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Oregon Department of Consumer and Business Services Division of Financial Regulation, Bulletin No. DFR 2025-4

To: All entities offering health benefit plans in Oregon

Date: May 15, 2025

RE: Health benefit plan coverage of gender-affirming treatment under ORS 743A.325 and OAR 836-053-0441

I. Purpose

The purpose of this bulletin is to provide supplemental guidance for health benefit plans regarding coverage of gender-affirming treatment under ORS 743A.325 and OAR 836-053-0441 to ensure consistent and uniform implementation of these requirements across the health insurance market. This bulletin supersedes Bulletin DFR 2024-2, which is withdrawn as of the effective date of OAR 836-053-0441 (January 1, 2025).

II. Definitions

As used in this bulletin:

“Accepted standards of care” includes, but is 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).

“Carrier” has the meaning given that term in ORS 743B.005.

“Cost sharing” includes deductibles, coinsurance, copayments, and any similar charges, but excludes premiums, balance billing amounts for out-of-network providers, and spending for non-covered services.

“Gender-affirming treatment” has the meaning given that term in ORS 743A.325.

“Health benefit plan” has the meaning given that term in ORS 743B.005.

III. Background

During the 2023 legislative session, the Oregon Legislative Assembly enacted Oregon House Bill 2002, including Section 20, since codified as ORS 743A.325. The statute prohibits a carrier offering a health benefit plan from denying or limiting coverage for gender-affirming treatment that is medically necessary as determined by the physical or behavioral health care provider who prescribes the treatment and is prescribed in accordance with accepted standards of care. The bill prohibits carriers from applying

categorical cosmetic or blanket exclusions to medically necessary gender-affirming treatment, including but not limited to tracheal shave, hair electrolysis, facial feminization surgery or other facial gender-affirming treatment, revisions to prior forms of gender-affirming treatment, and any combination of gender-affirming treatment procedures.

HB 2002 also prohibits carriers from issuing an adverse benefit determination denying or limiting access to gender-affirming treatment unless a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment in accordance with accepted standards of care first reviews and approves the denial or limitation. In addition, the bill requires health benefit plans to contract with gender-affirming treatment providers in sufficient numbers and geographic locations to ensure that all enrollees may access gender-affirming treatment without unreasonable delay or, alternatively, to ensure that enrollees have geographical access without unreasonable delay to out-of-network gender-affirming treatment services with cost sharing or other out-of-pocket costs that are no greater than if such services were provided by an in-network provider.

HB 2002 requires the Department of Consumer and Business Services to adopt rules to implement these provisions. Such rules were adopted as OAR 836-053-0441, effective January 1, 2025. The rules clarify that WPATH-8 provides the minimum standards for the gender-affirming treatment services that a health benefit plan must cover, require that health care providers reviewing adverse benefit determinations on behalf of an issuer of a health benefit plan complete the “WPATH SOC-8 Health Plan Providers training program” or an equivalent training program, and provide a variety of other clarifications to ensure full implementation of the requirements of the statute.

Also, Section 21 of HB 2002 requires the department to conduct targeted market conduct exams of all carriers subject to HB 2002 no later than January 2, 2027.

IV. Director’s Guidance

Carriers offering health benefit plans must administer coverage for gender-affirming treatment in accordance with ORS 743A.325, OAR 836-053-0441, DFR Bulletin 2016-1 and all applicable state and federal statutes and regulations. The following guidance is intended as a supplement to clarify the department’s supervisory expectations in implementing and ensuring compliance with these requirements in the following areas.

- **WPATH-8 as minimum standard for coverage**

Having a clear and comprehensive minimum coverage standard is essential for ensuring that gender-affirming care services are provided in a consistent and equitable way across the health insurance market. The inclusion of WPATH-8 in OAR 836-053-0441 is intended solely to provide a minimum standard for what gender-affirming treatment services must be covered by a health benefit plan. Carriers may and should continue to consult all applicable clinical guidelines and evidence in making coverage decisions, but may not deny coverage for a service recommended by WPATH-8 if it is prescribed appropriately by a physical or behavioral health care provider.

Adopting WPATH-8 as a minimum coverage standard does not limit what carriers must cover. There may be situations where gender-affirming care items and services are medically necessary and prescribed according to a different accepted standard of care. In such situations, carriers will be expected to cover those items and services.

There are a small number of instances where items and services are mentioned in the WPATH-8 without being specifically recommended as clinical best practices, and that may still widely be considered experimental and investigational. For example, uterine transplantation surgery is listed in the guidelines as an example of a gender-affirming treatment, but is not specifically discussed or recommended as a standard of care. In such instances, carriers are advised to consult the latest evolving clinical evidence in evaluating the medical necessity of such treatments.

- **Guidance not applicable to health care providers**

ORS 743A.325, OAR 836-053-0441, DFR Bulletin 2016-1, the current bulletin and all statutes, rules and bulletins administered by the department related to gender-affirming treatment apply solely to health insurance carriers issuing health benefit plans and do not govern the activities of health care providers.

