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November 29, 2021

Dr. Leanette Henagan
Behavioral Health Program Administrator
Arizona Department of Insurance and Financial Institutions

Submitted electronically via email to public_comments@difi.az.gov

Re: MHPAEA II Draft Rule

Dear Dr. Henagan:

Thank you for the opportunity to provide comments in response to the Arizona Department of Insurance and Financial Institutions' ("DIFI") draft regulations ("draft rule") implementing Arizona SB 1523 (Chapter 4, Laws 2020) released November 1, 2021. Medica (also referred to as "we," "our," or "us,") is an independent and nonprofit health care organization with approximately 900,000 members, and is proud to be a new entrant to the Arizona individual health insurance market. Medica's mission is to be the trusted health plan of choice for customers, members, partners, and our employees. Medica offers health insurance coverage in Minnesota, Wisconsin, North Dakota, South Dakota, Iowa, Nebraska, Kansas, Oklahoma, and Missouri.

Medica appreciates DIFI's engagement with health care insurers on this subject. We understand the importance of ensuring compliance with MHPAEA, and we are familiar with a number of different approaches adopted by states to evaluate MHPAEA compliance.

Our comments and recommendations to the draft rule are divided into two categories: recommending alignment with federal law; and offering specific changes to the draft rule. We also have included a redline version of the draft rule to illustrate our recommended changes identified in section II of this letter.

Accordingly, on behalf of Medica, I respectfully submit the following comments to DIFI:

I. ALIGNMENT TO FEDERAL LAW AND REQUIREMENTS

We recommend DIFI align the draft rule with federal MHPAEA regulations and requirements. Congress amended the ERISA, IRC, and PHSA in 2020 to require issuers in the fully-insured and self-insured markets to be able to complete comparative analyses at the request of federal or state regulators on Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") compliance.[1] Rather than creating its own format for reporting, we recommend DIFI leverage the federal reporting structure through these comparative analyses.

[1] 42 U.S.C. § 300gg-26.

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We also noted instances where the draft rule does not match the federal regulations on MHPAEA.[2] Inconsistencies in the language may create confusion and inconsistency in reporting. We have indicated our recommended changes to align with the federal regulations in our attached redline of the draft rules. Per requirements in the federal Consolidated Appropriations Act, we also expect the U.S. Department of Labor ("DOL") and U.S. Department of Health and Human Services ("HHS") to release additional subregulatory guidance and rules on MHPAEA by July 1, 2022, so our recommended language is based on the regulatory text as it appears in the Code of Federal Regulations on November 29, 2021. If the federal agencies revise the regulations in 2022, as expected, we would encourage DIFI to also adopt those changes.

Thus, to ensure alignment and consistency with federal law, we recommend DIFI either revise the proposed rule to reference federal law, or suspend rulemaking temporarily until the federal government completes its rulemaking. As a health care insurer offering fully-insured products across 10 different states, we recommend alignment so that we do not have to create unique reporting processes for each state.

II. SPECIFIC CHANGES

Medica offers several drafting suggestions in our attached redline to improve the alignment with federal regulations on MHPAEA and ease insurers' compliance burdens.

A. R20-6-1301. Definitions

We recommend DIFI update the cross-reference in the definition of "coverage unit" from 146.136(a) to 146.136(c). The definition in 45 CFR 146.136(a) for coverage unit cross-references to the definition in 45 CFR 146.136(c), and this change would ensure readers can find the appropriate definition quickly.

We recommend DIFI revise the definition of "HHS MHPAEA tool" to reference the DOL's self-compliance tool.[3] We are unaware of a MHPAEA tool offered by HHS, and believe DIFI intended to reference the DOL self-compliance tool. The references to "HHS MHPAEA tool" should also be changed in R20-6-1310(B) to align with this change.

Additionally, the draft rules uses the term "health care insurer" to refer to the entities that offer health plans subject to the Arizona Mental Health Parity Act. The draft rule, however, often uses the terms "health insurer" or "insurer" when referring to the regulated entities. We recommend the draft rule be revised to use the define term of "health care insurer" instead of "health insurer" or "insurer," and our attached recommended changes include this technical suggestion.

