CHAPTER 721

AN ACT HB 3391

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 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) 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;

(I) Urinary tract infection;

(J) Pregnancy;

(K) Rh incompatibility;

(L) Gestational diabetes;

(M) Osteoporosis;

(N) Breast cancer; and

(O) Cervical cancer.

(d) 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) Screening and appropriate counseling or interventions for:

(A) Tobacco use; and

(B) Domestic and interpersonal violence.

(f) Folic acid supplements.

(g) Abortion.

(h) Breastfeeding comprehensive support, counseling and supplies.

(i) Breast cancer chemoprevention counseling.

(j) 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) Voluntary sterilization.

(L) 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) 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 Adminis-

tration 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) 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 3. No later than September 15, 2019, 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 medically appropriate 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 author-

ized 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 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. A public body as defined in ORS 174.109 or, except as provided in ORS 435.225, an officer, employee or agent of a public body may not:

(1) Deprive a consenting individual of the choice of terminating the individual's pregnancy;

(2) Interfere with or restrict, in the regulation or provision of benefits, facilities, services or information, the choice of a consenting individual to terminate the individual's pregnancy;

(3) Prohibit a health care provider, who is acting within the scope of the health care provider's license, from terminating or assisting in the termination of a patient's pregnancy; or

(4) Interfere with or restrict, in the regulation or provision of benefits, facilities, services or information, the choice of a health care provider, who is acting within the scope of the health care provider's license, to terminate or assist in the termination of a patient's pregnancy.

SECTION 9. The Health Evidence Review Commission shall review the coverage described in section 2 (2) of this 2017 Act and, no later than November 1 of each even-numbered year, report to the interim committees of the Legislative Assembly related to health any recommended changes to the coverage described in section 2 (2) of this 2017 Act based upon the latest clinical research.

SECTION 10. (1) As used in this section, "health benefit plan" has the meaning given that term in section 2 of this 2017 Act.

(2) In consultation with the Department of Consumer and Business Services, the Oregon Health Authority shall design a program to provide statewide access to abortion coverage for Oregon residents enrolled in health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act.

(3) In developing the design of the program described in subsection (2) of this section, the authority and the department shall consult with consumer advocates, insurers transacting insurance in this state that offer the health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act and other stakeholders.

(4) The authority, in collaboration with the department, shall:

(a) If funding is available, take any actions authorized by state law to implement the program described in subsection (2) of this section; and

(b) Not later than November 1, 2017, report to the Speaker of the House of Representatives, the President of the Senate and the interim committees of the Legislative Assembly related to health:

(A) Any actions taken by the authority under paragraph (a) of this subsection; and

(B) Recommendations for legislative changes necessary to fully implement the program described in subsection (2) of this section.

SECTION 11. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2017, out of the General Fund, the amount of $10,195,935, which may be expended for carrying out the provisions of section 5 of this 2017 Act.

SECTION 12. Section 2 of this 2017 Act applies to health benefit plan policies or certif-

icates issued, renewed, modified or extended on or after January 1, 2019.

SECTION 13. (1) Sections 5 and 9 of this 2017 Act become 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 sections 5 and 9 of this 2017 Act on or after January 1, 2018.

SECTION 14. Section 10 of this 2017 Act is repealed on January 2, 2019.

SECTION 15. 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.

Approved by the Governor August 15, 2017
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