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March 12, 2021

VIA ELECTRONIC MAIL

Arizona Department of Insurance and Financial Institutions
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Phoenix, AZ 85007
Public_comments@difi.az.gov

Re: Comments on proposed mental health parity rulemaking

Introduction

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 order to be valid, DIFI's proposed rules must be adopted in compliance with the rulemaking procedures under Arizona's Administrative Procedures Act. A.R.S. § 41-1030(A). Moreover, a state agency must exercise their rulemaking authority "within the parameters of its statutory grant; to do otherwise would usurp its legislative authority." *Canon Sch. Dist. No. 50 v. W.E.S. Constr. Co.*, 177 Ariz. 526, 530, 869 P.2d 500, 504 (1994). To that end, "a rule or regulation of an administrative agency should not be inconsistent with or contrary to the provisions of [the] statute it seeks to effectuate." *Ferguson v. Arizona*

Dep't. of Econ. Sec., 122 Ariz. 290, 292, 594 P.2d 544, 546 (App. 1979). Finally, the proposed rules must meet additional standards and requirements in order to be valid and be approved by the Governor's Regulatory Review Council. These standards require the rules to be: (i) clear, concise and understandable, (ii) the least burdensome and least costly necessary to achieve the underlying regulatory objective, (iii) not more stringent than a corresponding federal law unless the legislature has expressly granted the agency with the authority to exceed the requirements of federal law. A.R.S. § 41-1052(D).

It is the Insurers' position that DIFI's proposed rules generally fail 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.

As explained in detail below, because the proposed rules fail to meet these standards and requirements, the Insurers respectfully request that DIFI withdraw the current proposed rules and prepare revised rules that follow the statutory reporting required by A.R.S. § 20-3502(B) and which mirror federal requirements in the recently enacted federal Consolidated Appropriations Act. This will enable DIFI to fulfill the statutory reported requirements under SB 1523, while affording adequate time to engage in a meaningful stakeholder input process to formalize reporting requirements and compliance standards. The federal reporting requirements under the MHPAEA and related regulations are significant requiring that insurers prepare and submit these reports in the first year of SB 1523's implementation will constitute a large undertaking, but still afford DIFI with significant relevant information.

The proposed rules far exceed DIFI's statutory authority to promulgate MHPAEA compliance reporting.

As enacted in SB 1523, A.R.S. § 20-3502 requires health insurers to comply with the MHPAEA by demonstrating, through reporting, that they do not impose less favorable benefit limitations for MH/SUD benefits than they do for Med/Surg benefits. As noted above, in order to implement this statutory mandate, SB 1523 granted DIFI rulemaking authority to adopt "forms or worksheets that health care insurers must use to prepare the reports required by section 20-3502 . . ." *See* Laws 2020, Ch. 4 § 8. Notwithstanding the foregoing, DIFI "may also allow health care insurers to

demonstrate compliance with . . . section 20-3502 . . . by other means that are at least as comprehensive as the forms or worksheets" promulgated by DIFI. *Id*. Thus, DIFI's statutory rulemaking authority is expressly limited to adopting forms and worksheets required by section 20-3502, or reporting required by the MHPAEA, unless the information is otherwise provided to DIFI. For the following reasons, the proposed rules far exceed this grant of statutory authority.

A.R.S. § 20-3502(B) specifies the allowable content of the required triennial report as follows: "Each health care insurer…shall submit a report…for each fully insured product network type." "Product network type" is defined in A.R.S. § 20-3501(5) as "the network model associated with the type of health plan…" The definition illustrates the meaning of the phrase by referencing preferred provider organization (PPO), health care services organization (HCSO[1]), point-of-service (POS) plan, and indemnity plan.

A.R.S. § 20-3502(B) also provides that if the reportable information varies by market (individual, small group, large group) that the insurer must report on each variation. Therefore, the statute contemplates at most 12 separate reports per insurer, or more for an insurer that offers some other product network type:

Product Network Type➔	PPO	HMO	POS	Indemnity
Market⬇				
Individual				
Small Group				
Large Group				

A.R.S. § 20-3502(B) further limits the scope of information that DIFI may require *as routine reporting* to three specific types of information:

A. A.R.S. § 20-3502(B)(1) – A <u>description of the processes</u> that the insurer uses to develop or select medical necessity criteria for (i) MH/SUD, and for (ii) Med/Surg benefits. If an insurer uses the same process for both Med/Surg and MH/SUD benefits, for all product types and lines of business, this will mean one process description.

B. A.R.S. § 20-3502(B)(2) – <u>Identification of all nonquantitative treatment limits (NQTLs)</u> applied to MH/SUD benefits, and all NQTLs applied to Med/Surg benefits. Both federal law and state law explain that NQTLs are at least the following:

[1] Health care services organization is the Arizona statutory term for what is more commonly referred to as a health maintenance organization, or "HMO". See A.R.S. § 20-1051 et. seq.

- Medical management standards (e.g. precertification, concurrent review, requirements)
- Formulary design
- Network tier designs
- Standards for provider admission to a network, including reimbursement.
- Methods for determining usual, customary and reasonable charges
- Step therapy and fail first protocols
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty
- Any other criteria that limit the scope or duration of benefits

The word "identification" means "an action or process of identifying someone or something"; "a means of providing a person or thing's identity." *See* Merriam Webster Online Dictionary.[2] Thus, A.R.S. § 20-3502(B)(2) contemplates simply requiring insurers to report a list of plan benefits and an identification of which NQTLs apply to each benefit type.

C. A.R.S. § 20-3502(B)(3) – Demonstration through analysis that any NQTL applied to MH/SUD benefits is comparable to and is applied no more stringently than how it is applied to Med/Surg benefits. This demonstration is by benefit classification.[3] Importantly, this statute requires an examination of **process, not outcomes**. More specifically, it requires an analysis of whether an insurer's process, strategy, evidentiary standard, or other factor used to apply an NQTL to a MH/SUD benefit is applied comparably, and no more stringently than how the insurer applies the NQTL to a Med/Surg benefit. As explained below, the recently enacted federal Consolidated Appropriations Act has codified exactly what is required for the NQTL analysis.

Federal regulators have explained the meaning of the NQTL requirement, in relevant part, as follows:

> An NQTL is generally a limitation, often non-numeric, on the scope or duration of benefits for treatment. In developing and applying an NQTL, the regulations provide that a plan or issuer may consider a wide array of factors. For example, a plan can consider economic factors, such as high cost growth, or other factors such as the incidence of fraud with respect to services in a particular classification. In applying those factors, ***the NQTL analysis does not focus on whether the final result*** (for example coverage denial rates) ***is the same for MH/SUD benefits and medical/surgical benefits; instead, compliance depends on parity in development***

[2] In construing statutes, courts apply the statute's words their ordinary and plain meanings. Courts may defer to respected dictionaries to determine that meaning. *Woestman v. Russell*, 238 Ariz. 33, 35 ¶ 10, 356 P.3d 319, 321 (App. 2015).

[3] Both federal and state law specify the 6 benefit classifications: (1) inpatient in-network; (2) inpatient out- of-network; (3) outpatient in-network; (4) outpatient out-of-network; (5) prescription drugs; and (6) emergency care.

> ***and application of the underlying processes and strategies.*** There should not be arbitrary or discriminatory differences in how a plan or issuer is applying those processes and strategies to medical/surgical benefits and MH/SUD benefits. (E*mphasis added*).[4]

Thus, federal regulators have codified what is properly included in an NQTL analysis. Under A.R.S. § 41-1052(D)(9), DIFI is limited to requiring no more than what is required by federal regulators, because DIFI has no statutory authority to require more.

