

Senate Bill 1530

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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 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

1
2 Relating to infertility; creating new provisions; amending ORS 743B.005; and declaring an emer-
3 gency.

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

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

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

12 Whereas access to insurance coverage reduces health disparities for racial and ethnic minorities
13 as well as for lesbian, gay, bisexual, transgender and queer individuals; now, therefore,

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

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

16 **SECTION 2. (1) As used in this section, "infertility" means:**

17 **(a) A disease, condition or status that results in a failure to establish a pregnancy or to**
18 **carry a pregnancy to a live birth after regular, unprotected sexual intercourse for:**

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

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

21 **(b) An individual's inability, without medical intervention, to reproduce either as a single**
22 **person or with the person's partner.**

23 **(2) Health benefit plans offered in this state to large or small employers and individual**
24 **health benefit plans offered in this state shall reimburse the cost of:**

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

27 **(A) Based on the practitioner's physical findings and diagnostic testing and an**

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.

1 individual's medical history, sexual history, reproductive history and age; and

2 (B) Consistent with established, published or approved medical practices or professional
3 guidelines from the American College of Obstetricians and Gynecologists or the American
4 Society for Reproductive Medicine, or a successor organization.

5 (b) Procedures recommended by a licensed treating practitioner, including but not limited
6 to the storage of reproductive specimens for the period of time deemed medically necessary
7 by the practitioner, and that are:

8 (A) Based on the practitioner's physical findings and diagnostic testing and an
9 individual's medical history, sexual history, reproductive history and age; and

10 (B) Consistent with established medical practices or professional guidelines published by
11 the American Society for Reproductive Medicine or the American Society of Clinical
12 Oncology, or a successor organization, for an individual who is at risk of infertility due to:

13 (i) A medical condition; or

14 (ii) An expected medication therapy, surgery, radiation, chemotherapy or other medical
15 treatment that is recognized by medical professionals to cause a risk of infertility.

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

17 (a) Includes a minimum of three completed oocyte retrievals with unlimited embryo
18 transfers in accordance with guidelines of the American Society for Reproductive Medicine,
19 or a successor organization, using single embryo transfer if recommended by a licensed
20 treating practitioner and medically effective.

21 (b) Must be provided to all beneficiaries under the health benefit plan policy or certif-
22 icate, including a covered spouse and covered non-spouse dependents, to the same extent as
23 other pregnancy-related benefits under the plan.

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

26 (a) Medications for the treatment of infertility described in subsection (2) of this section
27 that are not imposed on other prescription benefits under the plan.

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

29 (A) Based on an enrollee's participation in fertility services provided by or to a third
30 party.

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

32 (5) Subsection (4) of this section does not permit a health benefit plan to require step
33 therapy for services described in subsection (2) of this section that are determined by a
34 treating practitioner to be medically necessary.

35 (6) This section does not require a religious insurer to provide coverage of fertility or
36 reproductive endocrinology services for men or women in a health benefit plan offered by the
37 insurer if coverage of fertility or reproductive endocrinology services is contrary to the re-
38 ligious tenets of the insurer.

39 **SECTION 3.** (1) The Oregon Health Authority shall explore the inequalities in assisted
40 reproduction for individuals who are lesbian, gay, bisexual, transgender, queer or are mem-
41 bers of other minority gender identities or sexual orientations.

42 (2) No later than January 31, 2025, the authority shall issue a report on its findings under
43 subsection (1) of this section, including recommendations to ensure that assisted repro-
44 duction is available in an equitable, inclusive and nonexploitive way for low-income Oregonians
45 enrolled in the medical assistance program, the program described in ORS 414.432 and other

1 **state-funded programs that provide medical care to low-income individuals residing in this**
 2 **state.**

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

4 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.416, 743.417, 743.535, 743B.003 to
 5 743B.127, 743B.109, 743B.128, 743B.250 and 743B.323 **and section 2 of this 2022 Act:**

6 (1) "Actuarial certification" means a written statement by a member of the American Academy
 7 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
 8 Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon
 9 the person's examination, including a review of the appropriate records and of the actuarial as-
 10 sumptions and methods used by the carrier in establishing premium rates for small employer health
 11 benefit plans.

12 (2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly
 13 or indirectly through one or more intermediaries, controls or is controlled by or is under common
 14 control with a specified person. For purposes of this definition, "control" has the meaning given that
 15 term in ORS 732.548.

16 (3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health
 17 care service contractor, a period:

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

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

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

23 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs
 24 concurrently with any eligibility waiting period under the plan.