[2] 45 CFR § 146.136.
[3] *See* https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

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We respectfully request DIFI remove the definition of "medical necessity" or "medically necessary." We question the need to define medical necessity in the rule while federal regulations do not define this term. We also question why the definition differs significantly from the medical necessity definition in state law (Ariz. Rev. Stat. § 20-3401(8)). Creating two competing definitions of medical necessity creates confusion as to which definition applies in which circumstances and may work against the goal of applying parity in how medical necessity is determined for medical / surgical services and behavioral health services. Additionally, the Arizona legislature did not direct DIFI to adopt this definition of medical necessity or medically necessary.

We noted several instances in which the draft rules combine several definitions from the MHPAEA regulations. For clarity and alignment, we recommend DIFI revise the draft rule to separate the definitions, such as by removing the phrase "a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage" from the "Nonquantitative treatment limitation (NQTL)", and creating a definition of "treatment limit." Additionally, the draft rule includes definitions for the "predominant test" and the "substantially all test;" while the text aligns with the federal MHPAEA regulations, the federal regulations do not delineate the tests in the definitions, but rather, codify them in the substance of the rule for clarity. We have found it easier to understand our obligations when these kinds of tests are included in the substantive text rather than in the definitions section.

B. R20-6-1302. Medical Necessity Criteria and NQTL Reporting

We recognize the importance of establishing clear standards for analyzing a plan's compliance with MHPAEA. Medica, like many other plans, have built infrastructure and processes around our obligations under MHPAEA and closely monitor federal regulatory requirements. As a plan offering coverage in multiple states, we have experience with the different approaches states have taken to measuring and assessing plans' compliance with MHPAEA. To ease the compliance burden of the health care insurers offering products in Arizona and in other states, we recommend Arizona requires carriers to submit the comparative analysis to DIFI, instead of the information required in Exhibit A, which was codified in the Consolidated Appropriations Act of 2021 (Pub. L. 116-260) and effective February 10, 2021. Health care insurers in the fully-insured and self-insured markets already must make available the comparative analyses and the following information:

> (i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use order and medical or surgical benefits to which each such term applies in each respective benefits classification.
> (ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
> (iii) The evidentiary standards used for the factors in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.
> (iv0 The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use

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> disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.
> (v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.[4]

Given that the federal agencies have requested such comparative analyses from health care insurers in 2021 to support their public report, due December 27, 2021, we recommend DIFI contact the federal agencies to determine in what form and manner they requested this information from health care insurers, and adopt those standards into the draft rule. This would ease the compliance burden on health care insurers, and ensure consistency between federal and state reporting on MHPAEA NQTL compliance.

If DIFI does not adopt our suggestion to align with the federal MHPAEA comparative analyses, we recommend DIFI clarify the draft rule. The draft rule proposes to require health care insurers to complete a separate report for all health plans it offers in the state. While Medica will be offering only individual market coverage in Arizona in 2022, we are unclear how to aggregate the data. We recommend DIFI clarify that health care insurers must submit separate reports for each different product, which could be accomplished by referencing the definition in 45 C.F.R. § 144.103. Medica submits MHPAEA compliance information to the state of Oklahoma, and we recommend DIFI consider following their data collection process for plans and products. The Oklahoma reporting requires health care insurers to cross-walk the health plans into the health product on one tab, and uses a second tab to identify the NQTLs which apply to all the health plans. The Oklahoma instructions and templates are available online.[5] We also recommend DIFI clarify that health care insurers only have to report differences in the NQTLs between health plans, rather than submitting identical information for all health plans within the same product.

Additionally, we recommend DIFI clarify how the annual report and the triennial report relate to and differ from each other. We recommend DIFI require the health care insurer to complete more reporting in the triennial report, and submit an annual report only if there were changes in the NQTLs in the previous year. We also suggest DIFI revise the draft rule to require reporting in May, rather than March. Claims processing and run-out from the previous year often occurs until the end of March in the next year, so requiring reporting on March 15 annually would not allow health care insurers the time needed to include the totality of information from the prior year.

