

Senate Bill 1527

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

Digest: The Act tells health insurers to pay for some cancer screenings and exams. (Flesch Readability Score: 76.5).

Prohibits cost-sharing on certain health insurance coverage of cervical cancer screenings and follow-up examinations.

A BILL FOR AN ACT

Relating to health care; creating new provisions; and amending ORS 743B.005.

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:

(a)(A) “Cervical cancer screening” means health care services or products provided to an individual without apparent symptoms of an illness, injury or disease, as recommended by the United States Preventive Services Task Force as grade A or B or as recommended by the Health Resources and Services Administration’s guidelines, for the purpose of detecting the presence of cervical cancer or precancerous lesions.

(B) “Cervical cancer screening” does not include services that occur primarily for the treatment of diagnosed cervical cancer.

(b)(A) “Follow-up examination” means additional cervical cancer examinations used to evaluate an abnormality seen or suspected from a cervical cancer screening.

(B) “Follow-up examination” does not include services that occur primarily for the treatment of diagnosed cervical cancer.

(2) Except as provided in ORS 742.008, a carrier offering a group health benefit plan or an individual health benefit plan in this state that reimburses the cost of cervical cancer screenings may not impose deductibles, coinsurance, copayments or other out-of-pocket costs on the coverage of medically necessary:

(a) Cervical cancer screenings; and

(b) Follow-up examinations, regardless of whether different samples from the prior cervical cancer screening are used or the follow-up examination is performed on a different date than the cervical cancer screening. Follow-up examinations include human papillomavirus examinations with typing, cytology, dual stain or colposcopy with biopsy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (f) Has a constitution and bylaws; and

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

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

33 (a) A licensed insurance company;

34 (b) A health care service contractor;

35 (c) A health maintenance organization;

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

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

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

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

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

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

1 benefit plan.

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

3 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible

4 for a group or individual health benefit plan who has enrolled for coverage under the terms of the

5 plan.

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

7 (11) "Exclusion period" means a period during which specified treatments or services are ex-

8 cluded from coverage.

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

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

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

12 (13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the

13 corresponding highest premium to be charged by a carrier in a geographic area established by the

14 director for the carrier's:

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

16 (B) Individual health benefit plans.

17 (b) "Geographic average rate" does not include premium differences that are due to differences

18 in benefit design, age, tobacco use or family composition.

19 (14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Sec-

20 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that

21 is in effect on January 1, 2017.

22 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the

23 period of employment or membership with the group that a prospective enrollee must complete be-

24 fore plan coverage begins.

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

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

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

28 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-

29 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the

30 extent that the plan is subject to state regulation.

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

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

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

34 (C) Medicare supplement insurance policies;

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

36 (E) Benefits delivered through a flexible spending arrangement established pursuant to section

37 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition

38 to a group health benefit plan;

39 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-

40 ing home care, home health care and community-based care;

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

42 surance;

43 (H) Short term health insurance policies;

44 (I) Dental only coverage;

45 (J) Vision only coverage;

1 (K) Stop-loss coverage that meets the requirements of ORS 742.065;
2 (L) Coverage issued as a supplement to liability insurance;
3 (M) Insurance arising out of a workers' compensation or similar law;
4 (N) Automobile medical payment insurance or insurance under which benefits are payable with
5 or without regard to fault and that is statutorily required to be contained in any liability insurance
6 policy or equivalent self-insurance; or
7 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
8 eral Employee Retirement Income Security Act of 1974, as amended.

9 (17) "Individual health benefit plan" means a health benefit plan:
10 (a) That is issued to an individual policyholder; or
11 (b) That provides individual coverage through a trust, association or similar group, regardless
12 of the situs of the policy or contract.

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

15 (19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent
16 to the initial enrollment period during which the individual was eligible for coverage but declined
17 to enroll. However, an eligible individual shall not be considered a late enrollee if:
18 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
19 or as prescribed by rule by the Department of Consumer and Business Services;
20 (b) The individual applies for coverage during an open enrollment period;
21 (c) A court issues an order that coverage be provided for a spouse or minor child under an
22 employee's employer sponsored health benefit plan and request for enrollment is made within 30
23 days after issuance of the court order;
24 (d) The individual is employed by an employer that offers multiple health benefit plans and the
25 individual elects a different health benefit plan during an open enrollment period; or
26 (e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a
27 publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance
28 program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for
29 coverage in a group health benefit plan.

30 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
31 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
32 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

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

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

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

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

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

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

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

9 **SECTION 4. Section 2 of this 2026 Act applies to policies or certificates of insurance is-**
10 **sued, renewed or extended on or after the effective date of this 2026 Act.**

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