

October 6, 2023

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

The Honorable Lisa M. Gomez  
Assistant Secretary  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20002

The Honorable Douglas W. O'Donnell  
Deputy Commissioner for Services and Enforcement  
Internal Revenue Service  
U.S. Department of the Treasury  
1111 Constitution Avenue, NW  
Washington, DC 20224

**Re: Proposed Rule on Requirements Related to the Mental Health Parity and Addiction Equity Act (0938-AU93; 1210-AC11; 1545-BQ29)**

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

On behalf of our more than 200 hospital and nearly 40 health system members, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the proposed rule issued on Aug. 3, 2023 by the Employee Benefits Security Administration, Internal Revenue Service and the Department of Health and Human Services (the "Departments").

**Mental Health and Substance Use Disorder Benefit Parity**

**IHA strongly supports the Departments' proposals to clarify and improve plan and issuer requirements for benefits, including prior authorization, in-network coverage and payments.** The intent of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was to ensure plan/issuer management techniques did not result in more stringent treatment limitations for mental health and substance use disorder

TRUSTEES & OFFICERS

- Chair**  
J.P. Gallagher  
*NorthShore – Edward-Elmhurst Health*
- Chair-Elect**  
Ruth Colby  
*Silver Cross Hospital*
- Immediate Past Chair**  
Ted Rogalski  
*Genesis Medical Center*
- Treasurer**  
Shawn P. Vincent  
*Trinity Health Illinois/Loyola Medicine*
- Secretary**  
Robert Sehring  
*OSF HealthCare*
- President**  
A.J. Wilhelmi  
*Illinois Health and Hospital Association*
  
- Steven Airhart  
*Hartgrove Behavioral Health System and Garfield Park Behavioral Hospital*
- Tracy Bauer  
*Midwest Medical Center*
- Damond W. Boatwright  
*Hospital Sisters Health System*
- Ned Budd  
*Thorek Memorial Hospital*
- Katherine Bunting  
*Fairfield Memorial Hospital*
- Trina Casner  
*Pana Community Hospital*
- Polly Davenport  
*Ascension Illinois*
- William E. Davis  
*Deaconess Illinois*
- William Dorsey, MD  
*Jackson Park Hospital and Medical Center*
- Raymond Grady  
*Franciscan Health Olympia Fields*
- Damon Harbison  
*SSM Health St. Mary's Hospital - Centralia*
- Dean M. Harrison  
*Northwestern Memorial HealthCare*
- Omar B. Lateef, DO  
*Rush University Medical Center*
- James Leonard, MD  
*Carle Health*
- Michael McManus  
*Memorial Hospital Belleville and Shiloh*
- Dia Nichols  
*Advocate Health Care*
- Israel Rocha Jr.  
*Cook County Health*
- Leslie M. Rogers  
*South Shore Hospital*
- David Schreiner  
*Katherine Shaw Bethea Hospital*
- Tom Shanley, MD  
*Ann & Robert H. Lurie Children's Hospital of Chicago*
- Thor Thordarson  
*AdventHealth Great Lakes*

(MH/SUD) benefits than for medical and surgical (M/S) benefits. However, compliance with previous regulations has been inconsistent and clarity around certain provisions has been greatly needed to address loopholes that have been used in the past.

Currently, Illinois has some of the strongest MH/SUD insurance parity laws in the nation under the Illinois Insurance Code ([215 ILCS 5/370c](#), 370c.1, and 356z.14) and the Illinois Network Adequacy and Transparency Act ([215 ILCS 124/](#)). However, there is a lack of clarity around how data should be collected and evaluated for variables, such as non-quantitative treatment limitations (NQTLs) and network adequacy, to determine access to MH/SUD and M/S benefits. This has resulted in confusion and disagreement between regulators and plans/issuers regarding required oversight. **To streamline expectations and requirements across federal and state departments, we strongly support the newly proposed content requirements for NQTL comparative analyses, specifications on how plans/issuers must make analyses available to requesting parties, and examples of how to apply the rules.**

As MHPAEA's intent was to limit the "scope or duration of treatment," **we also encourage the Departments to focus regulatory implementation on whether limitations on treatment are adversely impacting access to MH/SUD treatment.** For example, Illinois hospitals and health systems have shared that plans/issuers may fail to contract with available MH/SUD providers if proposed reimbursement rates do not cover operational costs. Providers have also reported burdensome reviews by plans/issuers for MH/SUD treatment that unnecessarily restrict access to care, including reviews that are concurrent, retrospective, or for prior authorization or medical necessity. Abuse of these reviews has resulted in inappropriate denials of care and delays in critical assessments, testing and treatment.

