

D R A F T

SUMMARY

Requires health insurance coverage of specified fertility services and treatments.

Requires Oregon Health Authority to study inequalities in assisted reproduction for individuals who are lesbian, gay, bisexual, transgender, queer or are members of other minority gender identities or sexual orientations and to issue report no later than January 31, 2025, on authority's findings and make recommendations for ensuring that assisted reproduction is available in equitable, inclusive and nonexploitive ways for Oregonians enrolled in state-funded programs that provide medical care to low-income individuals.

Declares emergency, effective on passage.

A BILL FOR AN ACT

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Relating to infertility; creating new provisions; amending ORS 743B.005; and declaring an emergency.

Whereas according to the federal Centers for Disease Control and Prevention, over 12 percent of women in the United States who are of reproductive age have difficulty becoming pregnant or carrying a pregnancy to term; and

Whereas infertility is evenly divided between men and women and approximately one-third of cases of infertility involve both partners being diagnosed or are unexplained; and

Whereas increasing accessibility for infertility treatment will expand health services in this state and improve the short-term and long-term outcomes for the resulting children and mothers, which may also reduce health care costs by reducing adverse outcomes; and

Whereas access to insurance coverage reduces health disparities for racial

1 and ethnic minorities as well as for lesbian, gay, bisexual, transgender and
2 queer individuals; now, therefore,

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

4 **SECTION 1. Section 2 of this 2022 Act is added to and made a part**
5 **of the Insurance Code.**

6 **SECTION 2. (1) As used in this section, “infertility” means:**

7 **(a) A disease, condition or status that results in a failure to estab-**
8 **lish a pregnancy or to carry a pregnancy to a live birth after regular,**
9 **unprotected sexual intercourse for:**

10 **(A) Twelve months for a woman under the age of 35; or**

11 **(B) Six months for a woman 35 years of age or older; or**

12 **(b) An individual’s inability, without medical intervention, to re-**
13 **produce either as a single person or with the person’s partner.**

14 **(2) Health benefit plans offered in this state to large or small em-**
15 **ployers and individual health benefit plans offered in this state shall**
16 **reimburse the cost of:**

17 **(a) Procedures and medications to address infertility recommended**
18 **by a licensed treating practitioner that are:**

19 **(A) Based on the practitioner’s physical findings and diagnostic**
20 **testing and an individual’s medical history, sexual history, reproduc-**
21 **tive history and age; and**

22 **(B) Consistent with established, published or approved medical**
23 **practices or professional guidelines from the American College of**
24 **Obstetricians and Gynecologists or the American Society for Repro-**
25 **ductive Medicine, or a successor organization.**

26 **(b) Procedures recommended by a licensed treating practitioner,**
27 **including but not limited to the storage of reproductive specimens for**
28 **the period of time deemed medically necessary by the practitioner, and**
29 **that are:**

30 **(A) Based on the practitioner’s physical findings and diagnostic**
31 **testing and an individual’s medical history, sexual history, reproduc-**

1 **tive history and age; and**

2 **(B) Consistent with established medical practices or professional**
3 **guidelines published by the American Society for Reproductive Medi-**
4 **cine or the American Society of Clinical Oncology, or a successor or-**
5 **ganization, for an individual who is at risk of infertility due to:**

6 **(i) A medical condition; or**

7 **(ii) An expected medication therapy, surgery, radiation,**
8 **chemotherapy or other medical treatment that is recognized by med-**
9 **ical professionals to cause a risk of infertility.**

10 **(3) The coverage required by subsection (2) of this section:**

11 **(a) Includes a minimum of three completed oocyte retrievals with**
12 **unlimited embryo transfers in accordance with guidelines of the**
13 **American Society for Reproductive Medicine, or a successor organiza-**
14 **tion, using single embryo transfer if recommended by a licensed**
15 **treating practitioner and medically effective.**

