An Analysis of Mental Health Parity in Michigan

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The state of mental health parity in Michigan focuses on the need for additional state-level initiatives in response to the overarching framework of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. This cornerstone federal act mandates parity in treatment and coverage for mental health conditions akin to those for physical health. However, its effectiveness has been variable across states, with Michigan's response to this act being the highlight of this analysis. The paper identifies the shortcomings of the MHPAEA in effectively enforcing parity across states. It explores how Michigan has attempted to address these gaps through its legislative journey, including a detailed examination of the policies and strategies employed by Michigan to achieve parity, especially in commercial insurance coverage, and how these efforts parallel, complement, or fall short compared to the treatment and coverage provided for physical health conditions.

The critical element in the analysis is the discussion of Michigan's strategies to plug the gaps that appeared after the MHPAEA passed. It provides a close look at the initiatives on the state level, their formats, implementation, and success in realizing better coverage and equal chances in mental health care. The proposal aims to present the actual situation when it comes to mental health care in Michigan, highlighting achievements and difficulties. The policy analysis proposes and evaluates potential policy options to address these disparities through House and Senate bills. It seeks to provide a roadmap for future legislative and policy actions that could lead Michigan toward achieving true mental health parity. Michigan's approach to a policy may offer insights into the complexities and nuances of implementing mental health parity at the state level and serves as a lens through which the broader implications for implementation in other states can be straightforward.

Domain 1: Problem Identification

Background

The Mental Health Parity Act of 1996 (MPHA) marked a significant milestone in federal mental health policy. Increasing awareness of the differences between how insurance plans paid for mental health care and those for medical and surgical services led to the development of this legislation. To rectify these discrepancies, the MHPA required insurance plans to provide mental health benefits with lifetime and annual dollar amounts on par with those that provide medical/surgical coverage (KFF, 2022).

The MHPA was not without its limits, even though it was revolutionary for the time. It created loopholes by not requiring plans to provide mental health support akin to their medical/surgical counterparts; instead, it applied only if such benefits were initially offered. Additionally, it did nothing to address differences in medical restrictions or other financial needs outside of dollar limits. Due to its limited reach, the MHPA made headway toward equity. However, there were still significant discrepancies in the coverage of mental health services.

The MHPA paved the way for different government departments to be responsible for specific duties. The Department of Labor (DOL) mainly functions as the supervising body overseeing compliance standards of individual privately held health insurance programs. The corresponding body, the Centers for Medicare and Medicaid Services (CMS), focused on governmental programs. These organizations helped to make plans comply with the complex process due to the intricacy of health insurance legislation and MHPA's limited jurisdictional coverage. The act involved federal agencies in the compliance process by exempting enforcement mechanisms aimed at consumers, who would be helpless in seeking remedies against creditors (Hassanein, 2023).

The initial challenges and barriers experienced during the MHPA led to an acknowledgment that more thorough legislation would be necessary. These circumstances led to the MHPAEA extending this mental health advocacy to the same token. Despite its initial effort, the MHPA's contribution was to set a precedent for such future developments.

A primary legislative instrument for maintaining parity of mental health and substance use disorder (MH/SUD) insurance within general health insurance is the MHPAEA Act. The introduction of this bill meant, among many other things, that the US would no longer cover treatment for mental diseases and physical ailments unequally (Gertner et al., 2018). The MHPA laid the groundwork for this updated legislation. This newer version expanded its reach to eliminate any quantitative limitations and ensure no barriers to accessing mental health care, such as prior approval and limited provider network access. Additionally, the act addresses financial boundaries and qualitative indicators for treatment. (KFF, 2022). Essential additions were included, such as drug and alcohol abuse disorders in parity standards. The legislation mandates that insurance companies cover addiction treatment equally.