[4] Consolidated Appropriations Act, 2021, Division BB, Title II, Section 203 (amending Public Health Services Act section 2726(a), ERISA section 712(a), and IRC section 9812(a)).
[5] https://www.oid.ok.gov/regulated-entities/financial/financial-regulation-forms/mentalhealthparity/.

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We suggest DIFI identify the health care insurer's compliance officer as the individual required to submit an attestation on MHPAEA compliance. This clarification would assist health care insurers in their annual planning.

Finally, we suggest DIFI amend paragraph (G) to address two issues. First, in the final sentence, we recommend DIFI clarify that it will establish a reasonable deadline for the insurer to respond, which will depend on the scope of information requested. Second, we recommend DIFI clarify that it will use the same format required for the comparative analysis under the Consolidated Appropriations Act of 2021 (Pub. Law. 116-260) for its data requests. Insurers have to manually complete MHPAEA reports, as there is no automated solution to support MHPAEA supporting. If, however, DIFI does not support using the comparative analysis format, we recommend DIFI use either Excel of Word documents. We ask that DIFI account for the time required to complete any manual reporting.

C. R20-6-1303. FR and QTL Reporting

We appreciate DIFI including examples of financial restrictions and qualitative treatment limits, but recommend DIFI remove them entirely, and cross-reference the examples in the federal regulations, or move them to subregulatory guidance, such as a bulletin or an FAQ. This would allow the state's examples to align with the examples provided by the federal regulators and ensure continuity in interpretations without needed to update the Arizona regulation. We also noted the draft rule's example for prescription drug classification in paragraph (D) did not recognize that the decision to tier a prescription drug formulary is an NQTL, not a QTL, and is therefore subject to different tests.

D. Exhibit A. Medical Necessity Criteria and NQTL Reports.

We strongly encourage DIFI to revise its reporting requirements for NQTLs and not adopt Exhibit A as included in the draft rule, in accordance with our previous recommendations. Postponing the finalization of this draft rule until the federal regulators complete their new regulations and subregulatory guidance on MHPAEA reporting would ensure continuity with federal enforcement, and ease compliance burdens on health care insurers.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail.

Sincerely,

Jay McLaren

Jay McLaren
Vice President, Public Policy and Government Relations

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE
ARTICLE 13. MENTAL HEALTH PARITY

Section
R20-6-1301. Definitions
R20-6-1302. ~~Medical Necessity Criteria and~~ NQTL Reporting
R20-6-1303. FR and QTL Reporting
R20-6-1304. Additional Information or Data
~~Exhibit A. Medical Necessity Criteria and NQTL Reports~~

ARTICLE 13. MENTAL HEALTH PARITY

R20-6-1301. Definitions

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

"Arizona Mental Health Parity Act" means the statutes found at A.R.S. §§ 20-3501 through20-3505.

"Coverage unit" has the meaning prescribed at 45 C.F.R. § 146.136(c)(1)(iv)~~(a)~~ "Coverage unit."

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Emergency care" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(5).

"Financial requirements (FR)" has the meaning at 45 C.F.R. § 146.136(a) "Financial requirements."

"Health care insurer" has the meaning prescribed at A.R.S. § 20-3501(2).

"Health plan" has the meaning prescribed at A.R.S. § 20-3501(3).

"~~HHS~~ DOL MHPAEA tool" means the Mental Health Parity tool offered by the U.S. Department of Labor ~~Department of Health and Human Services~~.

"Inpatient, in-network benefits" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(1) ~~are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan~~.

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"Inpatient, out-of-network benefits" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(2)~~are benefits furnished on an inpatient basis by providerswithout a contract under a health plan or for a health plan that has no network of providers~~.

