encoded at OAR 836- 200-0401 et seq with references to licensure. It also adds new data elements to our reporting rule and new market conduct requirements. It also adds language clarifying the bar on retaliation against pharmacies, noting that a pharmacy claims audit may be considered retaliation under certain circumstances. Finally, the rulemaking includes substantial revisions to the language related to pharmacy reimbursement in order to clarify expectations for PBMs when a pharmacy is reimbursed below acquisition cost under a maximum allowable cost schedule.

Filed: July 29, 2025

Effective: August 1, 2025

For more information on this recently adopted rule, please visit the division's website:

https://dfr.oregon.gov/laws-rules/Documents/id06-2025_rule-order.pdf

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PERMANENT ADMINISTRATIVE ORDER

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ID 6-2025
CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Updates to Pharmacy Benefit Manager Rules and DPT Insurer Reporting Rule

EFFECTIVE DATE: 08/01/2025

AGENCY APPROVED DATE: 07/28/2025

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RULES:
836-053-1630, 836-200-0401, 836-200-0406, 836-200-0411, 836-200-0416, 836-200-0418, 836-200-0421, 836-200-0436, 836-200-0440

AMEND: 836-053-1630

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Delineates reporting requirements for insurers related to annual data collected on prescription drugs. The amendments delete language creating a minimum enrollee threshold for required reports, pursuant to review by the office of Legislative Counsel.

CHANGES TO RULE:

836-053-1630
Drug Price Transparency Insurer Reporting
(1) For the purposes of this rule, "insurer" means a licensed insurance company, health care services contractor, or health maintenance organization that issues health benefit plans as defined in ORS 743B.005(16) in this state. ¶
(2) No later than May 1 of each year, an insurer ~~with 200 or more enrollees in the state of Oregon~~ must report to the department the information described in ORS 743.025(2) in the form and manner prescribed by the department. For drugs reimbursed by the insurer under both pharmacy and medical benefits in health benefit plans during the prior calendar year, the reporting must include all of the following:¶
(a) The 25 most frequently prescribed drugs.¶
(b) The 25 most costly drugs. In determining this list, the insurer must consider total annual spending, including the net impact of any rebates or other price concessions if applicable.¶
(c) The 25 drugs that have caused the greatest increase in total plan spending from one year to the next. In determining this list, the insurer must consider the net impact on total plan spending of any rebates or other price concessions if applicable.¶
(d) The impact of the costs of prescription drugs on premium rates, on a per member per month basis, including the net impact of any rebates or other price concessions if applicable.
Statutory/Other Authority: ORS 731.244
Statutes/Other Implemented: ORS 743.025~~, 735.537~~

AMEND: 836-200-0401

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Updates statutory references.

CHANGES TO RULE:

836-200-0401
Statement of Purpose; Authority; Applicability ¶

Under the authority of ~~section 1, chapter 570, Oregon Laws 2013~~Oregon Laws 2013, chapter 570, section 1, ORS 735.530 to 735.552 shall be administered and enforced in accordance with the Insurance Code. The rules promulgated under ORS 735.530 to 735.552 are authorized and reasonably necessary for, or as an aid to, the effectuation of the Insurance Code.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 1, Ch. 570, OL 2013, Sec. 1-3, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530 ~~to~~- 735.552

AMEND: 836-200-0406

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Defines application requirements for pharmacy benefit managers to license with DCBS. The amendments replace registration language with equivalent language on licensure.