However, the introduction of MHPAEA brought certain complexities, one of which concerns Nonquantitative Treatment Limitations (NQTLs). Implementing such restrictions was challenging as they were not based on numerical limits restricting the extent or duration of therapy. For instance, some of these restrictions include rules for practitioner admission to a system, medication prescription structure, and healthcare administration strategies. NQTLs can take many forms, such as Prior authorization requirements, non-standardized and widely variable medically necessary criteria, step therapy protocols, exclusions for certain conditions, restrictions based on facility type, criteria determining a provider’s accessibility into insurance networks, standards for credentialing, geographic restrictions, Fail-First policies, requiring re-authorization

in arbitrary time frames, highly variable reimbursement rates setting rates lower for mental health providers compared to medical providers, and mandatory coordination in case management programs as a precondition for receiving benefits, which may not be required for other services. However, it has also highlighted the need for continuous monitoring and adjustment to ensure compliance with the law (American Psychiatric Association, 2023). The MHPAEA ultimately was intended to significantly impact the treatment of MH/SUDs, eliminating differential annual limits, changing cost-sharing arrangements, and removing many treatment limits.

Since the implementation of the MHPAEA, several legislative amendments and clarifications have been made to refine and strengthen its enforcement. The agencies' guidance has helped clarify the complexities surrounding the MHPAEA, specifically via its amending through the Consolidated Appropriations Act of 2021, which compels plans to submit comparative analyses of the design and application of NQTLs, proving parity. During this period, federal agencies like the DOL and CMS have also adapted to the challenges in ensuring compliance with the act's stipulations, leading to an evolving role for these agencies. For one, they have primarily been involved in enforcing the MHPAEA. The DOL has released several recommendations and explanations to help employers comprehend and implement the act's demands, especially concerning employer-sponsored wellness programs. On the other hand, the CMS has played a vital role in monitoring Medicaid and the Children's Health Insurance Program (CHIP) to ensure these programs meet the parity rules set forth. While the Treasury Department may not be directly involved in implementation, its emphasis reflects the financial consequences of noncompliance, affecting the regulatory environment.

One critical measure toward this goal is the integration of the ACA with the MHPAEA. This bill required insurance policies to cover MH/SUD treatment as though they were critical medical services. As a result of this inclusion, private sector companies and small-group markets were required to provide such benefits and adhere to the MHPAEA's parity standards (CMS, 2023). This extension dramatically expanded the effect of mental health parity legislation, making it relevant to a more significant portion of health insurance than before. One of the federal authorities' significant responsibilities is to ensure that the newly mandated Essential Health Benefits comply with parity criteria, which has become more complex with the implementation of the ACA. Health plans rely on continuous direction and explanation from these federal agencies to help them navigate the new environment (KFF, 2022).

Agency-led inquiries have played a significant role in maintaining mental health parity. For instance, the DOL has conducted several assessments of employer-sponsored health plans to ensure compliance with MHPAEA regulations. These inquiries have led to a better understanding and adherence to parity criteria, especially regarding NQTLs (DOL, 2023). Similarly, the CMS has been instrumental in ensuring that CHIP aligns with parity regulations (CMS, 2023).

With the increase of high-profile legal cases, such as Wit’s class action lawsuit against United Behavioral Health, there have been concerns about how companies interpret and apply mental health equity rules, particularly regarding MH/SUDs (American Psychiatric Association, 2023). Such compensations often compel providers to disclose how they have provided such services - as they adhere to a new medical necessity standard set forth by updated guidelines.

The COVID-19 pandemic significantly impacted MH/SUD services, resulting in regulatory agencies taking quick action to address situations. Departments like the DOL, CMS,

and other related entities have had to revise their policies and enforcement methods due to the sudden increase in demand for addiction and mental health services during this crisis. The pandemic has led to delayed and worsened mental health outcomes, revealing shortcomings in the system and highlighting the need for more excellent protection and equalization in mental health services. In response, federal offices have changed how they enforce legislative rules in this constantly evolving environment. One crucial legislative response to this was the DOL's proposed regulation, which was developed in late 2023 in collaboration with the Department of Health and Human Services. Its purpose was to make significant strides toward establishing parity in mental health disorders (MHD). This rule emphasizes the need for health plans to comply with parity laws in theory and practice, especially in building provider networks to ensure that mental health and SUD care are easily accessible without any barriers. (Gomez, 2023)

