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May 9, 2024

Lisa Emerson
Brooke Hall
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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 revised gender-affirming treatment (GAT) draft rules dated 4-25-2024 discussed during the April 25, 2024 Rule Advisory Committee (RAC) meeting.

Our comments focus on areas of the rules that remain unclear and provides our feedback and responses to questions the DFR asked of insurers at the last RAC meeting.

Definition of "Accepted Standards of Care"

At the April 25, 2024 RAC meeting, the DFR confirmed that it will not make further revisions to the definition of "Accepted Standards of Care" because it's the same standards adopted by the Oregon Health Evidence Review Committee (HERC) for the Oregon Health Plan. In our previous comment letters, we had asked that the DFR keep the suggested "statements of recommendation" because there are procedures that are included in other sections of the WPATH guidelines that are considered experimental or are not widely agreed by medical professionals to be safe. For example, uterine transplants are part of WPATH, but are still deemed experimental by most medical standards. Similarly, gluteal lipofilling is included in a WPATH appendix, but is not widely considered safe. Gluteal lipofilling has a safety advisory from a task force formed by the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery, International Society of Aesthetic Plastic Surgery, International Society of Plastic Regenerative Surgeons and the International Federation for

Adipose Therapeutics and Science. This is due to the high rate of mortality associated with this procedure.

Therefore, with the removal of "statements of recommendation" where does procedures considered "investigational" or not widely agreed by medical professionals to be safe fit within the rules? Can carriers exclude based on accepted medical standards of care? If so, we request that language be added to the rules accordingly.

Network Adequacy:

Thanks for clarifying at the last RAC meeting that the network adequacy portion of the draft rules are not final, and the DFR is still seeking carrier input. We are pleased the DFR is open to receiving feedback that will improve and make the network adequacy requirements clearer. We offer our comments and responses to the DFR's questions here.

1. Section 7

   "Unreasonable Delay": The DFR clarified that there are proposed CMS standards that will become effective in 2025 for federally facilitated exchanges. Therefore, it will apply to state-based and state exchanges on the federal platform. The DFR also mentioned that it will be engaging in network adequacy rulemaking soon. In response to the DFR's question, what does "unreasonable delay" mean and the timeframes, a wait time beyond 60 days is an unreasonable delay. A wait time of up to 60 days is a reasonable timeframe.

2. Section 8

   a. Member Contacting Insurer for Assistance First Before Going Out-of-Network: We had requested that the DFR include a provision that requires the member to contact the carrier first for assistance in finding a provider before going out-of-network (OON). While we understand that the insurance statutes govern insurers, this rulemaking is unique in that there are aspects of the requirements that entail the member and the insurer working together to provide the member with the best and convenient care. We feel including this provision is not only cost-effective for the member and the insurer but also allows the member to remain in-state and close to their home. In addition, should the member potentially seek services out of state to an OON provider, the first time we would know would be from a claim which may not process correctly the first time because we would not know the member sought coverage OON. This can cause member abrasion and unnecessary appeals.

   b. Cost-sharing: (8)(a) requires that "the carrier ensures coverage for out-of-network gender-affirming treatment services without additional cost-sharing to the enrollee beyond what would be incurred for in-network services." Types of cost-sharing in insurance are copayments, deductible, and coinsurance. Customarily, when a member goes OON, they are also subject to balance billing. While the draft rules require coverage for out-of-network without additional cost-sharing to the enrollee beyond what would be incurred for in-network services, will that also include the balance of billed charges? We believe the

member should be responsible for the balanced of billed charges as that exceeds the cost-sharing for in-network services.

c. Wait times: (8)(b) requires "the carrier communicates transparently with enrollees about the expected wait times for gender-affirming treatment services and provides assistance in finding the nearest available provider." As mentioned in (8)(a) above, it's essential that members contact carriers for information on wait times and assistance in finding a provider before the member seeks services OON. Carriers should be given the opportunity to assist members and should not be required to pay in-network rates if we are not given the opportunity to find an in-network provider for the member. Although members have the ability and choice to see an OON provider, carriers should not be financially penalized when an in-network provider might be available. This would also allow carriers to configure their claims systems on a member-specific basis to process the claim as in-network if the carrier approves for the member to seek OON services. As noted above, it will prevent member abrasion and appeals.

   We request the following provision be added as (9):

   > An enrollee must contact the carrier before obtaining out-of-network gender-affirming treatment. If an enrollee fails to contact the carrier, the carrier is not obligated to cover out-of-network gender-affirming treatment services without additional cost-sharing to the enrollee beyond what would be incurred for in-network services if the enrollee does not allow the opportunity for the carrier to assist in finding the nearest available provider.

Special Case Agreements (SCA)

At the last RAC meeting, the DFR wanted to learn more about special case agreements (SCAs) and how they work. SCAs are used on a member-specific basis when the provider is either (a) not contracted at all or (b) not contracted for the member's specific network. The SCA is a one-time, member-specific contract for specific services. The rates may be negotiated between the carrier and the provider. By entering into the SCA, it allows the carrier to process the claim at an in-network benefit and avoid member balance billing.

Conclusion

Thanks for the opportunity to provide comments and answer the DFR's questions. We care about our members safety and that they have access to a broad range of providers they need for their care. We appreciate working together to achieve this.

Thank you.

Sincerely,

Antoinette Awuakye
Sr. Public and Regulatory Affairs Specialist