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To:
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Thank you for this opportunity for Oregon Consumer Justice (OCJ) to provide feedback on the draft rule related to the gender-affirming treatment provisions of HB 2002 (2023).

1. In section 1(b) of the rule, OCJ supports the language defining "accepted standards of care" as including, "at a minimum," the World Professional Association for Transgender Health's Standards of Care for Transgender and Gender Diverse People, Version 8.

2. In section 2, we support the language "or limit" to ensure parity in coverage of gender-affirming treatment.

3. In section 3, OCJ supports language to revise the draft language as follows to better ensure that providers reviewing adverse benefits determination have appropriate experience:

   "Prior to issuing an adverse benefit determination that denies or limits access to gender-affirming treatment, a carrier offering a health benefit plan must have the adverse benefit determination reviewed and approved by a physical or behavioral health care provider who has at a minimum completed a GEI training course and can demonstrate experience relevant to the gender-affirming treatment."

4. In section 4, OCJ supports adding the following language, which is modeled off of existing network-adequacy rules to better ensure network adequacy for gender-affirming treatment:

   "An insurer electing to demonstrate compliance with network adequacy requirements required under ORS 743.505B via the factor-based approach shall include in the insurer's evidence of compliance a narrative description of how the insurer complies with section (4)(a), along with the source and

methodology, where applicable. The narrative description must include, at minimum:

(a) Median enrollee wait times for gender-affirming treatment appointments for the prior calendar year; and

(b) Evidence that the network includes a full range of gender-affirming treatment providers, including primary care providers, mental healthcare providers, endocrinologists, and surgeons providing gender-affirming treatment."

OCJ also suggests that DCBS considers language included in rulemaking in Washington that provides more specific language around patients being able to request information on denials, providers having to provide their credentials, and an explanation of the rule when a denial takes place so that patients have adequate information to reach out to the Division of Financial Regulation or for legal support if that is necessary.

Thank you for your consideration of these comments.

Regards,

Chris Coughlin
Policy Director