Senate Bill 749

Sponsored by Senator BOQUIST (at the request of Jill Payne)

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 plans to cover fertility and reproductive endocrinology services.

A BILL FOR AN ACT

Relating to insurance coverage of reproductive health services; creating new provisions; and amending ORS 414.432 and 743A.067.

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

SECTION 1. ORS 743A.067 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) "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 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) Fertility and reproductive endocrinology services for men or women.

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

[*(c)*] **(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;

(G) Syphilis;

(H) Anemia;

(I) Urinary tract infection;

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.

(J) Pregnancy;

(K) Rh incompatibility;

(L) Gestational diabetes;

(M) Osteoporosis;

(N) Breast cancer; and

(O) Cervical cancer.

[*(d)*] **(e)** 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)*] **(f)** Screening and appropriate counseling or interventions for:

(A) Tobacco use; and

(B) Domestic and interpersonal violence.

[*(f)*] **(g)** Folic acid supplements.

[*(g)*] **(h)** Abortion.

[*(h)*] **(i)** Breastfeeding comprehensive support, counseling and supplies.

[*(i)*] **(j)** Breast cancer chemoprevention counseling.

[*(j)*] **(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 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 control techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

[*(k)*] **(L)** Voluntary sterilization.

[*(L)*] **(m)** 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)*] **(n)** 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;

(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 techniques 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)(h) and (k)** 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.

SECTION 2. ORS 414.432 is amended to read:

414.432. (1) The Oregon Health Authority shall administer a program to reimburse the cost of medically appropriate services, drugs, devices, products and procedures described in ORS 743A.067 **(2)(a) and (c) to (n)**, 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 Title XXI, section 2112, of the Social Security Act (42 U.S.C. 1397ll) for 60 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 3. The amendments to ORS 743A.067 by section 1 of this 2019 Act apply to health benefit plans issued, renewed or extended on or after the effective date of this 2019 Act.