

A-Engrossed Senate Bill 491

Ordered by the Senate March 23
Including Senate Amendments dated March 23

Sponsored by Senator PATTERSON, Representative GRAYBER, Senator MANNING JR; Senators GELSER BLOUIN, WOODS (Pre-session 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.

Requires health insurance coverage of specified fertility services and treatments with exemption for certain insurers.

Requires Oregon Health Authority to contract with health insurance carrier or third party administrator to provide infertility coverage to enrollees in exempt plans. Imposes fee on exempt plans to pay for cost of coverage.

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

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to infertility; creating new provisions; amending ORS 646A.628, 731.804 and 743B.005; and
3 declaring an emergency.

4 Whereas according to the federal Centers for Disease Control and Prevention, over 12 percent
5 of women in the United States who are of reproductive age have difficulty becoming pregnant or
6 carrying a pregnancy to term; and

7 Whereas infertility is evenly divided between men and women and approximately one-third of
8 cases of infertility involve both partners being diagnosed or are unexplained; and

9 Whereas increasing accessibility for infertility treatment will expand health services in this
10 state and improve the short-term and long-term outcomes for the resulting children and mothers,
11 which may also reduce health care costs by reducing adverse outcomes; and

12 Whereas access to insurance coverage reduces health disparities for racial and ethnic minorities
13 as well as for lesbian, gay, bisexual, transgender and queer individuals; now, therefore,

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

15 **SECTION 1. Section 2 of this 2023 Act is added to and made a part of the Insurance Code.**

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

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

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

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

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

23 **(2) Health benefit plans offered in this state to large or small employers and individual**

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 health benefit plans offered in this state shall reimburse the cost of:

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

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

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

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

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

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

17 (i) A medical condition; or

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

20 (3) The coverage required by subsection (2) of this section:

21 (a) Includes, but is not limited to:

22 (A) A minimum of three completed oocyte retrievals with unlimited embryo transfers in
23 accordance with guidelines of the American Society for Reproductive Medicine, or a succes-
24 sor organization, using single embryo transfer if recommended by a licensed treating prac-
25 titioner and medically effective.

26 (B) Intrauterine insemination.

27 (C) Assisted hatching.

28 (D) Cryopreservation and thawing of eggs, sperm and embryos.

29 (E) Cryopreservation of ovarian tissue.

30 (F) Cryopreservation of testicular tissue.

31 (G) Embryo biopsy.

32 (H) Consultation and diagnostic testing.

33 (I) Fresh and frozen embryo transfers.

34 (J) Six completed egg retrievals per lifetime, with unlimited embryo transfers in accord-
35 ance with the guidelines of the American Society for Reproductive Medicine, using single
36 embryo transfer when recommended and medically appropriate.

37 (K) In vitro fertilization, including in vitro fertilization using donor eggs, sperm or
38 embryos, and in vitro fertilization in which the embryo is transferred to a gestational carrier
39 or surrogate.

40 (L) Intra-cytoplasmic sperm injection.

41 (M) Medications.

42 (N) Ovulation induction.

43 (O) Storage of oocytes, sperm, embryos and tissue.

44 (P) Surgery, including microsurgical sperm aspiration.

45 (Q) Medical and laboratory services that reduce excess embryo creation through egg

1 cryopreservation and thawing.

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

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

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

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

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

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

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

16 (6) Subject to ORS 746.021, this section does not require a health benefit plan offered by
17 an insurer described in ORS 743A.067 (7)(e) to reimburse the cost of:

18 (a) Procedures described in subsection (3)(a)(C), (G), (I), (K) or (L) of this section; or

19 (b) Embryo transfer, cryopreservation or storage procedures described in subsection
20 (3)(a)(A), (D), (J) or (O) of this section.

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

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

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

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

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

33 (2) No later than September 15, 2024, the authority shall report to the interim commit-
34 tees of the Legislative Assembly related to health, in the manner provided in ORS 192.245,
35 the findings of the study described in subsection (1) of this section and recommendations for:

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

38 (b) Strategies to promote equal access to fertility and reproductive endocrinology ser-
39 vices, including protections against discrimination in the provision of fertility and reproduc-
40 tive endocrinology services;

41 (c) A plan to provide equitable access to assisted reproductive technology for all residents
42 of this state;

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

45 (e) Legislative changes necessary to implement the recommendations under this sub-

1 **section.**

2 **SECTION 4. (1) The Oregon Health Authority shall contract with a third party adminis-**
3 **trator or a health insurance carrier to provide to enrollees in health benefit plans described**
4 **in section 2 (6) of this 2023 Act reimbursement for the costs of:**

5 (a) **Procedures described in section 2 (3)(a)(C), (G), (I), (K) or (L) of this 2023 Act.**

6 (b) **Embryo transfer, cryopreservation or storage procedures described in section 2**
7 **(3)(a)(A), (D), (J) or (O) of this 2023 Act.**