~~"Medical necessity" or "Medically necessary" means an item or service is from a provider who is exercising prudent clinical judgment, is safe and effective, is not experimental or investigational, and is appropriate. An appropriate item or service is appropriate in duration and frequency, is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition, is furnished in a setting appropriate to the patient's medical needs and condition, is ordered and furnished by qualified personnel, meets, but does not exceed, the patient's medical need, and is at least as beneficial as an existing and available medically appropriate alternative.~~

"Medical/surgical (Med/Surg) benefits" has the meaning prescribed at 45 C.F.R. § 146.136(a) "Medical/surgical benefits."

"Mental (MH) health benefits" has the meaning prescribed at 45 C.F.R.§ 146.136(a) "Mental health benefits."

"MHPAEA" means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

"Nonquantitative treatment limitation (NQTL)" ~~is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs~~ are treatment limitations that include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigativeas identified under 45 C.F.R. 146.136(c)(4)(ii)(A); formulary design for prescription drugs asidentified under 45 C.F.R. 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 C.F.R. 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified under 45 C.F.R. 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45
C.F.R. 146.136(c)(4)(ii)(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") as identified under 45 C.F.R. 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 C.F.R. 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than

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limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 C.F.R. 146.136(c)(4)(ii)(H).

"Outpatient, in-network benefits" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(3)~~are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan~~.

"Outpatient, out-of-network benefits" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(4)~~are benefits furnished on an outpatient basis and outsideany network of providers established or recognized under a health plan or under a health planthat has no network of providers~~.

"Predominant test" has the meaning prescribed in 45 C.F.R. § 146.136(c)(3)(i)(B).

"Prescription drugs" has the meaning prescribed in 45 C.F.R. § 146.136(c)(2)(ii)(A)(6).

"Quantitative treatment limitation (QTL)" is a limitation on the scope or duration of a benefit that can be expressed numerically that includes financial requirements, and day or visit limits such as "50 outpatient visitsper year." QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

"Substance use disorder (SUD) benefits has the meaning prescribed at 45 C.F.R.§ 146.136(a) "Substance use disorder benefits."

"Substantially all test" has the meaning prescribed in 45 C.F.R. § 146.136(c)(3)(i)(A).

"Treatment limitations" has the meaning prescribed in 45 C.F.R. § 146.136(a).

R20-6-1302. ~~Medical Necessity Criteria and~~ NQTL Reporting

A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Division.

B. Health plans subject to reporting. A health care insurer shall submit a separate report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (B)(4) of this Section. If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a report for each variation.

1. The health plan offers either MH or SUD benefits in addition to Med/Surg benefits.

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2. The health plan offers either MH or SUD benefits in any one of the following classifications:
   a. Inpatient, in-network;
   b. Inpatient, out-of-network;
   c. Outpatient, in-network;
   d. Outpatient, out-of-network;
   e. Emergency care; or
   f. Prescription drugs.
3. The health plan is offered on a group (large or small) or individual basis.
4. The health plan has not received and notified the Division of an increased cost exemption pursuant to 45 C.F.R. 146.136(g).

C. Health plans exempt from reporting. A health plan that meets the criteria of Subsection (B) above is exempt from reporting under this Article if it is one of the following types of health plans:
1. A small group grandfathered health plan; or
2. A health plan that meets the definition of excepted benefit provided in 45 C.F.R. 146.145(b) or 45 C.F.R. 148.220.

D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona that complies with the requirements of 42 U.S.C. 300gg-26(a)(8) and any implementing regulations or subregulatory guidance thereof. If the information to be reported varies bynetwork or health plan, or varies in the individual, small group or large group market, the

health care insurer must file a separate report for each variation.