16 **(b) Must be provided to all beneficiaries under the health benefit**
17 **plan policy or certificate, including a covered spouse and covered**
18 **non-spouse dependents, to the same extent as other pregnancy-related**
19 **benefits under the plan.**

20 **(4) The health benefit plan may not impose exclusions, limitations**
21 **or other restrictions on coverage of:**

22 **(a) Medications for the treatment of infertility described in sub-**
23 **section (2) of this section that are not imposed on other prescription**
24 **benefits under the plan.**

25 **(b) Procedures described in subsection (2) of this section:**

26 **(A) Based on an enrollee's participation in fertility services pro-**
27 **vided by or to a third party.**

28 **(B) That do not apply to other covered procedures under the plan.**

29 **(5) Subsection (4) of this section does not permit a health benefit**
30 **plan to require step therapy for services described in subsection (2) of**
31 **this section that are determined by a treating practitioner to be med-**

1 ically necessary.

2 (6) This section does not require a religious insurer to provide cov-
3 erage of fertility or reproductive endocrinology services for men or
4 women in a health benefit plan offered by the insurer if coverage of
5 fertility or reproductive endocrinology services is contrary to the reli-
6 gious tenets of the insurer.

7 **SECTION 3.** (1) The Oregon Health Authority shall explore the in-
8 equalities in assisted reproduction for individuals who are lesbian, gay,
9 bisexual, transgender, queer or are members of other minority gender
10 identities or sexual orientations.

11 (2) No later than January 31, 2025, the authority shall issue a report
12 on its findings under subsection (1) of this section, including recom-
13 mendations to ensure that assisted reproduction is available in an eq-
14 uitable, inclusive and nonexploitive way for low-income Oregonians
15 enrolled in the medical assistance program, the program described in
16 ORS 414.432 and other state-funded programs that provide medical care
17 to low-income individuals residing in this state.

18 **SECTION 4.** ORS 743B.005 is amended to read:

19 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.416, 743.417,
20 743.535, 743B.003 to 743B.127, 743B.109, 743B.128, 743B.250 and 743B.323 **and**
21 **section 2 of this 2022 Act:**

22 (1) “Actuarial certification” means a written statement by a member of
23 the American Academy of Actuaries or other individual acceptable to the
24 Director of the Department of Consumer and Business Services that a carrier
25 is in compliance with the provisions of ORS 743B.012 based upon the person’s
26 examination, including a review of the appropriate records and of the
27 actuarial assumptions and methods used by the carrier in establishing pre-
28 mium rates for small employer health benefit plans.

29 (2) “Affiliate” of, or person “affiliated” with, a specified person means any
30 carrier who, directly or indirectly through one or more intermediaries, con-
31 trols or is controlled by or is under common control with a specified person.

1 For purposes of this definition, “control” has the meaning given that term
2 in ORS 732.548.

3 (3) “Affiliation period” means, under the terms of a group health benefit
4 plan issued by a health care service contractor, a period:

5 (a) That is applied uniformly and without regard to any health status
6 related factors to an enrollee or late enrollee;

7 (b) That must expire before any coverage becomes effective under the plan
8 for the enrollee or late enrollee;

9 (c) During which no premium shall be charged to the enrollee or late
10 enrollee; and

11 (d) That begins on the enrollee’s or late enrollee’s first date of eligibility
12 for coverage and runs concurrently with any eligibility waiting period under
13 the plan.

14 (4) “Bona fide association” means an association that:

15 (a) Has been in active existence for at least five years;

16 (b) Has been formed and maintained in good faith for purposes other than
17 obtaining insurance;

18 (c) Does not condition membership in the association on any factor re-
19 lating to the health status of an individual or the individual’s dependent or
20 employee;

21 (d) Makes health insurance coverage that is offered through the associ-
22 ation available to all members of the association regardless of the health
23 status of the member or individuals who are eligible for coverage through
24 the member;

25 (e) Does not make health insurance coverage that is offered through the
26 association available other than in connection with a member of the associ-
27 ation;

28 (f) Has a constitution and bylaws; and

29 (g) Is not owned or controlled by a carrier, producer or affiliate of a
30 carrier or producer.

