

A-Engrossed House Bill 4155

Ordered by the House February 17
Including House Amendments dated February 17

Sponsored by Representative ELMER; Representatives BOICE, BUNCH, EDWARDS, GOMBERG, GRAYBER, HELFRICH, HUDSON, LEVY B, LEVY E, LEWIS, MANNIX, MCINTIRE, OSBORNE, SCHARF, SKARLATOS, YUNKER (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. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act tells some insurers to cover care for some fertility treatments and exempts some insurers from parts of this requirement. Tells DCBS to make a program to cover costs for exempt insurers. Creates a new fund. (Flesch Readability Score: 66.2).

[Digest: The Act tells some insurers, OEBB and PEBB to cover care for some fertility treatments. The Act tells OHA and DCBS to study access to reproductive treatments and report back to the committee on health. The Act makes it an emergency. (Flesch Readability Score: 65.0).]

Requires certain health insurers[, the Oregon Educators Benefit Board and the Public Employees' Benefit Board] to cover fertility services and treatments. **Exempts certain insurers from specific coverage requirements.**

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

[Declares an emergency, effective on passage.]

Directs the Department of Consumer and Business Services to administer a program to provide reimbursement for the costs for treatments when not covered by exempted insurers. Establishes the Family Building Fund in the State Treasury.

A BILL FOR AN ACT

Relating to infertility; creating new provisions; and amending ORS 731.292, 731.804 and 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, "infertility" means:

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

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

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

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

(2) Health benefit plans offered in this state to large or small employers and individual health benefit plans offered in this state shall reimburse the cost of:

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

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

(B) Consistent with established, published or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists or the American

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 Society for Reproductive Medicine, or a successor organization.

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

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

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

10 (i) A medical condition; or

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

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

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

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

19 (B) Six completed egg retrievals per lifetime, with unlimited embryo transfers in ac-
20 cordance with the guidelines of the American Society for Reproductive Medicine, using single
21 embryo transfer when recommended and medically appropriate.

22 (C) Assisted hatching.

23 (D) Cryopreservation and thawing of embryos.

24 (E) Embryo biopsy.

25 (F) Fresh and frozen embryo transfers.

26 (G) Storage of embryos.

27 (H) In vitro fertilization, including in vitro fertilization using donor eggs, sperm or
28 embryos, and in vitro fertilization in which the embryo is transferred to a gestational carrier
29 or surrogate.

30 (I) Intracytoplasmic sperm injection.

31 (J) Storage of oocytes, sperm and tissue.

32 (K) Intrauterine insemination.

33 (L) Cryopreservation of ovarian tissue.

34 (M) Cryopreservation of testicular tissue.

35 (N) Cryopreservation and thawing of eggs and sperm.

36 (O) Consultation and diagnostic testing.

37 (P) Medications.

38 (Q) Ovulation induction.

39 (R) Surgery, including microsurgical sperm aspiration.

40 (S) Medical and laboratory services that reduce excess embryo creation through egg
41 cryopreservation and thawing.

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

45 (4) The health benefit plan may not impose exclusions, limitations or other restrictions

on coverage of:

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

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

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

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

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

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

(a) Embryo transfer procedures as part of the coverages described in subsection (3)(a)(A) and (B) of this section; and

(b) Procedures described in subsection (3)(a)(C) to (I) of this section.

(7) The coverage requirements described in this section do not apply to health benefit plans offered by the Oregon Educators Benefit Board and Public Employees' Benefit Board, unless the Oregon Educators Benefit Board or Public Employees' Benefit Board elect to provide the coverage.

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

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:**

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (f) Has a constitution and bylaws; and

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

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

11 (a) A licensed insurance company;

12 (b) A health care service contractor;

13 (c) A health maintenance organization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 (B) Individual health benefit plans.

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

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

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

period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

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

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

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

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

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

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

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

(C) Medicare supplement insurance policies;

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

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

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

(H) Short term health insurance policies;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

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

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

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

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

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

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

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

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30

days after issuance of the court order;

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

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

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

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

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

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

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

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

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

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

SECTION 4. (1) The Department of Consumer and Business Services shall administer a program to provide reimbursement for the costs of procedures described in section 2 (6) of this 2026 Act that are incurred by individuals enrolled in health benefit plans described in ORS 743A.067 (7)(e). The department shall establish application processes for the program and contract with a third party administrator or health insurance carrier to process claims for enrollees in the program.

(2) The department may adopt rules necessary to carry out the provisions of this section.

SECTION 5. The Family Building Fund is established in the State Treasury, separate and distinct from the General Fund, consisting of moneys collected from the portion of assessments imposed under ORS 731.804 (3) for the costs of administering the program described in section 4 of this 2026 Act. Interest earned by the Family Building Fund shall be credited to the fund. Moneys in the Family Building Fund are continuously appropriated to the Department of Consumer and Business Services to carry out the provisions of section 4 of this 2026 Act.

SECTION 6. ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2), (3), *[and]* (4) **and (5)** of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

(4) Assessments received by the department under sections 3 and 5, chapter 538, Oregon Laws 2017, and penalties received by the department under section 6, chapter 538, Oregon Laws 2017, shall be paid into the State Treasury and credited to the Health System Fund established under section 2, chapter 538, Oregon Laws 2017.

(5) Assessments received by the department under ORS 731.804 (3) shall be paid to the Family Building Fund established under section 5 of this 2026 Act.

SECTION 7. ORS 731.292, as amended by section 16, chapter 4, Oregon Laws 2025, is amended to read:

731.292. (1) Except as provided in subsections *[(2) and (3)]* **(2), (3) and (4)** of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

(4) Assessments received by the department under ORS 731.804 (3) shall be paid to the Family Building Fund established under section 5 of this 2026 Act.

SECTION 8. ORS 731.804 is amended to read:

731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business in this state shall pay assessments that the Director of the Department of Consumer and Business Services determines are necessary to support the legislatively authorized budget of the Department of Consumer and Business Services with respect to functions of the department under the Insurance Code. The director shall determine the assessments according to one or more percentage rates established by the director by rule. The director shall specify in the rule when assessments shall be made and payments shall be due. The premium-weighted average of the percentage rates may not exceed nine-hundredths of one percent of the gross amount of premiums received by an insurer or the insurer's insurance producers from and under the insurer's policies covering direct domestic risks, after deducting the amount of return premiums paid and the amount of dividend payments made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount

1 of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount
 2 of premiums. In establishing the percentage rate or rates, the director shall use the most recent
 3 premium data approved by the director. In establishing the amounts to be collected under this sub-
 4 section, the director shall take into consideration the expenses of the department for administering
 5 the Insurance Code and the fees collected under subsection (2) of this section. When the director
 6 establishes two or more percentage rates:

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

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

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

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

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

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

25 (d) Notwithstanding ORS 646A.628, fees paid in accordance with paragraph (a) of this subsection
 26 shall be deposited in the [*General Fund to become available for general governmental expenses*]
 27 **Family Building Fund established under section 5 of this 2026 Act.**

28 (4) Establishment and amendment of the schedule of fees under subsection (2) of this section are
 29 subject to prior approval of the Oregon Department of Administrative Services and shall be within
 30 the budget authorized by the Legislative Assembly as that budget may be modified by the Emergency
 31 Board.

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

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

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

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

38 (a) Workers' compensation insurance policies.

39 (b) Wet marine and transportation insurance policies.

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

41 **SECTION 9. Section 2 of this 2026 Act applies to policies or certificates issued, renewed**
 42 **or extended on or after January 1, 2027.**