House Bill 2232

Sponsored by Representative BARKER, Senator MONNES ANDERSON (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.**

Requires health benefit plan coverage of specified health care services, drugs, devices, products and procedures related to reproductive health. Allows exemption for plans sold to religious employers.

Requires Oregon Health Authority to implement program to reimburse costs of services, drugs, devices, products and procedures related to reproductive health provided to individuals who can become pregnant and who would be eligible for medical assistance if not for certain federal requirements.

Prohibits discrimination in provision of health care coverage.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to reproductive health care; and declaring an emergency.

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

SECTION 1. Section 2 of this 2017 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Contraceptives" means services, drugs, devices, products or 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) "Religious employer" has the meaning given that term in ORS 743A.066.

(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, including screenings, assessments and counseling.

(b) Pregnancy-related services, including pregnancy tests, preconception care, abortion and prenatal care.

(c) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome.

(d) Screening for:

(A) Chlamydia;

(B) Gonorrhea;

(C) Hepatitis B;

(D) Hepatitis C;

(E) Human immunodeficiency virus and acquired immune deficiency syndrome;

(F) Human papillomavirus;

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.

(G) Syphilis;

(H) Anemia;

(I) Urinary tract infection;

(J) Rh incompatibility;

(K) Gestational diabetes;

(L) Osteoporosis; and

(M) Cervical cancer.

(e) Screening and appropriate counseling or interventions for:

(A) Tobacco use; and

(B) Domestic and interpersonal violence.

(f) Folic acid supplements.

(g) Breastfeeding comprehensive support, counseling and supplies.

(h)(A) Screening to determine whether genetic counseling related to the BRCA1 or BRCA2 genetic mutations is indicated;

(B) Genetic counseling; and

(C) If indicated, BRCA testing.

(i) Breast cancer mammography.

(j) Breast cancer chemoprevention counseling.

(k) 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 provide coverage without a prescription for 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 contraception and may not require prior authorization, step therapy or other utilization control techniques for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(L) Voluntary sterilization.

(m) Patient education and counseling on contraception.

(n) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(A) Management of side effects;

(B) Counseling for continued adherence to a prescribed regimen;

(C) Device insertion and removal;

(D) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider; and

(E) Diagnosis and treatment services provided pursuant to or as a follow-up to a service required under this section.

(o) Any additional preventive services for women that must be covered without cost sharing under the 42 U.S.C. 300gg-13, as identified after the effective date of this 2017 Act 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.

(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) A health benefit plan must cover the services, drugs, devices, products and procedures required by this section regardless of whether the services, drugs, devices, products and procedures are provided in the course of or as a follow-up to other covered services and shall reimburse the cost of the service, drug, device, product or procedure separately from a global or bundled payment for or a diagnostic related group code associated with the other covered services.

(6) 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.

(7) 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.

(8) 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.

(9) 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; or

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

(10) 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 or procedures the employer refuses to cover for religious reasons.

(11) 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 neces-

sary to ensure the continued receipt of federal funds.

(12) 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;

(b) In writing to an enrollee in a summary of benefits and coverage and no later than 14 days after a request by an enrollee; and

(c) In written materials about benefits or coverage that are provided to enrollees and potential enrollees.

SECTION 3. No later than September 15, 2018, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health on the degree of compliance by insurers with section 2 of this 2017 Act and of any actions taken by the department under ORS 731.988 to enforce compliance with section 2 of this 2017 Act.

SECTION 4. Section 5 of this 2017 Act is added to and made a part of ORS chapter 414.

SECTION 5. (1) The Oregon Health Authority shall administer a program to reimburse the cost of services, drugs, devices, products and procedures described in section 2 of this 2017 Act, for individuals who can become pregnant and who would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612.

(2) The authority shall provide the medical assistance for pregnant women that is authorized by 8 U.S.C. 1611(b)(1)(A) for 180 days immediately postpartum.

(3) The authority shall collect data and analyze the cost-effectiveness of the services, drugs, devices, products and procedures paid for under this section.

(4) The authority, in collaboration with the Department of Consumer and Business Services if necessary, shall explore any and all opportunities to obtain federal financial participation in the costs of implementing this section, including but not limited to waivers or demonstration projects under Title X of the Public Health Service Act or Title XIX or XXI of the Social Security Act. However, the implementation of this section is not contingent upon the authority's receipt of a waiver or authorization to operate a demonstration project.

SECTION 6. Not later than September 15, 2018, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health on the implementation of section 5 of this 2017 Act.

SECTION 7. (1) An individual may not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied the benefits of or otherwise be subjected to discrimination by any health benefit plan issued or delivered in this state, in the receipt of medical assistance as defined in ORS 414.025 or in the coverage of or payment for the services, drugs, devices, products and procedures described in section 2 of this 2017 Act.

(2) Violation of this section is an unlawful practice under ORS 659A.403.

(3) Nothing in this section shall be construed to invalidate or limit the rights, remedies, procedures or legal standards available to individuals under ORS 659A.820 or 659A.885 or to supersede state or local laws that provide additional protections against discrimination on any basis described in subsection (1) of this section.

SECTION 8. In addition to and not in lieu of any other appropriation, there is appropri-

ated to the Oregon Health Authority, for the biennium beginning July 1, 2017, out of the General Fund, the amount of $_____, which may be expended for carrying out the provisions of section 5 of this 2017 Act.

SECTION 9. Section 2 of this 2017 Act applies to health benefit plan policies or certificates issued, renewed, modified or extended on or after January 1, 2018.

SECTION 10. (1) Section 5 of this 2017 Act becomes operative on January 1, 2018.

(2) The Oregon Health Authority shall take any action before January 1, 2018, that is necessary for the authority to implement the provisions of section 5 of this 2017 Act on or after January 1, 2018.

SECTION 11. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.