~~**E.** Triennial Reports.~~

~~1. Existing health care insurers. Beginning on March 15May 1, 2023 and every third year thereafter,a health care insurer issuing health plans and collecting premium in Arizona as of January1, 2022 shall file a triennial report with the Division for each health plan subject to reporting.~~

~~2. Entering or re-entering health care insurers. On or before March 15 May 1 of the second year anentering or re-entering health care insurer issues health plans and collects premiums in Arizona, a health care insurer shall file an original triennial report with the Division for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1) of this Section.~~

~~3. Due date for triennial reports. Triennial reports are due on or before May 1March 15 of each reporting year.~~

~~4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Division under A.R.S. § 20-3502(B) that provides the required information in Exhibit A.~~

~~5. Subsequent triennial reports.~~

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a. A health care insurer must file an updated triennial report, including the information required in Exhibit A, unless the insurer can attest that it has made no changes since the previously filed triennial report.
b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Division for each health plan subject to reporting:
i. An updated triennial report, including the information required in Exhibit A; or
ii. The last triennial report filed with the Division and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.

F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), starting May 1, 2023, and on or before March 15 May 1 of the third each intervening year between the filing of a triennial report, a health care insurer shall file :
1. A report that summarizes any changes made to its medical necessity criteria and NQTLs (Exhibit A, Parts I, II, and III) that complies with the requirements of 42 U.S.C. 300gg-26(a)(8) and any implementing regulations or subregulatory guidance thereof;
2. A written attestation signed by the compliance officer that the insurer is in compliance with MHPAEA.; and
3. If requested, any additional data required by the Division including Exhibit A, Part IV.

G. Interim Reports. A health care insurer shall submit a report summarizing any changes made to its NQTLs in the previous year by May 1 of the year after.

H. Additional information. At any time after an insurer files a report under this Section, the Division may request additional information, including an updated triennial or annual report, by contacting the health care insurer and making the request in writing. The health care insurer shall provide contact information to the Division when it files any of the reports required by this Section. The Division may set a reasonable deadline for a health care insurer to respond to its request, which shall be adjusted depending on the complexity and amount of information requested by the Division, and specify the format for the response.

R20-6-1303. FR and QTL Reporting

A. Method of reporting. 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.

B. Division's authority to require additional data. In addition to the forms filed by a health insurer, the Division may require a health care insurer to submit additional data relating to itsmethods for meeting, and complying with, the MHPAEA FR and QTL standards. The

Division may also utilize the HHS DOL MHPAEA tool and request samples of a health care insurer'sinternal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.

C. Separate consolidated report for large group health plans. The Division may require a health care insurer that issues large group health plans to file a report that demonstrates compliance

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with the substantially all and predominant tests within each classification of benefits for health planswith similar benefit structures.

~~**D.** Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as follows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name Drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.~~

~~**E.** Special rules for FRs and QTLs.~~

~~1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has 2 tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network classifications are divided into 2 subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.~~

~~2. Outpatient Classifications. The sub-classification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into 2 subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.~~

~~The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are: 1. Office visits (such as physician visits); and 2. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).~~

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R20-6-1304. Additional Information or Data

Pursuant to A.R.S. § 20-3502(F), the Department is not prohibited from otherwise requesting information or data that is necessary to verify compliance with MHPAEA and the Arizona Mental Health Parity Act.

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Exhibit A
Medical Necessity Criteria and NQTL Reports

Instructions for Exhibit A:
Submit an Exhibit A for each fully insured health plan subject to reporting under Section R20-6-1303(B). Please submit the information in a word-searchable PDF file which is organized and identified in accordance with the numbered sections that appear below.

Part I: Identify Plan and Reporting Year.
Instructions for Part I:
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types:	☐PPO	☐HMO (HCSO)

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~~(Check all that apply)~~	~~☐POS~~	~~☐Indemnity~~

~~**Part II: Medical necessity criteria.**~~
~~**Instructions for Part II:**~~
~~To comply with A.R.S. § 20-3502(B)(1), describe the process that is used to develop or select medical necessity criteria for the plan and reporting year identified in Part I. When the plan~~

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describes the process used to develop or select criteria for MH/SUD benefits, then it must also describe the process used to develop or select criteria for Med/Surg benefits.