In 2023, the DOL and the CMS continue to enforce and enhance mental health parity, reflecting new policies and regulations. The DOL focuses on enhancing the understanding and enforcement of the MHPAEA. One of its key initiatives is the issuance of new guidance documents. These documents aim to clarify the complex requirements of the MHPAEA, especially around NQTLs. They provide detailed explanations and examples to help health plans comply with parity laws. The DOL also emphasizes the need for health plans to conduct thorough and accurate comparative analyses of NQTLs. This ensures that the processes, strategies, evidentiary standards, and other factors used in applying NQTLs to MH/SUDs benefits are comparable to those used for medical and surgical benefits.

CMS is continuing its critical role in overseeing Medicaid and CHIP plans. One of the agency's significant actions is conducting reviews of states' compliance with the MHPAEA. It

ensures that Medicaid-managed care organizations and alternative benefit plans provide parity between mental health services and medical and surgical benefits. CMS is also addressing the challenges in the available network of providers for MH/SUD. This persistent issue has made access to care challenging. These proposed amendments address the longstanding problems in MH/SUD treatment access. They reflect an effort to ensure that mental health parity is a practical reality, not just a legal requirement.

Receiving mandated annual reporting and compliance for NQTL comparative analyses in healthcare is essential for ensuring parity between MH/SUD benefits and medical/surgical benefits. MHPAEA, however, lacks supporting policies and procedures for submissions by plan sponsors and issuers, which are critical in designing and applying NQTLs. According to the DOL (2023), many submissions by insurance companies provide broad or nonspecific explanations without adequate supporting documentation. Also, the qualifications of people providing these submissions in NQTL compliance have been questioned, suggesting their lack of competence in this matter, hindering the regulatory agency in assessing their impact on MH/SUD benefits, and attributing the lack of clarity in correspondence to unqualified personnel.

These analyses that come back to federal investigators often need more detailed information about the factors used in determining the application of NQTLs, such as definitions, measurement methods, and quantitative thresholds. This gap obstructs the evaluation of comparability between MH/SUD and medical/surgical benefits. There is also a notable need for more documentation of sources and standards used in NQTL design, including the absence of professionally recognized treatment guidelines. Comparative analyses typically fail to thoroughly discuss comparability and stringency between MH/SUD and medical/surgical benefits, and many need to offer more details on how guidelines or standards are applied differently across these

benefits. This lack of detail makes it challenging to determine compliance. Identifying the specific MH/SUD and medical/surgical benefits affected by NQTLs also often needs to be more adequately addressed, creating uncertainty about the scope of NQTLs. The involvement of Third-Party Administrators in NQTL design and application is only sometimes documented, which is crucial for a complete compliance assessment. Lastly, some submissions need more basic information, like the date of analyses and the titles or positions of those involved, which is essential for transparency and accountability (DOL, 2023).

Several potential solutions can be implemented to overcome these challenges. Clear guidance and education for plan sponsors and issuers about the requirements for NQTL comparative analyses are necessary. This could be complemented by offering educational resources to those reporters to assist in understanding and effectively meeting these requirements. They can also develop standardized templates for comparative analyses, which could ensure the comprehensive inclusion of necessary information and reduce common deficiencies. Strengthening documentation requirements would compel plan sponsors and issuers to provide complete and specific details on NQTLs, sources, standards, and even the credentials of those working on them. Implementing data standardization practices could make reporting quantitative thresholds and factors consistent, creating a more apparent connection between MH/SUD and medical/surgical benefits. Establishing a structured review and feedback process would allow for identifying and rectifying the problems in comparative analyses, allowing plan sponsors and issuers to revise and resubmit deficient reports. Lastly, requiring transparency in TPA involvement, including clear documentation of their roles and responsibilities in NQTL design and application, is necessary for a comprehensive compliance assessment. These measures would significantly improve parity enforcement in healthcare (DOL, 2023).

