OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
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CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILED
10/30/2024 11:50 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: 2025 Gender-Affirming Treatment Rule

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/26/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Karen Winkel
503-947-7694
karen.j.winkel@dcbs.oregon.gov

350 Winter St. NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/19/2024
TIME: 11:00 AM - 12:00 PM
OFFICER: Brooke Hall

IN-PERSON HEARING DETAILS
ADDRESS: Labor and Industries Building, 350 Winter St. NE, Basement, Conf Rm A, Salem, OR 97301
SPECIAL INSTRUCTIONS:
This is a hybrid meeting conducted in-person and virtually via Microsoft Teams:

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 503-446-4951
CONFERENCE ID: 599636230
SPECIAL INSTRUCTIONS:
Meeting ID: 267 195 468 800
Passcode: j3NgqJ

NEED FOR THE RULE(S)

House Bill 2002 (2023) prohibits a carrier offering a health benefit plan from denying or limiting coverage for medically necessary gender-affirming treatment that is prescribed in accordance with accepted standards of care. The bill also prohibits health benefit plans from applying cosmetic or blanket exclusions to medically necessary gender affirming treatment and establishes requirements for notices of adverse benefit determinations and network adequacy.

HB 2002 (2023) requires the Department of Consumer and Business Services (DCBS) to adopt rules to implement these provisions. DCBS convened a Rulemaking Advisory Committee (RAC) which met on Dec. 12, 2023, Jan. 25, Mar. 21, Apr.

25, Jun. 11, Jul. 18, and Aug. 7, 2024. The RAC included insurers, health care providers, consumer and patient advocates. Basic Rights Oregon and the Oregon Medical Association were both members of the RAC, serving as advocacy organizations that represent affected small businesses, including independent healthcare providers.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Draft rules are available from Karen Winkel, Rules Coordinator, Division of Financial Regulation located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's website: https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

House Bill 2002 (2023)
ORS 743A.325 (4)(b)

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

A Rulemaking Advisory Committee was consulted regarding this equity statement. This rule implements HB 2002, which increases access to gender affirming care. This rule is not anticipated to have any disparate negative impact on any particular demographic of Oregon consumers.

This rule is expected to have a positive impact on equity in the state by increasing access to healthcare services for underserved individuals, particularly for transgender and non-binary individuals, resulting in reduced barriers to necessary medical treatments, enhanced affordability, and improvements in behavioral health and overall well-being for those receiving gender-affirming care.

FISCAL AND ECONOMIC IMPACT:

The rule primarily affects health insurance carriers issuing health benefit plans. The rule mandates that health care providers reviewing adverse benefit determinations denying or limiting access to gender-affirming treatment complete the "WPATH SOC-8 Health Plan Providers Training," which is specifically designed for providers responsible for such reviews, or an equivalent training.

This training comes with a cost. Based on the information available to the department, the training sessions facilitated by WPATH are priced based on contractual arrangements that depend on factors including the number of participants. DCBS does not have specific information about the number of insurance company employees that will take the training as a result of this rule, so it is not possible to estimate the total cost to affected industry entities. However, since the training can be made available to an insurer's existing reviewers, the training requirement is likely less financially burdensome than alternative approaches that could require hiring or contracting with different or additional reviewers.

The rule will have indirect positive effects on health care providers, including small businesses, to the extent that it requires health insurance carriers to reimburse for services that may not previously have been covered, but the extent of this impact is impossible to estimate from the information available to DCBS.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on information currently available to DCBS, the proposed rule would not (or does not have) a fiscal or

economic impact on state agencies, local government units, nor the public.

(2)(a) Based on financial filings made to the Division of Financial Regulation (DFR), no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated. As noted above, the rule will have indirect effects on health care providers, including small businesses, but DCBS does not have access to information to determine the number of small provider organizations that would be affected.

(2)(b) The rule primarily affects health insurance carriers. It does not require additional reporting or recordkeeping activities. In accordance with the statute, the rule requires carriers to meet certain standards for providers reviewing adverse benefit determinations, which will impose additional administrative costs on carriers. As noted above, the specific cost will depend on the number of employees that take the required training, which cannot be estimated based on information currently available to the department.

(2)(c) The rule primarily affects health insurance carriers. Based on the information available to the department, it does not require additional professional services, equipment or supplies. In accordance with the statute, the rule requires carriers to meet certain standards for providers reviewing adverse benefit determinations, which will impose additional administrative costs on carriers. As noted above, the specific cost will depend on the number of employees that take the required training, which cannot be estimated based on information currently available to the department.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The rule primarily applies to health insurance carriers. Based on financial filings made to DFR, no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated. As noted above, the rule has indirect impacts on health care providers, some of whom are small businesses.

Basic Rights Oregon and the Oregon Medical Association were both members of the RAC, serving as advocacy organizations that represent affected small businesses, including independent healthcare providers. The department also received written and oral public comment during the RAC process from small business health care provider representatives.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

ADOPT: 836-053-0441

RULE SUMMARY: 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, issuing automatic denials of coverage or imposing 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.

CHANGES TO RULE:

836-053-0441
Gender-Affirming Treatment
(1) For purposes of this rule:¶
(a) "Gender-affirming treatment" has the meaning given to that term under ORS 743A.325; and¶
(b) "Accepted standards of care" includes, at a minimum, the World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (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, issuing automatic denials of coverage or imposing 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.¶
(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, OAR 836-053-1200, 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.¶
(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: ¶
(A) Tracheal shave;¶
(B) Hair electrolysis; ¶
(C) Facial feminization surgery or other facial gender-affirming treatment; ¶
(D) Revisions to prior forms of gender-affirming treatment; or¶
(E) Any combination of gender-affirming treatment procedures.¶
(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: ¶
(a) The adverse benefit determination is reviewed by a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment.¶
(b) To demonstrate experience the reviewing provider must:¶
(A) Meet the criteria for external medical review found in OAR 836-053-1325(6)(b)(A-C);¶
(B) Have experience utilizing the WPATH-8; and¶
(C) Have completed the WPATH SOC-8 Health Plan Providers training program or an equivalent training program.¶
(c) This subsection (5) does not apply to 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 information to demonstrate experience prescribing or delivering gender-affirming treatment:¶
(A) The provider's job title and specific role in the review process; and¶
(B) The provider's specialty, board certification status, and any other relevant qualifications that affirm their experience in gender-affirming treatment.¶
(b) OAR 836-053-1030; and¶
(c) OAR 836-053-1100. ¶
(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; 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 other out-of-pocket costs for the services when furnished by an in-network provider, and meet all the requirements in:¶
(i) OAR 836-053-1030;¶
(ii) OAR 836-053-1035; and¶
(iii) OAR 836-053-1408.
Statutory/Other Authority: ORS 731.244, ORS 743A.325
Statutes/Other Implemented: ORS 743A.325