### **Exceptions to NQTL Requirements**

**Although we strongly support the majority of the proposed rule, we urge the Departments to remove the proposed exceptions for "independent professional medical or clinical standards" and "fraud, waste, and abuse," both of which could be used by plans/issuers as a loophole, weakening the proposed regulations.** Language in MHPAEA does not include exceptions to the requirement that treatment limitations for MH/SUD benefits be no more restrictive than those applied to M/S benefits. Furthermore, the Departments removed a similar exception from 2010's interim final rules for MHPAEA's NQTL requirements. The "clinically appropriate standards of care" exception was removed due to commenter concerns for abuse of the provision. Instead of an exception, **we encourage the Departments to follow their 2013 decision to place the clinically appropriate standards of care requirements within the framework of the NQTL requirements, rather than as an exception.** If both "independent professional medical or clinical standards" and "fraud, waste, and abuse" are incorporated as factors for applicable NQTLs, they can be analyzed within that framework under MHPAEA requirements that compare MH/SUD and M/S benefits.

To encourage plans/issuers to apply standards that use “independent professional medical or clinical standards,” **we encourage the Departments to use a strong definition of that term in evaluating whether plans deviate from these standards.** Otherwise, plans/issuers may use proprietary criteria licensed by for-profit publishers to establish “independent, peer-reviewed” standards that are technically “unaffiliated with plans and issuers” to meet the Departments proposed guidelines. Similar to Illinois’ current definition of a similar standard for “generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care” ([215 ILCS 5/370c](#)), **we join the Kennedy Forum in support of the following definition for “independent professional medical or clinical standards”:**

*“Independent professional medical or clinical standards” mean standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting independent professional medical or clinical standards are peer-reviewed scientific studies and medical literature, recommendations of federal government agencies, drug labeling approved by the United States Food and Drug Administration, and recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines.”*

Similarly, if “fraud, waste and abuse” is compared between MH/SUD and M/S benefits within the context of applicable NQTLs, regulators will be able to transparently analyze how treatment is limited in each service area under the proposed intent of “fraud, waste and abuse” prevention. **If either “independent professional medical or clinical standards” or “fraud, waste and abuse” remain as exceptions, we are strongly concerned that it will be more difficult for regulators to determine if plans/issuers unnecessarily limited treatment for MH/SUD in comparison to M/S benefits. In turn, beneficiary access to care will be unnecessarily delayed or denied.**

### **Network Composition**

**We are very supportive of the Departments proposed changes to evaluate “network composition” NQTLs, to ensure access to in-network MH/SUD benefits do not show material differences when compared to M/S benefits.** To build on this, we support the Departments collection and evaluation of ratios of providers to participants, beneficiaries, and enrollees from plans and issuers, in order to better evaluate overall network adequacy. The Illinois Network Adequacy and Transparency Act ([215 ILCS 124/](#)) may help to inform the development of this measure, in addition to other federal and state network adequacy requirements.

The Act specifies that the provider-to-enrollee ratio must be identified by specialty and facility-based clinicians when applicable, travel and distance standards for in-person care, and that **telehealth may only be used to partially meet standards.** These specifications within an

October 6, 2023

Page 4

analysis of network adequacy help to better meet the healthcare needs and service demands of beneficiaries and enrollees. For example, if beneficiaries do not have adequate access to in-person care for MH/SUD benefits, but do maintain that access for M/S benefits, a material difference is indicated between the two types of services.

Thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi  
President & CEO  
Illinois Health and Hospital Association