DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE DIVISION

DIVISION 053
Health Benefit Plans

836-053-XXXX (Adopt)
Gender Affirming Treatment

(1) For purposes of this rule:

(a) "Gender-affirming treatment" has the meaning given to that term under ORS 743A.325~~Oregon Laws 2023, chapter 228, section 20~~; and

(b) "Accepted standards of care" includes, at a minimum~~ and without limitation~~, the ~~statements of recommendation in the~~ World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People, Version 8~~,~~ (WPATH-8). ~~which is incorporated as Exhibit 1 to this rule.~~ ~~Other evidence-based guidelines and recommendations set forth by professional, non-profit organizations with recognized expertise in gender-affirming healthcare may be used, but only in conjunction with, and not as a substitute for, the WPATH-8.~~

(2) A carrier offering a health benefit plan may not deny or limit coverage under the plan~~,~~ including, but not limited to denying or limiting coverage of a claim, issuinge~~e~~ automatic denials of coverage or imposinge~~e~~ 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) ~~p~~Prescribed in accordance with accepted standards of care.

(3) Carriers may use utilization review practices to verify adherence to the accepted standards of care described in subsection (2)(b), provided that such practices are consistent with the requirements of this rule and all other applicable provisions of Oregon law. Utilization review practices shall be implemented in a manner that does not unreasonably limit or delay access to care.

(~~3~~4) A carrier offering a health benefit plan may not:

(a) Apply a categorical cosmetic or blanket exclusion to medically necessary gender-affirming treatment; or

(b) Exclude, as a cosmetic service, a medically necessary procedure prescribed by a physical or behavioral health care provider as gender-affirming treatment, including but not limited to:

(i) tracheal shave;

(ii) hair electrolysis;

(iii) facial feminization surgery or other facial gender-affirming treatment;

(iv) revisions to prior forms of gender-affirming treatment; or

(v) any combination of gender-affirming treatment procedures.

(~~3~~5) Prior to issuing an adverse benefit determination that denies or limits access to gender-affirming treatment, a carrier offering a health benefit plan must ensure that the adverse benefit determination is reviewed and approved in accordance with the following requirements:

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~~plan must have the adverse benefit determination reviewed and approved by a physical or behavioral health care provider with experience prescribing gender-affirming treatment.shall ensure that:~~

(a) The adverse benefit determination is reviewed by a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment.

(b) The reviewing provider:

(i) Meets the criteria for external medical review found in OAR 836-053-1325~~-~~(6)(b)(A-C);

~~(i) Holds a valid license issued by a health professional regulatory board;~~

~~(ii) Practices within the scope of practice as defined by their licensing board;~~

(ii~~ii~~) Has experience utilizing the WPATH-8~~ s~~Standards~~ of cCare that include, but are not limited to, the World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (WPATH-8);~~ and

(i~~v~~ii) Has completed ~~a~~the WPATH Global Education I~~I~~nitiative "Foundations in Transgender Health" training program or an equivalent training program listed on the division's website.~~on gender equality and inclusivity (GEI).~~

(c) ~~–~~This subsection (5) does not apply to ~~require a health care provider to review or approve~~ an adverse benefit determination that only involves the application of cost sharing, such as deductibles, coinsurance, or copays, to gender-affirming treatment.

(6) In the event of an adverse benefit determination that denies or limits coverage for gender-affirming treatment, the carrier must meet all the requirements in:

(a) ORS 743B.250,~~;~~ and if requested under ORS 743B.250(2)(h)(B), disclosure of the identity of the physical or behavioral health care provider who reviewed the determination, which at a minimum includes:

(i) the provider's job title and specific role in the review process;

(ii) a statement indicating whether the provider is an employee of the carrier or an independent contractor; and

(iii) the provider's specialty, board certification status, and any other relevant qualifications that affirm their expertise in gender-affirming treatment~~care~~.

(b) OAR 836-053-1030; and

(c) OAR 836-053-1100.

(~~6~~7) Carriers offering health benefit plans shall:

(a) Satisfy any network adequacy standards under ORS 743B.505 related to gender-affirming treatment providers; and

(b)(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~~Make reasonable efforts to contract with an adequate number of providers to facilitate access to gender-affirming treatment without unreasonable delay~~; or

(B~~a~~) ~~The carrier must e~~Ensures 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 other out-of-pocket costs for the services when furnished by an in-network provider, and meets~~ ~~all the requirements in:

(i) -OAR 836-053-1030;

(ii) OAR 836-053-1035; and

(iii) OAR 836-053-1408.

.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; and.

(b) The carrier must communicates transparently with enrollees about the expected wait times for gender-affirming treatment services and provides assistance in finding the nearest available provider.

(8) For the purposes of this rule, unreasonable delay is defined as an appointment wait time that exceeds 30 business days for specialty care, 15 business days for primary care, and 10 business days for behavioral health care.

(798) If a carrier demonstrates due diligence in attempting to contract, without success, with an adequate number a sufficient network of providers for gender-affirming treatments, without success, due to provider scarcity, the carrier will not be found in violation of network adequacy standards., provided that:

(a) 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.

(b) 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."4) 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; 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.

Stat. Auth: ORS 731.244, Or Laws 2023, chapter 228ORS 743A.325

Stats. Implemented: Or Laws 2023, chapter 228ORS 743A.325

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