How the proposed rules exceed DIFI's authority

As explained above, A.R.S. § 20-3502 limits reporting to three specific categories of information. Once DIFI has obtained and reviewed this information, it has the authority to request additional information to verify compliance. However, such requests should be targeted to specific QTLs or NQTLs and based on indicators of non-compliance by a specific insurer.

In the proposed rules, DIFI mandates reporting of extensive information about outcomes rather than processes and has taken the approach of assuming non-compliance by all insurers from the outset. The approach dictated by statute, however, strikes a more reasonable balance between the need to enforce MHPAEA, and regulators' obligations to avoid imposition of excessive regulations that unnecessarily increase administrative costs – which are ultimately passed on to insurance consumers in added premium expense. DIFI must adhere to the limitations of the statute. The following reporting exhibits contained in DIFI's proposed rules exceed MHPAEA and A.R.S. § 20-3502:

1) R20-6-1503(E)(4); Exhibit B – HEDIS Measures Reporting

HEDIS, an acronym for Healthcare Effectiveness Data and Information Set, is a comprehensive set of 92 standardized performance measures designed to enable consumers to compare health plan performance.[5] Not all health insurers use or report on HEDIS measures, and not all health insurers report on all 92 HEDIS measures.[6] While HEDIS measures may help consumers evaluate plan performance, the MHPAEA does not require or contemplate reporting on HEDIS measures to evaluate equality in MH/SUD versus Med/Surg benefits. Moreover, DIFI has explained how HEDIS measures will enable it to evaluate insurers' compliance with the MHPAEA. As a result, R20-6-1503(E)(4) and Exhibit B exceed DIFI's rulemaking authority and must be removed from the proposed rules.

2) R20-6-1506(I); Exhibit C – Complaints; Access to Network Providers

[4] *See* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-39.pdf
[5] *See* https://www.webmd.com/health-insurance/terms/hedis
[6] *See* https://www.ncqa.org/hedis/reports-and-research/ratings-2019/

R20-6-1506(I) and Exhibit C require insurers to report information about complaints related to inability to access care through network providers. There is nothing in the MHPAEA that requires reporting on access to care through network providers. Moreover, DIFI has not explained how evaluating access to care through network providers will enable it to evaluate insurers' compliance with the MHPAEA. As a result, R20-6-1506(I) and Exhibit C exceed DIFI's rulemaking authority and must be removed from the proposed rules.

3) R20-6-1506(I); Exhibit D – Allowed Claims for Out of Network ("OON") Services

There appears to be a typographical error in R20-6-1506(I) and Exhibit D. The language of Exhibit D requires insurers to report on complaints concerning inability to access care through network providers, which is identical to Exhibit C. We believe this was intended to require insurers to report on complaints related to denial of claims for OON services. R20-6-1506(I)(2) further requires that if the ratio of all allowed claims for MH/SUD OON services to allowed claims for Med/Surg OON specialist services exceeds a factor of three to one, the insurer must explain proposed corrective actions that it will implement to improve the ratio.

As an initial matter, nothing in the MHPAEA requires reporting on OON services claim approval or denial and, as a result, these provisions of the proposed rules should be omitted. Notwithstanding the foregoing, DIFI has not demonstrated how denial of claims for Med/Surg specialists (as compared to all MH/SUD claims) demonstrates equality in access to care for MH/SUD versus Med/Surg benefits. Nor has DIFI explained how a three to one ratio of denied claims infers violation of the MHPAEA. By way of example, HMO plans generally limit coverage to only benefits received from in-network providers, unless the insurer has not contracted with a qualified provider to provide the required service or unless the enrollee is obtaining emergent care, which by law must be covered for OON providers. Given that HMOs are both expressly permitted by law to deny OON services and also required to cover OON services in certain circumstances, HMOs will likely have OON claim denial rates that run afoul of this proposed claim denial ratio but that remain in compliance with Arizona's Insurance Code and in no way relate to the MHPAEA. DIFI has not explained how this data will demonstrate MHPAEA compliance.

4) R20-6-1506(I); Exhibit E – Percentage of in-network providers accepting new patients

R20-6-1506(I) and Exhibit E require insurers to report on the number of in-network providers accepting new patients. R20-6-1505(I) further provides that if the number of MH/SUD providers accepting new patients is less than half of the percentage of Med/Surg specialist providers accepting new patients, the insurer is to report proposed corrective action to DIFI. This reporting is to be made by network, which is inconsistent with the language of A.R.S. § 20-3502. As explained above, the statute requires reporting by "product network type," which is defined in A.R.S. § 20-3501(5) as "the network model associated with the type of health plan…" unless the information varies by plan type. Thus, the proposed rules mandate reporting in a manner inconsistent with DIFI's statutory authority, in violation of A.R.S. § 41-1052(D). Moreover,

nothing in the MHPAEA requires reporting on this data point. Finally, DIFI has not established that this proposed threshold is a standard that violates MHPAEA or how this data will otherwise demonstrate insurers provide equality in access to MH/SUD versus Med/Surg benefits.

5) R20-6-1506(I); Exhibit F – Active providers by provider type

R20-6-1506(I) and Exhibit F require insurers to report on the number of in-network providers who are actively treating patients for MH/SUD versus Med/Surg claims and if the percentage of MH/SUD providers who file no claims exceeds the percentage of Med/Surg providers who file no claims, to report corrective information to DIFI, with breakdown in reporting based on number of unique members seen by such providers. Reporting under Exhibit F is to be made for major medical plans, notwithstanding that A.R.S. § 20-3502 mandates reporting to be made by product network type, unless information varies by subcategory. As such, the proposed Rule and Exhibit exceed DIFI's statutory authority in establishing reporting requirements. Nor has DIFI established that having a greater percentage of MH/SUD providers not actively treating enrollees than specialty Med/Surg providers not actively treating enrollees demonstrate violations of the MHPAEA. Finally, the MHPAEA does not require reporting of active providers by provider type. As a result, the proposed rule and reporting exhibit is not consistent with SB 1523 or the MHPAEA and should be stricken from the proposed rules pursuant to A.R.S. § 41-1052(D).

6) R20-6-1506(H); Exhibit G- provider network tiers

R20-6-1506(H) and Exhibit G require insurers with multiple network tiers to report information concerning their network tiers, and if the percentage of Med/Surg specialty providers exceed the percentage of MH/SUD providers in the lowest tier by a factor of more than two to one, to make additional reporting to DIFI in how the insurer establishes tiers. As noted above, A.R.S. § 20-3502 requires reporting to be based on product network type and subcategories where reported information varies. As a result, R20-6-1506(H) and Exhibit G violate SB 1523 by mandating a different reporting standard. Additionally, DIFI has not explained how the proposed ratio demonstrates violation of the MHPAEA. Finally, nothing in the MHPAEA requires reporting on provider network tiers. As a result, R20-6-1506(H) and Exhibit G should be stricken from the proposed rules.

7) R20-6-1506(G); Exhibit H – Formulary tiers

R20-6-1506(G) and Exhibit H of the proposed rules require insurers to report information about 28 categories and classes of prescription drugs, some of which are used to treat MH/SUD-related conditions and others used to treat Med/Surg-related conditions. However, DIFI has not explained why it chose the 28 categories of drugs, including the Med/Surg-related drugs that are included in Exhibit H. Nor does DIFI explain how these categories or drug comparisons demonstrate compliance with the MHPAEA. To that end, there is nothing in the MHPAEA that requires reporting on formulary tiers to demonstrate that MH/SUD drug benefits are provided equally to

Med/Surg drug benefits. As such, R20-6-1506(H) and Exhibit G exceed the reporting permitted by SB 1523 and the MHPAEA and, as a result, must be stricken from the proposed rules in accordance with A.R.S. § 41-1052(D).

