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Lisa Emerson
Brooke Hall
Senior Policy Analysts
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 3-15-2024 that was discussed during the March 21, 2024 Rule Advisory Committee (RAC) meeting.

Although we didn't finish reviewing the entire revised draft rule at the RAC meeting, we are still not clear about some of the changes that were discussed and the remaining changes that have yet to be discussed. As such, we request that the following requirements be revised or clarified to avoid any confusion by consumers, providers, and insurers.

Definition of "Accepted Standards of Care"

Thank you for adding "statements of recommendation" within the definition as requested by us in our previous comment letter. However, at the March 21st RAC meeting, there was disagreement by some non-insurance industry RAC members about the addition of it. We request that the DFR keep it as is 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, also listed in the appendix, 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.

Also, you asked RAC members, specifically insurance carriers, what other accepted standards of care were there to justify the DFR including the language "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." One RAC member provided the Harvard produced standards of care "Fenway Health – Medical Care of Trans and Gender Diverse Adults" the Spring 2021 edition that is also used for clinical guidance. Evidence-based guidelines have also been published by the Endocrine Society that may be useful to support what is published in WPATH. We support keeping the additional language in the event other standards of care are developed in the future so that providers and insurers are not bound to one standards of care.

Denial of Claims

Regarding OAR 836-053-XXX (5) which provides the qualifications that a physical or behavioral health care provider reviewing an adverse benefit determination must have, it was mentioned at the RAC meeting that it was taken from "Washington's" although the RAC member who may have offered the suggested language didn't specify whether by rule or law. We reviewed both the Washington gender-affirming treatment law and rule and concise explanatory statement (the OIC uses this document to directly respond to comments received during the rulemaking process) and didn't find any mention of it. As such, we would like to know the origin of the language. Otherwise, we request that the language be removed.

Network Adequacy:

As we did not get to the network adequacy section of the revised rules during the RAC meeting, we offer our comments here and are seeking clarification on them:

> OAR 836-053-XXXX
> "(6): Carriers offering health benefit plans shall make reasonable efforts to contract with an adequate number of providers to facilitate access to gender-affirming treatment without unreasonable delay."
>
> (7) If a carrier can demonstrate due diligence in attempting to contract, without success, with an adequate number of providers for gender-affirming treatments 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.

With respect to (6), in our comment letter dated February 8, 2024, we requested that the DFR clarify "unreasonable delay". However, we have not received that clarification and are respectfully requesting it again. Many of these services are not considered urgent/emergent in nature, so wait times for some services are to be expected due to the current state of the provider/healthcare landscape. Therefore, we urge the DFR to include that if there is not an 'unreasonable delay' for an in-network (INN) provider for services, members should be required to see an INN provider and not go out-of-network (OON) without the carrier knowing and approving the OON care.

With respect to (7)(a), when must carriers allow members to go OON for services at INN rates?

With respect to (7)(b), we are aware there are a limited number of providers that offer surgical services, and there may be significant wait times for services. We can communicate transparently with the member and advise of the wait time in discussing with INN provider offices, but at what point are we required to pay for OON services because the member doesn't want to wait for an INN provider and wants to go OON? We see an opportunity here for potential abuse if it isn't clarified when carriers are required to pay for OON services.

Carriers should not be required to pay for OON services to providers not located in Oregon, even though they might be the 'nearest available' due to potential provider wait times. For example, we want to avoid the scenario where members have gone to California for services, and we were required to pay INN, even though the member never contacted us and we were not allowed the opportunity to connect them with an in-state, INN provider. We recommend revising the language to require that the member must contact the insurer for assistance in finding an INN provider first before seeking treatment from an OON provider. Should the insurer be unsuccessful in finding an INN provider due to wait times, among other things, and the member still chooses to seek treatment from an OON provider, the member must seek approval first from the insurer.

Additional ancillary questions we have related to "nearest available provider" are: (1) how does the DFR define it? (2) Is it within the state of Oregon, even though there might be a wait time for services? (3) Are we complaint as long as we are transparent with our members about the wait time? For us, the nearest available provider will be an INN provider so that the member gets to stay within Oregon and the costs of the

treatment are contained. We strongly recommend that treatment services and access be limited to INN benefits and providers who reside in Oregon.

We care about our members safety and ensuring they have access to a broad range of providers they need for their care. Accepting our recommendations above will help achieve this.

Thanks for the opportunity to provide comments.

Sincerely,

Antoinette Awuakye
Sr. Public and Regulatory Affairs Specialist