THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3406hh Coverage for mental health and substance use disorder services.

Sec. 3406hh.

(1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for mental health and substance use disorder services. All of the following apply to the coverage required under this subsection:

(a) Any financial requirements or quantitative treatment limitations applicable to mental health and substance use disorder benefits in any classification must be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all benefits provided for medical/surgical benefits in the same classification and there must be no separate cumulative financial requirements that are applicable only with respect to mental health or substance use disorder benefits.

(b) Except as otherwise provided in subsections (3) and (4), nonquantitative treatment limitations may 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 nonquantitative treatment limitation to mental health or substance use disorder 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/surgical benefits in the same classification.

(c) The insurer may divide its benefits furnished on an outpatient basis into the following subclassifications:

(i) Office visits, such as physician visits.

(ii) Any other outpatient benefit, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items.

(2) Benefits provided under subsection (1) must meet all applicable federal parity requirements, including, but not limited to, 42 USC 300gg-26 and the regulations promulgated under that section. An insurer that meets the federal parity requirements described in this subsection is considered to meet the requirements under subsection (1) if the federal parity requirements are not less stringent than the requirements under subsection (1).

(3) 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 is based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits 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 are established, the health insurance policy must 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 subclassification.

(4) 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 mental health or substance use disorder benefits, the health plan satisfies the parity requirements of this section with respect to prescription drug benefits. As used in this subsection, "reasonable factors" include cost, efficacy, generic versus brand name drugs, and mail order versus pharmacy pick-up.

(5) As used in this section:

(a) "Classification" means any 1 of the following:

(i) Inpatient in-network.

(ii) Inpatient out-of-network.

(iii) Outpatient in-network.

(iv) Outpatient out-of-network.

(v) Emergency services.

(vi) Prescription drugs.

(b) "Financial requirements" means deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

(c) "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 includes, but is not limited to, the limitations described under 45 CFR 146.136. Nonquantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(d) "Predominant" means that term as defined in 45 CFR 146.136.

(e) "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, but is not limited to, the limitations described under 45 CFR 146.136. Quantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(f) "Substantially all" means that term as defined in 45 CFR 146.136.

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