8) R20-6-1506(F); Exhibit I – Prior authorization denials not resulting in a claim

R20-6-1506(F) and Exhibit G require insurers to report on the number of prior authorization requests that are not denied and for which no claim is subsequently filed. The proposed rules also require that if the number of prior authorization denials for MH/SUD services exceed the number of prior authorization denials for Med/Surg services by a factor of more than three to one, the insurer must make additional reporting. Nothing in the MHPAEA requires reporting of this information. Moreover, DIFI has failed to explain how a proposed ratio of three to one demonstrates noncompliance with the MHPAEA. As a result, R20-6-1506(F) and Exhibit G violate SB 1523 and should be stricken from the proposed rules pursuant to A.R.S. § 41-1052(D).

Additionally, A.R.S. § 20-3502(F) prohibits DIFI requiring insurers to submit information that has already been provided in an existing filing or report. The Health Market Conduct Analysis Statement ("Health MCAS") that health insurers file each year requires insurers to report: total number of prior authorization requests, total prior authorizations approved, total prior authorizations denied, total number of prior authorizations requested for MH/SUD benefits, total number of prior authorizations for Med/Surg benefits, and total number of prior authorization requests for MH/SUD benefits approved and denied. The Health MCAS also requires reporting for non-pharmacy and separate reporting for pharmacy benefits. Because this information is already reported by insurers, we believe the additional reporting required under Exhibit I violates the provisions of A.R.S. § 20-3502(F).

9) R20-6-1506(F); Exhibit J – Claim denial rates

R20-6-1506(F)(3) and Exhibit I require insurers to report on the denial rates for medically necessary MH/SUD services versus the denial rates for medically necessary Med/Surg services. If the claim denial rate for MH/SUD benefits exceeds the denial rate for Med/Surg services by a rate of more than three to one, insurers are required to report additional information to DIFI. As noted herein, because R20-6-1506(F)(3) seeks denial information for "medically necessary" claims, the proposed rules presume that the insurers are violating Arizona's Insurance Code by denying medically necessary claims. Presumably, if a claim was for medically necessary services, there would be no denial of the claims on this basis. It may be that DIFI seeks reporting for claims that were denied for <u>lack of</u> medical necessity, but this is unclear from the text of the rule. Moreover, this provision requires reporting by major medical plan. However, as noted above, A.R.S. § 20-3502 requires reporting by product network type. As such, R20-6-1506(F)(3) and Exhibit I mandate reporting in violation of A.R.S. § 20-2503. Finally, nothing in the MHPAEA requires reporting on claim denial rates. As a result, these provisions of the proposed rules exceed DIFI's authority under SB 1523 and should be stricken pursuant to A.R.S. § 41-1052(D).

Additionally, the Health MCAS requires insurers to report on the total number of claims received, total number of claims by in-network provider, total number of claims by out-of-network providers and reporting of claim denials for lack of medical necessity broken down by MH/SUD and non-MH/SUD benefits. Because this information is already reported in the Health MCAS, we believe that this reporting requirement violates the prohibition contained in A.R.S. § 20-3502(F), which prohibits requiring reporting of information already reported to DIFI.

10) R20-6-1506(F); Exhibit K – Approval rates for lower level of care

R20-6-1506(F)(4) and Exhibit K require reporting of rates of denials on requested services but approval at a lower level of care for three types of services – inpatient facility stays, outpatient facility visits and office visits. If the rate of approval of lower level of care for MH/SUD benefits exceeds the approval rate for Med/Surg benefits at a rate of more than three to one, insurers are required to report additional information concerning the denial rates. Exhibit K requires reporting based on major medical plan. However, as noted above, A.R.S. § 20-3502 requires reporting by product network type with subcategory reporting only where information differs. Moreover, there is nothing in the MHPAEA that requires reporting of approval rates for lower level of care. This reporting requirement is based on a fundamental misunderstanding of how insurers typically handle prior authorization requests. Insurers must act on the request presented by approving it or denying it. If the requested service is denied, the insurer does not go on to approve a different level of care that the provider and member may or may not want to pursue. Additionally, office visits rarely require prior authorization. The visit just occurs, and the provider submits a claim after rendering the service. By comparison, most insurers generally require prior authorization for any inpatient stays. Thus, we believe no helpful information or proof of MHPAEA compliance will be gleaned from reporting on prior authorization for office visits. As a result, we believe that R20-6-1506(F) and Exhibit K should be modified to align with the requirements of the MHPAEA and SB 1523.

11) R20-6-1506(J); Exhibit M – Credentialing timeframes

R20-6-1506(J) and Exhibit M require insurers to report on the average credentialing time frames for MH/SUD providers compared to the average credentialing time frames for Med/Surg providers. Arizona has codified credentialing time frames in A.R.S. 20-3451 *et seq.* Because Arizona has codified credentialing time frames by statute, we believe that as long as the credentialing process complies with these statutory time frames, insurers should not be required to further track and report on average credentialing timeframes. DIFI has the authority to examine insurers who fail to comply with the required credentialing deadlines. Moreover, it is common for insurers to retain a third party to handle credentialing activities, or to delegate credentialing to a hospital system for its employed professional providers. As a result, insurers generally lack the specific credentialing information to confirm average timeframes and would potentially have to blend information from multiple sources to generate an "average." Finally, nothing in the MHPAEA requires reporting on average credentialing time frames. As a result, we believe that

R20-6-1506(J) and Exhibit M are unnecessary, in violation of SB 1523 and should be removed from the proposed rules.

12) R20-6-1506(F) and Exhibit N – medical management techniques

This reporting metric requires insurers to report which medical management categories applied to the identified list of benefits. This Exhibit partially duplicates information that is already required under Exhibit A. As explained herein, we believe this reporting metric is neither clear nor concise and requests duplicative information. For example, Subsections (B)(4) and (C)(4) in Exhibit A requires an insurer to identify all NQTLs that are applied, respectively, to MH benefits and SUB benefits within each of the six benefit classifications. The four medical management standards listed at the top of the table in Exhibit N are NQTLs that would already have been identified under Exhibit A. This Exhibit essentially asks for the information in reverse. It lists benefits and instructs the insurer to indicate whether a specified NQTL applies. Although DIFI has indicated that insurers are not required to duplicate information that is already reported, it is not clear whether that refers to information reported in a different way. Additionally, this level of reporting is not consistent with MHPAEA, which measures parity based on benefit classification, not based on individual benefits.

Reporting requirement B(9) of Exhibit A asks insurers to "furnish a list of all MH benefits which make approval contingent upon improvement within a specific number of days." This is another NQTL standard, but it is unclear why DIFI has asked for the information in a narrative fashion in Exhibit A and is requesting other information in chart form in Exhibit N. Moreover, many benefits cannot be easily categorized as a "yes" or "no" with respect to application of the listed medical management techniques. For example, all nonemergency inpatient services may require prior authorization, but for imaging services on line 18, prior authorization may or may not require prior authorization, depending on the CPT code, place of service and patient diagnosis.

Ultimately, the MHPAEA authorizes insurers to apply medical management standards. What MHPAEA requires is that these standards be applied consistently for both MH/SUD and Med/Surg benefits. Exhibit N does not, however, require the insurer to report on the process followed to reach the outcome, which is the evaluation needed to evaluate MHPAEA compliance. General reporting on NQTLs is already required by Exhibit A and will enable DIFI to evaluate disparities in application of NQTLs to MH/SUD benefits. As a result, Exhibit N appears to be duplicative of Exhibit A and unrelated to actual evaluation of MHPAEA compliance.

The proposed rules are not clear, concise or understandable.