31 (5) “Carrier” means any person who provides health benefit plans in this

1 state, including:

2 (a) A licensed insurance company;

3 (b) A health care service contractor;

4 (c) A health maintenance organization;

5 (d) An association or group of employers that provides benefits by means
6 of a multiple employer welfare arrangement and that:

7 (A) Is subject to ORS 750.301 to 750.341; or

8 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects
9 to be governed by ORS 743B.010 to 743B.013; or

10 (e) Any other person or corporation responsible for the payment of bene-
11 fits or provision of services.

12 (6) “Dependent” means the spouse or child of an eligible employee, subject
13 to applicable terms of the health benefit plan covering the employee.

14 (7) “Eligible employee” means an employee who is eligible for coverage
15 under a group health benefit plan.

16 (8) “Employee” means any individual employed by an employer.

17 (9) “Enrollee” means an employee, dependent of the employee or an indi-
18 vidual otherwise eligible for a group or individual health benefit plan who
19 has enrolled for coverage under the terms of the plan.

20 (10) “Exchange” means the health insurance exchange as defined in ORS
21 741.300.

22 (11) “Exclusion period” means a period during which specified treatments
23 or services are excluded from coverage.

24 (12) “Financial impairment” means that a carrier is not insolvent and is:

25 (a) Considered by the director to be potentially unable to fulfill its con-
26 tractual obligations; or

27 (b) Placed under an order of rehabilitation or conservation by a court of
28 competent jurisdiction.

29 (13)(a) “Geographic average rate” means the arithmetical average of the
30 lowest premium and the corresponding highest premium to be charged by a
31 carrier in a geographic area established by the director for the carrier’s:

1 (A) Group health benefit plans offered to small employers; or

2 (B) Individual health benefit plans.

3 (b) “Geographic average rate” does not include premium differences that
4 are due to differences in benefit design, age, tobacco use or family composi-
5 tion.

6 (14) “Grandfathered health plan” has the meaning prescribed by rule by
7 the United States Secretaries of Labor, Health and Human Services and the
8 Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.

9 (15) “Group eligibility waiting period” means, with respect to a group
10 health benefit plan, the period of employment or membership with the group
11 that a prospective enrollee must complete before plan coverage begins.

12 (16)(a) “Health benefit plan” means any:

13 (A) Hospital expense, medical expense or hospital or medical expense
14 policy or certificate;

15 (B) Subscriber contract of a health care service contractor as defined in
16 ORS 750.005; or

17 (C) Plan provided by a multiple employer welfare arrangement or by an-
18 other benefit arrangement defined in the federal Employee Retirement In-
19 come Security Act of 1974, as amended, to the extent that the plan is subject
20 to state regulation.

21 (b) “Health benefit plan” does not include:

22 (A) Coverage for accident only, specific disease or condition only, credit
23 or disability income;

24 (B) Coverage of Medicare services pursuant to contracts with the federal
25 government;

26 (C) Medicare supplement insurance policies;

27 (D) Coverage of TRICARE services pursuant to contracts with the federal
28 government;

29 (E) Benefits delivered through a flexible spending arrangement estab-
30 lished pursuant to section 125 of the Internal Revenue Code of 1986, as
31 amended, when the benefits are provided in addition to a group health ben-

1 efit plan;

2 (F) Separately offered long term care insurance, including, but not limited
3 to, coverage of nursing home care, home health care and community-based
4 care;

5 (G) Independent, noncoordinated, hospital-only indemnity insurance or
6 other fixed indemnity insurance;

7 (H) Short term health insurance policies;

8 (I) Dental only coverage;

9 (J) Vision only coverage;

10 (K) Stop-loss coverage that meets the requirements of ORS 742.065;

11 (L) Coverage issued as a supplement to liability insurance;

12 (M) Insurance arising out of a workers' compensation or similar law;

13 (N) Automobile medical payment insurance or insurance under which
14 benefits are payable with or without regard to fault and that is statutorily
15 required to be contained in any liability insurance policy or equivalent self-
16 insurance; or

17 (O) Any employee welfare benefit plan that is exempt from state regu-
18 lation because of the federal Employee Retirement Income Security Act of
19 1974, as amended.