To comply with ARS § 20-3502(B)(1), report:

A. Describe the process used to develop or select medical necessity criteria for MH/SUD benefits.
B. Describe the process used to develop or select medical necessity criteria for Med/Surg benefits.

Part III: Identify all NQTLs.
Instructions for Part III:
To comply with A.R.S. § 20-3502(B)(2), identify all NQTLs that are applied to MH/SUD benefits and all NQTLs that are applied to Med/Surg benefits for the plan and reporting year identified in Part I. NQTLs shall be identified within each classification of benefits.

A. Identify and report all NQTLs applied to MH/SUD benefits

1. All NQTLs applied to In-Patient, In-Network Classification
2. All NQTLs applied to In-Patient, Out-of-Network Classification
3. All NQTLs applied to Out-Patient, In-Network Classification
4. All NQTLs applied to Out-Patient, Out-of-Network Classification
5. All NQTLs applied to Emergency Care
6. All NQTSs applied to Prescription Benefits

B. Identify and report all NQTLs applied to Med/Surg benefits

1. All NQTLs applied to In-Patient, In-Network Classification
2. All NQTLs applied to In-Patient, Out-of-Network Classification
3. All NQTLs applied to Out-Patient, In-Network Classification
4. All NQTLs applied to Out-Patient, Out-of-Network Classification
5. All NQTLs applied to Emergency Care
6. All NQTSs applied to Prescription Benefits

Part IV: Demonstrate parity through analysis.
Instructions for Part IV:

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~~To comply with A.R.S. § 20-3502(B)(3), for **each** NQTL listed in Part III, demonstrate through analysis that the process, strategy, evidentiary standard, and other factor of applying the NQTL to MH/SUD benefits in a classification of benefits, as written and in operation, is comparable to, and applied not more stringently than, any process, strategy, evidentiary standard or other factor used in applying the NQTL to Med/Surg benefits in the same classification. The report should include qualitative and quantitative statistical data to support and explain the analysis.~~

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~~Identify and report on the NQTLs reported in Part III as follows.~~

~~A. Classification - Inpatient, in-network~~

~~1. Process~~
~~a. Process applying NQTL to MH/SUD benefit~~
~~b. Process applying NQTL to Med/Surg benefit~~
~~c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.~~
~~d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.~~

~~2. Strategy~~
~~a. Strategy applying NQTL to MH/SUD benefit~~
~~b. Strategy applying NQTL to Med/Surg benefit~~
~~c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.~~
~~d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.~~

~~3. Evidentiary Standard~~
~~a. Evidentiary standard applying NQTL to MH/SUD benefit~~
~~b. Evidentiary standard applying NQTL to Med/Surg benefit~~
~~c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.~~
~~d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.~~

~~4. Other Factor~~
~~a. Other factor applying NQTL to MH/SUD benefit~~
~~b. Other factor applying NQTL to Med/Surg benefit~~
~~c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.~~
~~d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.~~

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~~B. Classification - Inpatient, out-of-network~~

~~1. Process~~

~~a. Process applying NQTL to MH/SUD benefit~~

~~b. Process applying NQTL to Med/Surg benefit~~

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c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

C. Classification - Outpatient, in-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in

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~~operation, is comparable to and not applied more stringently than to Med/Surg benefits.~~

~~2. Strategy~~

~~a. Strategy applying NQTL to MH/SUD benefit~~

~~b. Strategy applying NQTL to Med/Surg benefit~~

~~c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.~~

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d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

D. Classification - Outpatient, out-of-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

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3. ~~Evidentiary Standard~~
   a. ~~Evidentiary standard applying NQTL to MH/SUD benefit~~
   b. ~~Evidentiary standard applying NQTL to Med/Surg benefit~~
   c. ~~Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.~~

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d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

E. Classification – Emergency care

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

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4. ~~Other Factor~~
   a. ~~Other factor applying NQTL to MH/SUD benefit~~
   b. ~~Other factor applying NQTL to Med/Surg benefit~~
   c. ~~Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.~~

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d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

F. Classification – Prescription benefits

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.