As noted above, in order to be valid, GRRC must find that an agency's rules are "written in a manner that is clear, concise and understandable." A.R.S. § 51-1052(D)(4). The following provisions of DIFI's proposed rules and related Exhibits are not clear, concise or understandable.

1) R20-6-1501- Definitions and other undefined terms

a) R20-6-1501 contains defined terms that are already defined in the federal law and regulations. If the federal rules are later amended, the state rules will conflict with the federal rules. Because SB 1523 directs insurers to follow the requirements of the federal law, we would recommend removing from the proposed rules any defined terms that are already defined in the federal rules and simply referring to the federal definition, which will ensure that the state rules conform to any future amendments.
b) "Coverage unit"- the proposed rule defines "coverage unit" in a manner that is consistent with the federal rules, which provide that a coverage unit "includes" certain types of groupings. Use of the term "includes" suggests that the listed items are not exhaustive. *See, e.g. Dept'. Econ. Sec. v. Torres*, 245 Ariz. 554, 558 ¶ 14, 431 P.3d 1207, 1211 (App. 2018) (noting that the word " 'includes' is most often a term of enlargement, rather than limitation. . . [construed] to also include other items that fall within the term's ordinary meaning." Insurers may define a "coverage unit" differently – to be a minimum number of two, three or five individuals. We request that DIFI clarify whether this term is meant to be left to the discretion of insurers or will be clearly defined by DIFI.
c) "Medical/surgical (Med/Surg) benefits" – we suggest revising this definition to correct a typographical error ("do" versus "does"): "means benefits with respect to items or services for medical conditions or surgical procedures as defined under the terms of the health plan or health insurance coverage and in accordance with federal and state law and consistent with generally recognized independent standards of current practice. Med/Surg benefits do not include mental health (MH) or substance abuse disorder (SUD) benefits."
d) "Mental health (MH) benefits" - This term is defined differently in the federal rules than in the proposed DIFI rules. Specifically, DIFI has included the following in state rules which is not included in the federal definition- "MH benefits include intermediate benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment), medication assisted treatment (MAT) and treatment for eating disorders." We respectfully request that this term be defined so as to be consistent with federal regulations since SB 1523 requires compliance and reporting in accordance with the MHPAEA. Additionally, by way of example, some of the treatments for an eating disorder may be for Med/Surg benefits that are a byproduct of an eating disorder. According to MHPAEA federal guidance, for the purpose of measuring predominance and substantiality, those medical services should be classified as Med/Surg benefits. We respectfully request that this definition be clarified so insurers understand how to classify such services.
e) "Network" – DIFI's proposed rules fail to include a definition of the term "network." A number of the proposed Exhibits require reporting by network, but the term is not defined and may be understood differently to different insurers. By

way of example, some insurers include in their network access to out of state providers contracted with affiliated insurance companies. However, the Arizona insurer would not have access to information concerning that out of state provider. Similarly, a "network" may be limited to one county, yielding data that is perhaps not large enough to provide credible information of MHPAEA compliance. While we have noted above that reporting by network is outside the scope of DIFI's authority, should it remain in the final rules, we respectfully request that this term be defined.

f) "Substance use disorder (SUD) benefits" – this term is defined differently than under federal law to include eating disorders. We respectfully request that this term be defined consistent with federal law.

g) "Specialist" – this term is not defined in the proposed rules. A number of the proposed Exhibits require reporting by specialist, but this term can be interpreted to have different meanings to different insurers. By way of example, does it apply only to physicians or can it also include a licensed social worker or other mid-level professional? As a result, insurers may not be reporting consistent information for "specialists." Therefore, we respectfully request that DIFI define the term "specialist."

h) "Major medical health plan" – a number of the proposed reporting exhibits require reporting based on "major medical health plan." Not only does this reporting requirement conflict with the requirement in A.R.S. § 20-3502 that reporting be made by product network type, with additional reporting required only if there is variation by market, but this term is not defined in the proposed rules and is subject to different interpretation. Because SB 1523 does not contemplate or require reporting based on major medical health plan, we respectfully request that the proposed rules and all final exhibits be modified to require reporting consistent with the statute's requirements. However, in the event the final rules continue to require reporting based on "major medical health plan," we respectfully request that this term be defined so that it will be applied and interpreted consistently by all insurers.

i) "Complaints" – Exhibit C requires insurers to report on complaints from members related to inability to access network providers. However, the proposed rules failed to define what constitutes a "complaint." For example, does it have to be a written complaint, does any call for assistance to access services from a network provider constitute a complaint? This undefined term will likely be subject to different interpretation by insurers, and we would request that it be clarified so that it can be consistently reported on by insurers.

j) "Health plans with similar benefit structures" – R20-6-1504(C) enables DIFI to require insurers to file a report demonstrating compliance with the substantially all and predominant tests within each classification of benefits for health benefit plans with "similar benefit structures." However, DIFI has not defined or clarified what this phrase means. We respectfully request that this provision be clarified to enable consistent reporting by all insurers.

k) "relative cost to the insurer" – R20-6-1506(H) (2) requires insurers to conduct an analysis of the relative cost to the insurer for Med/Surg providers compared to MH/SUD providers for services provide in the lowest network tier. The phrase "relative cost to the insurer" is not defined and may be subject to different interpretations. For example, is this meant to mean the negotiated reimbursement rate for each provider or some other metric of cost? We respectfully request that this provision be clarified to enable consistent reporting by all insurers.

2) R20-6-1502 – reference to NAIC additional guidance materials

R20-6-1502(E) indicates that insurers may refer to the NAIC for additional guidance. However, the NAIC is a large national organization that publishes numerous reference and guidance materials. Therefore, we respectfully request that DIFI clarify which NAIC materials are intended to be used as reference materials. Additionally, DIFI has failed to include as additional guidance FAQ guidance issued by the Triagencies (CMS, Department of Labor and Department of Treasury). *See, e.g.*, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17 and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-39.pdf

3) R20-6-1503(E)(4); Exhibit B – HEDIS Measures Reporting

As explained in detail above, we believe that R20-6-1506(E)(4) and Exhibit B should be removed from the proposed rules because they exceed the reporting authority set forth in SB 1523 and A.R.S. § 20-2503. Moreover, because the listed HEDIS reporting measures only address MH/SUD benefits and not Med/Surg benefits, we believe that this is an inappropriate data point to evaluate compliance with MHPAEA. These measures provide no basis to compare an insurer's quantitative and nonquantitative treatment limits for MH/SUD benefits against its quantitative and nonquantitative limits for Med/Surg benefits. However, to the extent that HEDIS reporting measures remain in the final rules, we believe that this proposed reporting requirement needs clarification. More specifically, the HEDIS reporting measures are regularly updated. We would respectfully request that DIFI clarify which edition date of the HEDIS measures are to be used so that insurers have clear guidance as to which version is applicable for a specific data reporting year.[7]

4) R20-6-1503(B) and (D) – inconsistent reporting requirements

Subsections (B) and (D) of section R20-6-1503 contain the primary reporting requirements for insurers under the proposed MHPAEA rules. However, these subsections appear to be

[7] Similarly, we would request that DIFI clarify which version of the HHS MHPAEA reporting tool DIFI intends to follow.

inconsistent. R20-6-1503(B) requires insurers to submit separate reports for "all health plans it offers" and to distinguish between grandfathered and non-grandfathered plans. However, subsection (D) requires reporting based on "each fully insured product network type" that the insurer offers, or subcategorization where reporting differs. As explained in greater detail below, we believe that all reporting must be based on "product network type", as required by A.R.S. § 20-3502(B). Ultimately, the rules must be consistent, and reporting must be made at the same level or on the same basis.