CHANGES TO RULE:

836-200-0406
Application Requirements for Pharmacy Benefit Manager ¶

(1) Each pharmacy benefit manager conducting business in Oregon must ~~register with~~obtain a license to transact business as a pharmacy benefit manager from the Department of Consumer and Business Services. To ~~register as a pharmacy benefit manager~~obtain a license under this rule, an applicant must submit a Pharmacy Benefit Manager Application, in form as posted on the ~~D~~department's Division of Financial Regulation website.¶
(2) An application for ~~registration~~licensure as a pharmacy benefit manager shall include:¶
(a) The name, address and FEIN of the pharmacy benefit manager;¶
(b) The names, business addresses and job titles of the principal officers of the pharmacy benefit manager;¶
(c) The name, business address, business telephone number, business e-mail address and job title of the officer or employee who should be contacted regarding any pharmacy benefit manager regulatory compliance concerns;¶
(d) The business telephone number and business e-mail address where pharmacy benefit manager personnel directly responsible for the processing of appeals may be contacted; and~~;~~¶
(e) Information relevant to a determination of the circumstances listed in ~~section 2(1), chapter 73, Oregon Laws 2017~~ORS 735.533(1).¶
(3) A pharmacy benefit manager shall provide the ~~D~~department with written notification of any change to its ~~registration~~licensure information not later than 30 days after the date of change.¶
(4) The application for ~~registration~~licensure as a pharmacy benefit manager must include a fee of $1100.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 2-3, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530, 735.532, ~~Sec. 2-5, Ch. 73, OL 201~~OL 2024, ch 87

AMEND: 836-200-0411

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Sets requirements for a pharmacy benefit manager to renew its license with DCBS. The amendments replace registration language with equivalent language on licensure.

CHANGES TO RULE:

836-200-0411
Renewal of Pharmacy Benefit ~~Registration~~License ¶

(1) All pharmacy benefit manager ~~registration~~licenses expire annually on September 1 unless renewed on or before that date. A pharmacy benefit manager must apply for renewal of the ~~registration~~license by submitting a renewal application, in form as posted on the ~~D~~department's Division of Financial Regulation website, to the ~~D~~director of the Department of Consumer and Business Services. The application to renew a ~~registration~~license to transact business as a pharmacy benefit manager must include a renewal fee of $1100.¶
(2) A pharmacy benefit manager shall provide the ~~D~~department with written notification of any change to its ~~registration~~licensure information not later than 30 days after the date of change.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 2-3, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530, 735.532, ~~Sec. 2-5, Ch. 73, OL 201~~OL 2024, ch 87

AMEND: 836-200-0416

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: States that licensure as a PBM does not exempt an entity from other state licensure requirements. The amendments replace registration language with equivalent language on licensure and add a clarification that this also applies to licensure by DCBS as a third-party administrator.

CHANGES TO RULE:

836-200-0416
~~Registration~~Licensure Requirements Not Exclusive ¶

Compliance with pharmacy benefit manager ~~registration~~licensure requirements is additional to and not in lieu of filing and other requirements established by law for the purpose of doing business in this state, including but not limited to licensure as a third-party administrator under ORS 744.700 et seq and compliance with registration requirements of the Secretary of State applicable to assumed business names and applicable to the business structure of an applicant.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 2-3, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530, 735.532, ~~Sec. 2-5, Ch. 73, OL 201~~OL 2024, ch 87

AMEND: 836-200-0418

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Defines the timing, data elements and requirements for required annual reports from PBMs to DCBS. The amendments replace registration language with equivalent language on licensure and add new reporting categories created by HB 4149 (2024).

CHANGES TO RULE:

836-200-0418
Aggregated Rebate and Payment Reports
(1) For the purposes of this rule, "health benefit plan" has the meaning defined in ORS 743B.005(16).¶
(2) For the purposes of this rule, "pharmacy benefit manager" has the meaning defined in ORS 735.530.¶
(3) For the purposes of this rule "administrative fee" has the meaning defined in ORS 735.537(a).¶
(4) For the purposes of this rule, "dispensing fee" means an amount paid to a pharmacy licensed in Oregon for dispensing a prescription in addition to reimbursement for the cost of the drug.¶
(5) No later than June 1 of each year, a pharmacy benefit manager required to be ~~register~~licensed with the Department of Consumer and Business Services must file a report using the form and manner prescribed by the department. The report must contain the following information for the immediately preceding calendar year:¶
(a) The aggregated amount of rebates, fees, price protection payments, and any other payments the pharmacy benefit manager received from manufacturers related to managing the pharmacy benefits for carriers issuing health benefit plans in this state. This amount must include payments that the pharmacy benefit manager received from manufacturers directly and payments the pharmacy benefit manager received from manufacturers by the pharmacy benefit manager's subsidiaries, any other entities that the pharmacy benefit manager holds an ownership in, or any entities which hold an ownership interest in the pharmacy benefit manager. This includes:¶
(~~b~~A) The aggregated amount of any payments, as described in subsection (~~3~~5)(a) of this rule, that were passed on to carriers issuing health benefit plans in this state.¶
(~~c~~B) The aggregated amount of any payments, as described in subsection (~~3~~5)(a) of this rule, that were passed on to enrollees in a health benefit plan at the point of sale in this state.¶
(~~d~~C) The aggregated amount of any payments, as described in subsection (~~3~~5)(a) of this rule, that were retained as revenue by the pharmacy benefit manager.¶
(4b) The amount described in section (~~3~~5)(a) of this rule should be equal to the sum of the amounts described in sections (~~3~~5)(~~b~~a)(A), (~~3~~5)(~~c~~a)(B), and (~~3~~5)(a)(~~d~~C) of this rule.¶
(5c) The ~~amounts described in section (3) of this rule must include all payments that the pharmacy benefit manager received from manufacturers directly and any payments the pharmacy benefit manager received from manufacturers by the pharmacy benefit manager's subsidiaries, any other entities that the pharmacy benefit manager holds an ownership in, or any entities which hold an ownership inter~~total dispensing fees paid to the pharmacy benefit manager in this state from insurers, coordinated care organizations, and the Oregon Prescription Drug Program.¶
(d) The total dispensing fees paid to pharmacies in this state by the pharmacy benefit manager.¶
(e) The total administrative fees received from manufacturers and carriers.¶
(f) The total administrative fees as described in subsection (e) that were retained by the pharmacy benefit manager.¶
(g) The total amount of revenue received by the pharmacy benefit manager through spread pricing, pay-for-performance arrangements, or similar means which includes the following: ¶
(A) The difference between the total amount the pharmacy benefit manager reimbursed pharmacies in Oregon for prescriptions, inclusive of ingredient cost and dispensing fee, and the total amount the pharmacy benefit manager was reimbursed by carriers for prescriptions dispensed by pharmacies~~t~~ in ~~the pharmacy benefit manager~~Oregon; and¶
(B) Any revenue obtained by the pharmacy benefit manager through spread pricing for prescriptions dispensed by pharmacies in Oregon as defined in ORS 735.537(1)(e).
Statutory/Other Authority: ORS 731.244
Statutes/Other Implemented: ~~ORS 743.~~735.537, OL 202~~5~~4, ~~735.53~~ch 87

AMEND: 836-200-0421

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Describes service requirements on a licensed PBM. The amendments replace registration language with equivalent language on licensure.

CHANGES TO RULE:

836-200-0421
Service on ~~Registrant~~Licensee ¶

The ~~D~~director of the Department of Consumer and Business Services may direct notices and inquiries to, and make service on a pharmacy benefit manager at, the address shown on the current ~~registration~~license of the pharmacy benefit manager on file with the director, in the manner provided in ORS Chapter 183.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 2-3, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530 ~~to~~- 735.552,~~ ORS~~ 731.23~~9~~6, 731.2~~96~~36, OL 2024, ch 87

AMEND: 836-200-0436

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Amends statutory citations.

