March 2, 2022

Evans G. Daniels, Director
Arizona Department of Insurance and Financial Institutions
100 North 15th Avenue, Suite 261
Phoenix, AZ 85007

Dear Director Daniels,

On behalf of the Board of Directors for Mental Health America of Arizona (MHA Arizona) and the Arizona Council of Human Service Providers (the Council), we want to thank you for your consideration of our comments regarding the proposed rule operationalizing Laws 2020, Chapter 4 (SB 1523), also known as "Jake's Law." As mental health advocates and providers, we are disappointed and deeply frustrated with the industry's repeated attempts to undermine the intent of Jake's Law which is, and has always been, to enforce federal law and ensure transparency and accountability, especially where the most profound and consequential barriers to mental health and addiction coverage occur – medical necessity criteria and other nonquantitative treatment limitations (NQTLs).

MHA Arizona and the Council supported the rulemaking package the Department of Insurance and Financial Institutions (DIFI or the Department) first developed in March 2021. We were disappointed with the enormous backwards pivot in the current proposal because it eliminates important oversight of NQTLs. We disagree with the industry's assertions that the March 2021 proposal exceeded DIFI's statutory authority and is overly burdensome. However, we believe the current proposal will still go a long way to achieving our goal of transparency and accountability and vociferously oppose any proposed changes requested by the industry in their response to the current proposal.

As evidenced by the disparity between the likelihood of going out-of-network for mental healthcare versus medical/surgical care, Arizonans continue to experience barriers to access for mental health treatment even when they have private insurance. We believe one reason for this disparity is due to how health plans operationally apply NQTLs. Unfortunately, the health plans have attempted to undermine the examination of NQTLs from the outset and continue to do so. In their response to the original draft proposed rules from March 2021, the health plans inaccurately claim that the Department exceeded its authority under federal parity regulations and state statute. Those claims seem to have resulted in the Department's massive departure from the original draft.

We know that access to mental healthcare remains an enormous issue for Arizonans. According to Mental Health America's 2021 State of Mental Health in America report, Arizona ranks 40th in the country for access to care and 49th for youth mental health.[1] People with insurance experience

[1] https://mhanational.org/issues/2021/mental-health-america-youth-data

significant difficulty locating in-network providers and facilities for mental health care compared to general or specialty medical care (inpatient and outpatient).[2] Indeed, the disparity uncovered by Milliman Research, is shocking. Arizonans are 10x more likely to go out-of-network for inpatient behavioral health facilities than med/surg facilities. Additionally, Arizonans are 6.69x more likely to go out-of-network for outpatient behavioral health facilities[3]. These statistics are indicative of the desperate need Arizona has to look under the proverbial hood of health plans purporting to provide mental health coverage at parity and hold accountable those who are failing.

Our organizations advocated fiercely for the passage of Jake's Law during the 2020 Legislative Session. We participated in stakeholder meetings on our own behalf and as part of a coalition with other advocacy organizations like the JEM Foundation. Our recollection of the stakeholder process was strong opposition by the insurance industry to the inclusion of data collection regarding NQTLs. In fact, in one of their proposed amendments, they suggested eliminating the NQTL provisions entirely. We, and many other advocates, successfully fought for the inclusion of the NQTL provision knowing that many patients experience disparity in how NQTLs, like medical management standards, are applied for mental health and substance use treatment. In fact, during their testimony before four separate legislative committees, Jake's parents described how their son needed additional in-patient treatment for his mental health condition but despite his doctor's insistence about the medical necessity of such treatment, the insurance company denied coverage as not medically necessary. His young life ended at the age of 15 and, sadly, his is NOT an uncommon story. The industry's strong opposition against the original proposed rules, as articulated in their 28-page public comment dated March 12, 2021, and the resulting elimination of a wealth of data collection on NQTLs in the new draft rule is a major blow to that hard fought and won battle.

In their comment to the Department regarding the original draft rules from March 2021, the health plans argued that the Department far exceeded federal regulations and its statutory authority. MHA Arizona strongly disagrees with this assertion. ARS 20-3502(F) clearly states, "the department is not prohibited from otherwise requesting information or data that is necessary to verify compliance with the mental health parity and addiction equity act or this chapter."[4] Further, the health plans additionally claim that statute and federal regulation merely require that health plans report "a list of plan benefits and an identification of which NQTLs apply." They additionally assert that federal regulation and state statute require only an analysis of the "process, not outcomes." Jake's Law and federal guidance suggests that both are required. ARS 20-3502(B)(3) requires demonstration through analysis the application of NQTL's "as written and in operation." The term "in operation" is so important to federal regulators that it was emphasized in bold and underline throughout the self-compliance tool developed by the United States Department of Labor. The tool explicitly states in several places that "while outcomes are NOT determinative of compliance" they "may be reviewed as a warning sign, or indicator of potential operational MHPAEA parity noncompliance." DOL additionally states, "While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance."[5]

