State PBM Reform Inventory

Updated October 2026

Oregon

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Department of Consumer and Business Services. To obtain a license, a PBM must submit an application to the department in a form determined by the department and pay a fee adopted by the department by rule. PBMs must renew their licenses every 12 months and pay a renewal fee. Initial application fees and renewal fees are set at $1,100.	Or. Rev. Stat. § 735.532; Administrative Order ID6-2025

Reporting Requirements	Not later than June 1 of each calendar year, a PBM shall file a report with the Department of Consumer and Business Services. The report must contain, for the immediately preceding calendar year:
	• The aggregated dollar amount of rebates, fees, price protection payments and any other payments the PBM received from manufacturers:
	  ○ Related to managing the pharmacy benefits for carriers issuing health benefit plans in this state; and
	  ○ That were:
	  ▪ Passed on to carriers issuing health benefit plans in this state or enrollees at the point of sale of a prescription drug in this state; or
	  ▪ Retained as revenue by the PBM.
	• The total dispensing fees paid to the PBM and to pharmacies.
	• The total administrative fees obtained and retained from manufacturers and carriers.
	• Money obtained through spread pricing, pay-for-performance, or similar means.
	
	Upon the request of the Department of Consumer and Business Services, a PBM shall submit to the department its contracts with pharmacies or PSAOs and its provider manuals.
		Or. Rev. Stat. § 735.537;
		
		Or. Rev. Stat. § 735.538

PBM Income	N/A	

Pharmacy Contracting	**MAC Pricing:**
	A PBM:
	• 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.
	• Shall ensure that all drugs on a list are generally available for purchase.
	• Shall ensure that no drug on a list is obsolete.
	• Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the specific source the PBM uses to determine the MAC set by the PBM.
	• Shall make a list available to a network pharmacy upon request in a format that:
	  ○ Is electronic;
	  ○ Is computer accessible and searchable;
	  ○ Identifies all drugs for which MACs have been established; and
	  ○ For each drug specifies:
	  ▪ The NDC; and
	  ▪ The MAC.
	• Shall update each list maintained by the PBM every 7 business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies.
	• Shall ensure that dispensing fees are not included in the calculation of MAC.
	• A PBM must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to MAC pricing. A network pharmacy may appeal a MAC if the reimbursement for the drug is less than the net amount 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.
	• A PBM must provide as part of the appeals process:
	  ○ A telephone number at which a network pharmacy may contact the PBM and speak with an individual who is responsible for processing appeals;
		Or. Rev. Stat. § 735.534

	○ A final response to an appeal of the reimbursement for a drug within seven business days; and ○ If the appeal is denied, the reason for the denial and the NDC of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the MAC. • If an appeal is upheld, a PBM shall: ○ Make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward; and ○ Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any additional charges. • 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, an adjustment approved under an appeal shall apply only to critical access pharmacies.	
Patient Cost-Sharing	**Copay Adjustment Programs:** To the extent permitted by federal law, an insurer offering a health plan that provides pharmacy benefits and a PBM shall include all amounts paid by an enrollee or paid by another person on behalf of an enrollee toward the cost of a covered prescription drug when calculating the enrollee's contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement applied to the drug if: • The drug does not have a generic equivalent; or • The drug has a generic equivalent and the enrollee has: ○ Obtained prior authorization from the insurer or PBM; ○ Complied with a step therapy protocol; or ○ Received approval from the insurer or PBM through the insurer's or the PBM's exceptions, appeal or review process. For high-deductible health plans, this requirement applies only to preventive services until the enrollee has satisfied the minimum deductible. **Copay Cap:** A health benefit plan offered in this state may not require an enrollee in the plan to incur cost-sharing or other out-of-pocket	Or. Rev. Stat. § 743B.603; Or. Rev. Stat. § 743A.069

	costs that exceed $35 for each 30-day supply of a type of insulin prescribed for the treatment of diabetes or $105 for each 90-day supply.	