8 (2) **The authority shall establish application processes and procedures for enrollees to**
9 **access the coverage under subsection (1) of this section.**

10 (3) **The authority may adopt rules necessary to carry out the provisions of this section.**

11 **SECTION 5. The Market Equity Fund is established in the State Treasury, separate and**
12 **distinct from the General Fund, consisting of fees paid to the Director of the Department**
13 **of Consumer and Business Services that are described in ORS 731.804 (3)(e). Moneys in the**
14 **Market Equity Fund are continuously appropriated to the Oregon Health Authority to carry**
15 **out the provisions of section 4 of this 2023 Act.**

16 **SECTION 6.** ORS 646A.628 is amended to read:

17 646A.628. Notwithstanding ORS 705.145 (2), (3) and (5), the Director of the Department of Con-
18 sumer and Business Services can allocate as deemed appropriate the moneys derived pursuant to
19 ORS 86A.095 to 86A.198, 86A.990, 86A.992, 650.005 to 650.100, 697.005 to 697.095, 697.602 to 697.842,
20 705.350, [and] 717.200 to 717.320 and 731.804 (1) and (2) and ORS chapters 59, 645, 706 to 716, 723,
21 725 and 726 to implement ORS 646A.600 to 646A.628.

22 **SECTION 7.** ORS 731.804 is amended to read:

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

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

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

44 (2) The director may collect fees for specific services provided by the department under the In-
45 surance Code according to a schedule of fees established by the director by rule. The director may

1 collect such fees in advance. In establishing the schedule for fees, the director shall take into con-
2 sideration the cost of each service for which a fee is imposed.

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

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

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

13 (d) *[Notwithstanding ORS 646A.628,]* **Except as provided in paragraph (e) of this subsection,**
14 fees paid in accordance with paragraph (a) of this subsection shall be deposited in the General Fund
15 to become available for general governmental expenses.

16 **(e) Fees paid under this subsection by insurers for health benefit plans described in sec-**
17 **tion 2 (6) of this 2023 Act shall be deposited in the Market Equity Fund established in section**
18 **5 of this 2023 Act.**

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

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

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

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

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

29 (a) Workers' compensation insurance policies.

30 (b) Wet marine and transportation insurance policies.

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

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

33 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.416, 743.417, 743.535, 743B.003 to
34 743B.127, 743B.109, 743B.128, 743B.250 and 743B.323 **and section 2 of this 2023 Act:**

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

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

45 (3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health

1 care service contractor, a period:

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

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

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

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

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

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

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

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

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

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

19 (f) Has a constitution and bylaws; and

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

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

22 (a) A licensed insurance company;

23 (b) A health care service contractor;

24 (c) A health maintenance organization;

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

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

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

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

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

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

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

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

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

41 (11) "Exclusion period" means a period during which specified treatments or services are ex-
42 cluded from coverage.

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

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

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

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

- 4 (A) Group health benefit plans offered to small employers; or
- 5 (B) Individual health benefit plans.

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

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

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

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

- 15 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 16 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or
- 17 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
18 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
19 extent that the plan is subject to state regulation.

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

- 21 (A) Coverage for accident only, specific disease or condition only, credit or disability income;
- 22 (B) Coverage of Medicare services pursuant to contracts with the federal government;
- 23 (C) Medicare supplement insurance policies;
- 24 (D) Coverage of TRICARE services pursuant to contracts with the federal government;
- 25 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
26 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
27 to a group health benefit plan;
- 28 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
29 ing home care, home health care and community-based care;
- 30 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
31 surance;
- 32 (H) Short term health insurance policies;
- 33 (I) Dental only coverage;
- 34 (J) Vision only coverage;
- 35 (K) Stop-loss coverage that meets the requirements of ORS 742.065;
- 36 (L) Coverage issued as a supplement to liability insurance;
- 37 (M) Insurance arising out of a workers' compensation or similar law;
- 38 (N) Automobile medical payment insurance or insurance under which benefits are payable with
39 or without regard to fault and that is statutorily required to be contained in any liability insurance
40 policy or equivalent self-insurance; or

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

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

- 44 (a) That is issued to an individual policyholder; or
- 45 (b) That provides individual coverage through a trust, association or similar group, regardless

1 of the situs of the policy or contract.

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

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

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

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

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

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

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

19 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
20 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
21 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

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

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

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

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

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

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

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

43 **SECTION 9. Section 2 of this 2023 Act applies to policies or certificates issued, renewed**
44 **or extended on or after January 1, 2024.**

45 **SECTION 10. The amendments to ORS 646A.628, 731.804 and 743B.005 by sections 6 to 8**

1 of this 2023 Act become operative on January 1, 2024.

2 SECTION 11. Section 3 of this 2023 Act is repealed on January 2, 2025.

3 SECTION 12. This 2023 Act being necessary for the immediate preservation of the public
4 peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect
5 on its passage.
6
