Comments on Second Draft to HB 2002 (2023) Rules

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1 attachments (168 KB)

Comments on Draft Rules Implementing House Bill 2002 (2023).pdf;

Hi Brooke and Lisa,

I hope you don't mind us submitting comments via email instead of via a formal letter. I had believed, based on comments Michael Schopf made in the first rulemaking advisory committee, that these rules would likely be going through substantial revision. I am going to attach our comments letter from the first rulemaking advisory committee, as they continue to apply to the latest draft. In particular, the addition of "impose additional cost sharing" under section (2) of the draft rule is an addition that does not appear in the underlying statute. We are also concerned about the near verbatim adoption of statutory language into the rule; we run the risk of inconsistent sets of legal standards if the rule text alters the statutory text. Section (4) of the draft rule is a good example; there are subtle but possibly important differences in construing the text of the rule versus construing the text of the statute.

To reiterate our comments during the committee:

- In the proposed changes to section (5)(a), we would ask whether the requirement in section 20(2)(d) of the HB 2002 needs clarification. After all, the rules governing external review organizations who must have a person with experience in the area of care do not go into such granular detail as these rules do for gender-affirming care. *See* OAR 836-053-1325 (Procedures for Conducting External Reviews). We do not believe that HB 2002 delegates the authority to define qualifications so precisely. Below is the language requiring "clinical peers" to conduct an external review in current insurance regulation:

  > (B) Be a clinical peer. For purposes of this paragraph, a clinical peer is a physician or other medical reviewer who is in the same or similar specialty that typically manages the medical condition, procedures or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession and the same licensure category as the attending provider. In a profession that has organized, board-certified specialties, a clinical peer generally will be in the same formal specialty.

  We also believe that since the statute did not grant that level of delegative authority, the rules themselves will work to impart a fiscal impact on insurers that DFR must quantify and note accurately.

- We would also ask DFR to remove sections (6) and (7) of the draft rule, and instead clarify what the statute deems "unreasonable delay" in care. The factor-based approach that proponents wish to write into rule is not a good model, as it only applies when an insurer elects to demonstrate compliance with network adequacy standards under OAR 836-053-0340. In addition, we worry about significant provider abrasion in locating and referring members to gender-affirming care specialists, who may be overwhelmed by requests from carriers. The more prudent approach would be to guide insurers through defining the delegative term "unreasonable delay."

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