CHANGES TO RULE:

836-200-0436
Submission of Complaints
(1) Any complaint filed with the Department of Consumer and Business Services by a pharmacy, or by an entity acting on behalf of a pharmacy, alleging a violation of ORS 735.530 to 735.552, shall be in form as posted on the ~~D~~department's Division of Financial Regulation website.¶
(2) A complaint shall include documentation of the alleged violation and of all efforts made to resolve the alleged violation prior to filing of the complaint.
Statutory/Other Authority: ORS 731.244, 735.532~~, Sec. 2, Ch. 73, OL 2017, 2017 Or Laws ch 73, §§ 1-3~~
Statutes/Other Implemented: ORS 735.530 ~~to~~- 735.552

AMEND: 836-200-0440

NOTICE FILED DATE: 05/29/2025

RULE SUMMARY: Describes restrictions on the conduct of licensed PBMs. The amendments replace registration language with equivalent language on licensure, add new requirements created by statute between 2019 and 2024, and reorder provisions to provide additional clarity about the department's expectations.

CHANGES TO RULE:

836-200-0440
Market Conduct Requirements for Pharmacy Benefit Managers
(1) A pharmacy benefit manager shall allow a network pharmacy to mail, ship or deliver prescription drugs to its patients as an ancillary service. A contract between a pharmacy benefit manager and a network pharmacy may establish limits and parameters on the pharmacy's mail, shipment and/or delivery of prescription drugs on the request of enrollees based on the pharmacy's total prescription volume. A pharmacy benefit manager is not required to reimburse a delivery fee charged by a network pharmacy unless the fee is specified in the contract between the pharmacy benefit manager and the pharmacy.¶
(2) Except as provided in subsection (6) of this ~~section~~rule, a pharmacy benefit manager 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.¶
(3) For the purposes of subsection (2) of this section, the department will consider a prescription drug to meet the definition of "specialty drug" under ~~Oregon Laws 2019, chapter 526, section 4~~RS 735.530 if, to be properly dispensed according to standard industry practice, the drug:¶
(a) Requires specialized preparation, administration, handling, storage, inventory, reporting or distribution;¶
(b) Is associated with difficult or unusual data collection or administrative requirements; or¶
(c) Requires a pharmacist to manage the patient's use of the drug by monitoring, provide disease or therapeutic support systems, provide care coordination including collaboration with patients or other health care providers to manage adherence, identify side effects, monitor clinical parameters, assess responses to therapy, or document outcomes.¶
(4) For the purposes of subsection (2) of this section, a pharmacy may demonstrate to the department that it meets the definition of "specialty pharmacy" under ~~Oregon Laws 2019, chapter 526, section 4~~RS 735.530 by showing that:¶
(a) Its business is primarily providing specialty drugs and specialized, disease-specific clinical care and services for people with serious or chronic health conditions requiring complex medication therapies; or¶
(b) It has been validated for meeting quality, safety and accountability standards for specialty pharmacy practice through accreditation in specialty pharmacy by a nationally recognized, independent accreditation organization such as URAC or the Accreditation Commission for Health Care (ACHC).¶
(5) Nothing in subsection (4) of this section shall be construed to prohibit a pharmacy benefit manager from specifying additional terms and conditions for a specialty pharmacy network contract, including terms and conditions related to reimbursement.¶
(6) A pharmacy benefit manager shall reimburse the cost of a specialty drug that is filled or refilled at a network pharmacy that is a long term care pharmacy, provided that the specialty drug is dispensed to an enrollee who is a resident of a long term care facility served by the long term care pharmacy.¶
(7) A pharmacy benefit manager 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.¶
(8) A network pharmacy may appeal its reimbursement from a pharmacy benefit manager for a drug subject to maximum allowable cost pricing on the basis that the ~~drug is only available at the specified price~~reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. ¶
(a) If the pharmacy benefit manager denies a pharmacy's appeal under this rule, it must provide the reason for the denial and identify a national drug code for the drug, generally available for purchase by similarly situated pharmacies, and national or regional wholesalers where that national drug code was listed at a price equal to or less than the maximum allowable cost for the drug at the time that the claim in question was adjudicated.¶
(b) For the purposes of this rule, "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. A drug is not "generally available for purchase" if the drug:¶
(A) May only be dispensed in a hospital or inpatient care facility;¶
(B) Is unavailable due to a shortage of the product or an ingredient;¶
(C) Is available to a pharmacy at a price at or below the maximum allowable cost only if purchased in substantial quantities in excess of its business needs. For the purposes of this subsection, a quantity in excess of the business