---

[2] https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf

[3] https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

[4] https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/20/03502.htm

[5] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

In their comments regarding the current proposed rules, which were released in draft form and dated November 1, 2021, the industry pushed back on definitions of medical necessity and medically necessary. This is deeply concerning to mental health advocates and providers as we know that medical necessity criteria, among other nonquantitative treatment limitations, are where the most profound and consequential barriers to mental health and addiction coverage occur. In fact, Jacob Edward Machovsky's case is a precise illustration of how medical necessity criteria was used to justify the insurance company's denial for in-patient treatment. Jake unnecessarily died at the age of 15 despite his doctors and parents fighting for his life and this law and its rules are meant to help prevent such discriminatory claims denials from occurring. While plan policies may look superficially compliant, inequities often exist in how benefits are being applied "in operation." The industry boldly claims in their comments that only their medical professionals are capable of developing definitions of medical necessity and medically necessary.

> *"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." (Marc Osborn's letter dated November 30, 2021, on behalf of the industry)*

This is a paternalistic, outrageous, and circuitous claim and belies the agency's purpose to regulate the activities of the industry. This claim suggests that the agency established to regulate its activities is not only ill-equipped to do so but should not even try. As advocates seeking transparency, especially regarding medical necessity criteria and NQTLs, we reject this notion and ask that you do so as well. Further, the definition of medical necessity within the definition of "nonquantitative treatment limitation" provided in the proposed rule comes directly from the United States Department of Health and Human Services code of federal regulations of mental health parity:

> *"(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include— (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; (B) Formulary design for prescription drugs; (C) Standards for provider admission to participate in a network, including reimbursement rates; (D) Plan methods for determining usual, customary, and reasonable charges; (E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)"(45 C.F.R.146.136)*

This same standard is additionally used in the Department of Labor's self-compliance tool. Further, insurers cannot claim in good faith claim, as they have tried, that the definition of medical necessity in the proposed rule is not "consistent with the intent of the authorizing legislation, nor is it the least burdensome approach" because the purpose of Title 20, Chapter 28, is compliance with the federal law as stated in 20-3502(A), "Each health care insurer that issues a health plan in this state shall comply with the mental health parity and addiction equity act." It would be disingenuous to suggest that the implementing federal regulation is somehow not within the scope of the law, especially since the definition of the mental health parity and addiction equity act in 20-3501 includes "implementing regulations." Additionally, the importance of these provisions and the intent of the legislature to allow

DIFI to have robust purview over medical necessity criteria is clear. Not only is each report under 20-3502 required to include the process used to develop or select medical necessity criteria but subsection E requires insurers to file a summary of any changes to medical necessity criteria in years in which the report is not required to be filed. Advocates fought to ensure transparency over medical necessity criteria, and we ask that you do not yield authority over this to the insurance industry regardless of the false claims they made in their letter regarding the proposed rules.

The industry's suggestion regarding Medical Necessity Criteria Instructions for Part II is inconsistent with the underlying state law and we ask DIFI to ignore it (20-3502(B)(1)).

The industry's response with regard to Part IV suggests that "qualitative and quantitative statistical data" demonstrating each NQTL exceeds statutory authority and is overly burdensome. The industry is once again attempting to undermine the intent advocates fought so hard to protect with regard to transparency within NQTLs. It is also demonstrably false. 20-3501 defines treatment limitations as "both quantitative treatment limits that are expressed numerically and nonquantitative treatment limits that otherwise limit the scope or duration of benefits for treatment under a health plan." As any public policy professional can attest, nonquantitative information is inherently qualitative but can sometimes additionally be expressed through statistical data. Further, 20-3502 requires that health plans "demonstrate through analysis" nonquantitative treatment limitations "as written and in operation any process, strategy, evidentiary standard or other factors." It is clear that the proposed rules do not exceed statutory authority and that it is not overly burdensome. It is, in fact, necessary for the full implementation of Jake's Law. We reject the industry's assertion that the more appropriate approach is to request this data after initial filing, and we request that you do the same. This is yet another attempt by the industry to limit transparency into NQTLs with nonsensical legal arguments.

Insurers have requested further clarity and definitions surrounding terms like "strategy" used in the proposed rulemaking package but over the last year, each attempt by DIFI to operationalize Jake's Law, which was structured using terminology from federal law and regulation, with such clarity is met with opposition by the industry as "overly burdensome" or "exceeding" the agency's "statutory authority." The terms strategy and strategies are used throughout the federal parity law and its implementing regulations, guidance, and self-reporting tools. As such, we believe there is a common meaning and understanding.

