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Dr. Leanette Henagan, DBH, LCSW
Behavioral Health Program Administrator
Arizona Department of Insurance and Financial Institutions
100 N. 15th Avenue, Suite 261
Phoenix, AZ 85007

Re: Comments on Proposed Mental Health Parity Rulemaking

Dear Dr. Henagan:

This comment letter is being submitted by the undersigned law firm generally on behalf of the Arizona health insurance industry. We conducted industry stakeholder meetings to review and evaluate the draft rules promulgated by the Arizona Department of Insurance and Financial Institutions ("DIFI") to implement Arizona's recently enacted mental health parity laws, SB 1523 (Laws 2020, Ch. 4). The comments contained herein represent a summary of the feedback and input received from Arizona's health insurance companies following their internal review of DIFI's proposed reporting requirements to implement SB 1523. Many of the individual insurers and America's Health Insurance Plans have referenced these comments in their separately submitted comments.

Overview

Jake's Law (SB 1523, Laws 2020, Ch. 4) codified into Arizona law the federal Mental Health Parity and Addiction Equity Act ("MHPAEA"), which generally prohibits health insurers from imposing less favorable benefit limitations on mental health and substance use disorder ("MH/SUD") benefits than they impose for medical and surgical ("Med/Surg") benefits. Through the enactment of SB 1523, the Arizona State Legislature also directed DIFI to enact rules to implement the MHPAEA, by setting standards to measure health insurers' compliance with MHPAEA's mandates and by developing forms and worksheets for health insurers to report the limited, specific items related to the MHPAEA.

In our March 12, 2021 comment letter, it was the Insurers' position that DIFI's proposed rules generally failed to meet the foregoing requirements under the Administrative Procedure Act in the following ways:

1. The proposed rules far exceed DIFI's statutory authority by mandating reporting not authorized by SB 1523 or the MHPAEA.

2. The proposed rules are not clear, concise, or understandable and as a result cannot be consistently or readily implemented by insurers.
3. DIFI failed to select the least burdensome option to implement SB 1523 in promulgating the required reporting in the proposed rules.
4. The proposed rules fail to establish standards against which compliance with the MHPAEA can be measured.
5. Given the short timeframe for promulgating the proposed rules, DIFI was unable to undertake a robust stakeholder input process in promulgating the proposed rules.

The industry appreciates the DIFI's efforts to bring these revised rules into close conformity with the MHPAEA; as result, the current draft is greatly improved. The majority of the March 12th objections have been addressed by the revised rules. The draft is dramatically clearer, more concise, and understandable because the rules closely mirror the federal law. The regulatory and administrative burden the rules place on plans is greatly reduced since health plans are already subject to the MHPAEA requirements, and the requirements for Arizona-specific reporting have been greatly reduced. The federal regulation of mental health parity is comprehensive, and as a result, by mirroring the federal regulatory system, Arizona will have a robust program that meets policy goals of Jake's Law. The purpose of this comment letter is to suggest some improvements to the rules that will enhance clarity and synchronization with the federal requirements. Some of the recommendations require rule modification while others can be addressed through administrative activities or clarifying Bulletins.

Consistency with Federal Mental Health Parity Laws

Health plans in Arizona anticipate the active regulation of the mental health parity laws at both the state and federal level. The costs of producing the parity analysis is significant for health plans, so it is important to streamline the filing and regulatory requirements to the greatest extent possible. Given the dual regulation at the federal and state level, the health plans suggest that DIFI work with the Department of Health and Human Services ("HHS") and the Department of Labor ("DOL") to ensure the implementation of the MHPAEA at the state and federal level does not unnecessarily burden health plans. One way this can be accomplished is to ensure that audit and data requests of the health plan are timed appropriately and that regulatory reviews do not overlap to the greatest extent possible. The current rules go a long way to synchronize federal and state regulatory requirements so that filing and compliance requirements are more uniform. As the federal government updates standards, rules, and guidance, the state should act accordingly to ensure uniformity between regulators. We anticipate this will be an ongoing process as the federal agencies responsible for MHPAEA enforcement evolve in their regulatory approaches and guidance.