needs of a network pharmacy is defined as a purchase quantity greater than a 3-month supply based on the pharmacy's total dispensing history over the most recent rolling 12 months. A pharmacy benefit manager may require a network pharmacy appealing its reimbursement for a drug in accordance with this subsection to submit applicable evidence of its dispensing history to the pharmacy benefit manager as part of the appeal process.~~A pharmacy benefit manager's compliance with this subsection is sufficient to demonstrate compliance with Oregon Laws 2019, chapter 526, section 4 (1)(a)(B)(iii)~~¶
(D) Is sold at a discount due to a short expiration date on the drug; or¶
(E) Is the subject of an active or pending recall.¶
(c) The appeals process required by ORS 735.534(4) must provide the pharmacy the opportunity to rebut an appeal on the basis that the NDC provided in the denial is not generally available for purchase for similarly situated pharmacies for one of the reasons described in subsection (8)(b) of this rule.¶
(d) If an appeal is upheld under this rule, the pharmacy benefit manager must make an adjustment for the appealing pharmacy from the date of initial adjudication forward and allow the pharmacy to reverse the claim and resubmit an adjusted claim without any charges.¶
(~~8~~e) If a prescription drug subject to a specified maximum allowable cost is available at that price if purchased in quantities that are consistent with the business needs of some pharmacies but inconsistent with the business needs of others, nothing in subsection (~~7~~8) shall be construed to prohibit a pharmacy benefit manager from applying the maximum allowable cost to pharmacies that can purchase the drug in the necessary quantities consistent with their business needs.¶
(f) If the request for an adjustment has come from a "critical access pharmacy", as defined by the Oregon Health Authority in OAR 431-121-2000, the adjustment approved under subsection (8) of this rule is only required to apply to critical access pharmacies.¶
(9) A pharmacy benefit manager 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. For the purposes of this section, "fraud" has the meaning defined in ORS 735.540;¶
(b) The payment 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) The payment was incorrect due to an error that the pharmacy and pharmacy benefit manager agree was a clerical error.¶
(10) A pharmacy benefit manager may not impose a fee for a particular claim on a pharmacy after the point of sale. For the purposes of this subsection, "point-of-sale" means the time that the claim was adjudicated.¶
(11) A pharmacy benefit manager may not penalize a network pharmacy for:¶
(a) Appealing the reimbursement of a drug to the pharmacy benefit manager;¶
(b) Filing a complaint against the pharmacy benefit manager with the department;¶
(c) Engaging in the legislative process; or¶
(d) Challenging the pharmacy benefit manager's practices or agreements.¶
(12) For the purposes of subsection (11) of this rule, "penalize" includes but is not limited any of the following actions if applied to a network pharmacy that has engaged in the protected conduct described in subsections (11)(a) to (d) of this rule differently from similarly situated pharmacies that have not engaged in said protected conduct: imposing charges or fees, requiring contract amendments, canceling or terminating contracts, demanding recoupment, or conducting an unnecessary or unwarranted audit of a pharmacy.¶
(13) A pharmacy benefit manager may not charge a fee to a pharmacy for submitting claims or for the adjudication of claims.¶
(14) Nothing in subsections (9) and (11) of this rule shall be construed as limiting a pharmacy benefit manager from conducting a pharmacy claims audit that is in compliance with the requirements of ORS 735.540 to 735.552.
Statutory/Other Authority: O~~r Laws 2019, ch 52~~RS 735.534, 735.536
Statutes/Other Implemented: O~~r Laws~~RS 735.534, 735.536, OL 20~~19~~24, ch ~~526~~87