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Sent: Tuesday, February 02, 2016 12:06 PM
To: HOLMAN Jeannette * DCBS; SAMPLE Tashia M * DCBS
Cc: Megan.L.Houston@healthnet.com
Subject: Proposed EHB Rules

Jeannette and Tashia, thank you for allowing us to present some concerns with this complex set of requirements. Megan Houston (who served on the advisory committee) and I offer the following suggestions:

Page 1 Line 22, delete "benefit" and replace with "service".

Page 2 Line 14, delete the word "if".
Page 2 Line 31, delete the word "is".
Page 2 Line 33, delete the word "is".

Page 3 Lines 13-14, suggest deleting. This seems redundant as we are required by state and federal law to comply with the laws, and carrier contracts already include provisions indicating that responsibility.

Page 5, Line 18, Delete "including services".
Page 5 Line 19, Delete "provided for the treatment of mental health conditions".

Page 5 Lines 26-27, clarification please. Was sexual dysfunction an exclusion in Pacific Source's plan, requiring this call-out? Or was a drug (s) to treat it excluded? Carriers are required to have a drug in each of the USP categories, so if it was a drug exclusion in Pacific Source policy, Page 13 Lines 14-20 in the rules it is acknowledges the requirements.

Page 5 Line 29, delete "surgeries and " and replace with "medically necessary".

Page 5 Lines 29-30, Clarify that cosmetic services are not required. There are three categories of services: non-surgical (ex: counseling, hormone), surgical (ex. genital reconstruction), cosmetic services which are not covered (ex. hair removal, facial structure).

Page 6 Lines 10-11, Delete. ORS 743A.184 does not require linkage to the USPSTF lists. As written, this ORS is clear as to what is required in Oregon for diabetes.

Page 6 Line 14, after "modified" strike remainder of line.
Page 6 Line 15, Delete.
Page 6 Line 16, Delete "under" and replace with "if medically necessary, in accordance with..."...
Page 6 Lines 40-42, Clarification. It appears DFR is attempting to reference the federal "anti-discrimination" language. The Feds have indicated this is not an "any willing provider" requirement. Further, the Feds have not required all categories of providers. If our interpretation is wrong, this should not be included in rules for essential health benefits.

Definitions appear throughout the pages. Putting the definitions together might ease some of the complexity of these proposed rules.

And finally, HN request the rules explicitly state they apply only to non-grandfathered Individual plans and non-grandfathered small group plans.

Thank you both for the opportunity to comment. Your efforts to develop these complicated rules are appreciated.

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