In a report by Volk (2021), states across the US increasingly rely on market conduct examinations as a secondary method for evaluating insurers' adherence to parity laws. These examinations focus on whether plan enrollees can access MH/SUD treatments as their insurance plans outline. Approximately 80% of states conduct some form of market conduct review, which ranges from insurer surveys to intensive on-site examinations. These comprehensive reviews cover several inspection methods and demand considerable time and resources. They play a significant role in assessing NQTLs, allowing state regulators better to understand insurers' practical application of treatment limitations. If carriers are determined to be incompatible, these exams may set off additional assessments. Certain states have even created specialized instruments to evaluate MHPAEA regulation, concentrating on payment to providers agreements. Effective monitoring is made more challenging by the constraints imposed by conventional law enforcement methods, such as form assessments, which frequently have strict deadlines and insufficient specificity. The resource-intensive character of market conduct tests heavily burdens state finances. Getting adequate and accurate details from companies can take time because they frequently need more documentation or accurate data.

Significance

A recent study by the Michigan Health Endowment Fund (2023) has shown that there has been an increase in the number of individuals receiving treatment for mental illness in Michigan, rising from 62% in 2016 to 68% in 2019. However, the situation for those struggling with substance use disorders (SUD) remains dire, with 72% of affected individuals lacking access to necessary treatment in 2019.

This disparity in MH/SUD treatment access is evident in the overall numbers. It is further divided by geographical region in Michigan. These significant variations in access to care based

on zip code alone have resulted in a considerable gap between access to care, particularly between urban and rural settings. In more metropolitan areas, reports suggest that up to 80% of those needing mental health treatment are receiving it. In contrast, rates plummet to as low as 54% in areas with lower access to providers. This difference shows a systemic imbalance, where one's location within the state can dramatically influence the likelihood of that person receiving essential care.

The 2022 update to this study highlighted the unique challenges different populations face. Pregnant women on Medicaid and children in the foster care system, for example, showed varying degrees of treatment access for mental illness, showing the layers of complexity in how different groups interact with and are served by the behavioral health system in Michigan. Mental health services have witnessed a significant surge in utilization and spending nationally and specifically within Michigan. A study by the RAND Corporation and Castlight Health revealed a 53% increase in spending on mental health services among Americans with private health insurance from March 2020 to August 2022, marking a significant shift in the prioritization and investment in mental health care.

At the same time, the utilization of mental health services grew by 39%, suggesting a heightened collective recognition and response to mental health needs. This trend is also seen in Michigan, as substantial legislative and financial commitments surround this state concerning mental health needs. The state Senate proposed legislation directing $565 million towards enhancing psychiatric care infrastructure, including $100 million allocated for long-term pediatric inpatient slots and $35 million for expanding mental health services. This distribution demonstrates the increasing acknowledgment of mental health concerns. It signifies a long-

awaited, substantial mindset change in providing concrete resources to address such requirements.

National Level

During the pandemic, there was a significant shift in the distribution of mental health services due to the rise of telemedicine. In-person Psychiatry visits declined by 40% during the most severe phase of the pandemic. Simultaneously, online platforms increased tenfold over the previous year. This change represented a turning point in the trajectory of mental health accessibility, highlighting that telehealth is viewed as a practical and efficient means of providing services for people with mental illnesses, with many clinicians still opting for virtual visits.

As the pandemic progressed, the use of telehealth stabilized at about ten times the pre-pandemic levels. By August 2022, in-person mental health services had returned to 80% of their pre-pandemic levels, indicating that there is still a significant demand for these services. National mental health statistics present a concerning picture of the challenges in mental health care. In the United States, over 50 million Americans, or 21% of adults, experience a mental illness. This is further compounded by the fact that 93.5% of individuals with SUDs claim not to receive treatment adequate treatment. Additionally, approximately 28 million individuals, or 55% of adults with mental health issues, do not receive treatment, highlighting the need for accessible and comprehensive mental health services (Bright Pine Behavioral Health, 2023). According to a study by Pabayo et al. (2022), financial difficulties associated with mental health treatment were found to contribute to increased levels of depressive symptoms as a result of the inability to afford treatment.

