

House Bill 4155

Sponsored by Representative ELMER; Representatives BOICE, BUNCH, EDWARDS, HELFRICH, LEVY B, LEWIS, MANNIX, MCINTIRE, OSBORNE, SCHARF, SKARLATOS, YUNKER (Presession filed.)

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**. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act tells some insurers, OEBB and PEBB to cover care for some fertility treatments. The Act tells OHA and DCBS to study access to reproductive treatments and report back to the committee on health. The Act makes it an emergency. (Flesch Readability Score: 65.0).

Requires certain health insurers, the Oregon Educators Benefit Board and the Public Employees' Benefit Board to cover fertility services and treatments.

Directs the Oregon Health Authority and the Department of Consumer and Business Services to study access to fertility and reproductive endocrinology services and report findings to the interim committees of the Legislative Assembly related to health.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to infertility; creating new provisions; amending ORS 243.144, 243.877 and 743B.005; and declaring an emergency.

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

SECTION 1. Section 2 of this 2026 Act is added to and made a part of the Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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.

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

(i) A medical condition; or

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

(3) The coverage for diagnosis and treatment related to infertility required by subsection (2) of this section:

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

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

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

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

(b) Procedures described in subsections (2) and (3) of this section:

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

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

(5) Subsection (4) of this section does not permit a health benefit plan to require step therapy for services described in subsections (2) and (3) of this section that are determined by a treating practitioner to be medically necessary.

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

SECTION 3. (1) The Oregon Health Authority, in collaboration with the Department of Consumer and Business Services, shall study access to fertility and reproductive endocrinology services by residents of this state, including:

(a) Availability and utilization of fertility and reproductive endocrinology services in the commercial health insurance markets, self-insured health plans and the state medical assistance program;

(b) Financial and access barriers to obtaining fertility and reproductive endocrinology services including assisted reproductive technology; and

(c) Inequities in access to fertility and reproductive endocrinology services based on race, ethnicity, gender identity, sexual orientation, income, marital status, immigration status and disability.

(2) No later than September 15, 2027, the authority shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, the findings of the study described in subsection (1) of this section and recommendations for:

(a) Reducing financial and access barriers to fertility and reproductive endocrinology services for residents of this state;

(b) Strategies to promote equal access to fertility and reproductive endocrinology services, including protections against discrimination in the provision of fertility and reproduc-

1 **tive endocrinology services;**

2 **(c) A plan to provide equitable access to assisted reproductive technology for all residents**
3 **of this state;**

4 **(d) The feasibility of obtaining federal financial participation in or securing other federal**
5 **resources to support the plan described in paragraph (c) of this subsection; and**

6 **(e) Legislative changes necessary to implement the recommendations under this sub-**
7 **section.**

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

9 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.416, 743.417, 743.535, 743A.101,
10 743B.003 to 743B.127, 743B.109, 743B.128, 743B.250 and 743B.323 **and section 2 of this 2026 Act:**

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

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

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

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

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

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

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

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

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

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

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

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

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

40 (f) Has a constitution and bylaws; and

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

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

43 (a) A licensed insurance company;

44 (b) A health care service contractor;

45 (c) A health maintenance organization;

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

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

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

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

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

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

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

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

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

(11) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

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

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

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

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

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

(B) Individual health benefit plans.

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

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

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

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

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

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

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

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

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

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

(C) Medicare supplement insurance policies;

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

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

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

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

(H) Short term health insurance policies;

(I) Dental only coverage;

(J) Vision only coverage;

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

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

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

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

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

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

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

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

(18) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

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

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

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

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

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

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

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

(21) "Preexisting condition exclusion" means a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was

recommended or received for the condition before the date of coverage or denial of coverage.

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

(23) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

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

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

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

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

SECTION 5. ORS 243.144 is amended to read:

243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.810;

(10) ORS 743A.325; *[and]*

(11) ORS 743A.114[.]; **and**

(12) Section 2 of this 2026 Act.

SECTION 6. ORS 243.144, as operative until June 30, 2026, is amended to read:

243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.810;

(10) ORS 743A.325;

(11) ORS 743A.051 (2)(c); *[and]*

(12) ORS 743A.114[.]; **and**

(13) Section 2 of this 2026 Act.

SECTION 7. ORS 243.877 is amended to read:

243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.810;

(10) ORS 743A.325; *[and]*

(11) ORS 743A.114[.]; **and**

(12) Section 2 of this 2026 Act.

SECTION 8. ORS 243.877, as operative until June 30, 2026, is amended to read:

243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.810;

(10) ORS 743A.325;

(11) ORS 743A.051 (2)(c); *[and]*

(12) ORS 743A.114[.]; **and**

(13) Section 2 of this 2026 Act.

SECTION 9. Section 2 of this 2026 Act applies to policies or certificates issued, renewed or extended on or after January 1, 2027.

SECTION 10. The amendments to ORS 243.144 and 243.877 by sections 5 and 7 of this 2026 Act apply to health benefit plans offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board that are issued, renewed or extended on or after January 1, 2027, and for self-insured health benefit plans in effect for periods beginning on or after

1 **January 1, 2027.**

2 **SECTION 11.** The amendments to ORS 243.144, 243.877 and 743B.005 by sections 4, 5 and
3 **7 of this 2026 Act become operative on January 1, 2027.**

4 **SECTION 12.** Section 3 of this 2026 Act is repealed on January 2, 2028.

5 **SECTION 13.** This 2026 Act being necessary for the immediate preservation of the public
6 **peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect**
7 **on its passage.**

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