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Lisa Emerson
Brooke Hall
Senior Policy Analysts
Department of Consumer and Business Services, Division of Financial Regulation
P.O. Box 14480
Salem, OR 97309

SENT VIA EMAIL

RE: Comments on Gender Affirming Treatment Rules for Section 20 of HB 2002 (2023)

Dear Ms. Emerson and Ms. Hall:

We appreciate the opportunity to provide comments on the draft rules concerning gender-affirming treatment (GAT). We also provided comments on the draft Bulletin that has since been issued as of February 2, 2024 as Bulletin No. DFR 2024-2.

Bulletin No. 2024-2 provides interim guidance until final rules implementing Section 20 of HB 2002 are adopted. The DFR accepted one of our recommendations which was to revise the definition of "Accepted standards of care" so that insurers can use other reliable and credible medical evidence sources as appropriate and not only WPATH's, version 8 standards. However, from the January 25, 2024 RAC, it was clarified that the statements of recommendations are the only part of the WPATH guidelines that are intended to be considered as standard of care. As such, we request that the draft rules follow the Bulletin's definition of "Accepted Standards of care" but also add "Statements of Recommendation" as it relates to WPATH as follows:

"Accepted standards of care" includes, but is not limited to, the Statements of Recommendation in the most recent version of the World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People."

There are other requirements in Bulletin No. 2024-2 that remain unclear, and we request that the rules address and clarify them as intended.

They are:

Denial of Claims

OAR 836-053-XXXX (2): A carrier offering a health benefit plan may not deny or limit coverage under the plan, ***deny or limit*** *(emphasis added)* coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage for gender-affirming treatment that is:
(a) Medically necessary, as determined by the physical or behavioral health care provider who prescribes the treatment; and
(b) Prescribed in accordance with accepted standards of care.

As we understand this requirement, it prohibits insurers from denying or limiting coverage for GAT if it's medically necessary as determined by the physical or behavioral health care provider **and** it's prescribed in accordance with accepted standards of care.

We request the DFR to confirm that as long as it's medically necessary (a covered benefit) as determined by the prescribing provider and it's prescribed in accordance with accepted standards of care, insurers must cover it. Conversely, insurers may deny or limit coverage in the situation where a prescribing provider has deemed it medically necessary, but the insurer finds based on its medical and clinical review policies that It's not in accordance with accepted standards of care because both conditions have not been met. While we understand the language is from HB 2002, we are concerned about the broad latitude given providers in this provision which could result in coverage of services well outside of what is contemplated by HB 2002 and procedures that are not safe based on valid clinical evidence. As such, we would like the rules to include language adding the ability for insurers to rely on their medical and clinical review policies to determine if it meets the appropriate standards of care chosen by the prescribing provider.

Network Adequacy:

OAR 836-053-XXXX(4)(a) and (b): A carrier offering a health benefit plan must:
(a) Contract with a network of gender-affirming treatment providers that is sufficient in numbers and geographic locations to ensure that gender-affirming treatment services are accessible to all enrollees without ***unreasonable delay*** *(emphasis added)*; or
(b) Ensure that all enrollees have geographical access without unreasonable delay to out-of-network gender-affirming treatment services with cost sharing or other out-of-pocket costs for the services no greater than the cost sharing or out-of-pocket costs for the services when furnished by an in-network provider.

Regarding (a), Bulletin No. 2024-2 did not address what the DFR considers an "unreasonable delay", and it is essential that the DFR include in the rules the factors that will be used to consider "unreasonable delay". Providers, especially specialty

providers, are currently experiencing higher than normal wait times for appointments. A lack of providers for specific treatments in the state should not be a basis for an "unreasonable delay" finding. For example, there are a few providers in Oregon engaged in gender-affirming surgical care. To date, we are only aware of one facility in Oregon that provides surgical care. As a result, enrollees may experience longer than usual appointment wait times for these services, which is out of the carrier's control. When there are not many providers of a specific service, carriers cannot be required to contract with a network of GAT providers that is sufficient in numbers and geographic locations to ensure gender-affirming treatment services are accessible to all enrollees. We raised this issue in early conversations with the legislature during the passage of HB 2002 and were ensured that a lack of providers would be accounted for in implementation of the statute. While we understand that some members may decide to seek care out-of-state to meet their needs, we believe that only in-state providers should be considered for network adequacy and "unreasonable delay" findings.

Lastly with respect to (b), we request that a provision be added requiring the enrollee to contact the insurer prior to seeking care out-of-state so that the insurer can assist the enrollee with finding an in-network provider or signing a special case agreement with the provider. What we've seen is that instead of the enrollee contacting Customer Service for assistance with finding an in-network provider, enrollees opt to seek care out-of-state and out-of-network without first working with the insurer to determine if there is in-state and in-network availability.

We also have the following questions about network adequacy we would like the DFR to address:

1. Would insurers be required to pay an out-of-network provider at in-network rates because the out-of-network provider could see a member a week sooner?
2. Would the DFR put carriers in a position where carriers would be contacting providers to advocate for a member to receive an appointment sooner for GAT versus a different medical diagnosis for it not to be considered an 'unreasonable delay'?
3. What about surgical situations? What is a 'reasonable delay' for a surgical appointment for an in-network provider versus an out-of-network provider? In cases where an out-of-network provider in another state may have an appointment that is closer in time, how would this be handled?
4. Would carriers be required to pay for these services at an in-network rate due to a week or two appointment difference?
5. What constitutes an "unreasonable delay" for in-network services – especially for services that are more specialized in nature where a limited amount of providers offer these services and appointment wait times may be lengthy?

The DFR should ensure that enrollees have an incentive to work with in-network providers as the primary option and only seek care as out-of-network when the in-state

and in-network provider cannot meet their needs or when the insurer is unable to find an in-network provider accepting new patients.

We care about our enrollees' safety and ensuring they have access to a broad range of providers they need for their care. Accepting our recommendations above will help achieve this.

Thanks for the opportunity to provide comments.

Sincerely,

Antoinette Awuakye
Sr. Public and Regulatory Affairs Specialist