Related to the rules, our first suggestion highlights an opportunity to better synchronize the interpretation and implementation of the rules. The health plans are pleased that DIFI utilized the definitions and explanatory language from the federal rules in the state definitions, but it is unclear

how DIFI will use related guidance from HHS to interpret the rules. As you know, federal guidance on interpreting the MHPAEA rules is evolving, and there is extensive federal guidance on MHPAEA as summarized in the most recently issued sub regulatory guidance [1]. The health plans believe that DIFI should clarify either in the rules, or through a Bulletin, that DIFI intends to interpret the rules consistent with not only MHPAEA rules, but the associated sub regulatory guidance as well. Health plans need to be able to rely on a consistent regulatory system regardless of which regulator is conducting the regulation review.

Definition of "Medical Necessity" and "Medically Necessary"

The rules create both a new definition and a new standard for the use of the terms "medical necessity" and "medically necessary". Typically, health plans define medical necessity as part of their clinical guidelines, or the term is included and defined as part of the member's benefit plan. These definitions vary from insurer to insurer. The definition of "medical necessity" and "medically necessary" are core elements of the clinical review criteria and, as a result, changes to these definitions could result in health plans being required to make significant revisions to their clinical guidelines. The current regulatory definition does not appear to be consistent with the intent of the authorizing legislation, nor is it the least burdensome approach.

The plans are concerned that a clinical standard is being defined in a rule by an agency with limited clinical resources to create such a definition. Such definitions are better suited to be created by the medical professionals within each health plan, under the direction of the plan's chief medical officer. As currently drafted, the rule could require plans to modify their clinical guidelines to meet the definitions contained in the rule, even if a plan's definition of "medical necessity" and "medically necessary" are more robust and comprehensive than DIFI's regulation provides. If the purpose of the definition is to provide clarity to the terms "medical necessity" and "medically necessary," the least burdensome and most clinically appropriate approach to accomplish this goal is to reference the terms "medical necessity" and "medically necessary" as presented by a plan's adopted clinical guidelines. Reference and deference to each plan's definition would improve the clarity of the rules while providing the health plans the flexibility to utilize clinically sound definitions of the terms "medical necessity" or "medically necessary." The DIFI took this approach in the rules for health care service organizations (see definition of medically necessary in A.A.C. R20-06-1902) and it has worked well. If needed for reporting purposes, DIFI could require the plans to include its definition of these terms in their parity filing to provide ease of reference for DIFI.

Confusion of Terms "Health Plan" and "Network Plan"

R20-6-1302. B. requires that a health insurer submit a report for all health plans it offers in the state with some listed regulatory exceptions. Later in Section D., the rule requires the health care

[1] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

insurer to file based on fully insured network type. The authorizing statute uses the term "Product network type" to define the reports that are to be submitted. The health plans believe the statute requires reporting on a network basis, not on a plan-specific basis. The purpose of this statutory definition was to limit excessive filings by health plans. We do not believe the intent of the statute is to require health plans to submit filings on each and every large group plan even though they rely on the same network type to provide coverage. Providing reports for each plan is overly burdensome and duplicative because they will rely on a similar analysis. The health plans believe that network-based reporting requirements will provide DIFI with the data the agency needs while limiting the time and expense of preparing plan-specific documents that are consistent at the network level of analysis. The plans suggest that R2-6-1302 B. be revised to make it consistent with the authorizing state statute and the provisions in R20-6-1302 D.

