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BILL ANALYSIS

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Senate Bill 27 (as enacted) **PUBLIC ACT 41 of 2024**
Sponsor: Senator Sarah Anthony
Senate Committee: Health Policy
House Committee: Insurance and Financial Services

Date Completed: 7-24-24

## RATIONALE

Federal law requires parity between mental health/substance abuse disorder (MH/SUD) benefits and medical/surgical benefits in federally provided health plans.[1] Some people are concerned that the Federal parity requirements could be repealed. Accordingly, it was suggested that similar parity requirements be enacted in State law.

## CONTENT

**The bill amends Chapter 34 (Disability Insurance Policies) of the Insurance Code to require an insurer that delivers, issues for delivery, or renews a health insurance policy in the State to provide coverage for MH/SUD. Generally, the MH/SUD's financial requirements must not be more restrictive than those of medical or surgical benefits, providing parity between the two.**

The bill will take effect 91 days after the Legislature adjourns sine die.

Requirements for Coverage

Specifically, all the following apply to the required coverage:

-- Any financial requirements or quantitative treatment limitations applicable to MH/SUD benefits in any classification must 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 must not be separate cumulative financial requirements that are applicable only with respect to MH/SUD benefits.
-- Except as provided below, nonquantitative treatment limitations may 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 are comparable to, and are 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 may 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).

[1] 29 USC 1185a

The benefits provided above must 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 meets these Federal parity requirements is considered to have met the requirements listed above if the Federal parity requirements are not less stringent than the requirements listed above.

If a health insurance policy provides 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 may divide its benefits provided on an in-network basis into subclassifications that reflect network tiers, if the tiering was 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 are established, the health insurance policy must not impose any financial requirement or treatment limitation on MH/SUD 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 subclassification.

If a health insurance policy applies different levels of 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 MH/SUD benefits, the health plan satisfies the parity requirements of the bill with respect to prescription drug benefits.

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

Definitions

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

"Nonquantitative treatment limitations" means 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 include the limitations described under 45 CFR 146.136. These Federal regulations regulate parity between MH/SUD and physical medical benefits. The term does not include a complete exclusion of all benefits for a certain condition or disorder.

"Quantitative treatment limitations" includes 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

includes the limitations described under 45 CFR 146.136. The term does not include a complete exclusion of all benefits for a certain condition or disorder.

"Substantially all" means 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" means 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

**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.

**ARGUMENTS**

*(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)*

**Supporting Argument**

Michigan is experiencing a surge in mental health issues that existed before the COVID-19 pandemic. The State ranks 17th in the nation in a metric that considers prevalence of mental health conditions and availability of mental health treatment, according to Mental Health America, a nonprofit focused on studying mental illness in the United States.[2] For children and adolescents specifically, Michigan ranks 35th in the nation by the same metric.[3] Codifying MH/SUD parity in State law may deter a worse mental health crisis if the Federal law requiring parity were ever repealed.

**Supporting Argument**

According to testimony before the House Committee on Insurance and Financial Services, the bill restricts the nonquantitative treatment limitations, such as preauthorization requirements, that may be imposed by health insurers on MH/SUD benefits by requiring the processes, strategies, evidentiary standards, or other factors used in developing and applying limitations to be comparable to medical or surgical benefits. This will help to keep health insurers honest about the limitations they use on MH/SUD treatment.

Legislative Analyst: Alex Krabill

[2] Reinert, M, Fritze, D. & Nguyen, T., Mental Health America, *"The State of Mental Health in America 2023"*, October 2022.

[3] *Id.*

## FISCAL IMPACT

The bill may 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.[4] 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.[5] 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 will 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 will be subject to meeting the requirement for MH/SUD parity. The State of Michigan employee health programs that are considered health insurance policies as defined by current law and do not meet the requirements listed in the bill will be a fiscal cost to the State.

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

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.