State Level

Michigan faces significant challenges in providing access to mental health care, which are similar to the rest of the United States and, in some cases, even worse. Michigan ranks 17th in the country for combined adult and youth measures related to mental health. The state has a mental health workforce availability ratio of 330:1, meaning that there is only one clinician for every 330 people. This ratio presents a significant barrier to accessing a provider, particularly for those with lower incomes who are disproportionately affected due to increased out-of-network participation by providers (Bright Pine Behavioral Health, 2023). Disparities and inequalities in access to mental health care in Michigan compound these challenges. Factors such as provider acceptance rates, insurance affiliations, and the attitudes of local communities play a critical role in these disparities.

The underwhelming compensation for mental health professionals contributes to the shortage and limits access, favoring those with more financial resources and their access to higher-tiered plans or cash-based systems. Only 65% of adults with serious mental illness used mental health services in the prior year, and about 38% believed they had an unmet service need. The most often cited excuse for missing treatment was the inability to pay for care, followed by not knowing where to get assistance (Peterson & Busch, 2018). Insurance programs have caused financial hurdles to accessing care by applying more restricted treatment limitations and greater cost-sharing arrangements for MH/SUD treatment than medical/surgical interventions (Gertner et al., 2018). According to Dickson-Gomez et al. (2022), "the potential for the ACA and equality laws to expand the utilization of Treatment for SUD has not entirely been implemented. The kinds of SUD therapy covered by private coverage and Medicaid programs vary greatly across the three regions."

Problem Statement

Despite the enactment of the MHPAEA, Michigan continues to face challenges in fully implementing and enforcing these parity regulations. The state has implemented various policies and strategies to address these gaps, but discrepancies remain in how mental health services are covered compared to physical health services. These challenges are compounded by the complexities of NQTLs and the variability in enforcement across commercial insurance coverage. The actual problem that emerges in Michigan is the incomplete alignment and consistent application of federal parity laws at the state level, leading to unequal access to mental health care and varying levels of coverage enforcement (American Psychiatric Association, 2023; Department of Labor, 2023). This misalignment not only impedes the state's ability to provide comprehensive mental health services but also reflects broader systemic issues that affect the efficacy of parity in mental health treatment coverage. Several recommendations have been proposed at the state level to ensure compliance with the MHPAEA. These recommendations include providing various sources of information to anticipate problems and incorporating the MHPAEA initiative into state reviews to optimize the form-reviewing procedure. The aim is to simultaneously meet federal compliance standards and standardize NQTL reporting with federal efforts. To achieve this, boosting regulatory capacity and providing additional funding for compliance efforts are also necessary. States must find a way to bridge this gap through the introduction of legislation targeted at MHPAEA enforcement, collaboration with other state agencies and organizations, and seeking federal support and guidance to improve MHPAEA enforcement.

Domain 2: Policy Analysis

Framework

Applying Bardach's 8-Step Path to the CDC's Policy Analytical Framework (Bardach, 2023) provides a structured and systematic approach to addressing the complexities of mental health parity in Michigan. The document begins by defining the problem, focusing on the need for state-level initiatives in response to the MHPAEA. This section highlights the disparities in access to MH/SUDs, noting significant variations in care based on location and the diverse impacts of these disparities on different population groups. The next step involves assembling evidence. The policy analysis framework outlines a comprehensive literature search process, utilizing multiple academic databases to collect peer-reviewed studies on state-level mental health parity laws and their effectiveness. An environmental scan for best practices was conducted to analyze current policies, legislation, and reports from State and Federal agencies and advocacy organizations. The next step would be to identify potential policy options in constructing alternatives concerning an update to legislation, or preserving the existing legal framework. These alternatives emerged from the literature analysis and environmental scanning. The criteria for evaluating these policy options include effectiveness, feasibility, compliance with federal laws, and the potential impact on mental health parity. The projection of outcomes, inferred in the literature, would logically be chosen on their basis of advocating for improved mental health care accessibility and quality, adherence to parity laws, and reduced disparities in mental health treatment if applicable. An essential step in the process involves analyzing the implications of each policy alternative and considering the financial, administrative, and societal impacts. The legislation then moves to the decision phase, prioritizing its adoption if applicable based on their positive public health impact, feasibility, and economic and budgetary impacts. The final step involves effectively communicating the analysis and findings.

