Legislative Analysis

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COVERING MEDICALLY NECESSARY TREATMENT OF MENTAL HEALTH OR SUBSTANCE ABUSE DISORDERS

House Bill 4707 as introduced
Sponsor: Rep. Felicia Brabec
Committee: Insurance and Financial Services
Complete to 6-19-23

SUMMARY:

House Bill 4707 would amend the Insurance Code to require health insurers in Michigan to provide coverage for medically necessary treatment of a mental health or substance abuse disorder. The bill would set requirements for coverage of out-of-network services and emergency services, as well as requirements related to prior authorization, utilization review, and the determination of level of care for insured individuals. The bill states that it would not apply to any entity or contracting provider that performs utilization review (defined as below) or utilization management functions on an insurer's behalf.

Currently, section 3425 of the act requires insurers that deliver, issue for delivery, or renew a health insurance policy in the state to provide coverage for both *intermediate* and *outpatient care* for substance use disorder. Those terms are defined to mean the use of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs: chemotherapy, counseling, detoxification services, or other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan. Intermediate care is provided in a residential therapy setting, and outpatient care is provided on both a scheduled and a nonscheduled basis.

The bill would amend section 3425 to instead require coverage for ***medically necessary treatment of a mental health or substance abuse disorder***.

Medically necessary treatment of a mental health or substance abuse disorder would mean a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing its progression, in a manner that meets all of the following:

- It is in accordance with the ***generally accepted standards of mental health and substance use disorder care***.
- It is clinically appropriate in terms of type, frequency, extent, site, and duration.
- It is not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

Mental health and substance use disorder would mean a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases and Related Health Problems of the World Health

Organization (WHO)[1] or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders.[2] [**Note**: Here and elsewhere in the bill, it may be unclear whether "most recent version" would mean only the most recent version at the time the bill is passed or include future editions of these works as developed by the relevant entities.]

Generally accepted standards of mental health and substance use disorder care would 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, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care would include peer-reviewed scientific studies and medical literature and recommendations of nonprofit health care provider professional associations and specialty societies, such as patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration (FDA).

An insurer would be required to provide coverage for the full continuum of service intensities and levels of care described in the most recent versions of the following:

- The ASAM Criteria by the American Society of Addiction Medicine.
- The Level of Care Utilization System by the American Association of Community Psychiatrists.
- The Child and Adolescent Level of Care/Service Intensity Utilization System by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.
- Early Child Service Intensity Instrument by the American Academy of Child and Adolescent Psychiatry.

An insurer would be prohibited from limiting benefits or coverage for medically necessary services, or enforcing a contract term that excludes otherwise covered benefits, on the basis that the services should or could be covered by a public program, including:

- Special education or an individualized education program (IEP).
- Medicaid.
- Medicare.
- Supplemental Security Income.
- Social Security Disability Insurance.

Utilization review

Under the bill, an insurer, or an entity acting on an insurer's behalf, would have to do all of the following when conducting a ***utilization review*** of all covered health care services for and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults:

- Make all medical necessity determinations consistent with current generally accepted standards of mental health and substance use disorders.

[1] https://www.who.int/standards/classifications/classification-of-diseases
[2] https://www.psychiatry.org/psychiatrists/practice/dsm

- Apply exclusively the level of care placement criteria and practice guidelines set forth in the most recent versions of ***utilization review criteria*** and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty within the scope of the criteria. Criteria and guidelines outside the scope of the nonprofit professional association criteria, including criteria described in section 2212e of the code, could be used if the criteria are fully consistent with current generally accepted standards of mental health and substance use disorder.
- *Not* limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

Utilization review would mean either of the following:

- Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively, or concurrently with the provision of health care services to insureds.
- Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

Utilization review criteria would mean any criteria, standards, protocol, or guidelines used by an insurer to conduct utilization review.

Prior authorization

The bill would amend section 2212e to provide that the prior authorization of medically necessary treatment of mental health and substance used disorders is subject to section 3425 (the primary section amended by the bill).

The bill would amend section 3425 to require that all prior authorization determinations for mental health and substance abuse services be conducted under section 2212e, except as otherwise provided in the provisions concerning utilization review, described above.

Level of care placement

For all level of care placement decisions, the insurer would have to authorize placement at the level of care consistent with the insurer's assessment using the relevant nonprofit professional association level of care placement criteria and guidelines described above. If that level of placement is not available, the insurer would have to authorize the next higher level of care.

If there is a disagreement between the insured's provider and the insurer, the insurer would have to provide the insured and insured's provider with full detail of its scoring using the relevant level of care placement criteria and guidelines.

Out-of-network services

If services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within the geographic or timeliness access standards under law, the insurer would have to arrange coverage to ensure the delivery of medically necessary out-

of-network services and any medically necessary follow-up that meet those geographic and timeliness standards to the maximum extent possible. In these cases, the insured would not have to pay more in total for benefits rendered than the cost-sharing they would pay for the same covered services received from an in-network provider.

Rescinding or modifying authorized treatment

An insurer that authorizes a specific type of treatment by a provider under the bill could not rescind or modify the authorization after the provider renders the health care service in good faith and under the authorization for any reason, including the insurer's subsequent recission, cancellation, or modification of the insured's or policyholder's contract or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility.

Adverse determination

For an ***adverse determination*** regarding a mental health or substance use disorder service, including one regarding a prior authorization, the reviewer would be required to have the appropriate training and relevant experience in the clinical specialty involved in the coverage determination.

Adverse determination would mean any of the following:

- A determination by an insurer or its designee utilization review organization that a request for a benefit, upon application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.
- A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- A recission of coverage determination.
- Failure to respond in a timely manner to a request for a determination.

Emergency services

Under the bill, an insurer would be prohibited from covering ***mental health and substance use disorder emergency services*** more restrictively than other emergency services and would be required to use the same coverage standards as for other emergency services, including using the prudent layperson standard and not applying prior authorization.

Mental health and substance use disorder emergency services would mean the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder that are wellness, resiliency, and recovery oriented. These would include, but not be limited to, crisis intervention, including counseling by 988 centers, mobile crisis teams, and

crisis receiving and stabilization services. 988 center would mean a center operating in Michigan that participates in the National Suicide Prevention Lifeline network to respond to 988 calls.

The insured would not have to pay more than the in-network cost-sharing amount for emergency services, regardless of provider participation status.

Annual report

By March 1, 2024, and each March 1 thereafter, insurers would have to submit a report to the director of the Department of Insurance and Financial Services (DIFS) that includes the comparative analyses and other information regarding the design and application of nonquantitative treatment limitations that apply to mental health or substance use disorder benefits required by 42 USC 300gg-26(a)(8)(A).[3]

Terms in policies or agreements

The bill would prohibit an insurer from adopting, imposing, or enforcing terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of the bill.

Penalties

If the director of DIFS determines that an insurer or any entity or person acting on the insurer's behalf has violated the bill, they would have to assess a civil penalty of $5,000 per violation after appropriate notice and opportunity for hearing under the Administrative Procedures Act. If an insurer or any entity or person acting on the insurer's behalf knew or reasonably should have known that the action was a violation, the penalty would be increased to $10,000 per violation.

The penalties under the bill would not be exclusive and could be combined with any other remedies available to the director under the Insurance Code.

MCL 500.2212e and 500.3425

FISCAL IMPACT:

A fiscal analysis is in progress.

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[3] https://www.law.cornell.edu/uscode/text/42/300gg-26