

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.

- 1 (I) Urinary tract infection;
- 2 (J) Pregnancy;
- 3 (K) Rh incompatibility;
- 4 (L) Gestational diabetes;
- 5 (M) Osteoporosis;
- 6 (N) Breast cancer; and
- 7 (O) Cervical cancer.

8 (d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic
 9 mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indi-
 10 cated.

11 (e) Screening and appropriate counseling or interventions for:

- 12 (A) Tobacco use; and
- 13 (B) Domestic and interpersonal violence.

14 (f) Folic acid supplements.

15 [(g) *Abortion.*]

16 [(h)] (g) Breastfeeding comprehensive support, counseling and supplies.

17 [(i)] (h) Breast cancer chemoprevention counseling.

18 [(j)] (i) Any contraceptive drug, device or product approved by the United States Food and Drug
 19 Administration, subject to all of the following:

20 (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by
 21 the United States Food and Drug Administration, a health benefit plan may provide coverage for
 22 either the requested contraceptive drug, device or product or for one or more therapeutic equiv-
 23 alents of the requested drug, device or product.

24 (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed
 25 medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative
 26 contraceptive drug, device or product prescribed by the provider.

27 (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive
 28 drugs available for over-the-counter sale that are approved by the United States Food and Drug
 29 Administration.

30 (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, de-
 31 vice or product and may not require prior authorization, step therapy or other utilization review
 32 techniques for medically appropriate covered contraceptive drugs, devices or other products ap-
 33 proved by the United States Food and Drug Administration.

34 [(k)] (j) Voluntary sterilization.

35 [(L)] (k) As a single claim or combined with other claims for covered services provided on the
 36 same day:

37 (A) Patient education and counseling on contraception and sterilization.

38 (B) Services related to sterilization or the administration and monitoring of contraceptive drugs,
 39 devices and products, including but not limited to:

40 (i) Management of side effects;

41 (ii) Counseling for continued adherence to a prescribed regimen;

42 (iii) Device insertion and removal; and

43 (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appro-
 44 priate in the judgment of the enrollee's provider.

45 [(m)] (L) Any additional preventive services for women that must be covered without cost

1 sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force
 2 or the Health Resources and Services Administration of the United States Department of Health and
 3 Human Services as of January 1, 2017.

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

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

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

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

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

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

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

18 (a) Experimental or investigational treatments;

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

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

21 **or**

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

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

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

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

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

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

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

42 (11) An insurer that is subject to this section shall make readily accessible to enrollees and
 43 potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives
 44 by each health benefit plan and the coverage of other services, drugs, devices, products and proce-
 45 dures described in this section. The insurer must provide the information:

1 (a) On the insurer's website; and

2 (b) In writing upon request by an enrollee or potential enrollee.

3 (12) This section does not prohibit an insurer from using reasonable medical management tech-
 4 niques to determine the frequency, method, treatment or setting for the coverage of services, drugs,
 5 devices, products and procedures described in subsection (2) of this section, other than coverage
 6 required by subsection [(2)(g) and (j)] (2)(i) of this section, if the techniques:

7 (a) Are consistent with the coverage requirements of subsection (2) of this section; and

8 (b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

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

10 **SECTION 2.** ORS 731.804 is amended to read:

11 731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business
 12 in this state shall pay assessments that the Director of the Department of Consumer and Business
 13 Services determines are necessary to support the legislatively authorized budget of the Department
 14 of Consumer and Business Services with respect to functions of the department under the Insurance
 15 Code. The director shall determine the assessments according to one or more percentage rates es-
 16 tablished by the director by rule. The director shall specify in the rule when assessments shall be
 17 made and payments shall be due. The premium-weighted average of the percentage rates may not
 18 exceed nine-hundredths of one percent of the gross amount of premiums received by an insurer or
 19 the insurer's insurance producers from and under the insurer's policies covering direct domestic
 20 risks, after deducting the amount of return premiums paid and the amount of dividend payments
 21 made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount
 22 of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount
 23 of premiums. In establishing the percentage rate or rates, the director shall use the most recent
 24 premium data approved by the director. In establishing the amounts to be collected under this sub-
 25 section, the director shall take into consideration the expenses of the department for administering
 26 the Insurance Code and the fees collected under subsection (2) of this section. When the director
 27 establishes two or more percentage rates:

28 (a) Each rate shall be based on such expenses of the department ascribed by the director to the
 29 line of insurance for which the rate is established.

30 (b) Each rate shall be applied to the gross amount of premium received by an insurer or its in-
 31 surance producers for the applicable line of insurance as provided in this subsection.

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

36 (3)(a) Notwithstanding the provisions of ORS [743A.067 (7)(e) and] 743A.067 (9), for the purpose
 37 of mitigating inequity in the health insurance market, the director may assess a fee on any insurer
 38 that offers a health benefit plan, as defined in ORS 743B.005, that is exempt from a provision of ORS
 39 chapter 743A or other provision of the Insurance Code that requires specified coverage by health
 40 benefit plans.

41 (b) Any fees collected under paragraph (a) of this subsection must be the actuarial equivalent
 42 of costs attributed to the provision and administration of the required coverage by an insurer that
 43 is not exempt.

44 (c) Nothing in this section limits the authority of the director to enforce the provisions of ORS
 45 chapter 743A if an insurer unlawfully fails to comply.

1 (d) Notwithstanding ORS 646A.628, fees paid in accordance with paragraph (a) of this subsection
2 shall be deposited in the General Fund to become available for general governmental expenses.

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

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

9 (a) A fraternal benefit society complying with ORS chapter 748.

10 (b) Any person or class of persons designated by the director by rule.

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

13 (a) Workers' compensation insurance policies.

14 (b) Wet marine and transportation insurance policies.

15 (c) Any category of policies designated by the director by rule.

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