5) R20-6-1504(E)(2) – "office visit" and "all other outpatient services"

In this provision, DIFI has recognized a permitted subclassification for "office visits" and "all other outpatient services." To ensure that insurers approach these subclassifications consistently, we would respectfully request that DIFI define the types of services encompassed within an "office visit." By way of example, would this include telehealth visits or urgent care visits? We respectfully request that this be clarified so that insurers are collecting and reporting information consistently.

6) R20-6-1506(I)(3) and Exhibit E - "Provider accepting new patients" –

In this reporting metric, insurers are required to report on the number of MH/SUD and Med/Surg providers accepting new patients. As explained above, we believe that this reporting metric should be removed since it is not required by A.R.S. § 20-2503 or the MHPAEA. However, in the event this reporting metric remains in the final rules, we respectfully request that this term be defined or clarified. More specifically, DIFI has not clarified whether this metric is meant to be reported at the individual provider level or whether a provider group qualifies as accepting new patients as long as one of its providers is accepting new patients. Additionally, we believe this metric is difficult to report and needs clarification because some providers, such as physician assistants, do not provide taxonomy or specialty codes to indicate that they are qualified to provide MH/SUD services, and some insurers do not separately categorize child psychiatrists as a subspecialty. For behavioral health services, it is not clear why DIFI needs reporting by detailed subspecialty, rather than by those who can prescribe medications vs those who cannot. For example, licensed clinical social workers, professional counselors, family therapists, and other similar provider types all render the same range of services for counseling and therapy, but they cannot prescribe. Members have a counseling benefit and need to be able to access counselors and therapists. Requiring reports by detailed subspecialty adds administrative burden but doesn't provide measurably greater evidence of member access (or lack of access) to benefits.

Moreover, because insurers rely on self-reporting by providers concerning whether they are accepting new patients, we request that the final rules include confirmation that this information can be based on self-reporting by providers rather than requiring insurers to

independently verify this information. Additionally, DIFI has already established access standards in R20-6-1914 – R20-6-1919 and has not explained how those standards should be reconciled with the assumption underlying the instructions noted above in this reporting metric when a certain threshold is met. By way of example, R20-61914(1) says that a member must be able to get preventive services within 60 days of an appointment request, or sooner if needed for timely vaccinations. Presumably, if a member can get an appointment within that period of time (or within other time periods specified in rule), such a provider should not be treated not accepting new patients.

7) R20-6-1506(L)(4) and Exhibit F

This rule and exhibit require insurers to report on the number of MH/SUD versus Med/Surg providers that are not actively providing care to enrollees. However, the term "actively providing care" is not defined and is subject to varying interpretations. As explained below, we believe this reporting metric exceeds the reporting requirements of SB 1523 and the MHPAEA and that it should, therefore, be removed from the final rules. However, in the event this metric remains in the final rules, we would request that the term be clarified so that insurers are able to measure and report information uniformly. Additionally, some of the requested information may not be available at the specialty level indicated in Exhibit F. By way of example, some insurers do not categorize child psychiatrists as a subspecialty, and certain providers, such as physician assistants, do not provide taxonomy/specialty codes to indicate that they are able to provide MH/SUD services.

8) R20-6-1506(H) and Exhibit G – provider network tiers

This reporting metric requires insurers to report on the percentage of providers included in the lowest tier of a tiered network. As explained below, we believe this reporting metric exceeds the requirements of SB 1523 and the MHPAEA and should, therefore, be removed from the final rules. However, in the event this reporting metric remains in the final rules, we would request that this metric be clarified to define what it means by the "lowest tier." For example, is this meant to be the tier with the lowest member cost sharing requirements? Moreover, network tiering is part of benefit design, with proprietary providers typically being in the tier with the most favorable cost sharing requirements, contracted providers being in a second tier and noncontracted providers being in the third tier with the highest cost sharing requirements. As such, insurers design benefit plans with network tiers, not product network types or networks with network tiers. We request that this reporting metric, if it remains in the final rules, be clarified to appropriately describe benefit plans with different network tiers and clarifying which tier is to be reported upon as "lowest."

9) R20-6-1506(G) and Exhibit H – formulary tiers

This reporting metric requires insurers to report on 28 specific categories and classes of drugs. As noted below, we believe this reporting metric exceeds the reporting requirements under SB 1523 and the MHPAEA and should, therefore, be removed. However, in the event this reporting metric remains in the final rules, we would request that it be clarified. Nationally, there are four primary sources for pharmacy categorization which are similar but not identical. Not all insurers use the same classification source. We request that the rules be clarified to specifically enable insurers to report the required data based on the insurer's standard classification source to avoid the additional cost and expense of changing to a new classification source,[8] or to manually convert information derived from one categorization scheme into that mandated in the rules.

10) R20-6-1506(F)(3) and Exhibit J – claim denial rates

This provision requires reporting on claim denial rates for medically necessary services. As explained above, we believe this reporting requirement should be removed from the final rules. However, in the event this metric remains in the final rules, we request that DIFI clarify how claim denials for investigational treatments or services be included or reported on.

11) General reporting time frames of January 1 through December 31

A number of the reporting Exhibits require reporting based on the calendar year for the year immediately preceding the year in which the report is submitted to DIFI. As explained herein, many of these exhibits are not easily capable of reporting based on the calendar year and, as a result, we respectfully request that these data points be revised to be capable of collection and reporting.

a) Exhibit C (network access complaints)- As explained above, we believe that Exhibit C's requirements to report "complaints" due to inability to access network providers fails to clearly identify what constitutes a complaint subject to reporting. Assuming that the term "complaint" is more clearly defined, we would also ask for clarity concerning the timing of complaints to be included in a calendar year. For example, is an initial inquiry from a member received before December 31 a complaint subject to reporting even if it is investigated, confirmed or resolved until after that date? At what level of insurer assistance would a member's inquiry concerning network access rise to the level of a "complaint" that needs to be reported? Should Exhibit C remain in the final rules, we respectfully request that not only the definition of "complaint" be defined but also the status at which an

[8] Classification source is normally determined by the Pharmacy Benefit Management (PBM) company with which the insurer is contracted for PBM services, which further limits the insurer's ability to change sources.

inquiry or complaint rises to the level of being reported by the end of a calendar year.

b) Exhibit D (percentage of allowed out-of-network claims)

Exhibit D requires percentage of allowed out-of-network claims in each calendar year. However, Exhibit D fails to clarify the point in time at which a claim becomes subject to reporting. For example, does Exhibit D only require reporting of those claims that are finally adjudicated by the end of a calendar year? Would it apply to those claims with a date of service in the data calendar year, but which claim is not received until the next calendar year? Should Exhibit D remain in the final rules, we respectfully request that this reporting requirement be clarified.

c) Exhibit E (in-network providers accepting new patients)

Exhibit E requires insurers to report on all in-network providers accepting new patients during a calendar year. However, this reporting metric fails to identify the timing for when an insurer must measure whether a provider is accepting new patients. By way of example, if a provider is accepting new patients on only one day during a calendar year, does this qualify for reporting, or does a provider need to be accepting new patients for a minimum number of days during the year to count for this reporting metric? Also, as otherwise explained herein, if a provider group has some providers accepting new patients at some point during the year but others are not, should this provider group be counted as accepting new patients? Should Exhibit E remain in the final rules, we respectfully request that this be clarified so that insurers know what information is required to be reported.

d) Exhibit F (active providers in network)

Exhibit F also fails to identify the time at which reporting is required to be made about active providers in an insurer's provider network. It is not uncommon for providers to join and leave a network during the year, and providers are continually added and leave an insurer's network. While Exhibit F requires reporting to be made for a full calendar year, the number of active providers may vary on a monthly or weekly basis. Therefore, we would respectfully request that DIFI clarify the time at which active provider information is to be reported, should Exhibit F remain in the final rules.

