House Bill 3061

Sponsored by Representative RESCHKE

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.

Eliminates requirement that health benefit plans cover abortions.

A BILL FOR AN ACT

Relating to abortion; amending ORS 731.804 and 743A.067.

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

SECTION 1. ORS 743A.067, as amended by section 12, chapter 45, Oregon Laws 2022, is amended to read:

743A.067. (1) As used in this section:
(a) “Contraceptives” means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.
(b) “Enrollee” means an insured individual and the individual’s spouse, domestic partner and dependents who are beneficiaries under the insured individual’s health benefit plan.
(c) “Health benefit plan” has the meaning given that term in ORS 743B.005, excluding Medicare Advantage Plans and including health benefit plans offering pharmacy benefits administered by a third party administrator or pharmacy benefit manager.
(d) “Prior authorization” has the meaning given that term in ORS 743B.001.
(e) “Religious employer” has the meaning given that term in ORS 743A.066.
(f) “Utilization review” has the meaning given that term in ORS 743B.001.
(2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:
(a) Well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration.
(b) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome.
(c) Screening for:
(A) Chlamydia;
(B) Gonorrhea;
(C) Hepatitis B;
(D) Hepatitis C;
(E) Human immunodeficiency virus and acquired immune deficiency syndrome;
(F) Human papillomavirus;
(G) Syphilis;
(H) Anemia;

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.

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(I) Urinary tract infection;
(J) Pregnancy;
(K) Rh incompatibility;
(L) Gestational diabetes;
(M) Osteoporosis;
(N) Breast cancer; and
(O) Cervical cancer.
(d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.
(e) Screening and appropriate counseling or interventions for:
(A) Tobacco use; and
(B) Domestic and interpersonal violence.
(f) Folic acid supplements.
(g) Abortion.
(h) Breastfeeding comprehensive support, counseling and supplies.
(i) Breast cancer chemoprevention counseling.
(j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:
(A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
(B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee’s provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.
(C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
(D) A health benefit plan may not infringe upon an enrollee’s choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization review techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.
(k) Voluntary sterilization.
(L) As a single claim or combined with other claims for covered services provided on the same day:
(A) Patient education and counseling on contraception and sterilization.
(B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:
(i) Management of side effects;
(ii) Counseling for continued adherence to a prescribed regimen;
(iii) Device insertion and removal; and
(iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee’s provider.
(m) Any additional preventive services for women that must be covered without cost
sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.

(3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.

(4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.

(5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:

(a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or

(b) Contraception that is necessary to preserve the life or health of an enrollee.

(6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.

(7) This section does not require a health benefit plan to cover:

(a) Experimental or investigational treatments;

(b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

(c) Treatments that do not conform to acceptable and customary standards of medical practice; or

(d) Treatments for which there is insufficient data to determine efficacy; or

[e] Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.

(8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:

(a) There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or

(b) An in-network provider is unable or unwilling to provide the service in a timely manner.

(9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives [or abortion procedures] that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives [and procedures] the employer refuses to cover for religious reasons.

(10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(11) An insurer that is subject to this section shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in this section. The insurer must provide the information:
(a) On the insurer’s website; and
(b) In writing upon request by an enrollee or potential enrollee.

(12) This section does not prohibit an insurer from using reasonable medical management tech-
niques to determine the frequency, method, treatment or setting for the coverage of services, drugs,
devices, products and procedures described in subsection (2) of this section, other than coverage
required by subsection [(2)(g) and (j)] (2)(i) of this section, if the techniques:
(a) Are consistent with the coverage requirements of subsection (2) of this section; and
(b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

(13) This section is exempt from ORS 743A.001.

SECTION 2. ORS 731.804 is amended to read:

731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business
in this state shall pay assessments that the Director of the Department of Consumer and Business
Services determines are necessary to support the legislatively authorized budget of the Department
of Consumer and Business Services with respect to functions of the department under the Insurance
Code. The director shall determine the assessments according to one or more percentage rates es-
tablished by the director by rule. The director shall specify in the rule when assessments shall be
made and payments shall be due. The premium-weighted average of the percentage rates may not
exceed nine-hundredths of one percent of the gross amount of premiums received by an insurer or
the insurer’s insurance producers from and under the insurer’s policies covering direct domestic
risks, after deducting the amount of return premiums paid and the amount of dividend payments
made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount
of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount
of premiums. In establishing the percentage rate or rates, the director shall use the most recent
premium data approved by the director. In establishing the amounts to be collected under this sub-
section, the director shall take into consideration the expenses of the department for administering
the Insurance Code and the fees collected under subsection (2) of this section. When the director
establishes two or more percentage rates:
(a) Each rate shall be based on such expenses of the department ascribed by the director to the
line of insurance for which the rate is established.
(b) Each rate shall be applied to the gross amount of premium received by an insurer or its in-
surance producers for the applicable line of insurance as provided in this subsection.

(2) The director may collect fees for specific services provided by the department under the In-
surance Code according to a schedule of fees established by the director by rule. The director may
collect such fees in advance. In establishing the schedule for fees, the director shall take into con-
sideration the cost of each service for which a fee is imposed.

(3)(a) Notwithstanding the provisions of ORS [743A.067 (7)(e) and] 743A.067 (9), for the purpose
of mitigating inequity in the health insurance market, the director may assess a fee on any insurer
that offers a health benefit plan, as defined in ORS 743B.005, that is exempt from a provision of ORS
chapter 743A or other provision of the Insurance Code that requires specified coverage by health
benefit plans.
(b) Any fees collected under paragraph (a) of this subsection must be the actuarial equivalent
of costs attributed to the provision and administration of the required coverage by an insurer that
is not exempt.
(c) Nothing in this section limits the authority of the director to enforce the provisions of ORS
chapter 743A if an insurer unlawfully fails to comply.
(d) Notwithstanding ORS 646A.628, fees paid in accordance with paragraph (a) of this subsection shall be deposited in the General Fund to become available for general governmental expenses.

(4) Establishment and amendment of the schedule of fees under subsection (2) of this section are subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting the fees and shall be within the budget authorized by the Legislative Assembly as that budget may be modified by the Emergency Board.

(5) The director may not collect an assessment under subsection (1) of this section from any of the following persons:

(a) A fraternal benefit society complying with ORS chapter 748.
(b) Any person or class of persons designated by the director by rule.

(6) The director may not collect an assessment under subsection (1) of this section with respect to premiums received from any of the following policies:

(a) Workers' compensation insurance policies.
(b) Wet marine and transportation insurance policies.
(c) Any category of policies designated by the director by rule.