- **Network adequacy**

ORS 743A.325 and OAR 836-053-0441 address the issue of network adequacy for gender-affirming treatment. ORS 743A.325 requires that carriers must satisfy any network adequacy standards under ORS 743B.505 related to gender-affirming treatment providers. A carrier offering a health benefit plan should 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. If a carrier is unable to meet this standard with respect to an enrollee, the carrier must allow an enrollee to access gender-affirming treatment from an out-of-network provider and ensure that the enrollee's cost sharing does not exceed the cost sharing that would have applied if the treatment had been provided by an in-network provider.

Carriers may implement utilization review processes to authorize out-of-network services, provided such practices are consistent with OAR 836-053-0441, OAR 836-053-1200, and all other applicable provisions of Oregon law.

The department intends to provide specific, quantifiable standards for network adequacy and unreasonable delay as part of broader statutory and rule changes applicable to all health care services covered by health benefit plans in the future. In the interim, the department will consider accessibility and delays in access on a case-by-case basis. Key factors in determining whether an enrollee has been subject to an unreasonable delay will include, but are not limited to, whether medically necessary gender-affirming treatments are available from in-network providers, as well as travel and wait times for in-network providers of covered gender-affirming treatments in comparison to travel and wait times to access these services from out-of-network providers.

- **Cost-sharing**

As noted above, ORS 743A.325 and OAR 836-053-0441 require that cost-sharing for out-of-network provision of gender-affirming treatment services not exceed in-network cost-sharing if in-network services are unavailable or subject to unreasonable delay. These provisions apply solely to the carrier issuing the health benefit plan and not to the health care provider, so the provider is not prohibited from balance billing the patient. To prevent consumer harm in these instances, the department urges carriers to negotiate in good faith for single-case agreements or other arrangements that protect consumers from balance billing.

OAR 836-053-0441 prohibits additional cost-sharing for gender-affirming treatment services. This provision is not intended to prohibit the application of cost-sharing altogether. It is solely intended to ensure that cost-sharing is comparable for items and services whether they are provided in the context of gender-affirming treatment or other clinical contexts. For example, cost-sharing for medically necessary hormone replacement therapy should be comparable whether the therapy is prescribed as gender-affirming treatment or any other clinical indication.

- **Coverage of detransition services**

HB 2002 requires coverage of medically necessary gender-affirming treatment, which it defines as a procedure, service, drug, device, or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth. ORS 174.100(4) defines gender identity as "an individual's gender-related identity, appearance, expression or behavior, regardless of whether the identity, appearance, expression or behavior differs from that associated with the gender assigned to the individual at birth."

"Detransition services" typically refers to clinical treatments intended to reverse the effect of prior gender-affirming treatments. In such a case, the individual is seeking treatment for an incongruence between their gender identity (e.g. their appearance) and their sex assigned at birth and such treatment would constitute gender-affirming treatment and must be covered when medically necessary and prescribed by a health care provider according to accepted standards of care.

Medical necessity for detransition services and other gender-affirming treatments is determined by health care providers. DCBS does not make medical necessity determinations or adjudicate their clinical appropriateness. Health benefit plan enrollees may appeal adverse benefit determinations based on medical necessity through an external review process conducted by independent review organizations under ORS 743B.250 through 743B.258.

- **Training for reviewing providers**

OAR 836-053-0441 requires that health care providers reviewing adverse benefit determinations on behalf of an issuer of a health benefit plan complete the "WPATH SOC-8 Health Plan Providers training program" or an equivalent training program. To

ensure feasibility of compliance with this requirement, the department expects carriers to work to achieve compliance by September 1, 2025. The division will exercise its discretion in enforcement of the training requirement on a case-by-case basis, with the goal of ensuring full compliance in a timely fashion.

The rule does not adopt the WPATH training program as a one-size-fits-all requirement, but grants carriers the flexibility to provide their reviewers with an equivalent training program. To be equivalent, the training program must be similarly comprehensive and similarly focused on ensuring familiarity with the responsibilities of health care providers reviewing adverse benefit determinations for gender-affirming treatment. As of the date of this bulletin, the department is not aware of any equivalent training programs that may be available, but will evaluate training programs developed by other organizations, or in-house by health insurance carriers, on a case-by-case basis.

V. Applicability

This bulletin is effective upon issuance and applies to carriers offering health benefit plans that are subject to ORS 743A.325 and OAR 836-053-0441. The bulletin remains in effect until repealed. This bulletin supersedes Bulletin DFR 2024-2, which is hereby withdrawn as of January 1, 2025.

The provisions of this bulletin are in addition to the requirements of DFR Bulletin 2016-1. To the extent there is a conflict between the requirements of this bulletin and DFR Bulletin 2016-1, the provisions of this bulletin control.

5/15/2025

Andrew R. Stolfi
Insurance Commissioner and Director
Department of Consumer and Business Services

Date