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Oregon Department of Consumer and Business Services Division of Financial Regulation, Bulletin No. DFR 2024-2

To: All entities offering health benefit plans in Oregon

Date: February 1, 2024

RE: Interim guidance for health benefit plans for Section 20 of 2023 Oregon House Bill 2002 (gender-affirming treatment)

I. Purpose

The purpose of this bulletin is to provide guidance for health benefit plans regarding coverage of gender-affirming treatment under Section 20 of 2023 Oregon House Bill 2002 until final rules implementing HB 2002 are adopted.[1]

II. Definitions

As used in this bulletin:

"Accepted standards of care" includes, but is not limited to, the most recent version of the World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People.

"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" means 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.

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

[1] The Division of Financial Regulation anticipates convening a rules advisory committee to advise on the rules required under HB 2002 in December of 2023. The division expects to adopt final rules implementing HB 2002 prior to January 1, 2025.

III. Background

During the 2023 legislative session, the Oregon Legislative Assembly enacted Oregon House Bill 2002, including Section 20 (HB 2002).[2] With respect to health insurance, HB 2002 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 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 and 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 should administer coverage for gender-affirming treatment in accordance with the following:

- **A carrier may not deny or limit coverage under the plan for gender-affirming treatment that is medically necessary and prescribed in accordance with accepted standards of care.**

  Except as otherwise allowed in HB 2002, a carrier may not deny or limit coverage of gender-affirming treatment that is (1) medically necessary and (2) prescribed in accordance with accepted standards of care. HB 2002 plainly states that medical necessity is determined by the provider who prescribes the treatment.

- **A carrier may not apply a categorical cosmetic or blanket exclusion to medically necessary gender-affirming treatment.**

[2] Or. Laws 2023, chapter 228.

Carriers offering health benefit plans should review their policy forms and internal policies and procedures and remove or revise any language or practices that have the effect of categorically excluding coverage for medically necessary gender-affirming treatment that is prescribed in accordance with accepted standards of care.

- **A carrier may not exclude, as a cosmetic service, a medically necessary procedure prescribed by a physical or behavioral health care provider as gender-affirming treatment.**

  This includes, but is not limited to tracheal shaves, 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.

- **Prior to issuing an adverse benefit determination that denies or limits access to gender-affirming treatment, a carrier must have the adverse benefit determination reviewed and approved by a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment.**

  In the event of an adverse benefit determination denying or limiting coverage for gender-affirming treatment, upon request, a carrier should be able to identify the physical or behavioral health care provider who reviewed the determination and confirmed that the denial is appropriate. At a minimum, carriers should be able to provide the provider's job title, a statement as to whether the provider is affiliated with the carrier as an employee, and the provider's specialty, board certification status, or other criteria related to the provider's qualifications. This bulletin does not require a health care provider to review or approve an adverse benefit determination that only involves the application of cost sharing to gender-affirming treatment, however any cost sharing applied to gender-affirming treatment must still comply with the requirements of this bulletin and any applicable laws.

- **A carrier must ensure that enrollees are able to access gender-affirming treatment providers on an in-network basis without unreasonable delay.**

  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 the 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.

V. Applicability

This bulletin is effective upon issuance and applies to carriers offering health benefit plans that are subject to HB 2002 on or after January 1, 2024. The bulletin remains in effect until repealed or until final rules adopted by the Division of Financial Regulation (DFR) to implement HB 2002 become effective, whichever is earlier.

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.

02/01/2024

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Insurance Commissioner and Director
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Date