e) Exhibit G (provider network tiers)

Exhibit G requires insurers to report on the number of providers in an insurer's lowest tier. As with Exhibit F, it is unclear how to identify when a provider is active

in an insurer's network- is the provider counted if active on any one day during a calendar year, or is the provider to be counted only of he or she is active for a minimum number of days during a calendar year? Should Exhibit G remain in the final rules, we respectfully request clarification of how this metric is meant to be captured.

f) Exhibit H (formulary tiers)

Exhibit H requires insurers to report certain information related to 28 classes and categories of drugs. It is fairly common for insurers to modify their formulary tiers during the year. Therefore, because the reporting period is a calendar year, it is unclear whether information to be reported should include all drugs in a formulary during the reporting calendar year or whether information should only be included if the drug is included as of a date certain within the year. Should Exhibit H remain in the final rules, we respectfully request clarification of how this metric is meant to be captured.

g) Exhibit I (prior authorization denials not resulting in a claim)

Exhibit I requires reporting on prior authorization denials that do not result in a claim. While this metric is to be reported for a calendar year, it is unclear how insurers are to report on claims where the prior authorization is requested towards the end of a calendar year, but services are received, and claims are filed in the following calendar year. Should Exhibit I remain the final rules, we respectfully request that Exhibit I be clarified to address those circumstances in which a prior authorization request is denied but the ultimate claim for related services is not resolved during the reporting calendar year.

h) Exhibit J (claim denial rates)

Exhibit J requires reporting on claim denial rates for MH/SUD versus Med/Surg services during a calendar year. Exhibit J does not clarify, however, how claims that are in process as of 12/31 of a given year are to be reported, or if they are even to be reported. If Exhibit J remains in the final rules, we respectfully request that Exhibit J be clarified to address claims that are pending at the end of a calendar year.

i) Exhibit K (approval rates for lower level of care)

Exhibit K requires insurers to report on denials of requested care where the insurer ultimately approves a lower level of care during a calendar year. However, it is a

frequent occurrence that requested care may be denied in one calendar year, but related services may be received during the following calendar year, which will occur after the reporting is to be made. As a result, Exhibit K appears to be incapable of accurate tracking and reporting. Assuming Exhibit K remains in the final rules, we respectfully request that this Exhibit be clarified to address those circumstances in which initial requests are denied but future related care is received after the end of the calendar year.

DIFI failed to select the least burdensome option to implement SB 1523 in promulgating the required reporting in the proposed rules.

As noted above, state agencies must adopt the least burdensome and most cost-effective option for reporting on MHPAEA compliance. A.R.S. § 41-1052(D)(3). For the reasons set forth herein, the proposed rules are not the least burdensome and most cost-effective option for insurer reporting. Rather, the proposed rules will require insurers to retain staff, change processes and begin tracking significant amounts of data to comply with the proposed rule's reporting requirements.

1) Initial reporting due date of March 15, 2022 and subsequent triennial reporting

The proposed rules contemplate that the first triennial report will be due by March 15, 2022, which will presumably cover the 2021 data year. By the time the rules are finalized, it could be mid-year of 2021, over halfway through the 2021 data reporting year. The rules, as proposed, require extensive new reporting requirements. As discussed herein in comments on the various specific exhibits, some of the reported information may require system configuration to be able to capture data, or even manual compilation.

March is typically the month in which numerous other reports are due, including annual reports and holding company reporting. Finally, between now and January 2022, insurers will also have other new administrative requirements that will require configuration, including new requirements under the federal Consolidated Appropriations Act.

In light of the foregoing, March of 2022 is an unreasonably short period of time to allow insurers to implement these reporting requirements when considered in the broader context of the overall MHPAEA reporting, and the breadth and complexity of the data to be collected and reported. As noted herein, for some exhibits, insurers will be required to make system enhancements to report the data in the categories and by the provider types specified in exhibits. The insurers recommend that the first triennial report be due in March of 2023 for the 2022 data reporting year. Alternatively, the insurers recommend that at a minimum, the initial triennial report be filed in September of 2022, with subsequent reports to be filed by July 1st each reporting year.

Additionally, in order to avoid excessive reporting requirements, we respectfully request that R20-6-1503(E)(5) be revised to report only material changes to avoid requiring insurers to report minor, nonsubstantive changes or to have to submit entire reports when only a few sections require reporting of material modifications. We would propose to define "material change" to mean "a change that is likely to impact an insurer's compliance with MHPAEA, or more than a ten percent change in a previously reported data point. We would propose that this section be revised as follows:

(E)(5) Subsequent *triennial reports.*

(a) A health care insurer must file an updated triennial report, including the information required in Exhibits A and B, and Section R20-6-1506, unless the insurer can attest that it has made no material 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 Exhibits A and B, and Section R20-6-1506; or

ii. The last triennial report filed with the Division and a written attestation that the health care insurer has made no material changes since it filed the previous triennial report.

iii. If only portions of the report have materially changed since the prior report, the insurer may submit the last triennial report, the updated sections, and an attestation as to sections with no material change.

Finally, A.R.S. § 20-3502(F) prohibits DIFI form requiring information already in its possession.[9] As a result, in the event insurers have no material changes to report, these insurers should not have to refile the same report, but pursuant to A.R.S. § 20-3502(F), the insurer should not have to resubmit the report but only need to reference the prior filed report.

2) R20-6-1504; FR and QTL Reporting

We appreciate that DIFI will enforce quantitative requirements through existing rate and form filings and agree with this general approach. However, we respectfully request clarification on how DIFI intends to address current permitted exemptions. In Order 15A-005-INS, DIFI exempted certain insurers and insurance product types from Arizona's form filing requirements. For those product types, such as large group PPO plans, insurers submit an annual attestation of compliance in lieu of filing their insurance forms. Having to submit a separate report for each exempt large group plan, by way of example, particularly in the absence of complaints of alleged MHPAEA violations, would be

unreasonably burdensome. We would recommend that this annual policy form also include MHPAEA compliance.

Additionally, we request that R20-6-1504(B) be revised to require DIFI to first review an insurer's submitted information prior to routinely requesting supplemental information from an insurer with respect to a specific filing. Should DIFI have questions concerning an insurer's attestation or reasonable basis to question whether a large group plan complies with the MHPAEA, DIFI can request the insurer's substantially/predominance testing but should not require the insurer to draft and submit an entirely separate report. We suggest revisions the text of R20-6-1504 as follows:

Text of rule with recommended modifications

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. If the health care insurer is exempt from filing requirements, in whole, or in part as to certain product form filings, the insurer shall demonstrate compliance by attestation as described in subsection (C).

B. *Division's authority to require additional data*. ~~In addition to the~~ After reviewing an insurer's rate and form~~s filed by a health insurer~~ filing, the Division may, if it has cause to question compliance, require a health insurer to submit additional data relating to its methods for meeting the MHPAEA FR and QTL standards. The Division may utilize the HHS MHPAEA tool and may request samples of a health insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a ~~health plan~~ product network type.

C. *Separate consolidated report for large group health plans.* The Division may require a health insurer that issues large group health plans that are exempt from form filing to annually attest to compliance with the requirements of this section. If it has cause to question compliance, the Division may require an insurer to submit its internal testing to ~~file a report that~~ demonstrate~~s~~ compliance with the substantially all and predominant tests within each classification of benefits for the specific group health plan~~s with similar benefit structures~~.