20 (17) "Individual health benefit plan" means a health benefit plan:

21 (a) That is issued to an individual policyholder; or

22 (b) That provides individual coverage through a trust, association or
23 similar group, regardless of the situs of the policy or contract.

24 (18) "Initial enrollment period" means a period of at least 30 days fol-
25 lowing commencement of the first eligibility period for an individual.

26 (19) "Late enrollee" means an individual who enrolls in a group health
27 benefit plan subsequent to the initial enrollment period during which the
28 individual was eligible for coverage but declined to enroll. However, an eli-
29 gible individual shall not be considered a late enrollee if:

30 (a) The individual qualifies for a special enrollment period in accordance
31 with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer

1 and Business Services;

2 (b) The individual applies for coverage during an open enrollment period;

3 (c) A court issues an order that coverage be provided for a spouse or
4 minor child under an employee's employer sponsored health benefit plan and
5 request for enrollment is made within 30 days after issuance of the court
6 order;

7 (d) The individual is employed by an employer that offers multiple health
8 benefit plans and the individual elects a different health benefit plan during
9 an open enrollment period; or

10 (e) The individual's coverage under Medicaid, Medicare, TRICARE, In-
11 dian Health Service or a publicly sponsored or subsidized health plan, in-
12 cluding, but not limited to, the medical assistance program under ORS
13 chapter 414, has been involuntarily terminated within 63 days after applying
14 for coverage in a group health benefit plan.

15 (20) "Multiple employer welfare arrangement" means a multiple employer
16 welfare arrangement as defined in section 3 of the federal Employee Retire-
17 ment Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject
18 to ORS 750.301 to 750.341.

19 (21) "Preexisting condition exclusion" means a limitation or exclusion of
20 benefits or a denial of coverage based on a medical condition being present
21 before the effective date of coverage or before the date coverage is denied,
22 whether or not any medical advice, diagnosis, care or treatment was recom-
23 mended or received for the condition before the date of coverage or denial
24 of coverage.

25 (22) "Premium" includes insurance premiums or other fees charged for a
26 health benefit plan, including the costs of benefits paid or reimbursements
27 made to or on behalf of enrollees covered by the plan.

28 (23) "Rating period" means the 12-month calendar period for which pre-
29 mium rates established by a carrier are in effect, as determined by the car-
30 rier.

31 (24) "Representative" does not include an insurance producer or an em-

1 ployee or authorized representative of an insurance producer or carrier.

2 (25)(a) “Short term health insurance policy” means a policy of health in-
3 surance that is in effect for a period of three months or less, including the
4 term of a renewal of the policy.

5 (b) As used in this subsection, “term of a renewal” includes the term of
6 a new short term health insurance policy issued by an insurer to a
7 policyholder no later than 60 days after the expiration of a short term health
8 insurance policy issued by the insurer to the policyholder.

9 (26) “Small employer” means an employer who employed an average of at
10 least one but not more than 50 full-time equivalent employees on business
11 days during the preceding calendar year and who employs at least one full-
12 time equivalent employee on the first day of the plan year, determined in
13 accordance with a methodology prescribed by the Department of Consumer
14 and Business Services by rule.

15 **SECTION 5. Section 2 of this 2022 Act applies to policies or certifi-**
16 **icates issued, renewed or extended on or after January 1, 2023.**

17 **SECTION 6. The amendments to ORS 743B.005 by section 4 of this**
18 **2022 Act become operative on January 1, 2023.**

19 **SECTION 7. This 2022 Act being necessary for the immediate pres-**
20 **ervation of the public peace, health and safety, an emergency is de-**
21 **clared to exist, and this 2022 Act takes effect on its passage.**

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