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BILL ANALYSIS

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Senate Bill 27 (Substitute S-3 as passed by the Senate)
Sponsor: Senator Sarah Anthony
Committee: Health Policy

Date Completed: 11-6-23

CONTENT

The bill would amend Chapter 34 (Disability Insurance Policies) of the Insurance Code to require an insurer that delivered, issued for delivery, or renewed a health insurance policy in the State to provide coverage for mental health and substance use disorder services (MH/SUD). Generally, the MH/SUD's financial requirements could not be more restrictive than those of medical or surgical benefits, providing parity between the two.

Requirements for Coverage

Specifically, all the following would apply to the required coverage:

-- Any financial requirements or quantitative treatment limitations applicable to MH/SUD benefits in any classification could not be more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all benefits provided for medical or surgical benefits in the same classification and there could not be separate cumulative financial requirements that were applicable only with respect to MH/SUD benefits.
-- Except as provided below, nonquantitative treatment limitations could be imposed on MH/SUD benefits in any classification only if the processes, strategies, evidentiary standards, or other factors used in developing and applying the nonquantitative treatment limitation to MH/SUD benefits in the same classification were comparable to, and were applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in developing and applying the limitation with respect to medical or surgical benefits in the same classification.
-- The insurer could divide its benefits furnished on an outpatient basis into the subclassifications of office visits (such as physician visits) or any other outpatient benefit (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items).

The benefits provided above would have to meet all applicable Federal parity requirements, including 42 USC 300gg-26, the Federal Law that governs parity between MH/SUD benefits and physical medical benefits, and the regulations promulgated under that law. An insurer that met these Federal parity requirements would be considered to have met the requirements listed above if the Federal parity requirements were not less stringent than the requirements listed above.

If a health insurance policy provided benefits through multiple tiers of in-network providers, including an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers, the health plan could divide its benefits provided on an in-network basis into subclassifications that reflected network tiers, if the tiering were based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a

provider provided services with respect to medical and surgical benefits, mental health benefits, or substance use disorder benefits. After the subclassifications were established, the health insurance policy could not impose any financial requirement or treatment limitation on MH/SUD benefits in any subclassification that was more restrictive than the predominant financial requirement or treatment limit that applied to substantially all medical and surgical benefits in the subclassification.

If a health insurance policy applied different levels of financial requirements to different tiers of prescription drug benefits that were based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a drug was generally prescribed with respect to medical and surgical benefits or with respect to MH/SUD benefits, the health plan would satisfy the parity requirements of the bill with respect to prescription drug benefits.

As used above, "reasonable factors" would include cost, efficacy, generic versus brand name drugs, and mail order versus pharmacy pick-up.

Definitions

"Classification" would mean any one of the following:

-- Inpatient in-network
-- Inpatient out-of-network
-- Outpatient in-network
-- Outpatient out-of-network
-- Emergency services
-- Prescription drugs.

"Financial requirements" would mean deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements would not include aggregate lifetime or annual dollar limits.

"Nonquantitative treatment limitations" would mean those limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a health insurance policy or coverage and would include, but would not be limited to, the limitations described under 45 CFR 146.136. These Federal regulations regulate parity between MH/SUD and physical medical benefits. The term would not include a complete exclusion of all benefits for a certain condition or disorder.

"Quantitative treatment limitations" would include limitations that are expressed numerically, such as limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment and would include, but would not be limited to, the limitations described under 45 CFR 146.136. The term would not include a complete exclusion of all benefits for a certain condition or disorder.

"Substantially all" would mean that term as defined in 45 CFR 146.136, which generally specifies that a type of financial requirement or quantitative treatment limitation is considered to apply to "substantially all" medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

"Predominant" would mean that term as defined in 45 CFR 146.136: 1) if a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification, the level of the financial requirement or quantitative treatment

limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation; or 2) if there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the requirement or treatment limitation, the plan may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment level in that classification; the least restrictive level within the combination is considered the predominant level of that type in the classification.

Proposed MCL 500.3406hh

BRIEF RATIONALE

Federal rules require the parity proposed by the bill in federally provided health plans. Some people have concern that the Federal parity requirements could be repealed, and so it has been suggested that the parity requirements be codified in State law.

PREVIOUS LEGISLATION

(This section does not provide a comprehensive account of previous legislative efforts on this subject matter.)

The bill is a reintroduction of House Bill 5709 from the 2021-2022 Legislative Session.

Legislative Analyst: Alex Krabill

FISCAL IMPACT

The bill could have a fiscal impact on State government and no fiscal impact to local units of government. As Medicaid and the Children's Health Insurance Program (CHIP) are public health plans through which enrollees acquire health coverage and are not group health plans or issuers of health insurance, these programs are subject to Federal rulemaking that requires MH/SUD parity for Medicaid managed care organizations and CHIP.[1] Self-funded non-Federal governmental health plan coverage to its employees may elect to exempt its plan from parity in the application of MH/SUD parity. As of July 31, 2023, the State of Michigan has four health plans that have elected to opt-out of the parity in the application of MH/SUD benefits.[2] Data from the Michigan Civil Service Commission shows that of the approximately 42,600 State employees who receive health benefits from the State, 24,500 or 57.5% of the health insurance coverage would not be subject to regulation under the bill. All four of these listed plans are for State of Michigan employees or retirees, rather than for local units of government. The remaining 42.5% of health insurance coverage for State employees would be subject to meeting the requirement for MH/SUD parity. The State of Michigan employee health programs that are considered health insurance policy as defined by current law and do not meet the requirements listed in the bill would be a fiscal cost to the State.

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[1] Federal Register 81 FR 18390, 42 CFR Parts 438, 440, 456, and 457
[2] https://www.cms.gov/files/document/hipaaoptouts03182021.pdf

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