From: **Denise Denslow** <denise@thejemfoundation.com>
Date: Thu, Mar 4, 2021 at 5:54 PM
Subject: Public Comment on SB1523, Jake's Law
To: <public_comments@difi.az.gov>

Hi, my name is Denise Denslow. Jake's Law is named after my son Jacob Edward Machobsky who was lost to suicide on January 11, 2016 after he was denied mental health care. We know if the insurance company was following parity we would not have lost our son to suicide. We fought very hard to make this law a reality to ensure no other parent would lose a child to suicide because of denied MH/SUD care. No parent should ever have to go through that.

My husband and I have been looking over the rules and we are concerned. The draft rules are using a 3-to-1 ratio (MH/SUD v med/surg) to trigger the extra reporting on claims denials, prior authorization, etc.? This does not seem to comply with the Federal Parity Law nor does it seem "equal." The question of why the 3:1 ratio was raised in the committee meeting and they said it isn't something they could discuss in that venue. They basically said we could write a public comment requesting a different ratio...but that doesn't answer the question of WHY it was chosen.

Here are the areas that have us concerned:

R20-6-1506. NQTL Compliance Indicators Reporting

F. Compliance indicators for medical management standards

2. Prior authorization denial rate for which no claim was subsequently submitted. As reported in Exhibit I, if the prior authorization denial rate for which no claim was subsequently submitted for any type of MH/SUD services (reported separately for prior authorization requests for inpatient facility stays, outpatient facility visits, and office visits and reported separately for prior authorization denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:

3. Claim denial rate for medically necessary services. As reported in Exhibit J, if the claim denial rate for MH/SUD claims (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported separately for claim denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg claims by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:

4. Approval of only lower level of care services. As reported in Exhibit K, if the rate at which an insurer approves services only for a lower level of care for MH/SUD benefits (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported

separately for benefit reductions due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same lower level of care approval rate for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:

H. Compliance indicators for network tier design.

If the percentage of Med/Surg specialty care providers placed in the lowest network tier exceeds the percentage of MH/SUD providers placed in the lowest network tier by more than a factor of two to one, the insurer shall submit additional information to the Division that includes:

I. Compliance indicators for provider admission standards.

2. Ratio of allowed claims. As reported in Exhibit D, if the ratio of allowed claims for MH/SUD out-of-network benefits to allowed claims for Med/Surg benefits received from a specialist exceeds a factor of three to one, the insurer must provide documentation of the corrective actions it will implement to improve the ratio.

3. Percentage of providers accepting new patients. As reported in Exhibit E, if the total percentage of providers accepting new patients for any type of MH/SUD provider type listed in Exhibit E is less than half of the percentage of Med/Surg specialist providers accepting new patients, the insurer shall report corrective data to the Division...

Per your own standards:

The conduct the rulemaking is designed to change is the practice of health care insurers that provide mental health or substance use disorder ("MH/SUD") benefits to provide those benefits on parity with the provision of medical and surgical ("Med/ Surg") benefits. This means that limitations insurers impose on MH/SUD benefits can be no more stringent or less favorable than the limitations the insurer imposes on Med/Surg benefits.

The failure of a health care insurer to provide MH/SUD benefits on parity with Med/Surg benefits may result in having an insured unable to obtain MH/SUD medical care because the limitations imposed on those benefits is more stringent or less favorable than imposed on other types of benefits.

Setting a 3-1 ratio does not seem to be on par with parity and a main portion of the law is to ensure parity. If these rules are based on insurance parity, and the Federal Parity Law, then shouldn't it be a 1:1 ratio? Party is all about equality and a 3:1 ratio does not seem equal.

Thank you,

Denise Denslow
Executive Director

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