MHA Arizona and the Council are deeply concerned about the industry's repeated assault on transparency and accountability, particularly around NQTLs and medical necessity criteria. They are not working in good faith and are only seeking to undermine the efforts of mental health advocates. They fought advocates during the legislative stakeholder process, attempting to remove nonquantitative treatment limitations from the scope of the law. They disingenuously argued during these same meetings that the bulk of the provisions should be left up to DIFI to determine in the rulemaking process only to then argue repeatedly that DIFI has exceeded its statutory authority with overly burdensome rules. The industry further fought DIFI over the more robust examination of NQTLs in DIFI's March 2021 proposed rules. Now they are fighting to water down the NQTLs and medical necessity criteria in this current draft. Meanwhile, the insurance industry is relentless in creating backstops to meaningful enforcement of state law by using the legislature to unwittingly neuter DIFI's ability to enforce laws like Jake's Law. HB 2599, among many other problematic provisions, will impede DIFI's ability to efficiently hold insurers accountable for patterns of non-compliance (changes

in 41-1009). Many of the arguments the industry used to kill the March 2021 proposed rules are also being codified in this bill (changes in 41-1030, 41-1033). They even go so far as to try to codify that GRRC cannot make a decision based on whether any person commented on the rulemaking (41-1033(L)) which could mean that comments made by advocates like MHA Arizona or the Council could not be weighed in the rulemaking process. These actions, especially in combination, cause us great concern over the future of Jake's Law and its ability to be meaningfully enforced.

Advocates are weary of fighting for meaningful reform only to be met at every possible juncture with bureaucratic obstacles erected through the orchestration of the insurance industry for their own benefit. Organizations like ours are no match for their power and influence. These tactics, as they've continuously played out through the entire process of enacting Jake's Law and its rules, demonstrate that insurers are afraid of what regulators will find beneath the proverbial hood of their plans. Please hold them accountable and do not relent to their continued aggressive lobbying against meaningful transparency and accountability.

Respectfully,

Ericka Irvin
Executive Director, MHA AZ

Candy Espino
President and CEO, Arizona Council of Human Service Providers

Enc: 2021-2022 Arizona Council Members

2021-2022 ARIZONA COUNCIL MEMBERS

Full Voting Members

A New Leaf
Alliance Behavioral Care
Amity Foundation
Arizona Behavioral Health Corporation
Arizona Complete Health
Arizona Health Care
Arizona Women's Recovery Center
Arizona Youth and Family Services, Inc
Arizona's Children Association
Banner University Health Plans
Beia's Families
Calvary Healing Centers
Caring Connections for Special Needs
Casa de los Niños
ChangePoint Integrated Health
CHEEERS
Chicanos Por La Causa
Child and Family Resources, Inc
Child and Family Services of Yuma
Child and Family Support Services, Inc
Chiricahua Community Health Centers, Inc
CODAC Health, Recovery, and Wellness, Inc
Community Bridges
Community Health Associates
Community Medical Services
Copa (formerly Marc Center)
Cope Community Services
Crisis Preparation and Recovery
Desert Star Addiction Recovery Center
Easter Seals Blake Foundation
Empowerment Systems, Inc
Equality Health
Family Involvement Center
Family Service Agency
Family Service Aides
Health Choice Arizona
Helping Associates
Helping Ourselves Pursue Enrichment (HOPE), Inc
Horizon Health and Wellness
Human Resource Training
Hushabye Nursery
InterMountain Centers for Human Development
Jewish Family and Children's Service of Southern AZ
Jewish Family and Children's Services
La Frontera Arizona, Inc
Lifeline Professional Counseling Services
Lifewell
Little Colorado Behavioral Health Centers
Lutheran Social Services of the Southwest
Mentally Ill Kids In Distress (MIKID)
Mercy Care
Mingus Mountain Academy
Mohave Mental Health Clinic, Inc
Molina Complete Care of Arizona
Onward Hope
Pathways of Arizona, Inc
Pinnacle Peak Recovery
Polara Health
Pynn and Associates
Recovery Empowerment Network (REN)
Resilient Health (formerly PSA)
RI International
Rio Salado Behavioral Health Services
Rise Services
SEEK Arizona
Solari Crisis & Human Services
Sonoran Prevention Works
Southwest Behavioral and Health Services
Southwest Human Development
Southwest Network
Spectrum Healthcare
STAR—Stand Together and Recover Centers
Sunset Community Health Centers
Terros Health
The Devereux Foundation
The Guidance Center
The Haven
Touchstone Behavioral Health
United Health Care Community Plan
Valle Del Sol
Valleywise Health (formerly MIHS)
Youth Advocate Program, Inc
Youth Development Institute
Zarephath

Associate Members

Arizona Health Reciprocal Insurance Company
Arizona Public Health Association
Center for Applied Behavioral Health Policy, ASU
Credible Behavioral Health Software
Health Current
Health Information Management System
innovaTel Telepsychiatry
iTether, LLC
Mutual Of America
Netsmart
Paxis
Qualifacts
Southwestern Provider Services, Inc
Streamline Healthcare Solutions
The Mahoney Group
Vantage Point Behavioral Resources, PLLC