3) R20-6-1503(E)(4); Exhibit B – HEDIS Measures Reporting

DIFI has provided no analysis on the expected costs to insurers to gather and report on HEDIS data, all of which increase administrative costs that are ultimately reflected in premiums charged to enrollees. To that end, HEDIS measures 7 through 12 are based on information contained solely in electronic medical records. As such, for insurers to evaluate and report on these HEDIS measures, insurers will need to retain additional staff

to review enrollee medical records or obtain such information from a health insurance exchange, which is not necessarily standardized in how information is collected and reported. Currently, in Arizona, some providers are able to report on some of these measures to Health Currant, Arizona's Health Information Exchange. Although the data exchange has a standardized clinical data format (HL7), it is not actually standardized. Certain insurers obtain data from Health Currant on only one data measure (admission discharge and transfer), for a limited subset of members. That data must be significantly manipulated to be useful. Health Currant is in the process of imposing new data reporting requirements on providers to enhance standardization. The costs associated with obtaining the data on a limited population and transforming it into useful information are extensive. In summary, insurers do not have access to the data in measures 7 through 12, and it would significantly burden providers and Health Currant to do the data submission and manipulation to extract the reporting. Moreover, as noted above, because HEDIS reporting is not required by the MHPAEA and does not contain evaluation factors for Med/Surg factors, we believe that the HEDIS reporting should be omitted from the final rules. However, even if the HEDIS reporting is included in the final rules, insurers would be unable to comply because HEDIS measures are evaluated at the enrollee level, so reporting based on each "major medical plan" as noted in the proposed rules is inconsistent with how insurers collect and report on HEDIS measures.

4) R20-6-1506- NQTL compliance indicators reporting

Subsection (D) of this section creates a reporting exception for insurers that insure "25 lives or less across all health plans which are otherwise subject to reporting." This exception is consistent with MHPAEA but should be broadened. If the final rules require reporting by a single network or major medical plan, and other than by product network type, DIFI should also provide for a reporting exception based on actuarial certification that the measured data is too small to yield statistically credible data, which could occur for a separate network or plan. Requiring NQTL reporting at a level that lacks statistical credibility does not result in meaningful data about an insurer's compliance with MHPAEA and will result in insurers having to collect data and prepare reports that greatly exceed valuable MHPAEA-related information.

5) R20-6-1506(I); Exhibit C – complaints related to network access

Insurers do not currently track complaints (as noted above, it's not clear what the term "complaints" is meant to encompass) related to network access in the form and at the level specified in the reporting. Requiring tracking and reporting this information, which is not required by the MHPAEA and therefore in excess of DIFI's statutory authority under SB 1523, will require insurers to undertake programing changes and retention of additional personnel to track, organize and report on this information. Because DIFI has failed to demonstrate that this data will aid towards demonstration of MHPAEA compliance, the

cost to insurers of collecting and reporting this data exceeds the value of any information to be gleaned therefrom. As a result, we believe this reporting requirement should be removed from the final rules.

6) R20-6-1506(I); Exhibit D – allowed claims for OON services

For the reasons set forth above, we believe that Exhibit D should be omitted from the final rules because allowance of OON claims is not required by the MHPAEA and will not likely lead to relevant information concerning MHPAEA compliance. Additionally, insurers do not currently track the percentage of claims permitted for OON services. Insurers will be forced to make programming changes and retain additional personnel in order to collect, track and report on this information. Because this information is unlikely to demonstrate MHPAEA compliance, DIFI has failed to establish that the information to be gleaned from this reporting requirement will outweigh the costs to insurers in having to collect and report this information. As a result, we believe this requirement should be removed from the final rules.

7) R20-6-1506(I); Exhibit E – network providers accepting new patients

As explained above, insurers rely on network providers to report whether they are accepting new patients for purposes of network directory reporting. With the exception of using this information for network directories, insurers do not track the number of providers accepting new patients. As explained above, we believe this data report should be omitted from the final rules because it does not tend to demonstrate compliance with MHPAEA. Insurers will need to make programming changes and retain additional personnel in order to track and report on this information. Moreover, for behavioral health services, it is not clear why DIFI needs reporting by detailed subspecialty, rather than by those who can prescribe medications vs those who cannot. For example, licensed clinical social workers, professional counselors, family therapists, and other similar provider types all render the same range of services for counseling and therapy, but they cannot prescribe. Members have a counseling benefit and need to be able to access counselors and therapists. Requiring reports by detailed subspecialty adds administrative burden but doesn't provide measurably greater evidence of member access (or lack of access) to benefits. Because this report is unlikely to demonstrate compliance with the MHPAEA, the costs insurers will incur to be able to report on this information greatly outweighs the benefit of the information to be gleaned from these reports. As a result, we believe this reporting requirement should be removed from the final rules.

8) R20-6-1506(I); Exhibit F – active providers by provider type

R20-6-1506 and Exhibit F requires insurers to report on the number of active providers by provider type. As noted immediately above concerning Exhibit E, insurers do not track

active providers but simply rely on providers to self-report whether they are accepting patients. Exhibit F further requires insurers to track the number of claims submitted by each network provider. Insurers do not currently track the number of claims submitted by each provider. To commence this type of tracking, insurers will need to undertake programming changes and retain additional personnel. As explained above, we do not believe that tracking claims by provider will demonstrate compliance with the MHPAEA. As a result, we believe that the costs for insurers to track and report on claims by provider greatly outweighs the benefits to be obtained from this information. As a result, we believe this reporting requirement should be removed from the final rules.

9) R20-6-1506(F)(2); Exhibit I – prior authorization denials without subsequent claims

Insurers do not currently track prior authorization request denials that do not result in a claim being filed. We believe that it would be extremely difficult, if not impossible, for insurers to track this information. In addition to the programming requirements and additional personnel that will be required to track this information, insurers may not logistically be able to track this information. For example, if a prior authorization request for one treatment code is denied but a claim is later submitted for a related but different treatment, an insurer may not necessarily know that the two are related or be able to accurately track this information. It is equally as likely that a later submitted claim may be for an unrelated service. As discussed above, the MHPAEA does not authorize or require collection of this information, and we believe that this information does not demonstrate compliance with the MHPAEA. Moreover, DIFI asks insurers to categorize the reporting into certain categories (*e.g.*, medical necessity, out of network, administrative) which insurers currently do not maintain. To report as DIFI has requested would require insurers to review each denied prior authorization requested and manually compile a report. Even if an insurer may categorize and code denial reasons in a way that can be extracted without manual intervention, that categorization system may be different from the categories requested by DIFI. Ultimately, because the costs to track and report this information far exceed the usefulness of any information to be obtained from this reporting, we respectfully request that Exhibit I be removed from the final rules.

10) R20-6-1506(F)(4); Exhibit K – approval rates for lower level of care

For the same reasons set forth above with respect to Exhibit I, we believe that the costs to track and report approval rates for lower level of care will far exceed the value of any information to be derived from such reports. As explained above, insurers do not currently track this information will have to undertake programming changes and retain additional personnel in order to track this information. However, insurers have no way of knowing for certain whether an initial claim denial is related to a future approval of a lower level of care or service. For example, what if there is a delay of six months or one year between the initial claim denial and later service. Certain treatments for different medical conditions

may be similar, so insurers will not be able to confirm whether the two are related. As a result, we believe this information is inherently unreliable. As such, the costs to be borne by insurers to collect and report on this information far outweighs the information to be gleaned from this information.