25 (4) "Bona fide association" means an association that:

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

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

28 (c) Does not condition membership in the association on any factor relating to the health status
 29 of an individual or the individual's dependent or employee;

30 (d) Makes health insurance coverage that is offered through the association available to all
 31 members of the association regardless of the health status of the member or individuals who are
 32 eligible for coverage through the member;

33 (e) Does not make health insurance coverage that is offered through the association available
 34 other than in connection with a member of the association;

35 (f) Has a constitution and bylaws; and

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

37 (5) "Carrier" means any person who provides health benefit plans in this state, including:

38 (a) A licensed insurance company;

39 (b) A health care service contractor;

40 (c) A health maintenance organization;

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

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

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

1 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-
 2 vices.

3 (6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms
 4 of the health benefit plan covering the employee.

5 (7) "Eligible employee" means an employee who is eligible for coverage under a group health
 6 benefit plan.

7 (8) "Employee" means any individual employed by an employer.

8 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible
 9 for a group or individual health benefit plan who has enrolled for coverage under the terms of the
 10 plan.

11 (10) "Exchange" means the health insurance exchange as defined in ORS 741.300.

12 (11) "Exclusion period" means a period during which specified treatments or services are ex-
 13 cluded from coverage.

14 (12) "Financial impairment" means that a carrier is not insolvent and is:

15 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

17 (13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the
 18 corresponding highest premium to be charged by a carrier in a geographic area established by the
 19 director for the carrier's:

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

21 (B) Individual health benefit plans.

22 (b) "Geographic average rate" does not include premium differences that are due to differences
 23 in benefit design, age, tobacco use or family composition.

24 (14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Sec-
 25 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that
 26 is in effect on January 1, 2017.

27 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the
 28 period of employment or membership with the group that a prospective enrollee must complete be-
 29 fore plan coverage begins.

30 (16)(a) "Health benefit plan" means any:

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

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

33 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
 34 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
 35 extent that the plan is subject to state regulation.

36 (b) "Health benefit plan" does not include:

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

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

39 (C) Medicare supplement insurance policies;

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

41 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
 42 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
 43 to a group health benefit plan;

44 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
 45 ing home care, home health care and community-based care;

- 1 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
2 surance;
- 3 (H) Short term health insurance policies;
- 4 (I) Dental only coverage;
- 5 (J) Vision only coverage;
- 6 (K) Stop-loss coverage that meets the requirements of ORS 742.065;
- 7 (L) Coverage issued as a supplement to liability insurance;
- 8 (M) Insurance arising out of a workers' compensation or similar law;
- 9 (N) Automobile medical payment insurance or insurance under which benefits are payable with
10 or without regard to fault and that is statutorily required to be contained in any liability insurance
11 policy or equivalent self-insurance; or
- 12 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
13 eral Employee Retirement Income Security Act of 1974, as amended.
- 14 (17) "Individual health benefit plan" means a health benefit plan:
- 15 (a) That is issued to an individual policyholder; or
- 16 (b) That provides individual coverage through a trust, association or similar group, regardless
17 of the situs of the policy or contract.
- 18 (18) "Initial enrollment period" means a period of at least 30 days following commencement of
19 the first eligibility period for an individual.
- 20 (19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent
21 to the initial enrollment period during which the individual was eligible for coverage but declined
22 to enroll. However, an eligible individual shall not be considered a late enrollee if:
- 23 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
24 or as prescribed by rule by the Department of Consumer and Business Services;
- 25 (b) The individual applies for coverage during an open enrollment period;
- 26 (c) A court issues an order that coverage be provided for a spouse or minor child under an
27 employee's employer sponsored health benefit plan and request for enrollment is made within 30
28 days after issuance of the court order;
- 29 (d) The individual is employed by an employer that offers multiple health benefit plans and the
30 individual elects a different health benefit plan during an open enrollment period; or
- 31 (e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a
32 publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance
33 program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for
34 coverage in a group health benefit plan.
- 35 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
36 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
37 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.
- 38 (21) "Preexisting condition exclusion" means a limitation or exclusion of benefits or a denial of
39 coverage based on a medical condition being present before the effective date of coverage or before
40 the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was
41 recommended or received for the condition before the date of coverage or denial of coverage.
- 42 (22) "Premium" includes insurance premiums or other fees charged for a health benefit plan,
43 including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by
44 the plan.
- 45 (23) "Rating period" means the 12-month calendar period for which premium rates established

1 by a carrier are in effect, as determined by the carrier.

2 (24) "Representative" does not include an insurance producer or an employee or authorized
3 representative of an insurance producer or carrier.

4 (25)(a) "Short term health insurance policy" means a policy of health insurance that is in effect
5 for a period of three months or less, including the term of a renewal of the policy.

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

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

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

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

18 **SECTION 7. This 2022 Act being necessary for the immediate preservation of the public
19 peace, health and safety, an emergency is declared to exist, and this 2022 Act takes effect
20 on its passage.**

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