Confidentiality of Data

ARS 20-3502 (G). provides that filings made by health plans shall remain confidential. However, the rule contains no provisions describing how DIFI will protect data confidentiality in the rule. We suggest that the rule be augmented to describe how the confidentiality protections will be implemented. In lieu of a rule, DIFI could consider issuing a Bulletin and other guidance documents describing the confidentiality protections. Historically, DIFI has a strong record of protecting confidential and trade secret documents, and we are optimistic this will occur with filings required under Jake's Law.

Part II; Medical Necessity Criteria. Instructions for Part II.

To reduce the regulatory burden on health plans, this section should be modified to allow health plans to utilize the NQTL analysis of their medical management techniques to satisfy the reporting requirements of this section. This will streamline the filing process. DIFI can request supplemental information if the NQTL analysis for medical management techniques is inadequate.

Part IV: Demonstrate Parity through Analysis. Instructions for Part IV.

Instructions for Part IV appears to require some customized reporting for Arizona that is different from the federal reporting requirements. While the reports are similar to the federal requirements, the health plans suggest that the NQTL analysis document report format mirror the federal reporting requirements.

In addition, Part IV requires health plans to report the qualitative and quantitative statistical data utilized to demonstrate each NQTL listed in Part III. This requirement exceeds the statutory requirements set forth in SB 1523 and is overly burdensome for plans to comply with for each filing. A more appropriate approach would be to request the statistical data only after DIFI has reviewed the initial filings and determines that the insurer's response warrants additional statistical support. This approach will limit size and scope of the standard filings but still provide data that

DIFI needs on a case-by-case basis. The health plans believe that supplementing files on a case-by-case basis is the least burdensome approach to effectuate the intent and purpose of Jake's Law.

Some of the health plans would like some definitional clarity on the term "Strategy". It is unclear what the term "Strategy" means and believe that an additional definition or examples would improve the clarity of this section of the rule.

Technical Comments

R20-6-1303 A. could be written to be more clear, concise, and understandable. Typically, it is not the insurer that is exempt from filing, but the insurer's policy form.[2] If additional disclosure is needed to highlight the exempt products and plans, the health plans could augment their annual report of exempt policy forms to require an additional MHPAEA attestation for the plans and products that are exempt. We recommend the following language be adopted:

A. A health care insurer that issues health plans in Arizona ~~and is not exempt from the form filing requirement~~ shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Division FOR POLICY FORMS THAT ARE NOT EXEMPT FROM FILING REQUIREMENTS. FOR ANY SUCH EXEMPT POLICY FORMS THAT WOULD OTHERWISE BE SUBJECT TO THESE RULES, THE HEALTH CARE INSURER SHALL INCLUDE, IN ITS ANNUAL CERTIFICATION OF COMPLIANCE FOR EXEMPT POLICY FORMS, AN ATTESTATION OF COMPLIANCE WITH MHPAEA.

R20-6-1303.C could require substantial and burdensome reporting, depending on what the DIFI chooses to require, which is unclear from the language about "a report." Assuming that the term "large group health plan" includes an employer with 100 or more employees, many insurers in the state issue hundreds of large group health plans, as one employer might offer multiple plan options. Many large plans are already exempt from policy form filing, and would be covered by the proposed revised language for subsection (A) above. For those not exempt (i.e. health care service organization policy forms), the DIFI could require a similar attestation, and could require health insurers to submit the underlying analysis on an as-needed basis.

C. Separate consolidated report for large group health plans. TO THE EXTENT NOT ALREADY PROVIDED UNDER SUBSECTION (A), The Division may require a health insurer that issues large group health plans to file aN ATTESTATION OF compliance with the substantially all and predominant tests.

[2] 150005-05042015115519 (2)_0.pdf (az.gov)

R20-6-1304 Additional Information or Data is a section that has pulled language directly out of the statute. We are not sure this provision is needed in the rule because the statute is clear that the Department has the authority to make additional information requests.

Thank you for the opportunity to submit these comments. We look forward to future dialogue on the development of the rules implementing Jake's Law.

Sincerely,

Dr. Marc Osborn
Senior Director of Government Affairs