11) R20-6-1506(J); Exhibit M – credentialing time frames

As explained above, we believe that tracking and reporting average credentialing time frames for various subspecialties is unnecessary because Arizona has codified credentialing deadlines. Nor is this reporting required by SB 1523 or the MHPAEA. As a result, we believe that this reporting requirement should be omitted from the final rules. Regardless, insurers generally do not currently track average credentialing time frames. Many insurers contract with third parties to complete credentialing or delegate credentialing to a hospital system. Consequently, insurers do not currently have access to this information on all providers. To be able to track this information, insurers will need to undertake programming changes or force their program partners to make programming changes and would also need to retain additional personnel in order to make the required reporting. As a result, the costs to be borne by insurers in implementing this reporting requirement will far outweigh the value of the information to be gleaned from this reporting.

12) R20-6-1506(I); Exhibit L – Allowed amounts for MH/SUD versus Med/Surg claims

R20-6-1506(I) and Exhibit L require insurers to report on the average allowed amounts, as compared to Medicare reimbursement rates, for MH/SUD services versus Med/Surg services based on certain CPT codes identified by DIFI. Insurers do not currently track this information. Moreover, to the extent that insurers contract with a third-party administrator ("TPA") to adjust and settle claims, TPAs also generally do not track this information. In order to track and report this information, insurers will need to perform extensive programming changes or require their contracted TPAs to undertake programming changes and to retain personnel to collect, track and report this information. As explained above, we believe this reporting requirement exceeds SB 1523 and the MHPAEA and that the information to be reported does not demonstrate compliance with the MHPAEA. Therefore, the costs that will be incurred to track and report this information far exceed the value of the information to be gleaned from this reporting.

The proposed rules fail to establish standards against which compliance with the MHPAEA can be measured.

The rulemaking requirements of SB 1523 direct DIFI to "adopt standards to determine compliance with" the MHPAEA. At the September 21, 2020 insurer stakeholder meeting, DIFI requested input and feedback from insurers to ascertain compliance with the MHPAEA. Some Exhibits fail

to contain such a standard at all. Others contain a number of ratios that trigger additional reporting, such as a two-to-one or a three-to-one difference between MH/SUD and Med/Surg benefits. However, DIFI has failed to establish how these ratios demonstrate a purported violation of the MHPAEA that justify additional reporting. More specifically, DIFI has taken the high level NQTL categories outlined in the federal rules and tied them to specific pieces of information outlined in the reporting Exhibits. However, DIFI fails to capture the essence of MHPAEA's NQTL requirement, which as explained above is about process rather than outcomes. The federal NQTL rule says that an insurer:

> May not impose [an NQTL] with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the [NQTL] to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in apply the limitation with respect to medical/surgical benefits in the classification. 45 CFR 146.136(c)(4)(i)

The federal rules, and subsequent federal FAQs incorporate numerous illustrative examples to help regulated parties understand the intent of this general requirement. 45 CFR 146.136.(c)(4)(iii). Example 2 illustrates the problem with DIFI's rulemaking:

> *Example 2*: (i) *Facts.* A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions. (ii) *Conclusion*: In this Example 2, the plan complies with the [NQTL rules]…because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Although SB 1523 instructed DIFI to set standards in rule, DIFI has, instead, gone straight to the compliance analysis without first setting a standard with which insurers are required to comply and has made assumptions about reporting and outcomes rather than focusing on processes. And it has done so in a way that is unsupported, costly and burdensome, as described above for nearly all of the proposed reporting metrics. As noted above, we believe that having insurers submit only the reports required under the MHPAEA and related regulations will afford DIFI with significant relevant information. Once DIFI has had an opportunity to evaluate these initial reports, we believe DIFI will be able to obtain stakeholder input to then establish standards for compliance as required by SB 1523.

Given the short timeframe for promulgating the proposed rules, DIFI was unable to undertake a robust stakeholder input process in promulgating the proposed rules.

As noted above, SB 1523 directed DIFI to engage with stakeholders in order to develop the reporting insurers will need to complete to demonstrate MHPAEA compliance. Specifically, Section 8 of SB 1523 required DIFI to "conduct workshops and listening sessions to seek and obtain input from stakeholders, including health care insurers, behavioral health providers, advocacy organizations and individuals who have been impacted by mental health or substance abuse disorders" when developing the forms and reporting requirements health insurers are to follow to demonstrate MHPAEA compliance pursuant to A.R.S. § 20-3502. Notwithstanding this requirement, due to the limited time allowed by SB 1523 for DIFI to implement the legislation's requirements, including creation of a website, hiring new staff and promulgating the required rules, DIFI lacked sufficient time to engage in a robust stakeholder process, such as conducting multiple stakeholder meetings and obtaining meaningful stakeholder input on the proposed reporting requirements and draft rules.

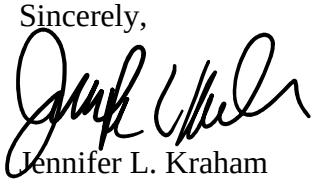
DIFI held one meeting with health insurers on September 21, 2020, at which meeting DIFI provided proposed worksheets and forms for data to be reported by health insurers. DIFI welcomed comments on the proposed data tables that were provided at this meeting, and a number of insurers provided comments on or before October 2, 2020, which comments included numerous concerns and issues with DIFI's proposed reporting metrics. Among other things, insurers noted the following concerns with DIFI's proposed data tables: the need for better definitions of terms, the need for specificity about the time periods for various reports and the data that should be included (*e.g.* total providers during a year, or total providers at some fixed point in time such as December 31st); the difficulty in reporting and lack of value in information about prior authorization and claims; lack of information about average credentialing time frames; and the need for clarification about data reporting by various categories such as plan, product and network.

We understand that DIFI conducted one other meeting with a different stakeholder group prior to finalizing the proposed rules. Following the stakeholder meetings, DIFI held a statutory advisory committee meeting on December 14, 2020. At that meeting, DIFI staff noted that they were working on the draft rules, and, when asked if DIFI would be amenable to providing a copy of the draft rules for stakeholders' review and comment, DIFI noted they had insufficient time to incorporate any feedback into the draft rules. DIFI conducted another advisory committee meeting on January 15, 2021 but did not engage in discussion concerning the draft rules at that meeting. DIFI sent its draft rules to the advisory committee on January 28, 2021 and published the draft rules on February 12, 2021. Thus, notwithstanding the requirement in Section 8 of SB 1523 that DIFI "conduct workshops and listening sessions to seek and obtain input from stakeholders" for preparation of the required rules, DIFI conducted only a total of two listening sessions with different stakeholder groups and two advisory committee meetings prior to publishing the proposed rules, and unfortunately, given the short time frame for publishing its draft rules, none

of these meetings afforded any meaningful input. Moreover, while insurers provided meaningful feedback and comments in early October that a number of the proposed data tables were either unclear, overly burdensome to collect and report, or were unlikely to provide meaningful demonstration of compliance with the MHPAEA, it appears that much of this feedback was not incorporated into the published draft rules. Additionally, in some cases where DIFI did attempt to address concerns, it did so in a way that created different problems. As a result of DIFI's inability to engage in a meaningful stakeholder input process or to afford due consideration to the concerns raised by insurers, the proposed rules are not clear, concise or understandable while also mandating reporting that far exceeds the scope of SB 1523 and the reporting required by the MHPAEA. We would respectfully request that DIFI engage in a much more robust stakeholder input process before finalizing the proposed rules.

We appreciate the opportunity to provide this input on DIFI's proposed MHPAEA rules. For the reasons set forth herein, however, DIFI was unable to complete a rigorous stakeholder process in promulgating the draft rules. Moreover, a number of the provisions either far exceed DIFI's statutory authority, fail to clearly and concisely articulate the standards against which insurers are expected to operate, collect and report or fail to provide a standard for evaluating MHPAEA compliance. We would welcome the opportunity to discuss these comments and any additional feedback to ensure the final rules comply with SB 1523 and the MHPAEA.

Sincerely,



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