Legislative Analysis

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REQUIRING COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Senate Bill 27 (S-3) as passed by the Senate
Sponsor: Sen. Sarah Anthony
House Committee: Insurance and Financial Services
Senate Committee: Health Policy
Complete to 11-8-23

SUMMARY:

Senate Bill 27 would amend the Insurance Code to require that insurers that deliver, issued for delivery, or renew health insurance policies in Michigan cover mental health and substance use disorder services.

Under the bill, mental health and substance use disorder benefits in any ***classification*** would not be allowed to be subject to ***financial requirements*** or ***quantitative treatment*** limitations more restrictive that the ***predominant*** limitations applied to ***substantially all*** benefits provided for medical/surgical benefits in the same classification. In addition, there could be no separate cumulative financial requirements applicable only to mental health or substance use disorder benefits.

Except as described below, nonquantitative treatment limitations would be allowed to be imposed on mental health or substance use disorder benefits in any classification only if the processes, strategies, evidentiary standards, or other factors used in developing and applying the limitation to mental health or substance use disorder benefits were comparable to, and applied no more stringently than, those used in developing and applying the limitation with respect to medical/surgical benefits in the same classification.

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. It would not include aggregate lifetime or annual dollar limits.

Quantitative treatment limitations would mean 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. It would include the limitations described under 45 CFR

146.136.[1] It would not include a complete exclusion of all benefits for a certain condition or disorder.

Predominant and ***substantially all*** would mean those terms as defined in 45 CFR 146.136.

Subclassifications

An insurer would be allowed to divide its benefits on an outpatient basis into the following subclassifications:

- Office visits, such as physician visits.
- Any other outpatient benefit, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items.

In addition, if an insurance policy provides benefits through multiple tiers of in-network providers, including a tier of preferred providers with more generous cost-sharing to participants, the plan would be allowed to divide its benefits provided on an in-network bases into subclassification that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits (described above) and without regard to whether a provider provides services with respect to medical and surgical benefits or mental health or substance use disorder benefits.

After the subclassifications were established, the policy could not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits in the same subclassification.

Federal parity requirements

The coverage required under the bill would be required to meet all applicable federal parity requirements, including 42 USC 300gg-26[2] and its associated regulations. An insurer that meets the applicable federal parity requirements would be considered in compliance with the bill if the federal requirements are not less stringent than the bill's proposed requirements.

If a health policy applied different financial requirements to different tiers of prescription drug benefits that are based on ***reasonable factors*** determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a drug is generally prescribed with respect to medical and surgical benefits or with respect to mental health or substance use disorder benefits, the policy would be considered to have satisfied the bill's parity requirements with respect to prescription drugs.

Reasonable factors would include cost, efficacy, generic versus brand name drugs, and mail order versus pharmacy pick-up.

Proposed MCL 500.3406hh

[1] https://www.law.cornell.edu/cfr/text/45/146.136
[2] https://www.law.cornell.edu/uscode/text/42/300gg-26

FISCAL IMPACT:

Senate Bill 27 may result in additional costs for the state and for local units of government, to the extent that any insurance plans that the state or local units of government utilize that are not in compliance with the provisions of the bill would need to comply with the requirements for mental health and substance use disorder service parity. The magnitude of the cost in currently unknown, as the cost would be dependent on the number of plans that are not in compliance and the cost differential with plans that do comply.

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