



March 12, 2021

Erin Klug
Assistant Director, Product Filing & Compliance Division
Arizona Department of Insurance
100 N. 15th Ave, Suite 261
Phoenix, AZ 85007

Re: Mental Health Parity Reporting Requirements Proposed Rulemaking

Dear Ms. Klug:

On behalf of America's Health Insurance Plans (AHIP)¹, I am providing comments respectfully opposing the proposed rulemaking regarding the mental health parity reporting requirements.

Health insurance providers are committed to providing safe, evidence-based behavioral health care on par with medical/surgical care, improving behavioral health care quality and outcomes, and eliminating stigma. In recognizing the importance of behavioral health care to ensure good overall physical and mental health, health insurance providers have long supported the increased access provided by the Mental Health Parity and Addiction Equity Act (MHPAEA).

AHIP members remain committed to implementing these protections and innovating improvements in care. The significant increase in the use of mental health and substance use disorder treatment services since the passage of the federal parity law provides strong evidence that MHPAEA is working and providing patients with access to the quality, affordable mental health care they deserve. Furthermore, the Consolidated Appropriations Act of 2021 includes new federal mental health parity provisions and provides the opportunity for federal guidance and individual state reporting requirements to establish a new, uniform, parity reporting requirement that states can now leverage to promote efficiency and uniformity in lieu of costly and duplicative or inconsistent requirements.

In our October 2, 2020 letter to the Arizona Department of Insurance (DIFI), we addressed our concerns regarding the following provisions, which were not addressed in this iteration of the rulemaking:

- **Appointment wait times** - Establishing a maximum number of days that a member may be expected to wait for a visit with a mental health/substance use disorder (MH/SUD) provider by comparing the average wait time for in-network office visits between MH/SUD providers and medical/surgical (M/S) providers, would result in new network adequacy standards being created and would not only go beyond the scope of SB 1523, but also goes beyond MHPAEA. While we are encouraged to see this provision removed from the current iteration of rulemaking, it was replaced with a new network adequacy requirement under Exhibit C, which requires health insurers to report complaints related to network adequacy. This, like the original requirement on appointment wait times, goes beyond the scope of SB 1523 and MHPAEA.
- **New network directory requirements** - The tables requesting active MH/SUD providers be listed in a network directory also appeared to establish new network adequacy standards, which go beyond the scope of SB 1523 and are not parity identifiers under MHPAEA.
- **Prior authorization denial rate reporting** - DIFI proposing a compliance standard that establishes a maximum ratio or percentage by which the prior authorization or claim denial rate for MH/SUD care is likely to exceed the denial percentage for M/S care, does not provide determinative information regarding compliance with MHPAEA.

¹ **America's Health Insurance Plans** is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

- **Reimbursement parity** - Parity under MHPAEA does not mean that reimbursement rates must be the same, and given the variation that occurs when determining provider reimbursement, it would be unrealistic to establish a parity requirement regarding the weighted average of allowed amounts for certain physician types compared to the Medicare allowed amount.
- **Provider credentialing standards** – Setting a compliance standard for credentialing providers and establishing a maximum time frame or ratio by which the average time for the credentialing process for MH/SUD providers that would exceed that of M/S providers is not consistent with the MHPAEA requirement regarding the process for developing and applying standards for provider admission into a health insurer network. be comparable among providers.

Unfortunately, the concerns raised in our original comment letter have not been resolved. Therefore, we respectfully request that the agency to reconsider our original comments as well as some additional concerns we have with the newly proposed rulemaking.

We believe the proposed rulemaking regarding the mental health parity reporting requirements for Arizona include many provisions that go beyond the scope of the federal MHPAEA requirements and do not address the fundamental issue at hand, which is the shortage of behavioral health providers and the need for behavioral health care that is integrated and measurement-based. There is great concern that the proposed reporting requirements do not appear to be useful in determining mental health compliance because there are no standards proposed that can be used to measure compliance with the MHPAEA.

Additionally, there is concern regarding the increased reporting under such rulemaking causing an undue burden on insurers that will be required in order to comply with the rules. For example:

- R20-6-1503 – *Medical Necessity Criteria and NQTL Reporting* appears to require separate reports for all plans, including by network and by individual, small group, and large group categorization, which would cause a high level of reporting for plans. We recommend that DIFI consider reporting requiring reporting for only a subset of products, such as those with the top sales volume.
- R20-6-1504 – *FR and QTL Reporting* appears to prohibit a plan from using subclassifications for generalists and specialists. As MHPAEA permits, insurers currently subclassify OP-Office by PCP and specialty, and by prohibiting plans from using subclassifications, this could lead to insurers having to change the way parity testing is conducted.
- R20-6-1505 – *HEDIS Reporting* appears to require insurers to submit the requested HEDIS measures identified in Exhibit B. However, MHPAEA does not require such reporting to evaluate equivalence in MH/SUD versus Med/Surg benefits and not all plans currently use this reporting. This would only add on to the reporting being requested of insurers in the proposed rulemaking in addition to federal requirements.

We would like the agency to also be aware that with the additional requirements being proposed, insurers will likely incur significant additional administrative costs, including the need to hire more full-time employees, in order to keep up with the incredibly high volume of reporting between the DIFI and the federal government, which likely will have a costly impact on enrollees over time.

Recommendations

Given the short timeframe for promulgating the proposed rules, as an initial recommendation, we would recommend that the agency return the rules, provide reporting requirements that mirror the new federal requirements, and utilize the uniform information and compliance guidance available under the new federal law. In addition, we strongly recommend gathering insight from the Mental Health Parity Advisory Committee prior to submitting newly proposed reporting requirements and holding stakeholder meetings following the enactment of the rulemaking to see where improvement or revision to the rules may be required.

If the intent of the agency is to address network adequacy standards (which given the forms proposed appears to be the case), trying to do so under the pretense of parity is not the appropriate way to

effectuate this intent. AHIP proposes that, before imposing compliance requirements, the agency should get a sense of what is happening in the market by conducting a gap analysis. Without an understanding of how many mental health and substance use disorder providers are practicing in Arizona, it is impossible to understand network adequacy. Also, as mentioned, policymakers and regulators must explore ways to increase the capacity of the behavioral health workforce to give patients better access to these providers.

Finally, any rule or regulation to implement SB 1523 must comply with *41-1052*, specifically *Subsection D.3.*, which states that the council shall not approve the rule unless the probable benefits of the rule outweigh the probable costs of the rule. The agency must demonstrate that it has selected the alternative that imposes the least burden and costs to persons regulated by the rule. As such, AHIP recommends that the agency first conduct a gap analysis before imposing new, burdensome reporting requirements, as some of the requirements proposed far exceed the scope of SB 1523 and the reporting requirements under the MHPAEA.

We understand Kutak Rock LLP has also submitted a letter with the consensus of multiple health insurers' concerns regarding this proposed rulemaking, including similar arguments in greater detail. We ask the agency to consider our comments along with our members' comments before proceeding. Again, thank you for the opportunity to provide comments and recommendations on the agency's proposed mental health parity reporting requirements. AHIP and our members look forward to working with you as this process unfolds.

Please do not hesitate to contact me at sberry@ahip.org should you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Stephanie" followed by a long, horizontal flourish.

Stephanie Berry
Regional Director, State Affairs