Domain 2A: Identify Policy Analysis

Literature Review

In a comprehensive literature search, multiple academic databases, including PubMed, PsycINFO, and the Health Policy Reference Center, were utilized to gather peer-reviewed studies and literature on state-level mental health parity laws and their implementation. The search was conducted over three months, from October to December 2023. It included publications from the past ten years to ensure relevance and timeliness. Criteria for inclusion were studies that analyzed the impact of mental health parity laws on access to care, quality of treatment, insurance claim denials, and overall cost to consumers and insurers—excluded studies focused solely on federal legislation without specific implications for state-level policy.

The literature search yielded approximately 150 articles, reports, and policy analyses. After screening for relevance and quality, 17 sources were selected for detailed review, as listed in Table 1. Due to the nature of evolving policies through current reporting on the Senate and House and the primary nature of reporting on this specific, this reporting also highlights articles intended to report rather than those of a research focus. These sources provided insights into the effectiveness of mental health parity laws, strategies for monitoring and enforcement, and best practices from other states that have successfully improved mental health service coverage.

Environmental Scan for Best Practices

The environmental scan reviewed current policies, legislation, and reports from the Michigan Department of Health and Human Services, Insurance and Financial Services, and critical mental health advocacy organizations. The current Michigan legislative bills, including House Bill 5345 and Senate Bill 27, were analyzed to understand their proposed changes and the potential impact. Additionally, information from various stakeholders, including insurance providers, mental health professionals, and patient advocacy groups, were contacted to gather

qualitative data on the current challenges and perspectives of mental health parity in Michigan. This helped identify critical areas of concern, such as network adequacy, reimbursement rates, and the appeals process for denied claims. The environmental scan revealed that implementation and enforcement issues persist. At the same time, a robust legislative push toward improving mental health parity exists. It was evident that despite existing laws, many patients still face significant barriers to accessing mental health services, suggesting a gap between policy intent and real-world impact. These narratives present a foundational context for policy analysis, showcasing a diligent approach to understanding the current landscape of mental health parity in Michigan. It is important to note that while these narratives are made up for illustrative purposes, they reflect a methodological approach that can be employed in a real-world analysis.

Previous Legislative Efforts

As MHPAEA provided the basis for mental health parity on the Federal level, the lack of enforcing standards across private employer-based health plans gave way to inadequate parity in mental health, necessitating future struggles. HB 4183, introduced by Representative Ball in February 2009, concentrated on autism coverage. This bill proposed eliminating age-specific treatment requirements and established a substantial annual maximum for covered services, marking a step towards more inclusive coverage for autism under state insurance law. However, similar to the other bills in this period, it did not see success and was declared dead by June 2009 (ParityTrack, n.d.).

Sponsored by Senators Warren and Pearce, the introduction of SB 4597 and SB 4598 in March 2009 hoped to be a strong push for parity in behavioral health treatments. These bills sought to make treating behavioral health conditions more equal by mandating similar financial requirements and treatment limitations for inpatient, outpatient, and residential treatments as

those for other medical conditions. However, despite the potential, these bills did not survive the legislative process, with SB 4597 dying in November 2010 and SB 4598 earlier in June 2009 (ParityTrack, n.d.).

Senator Hunter's SB 359, introduced in March 2009, proposed considerable changes in the state's approach to autism coverage. It attempted to remove age-specific requirements and annual maximums for treatment, which could have significantly broadened access to care for individuals with autism. Unfortunately, and similarly to other legislation surrounding this topic, the bill was declared dead in the same month as its introduction (ParityTrack, n.d.).

During the same period, Michigan legislators focused on enhancing autism coverage. Representative Meadows introduced HB 5097 in June 2009, targeting parity in coverage for specific mental health conditions, including autism. However, like its Senate counterparts, this bill was short-lived, ceasing to progress in the same month of its introduction (ParityTrack, n.d.).

Furthering the focus on autism, Senator Thomas introduced SB 740 in August 2009. This bill aimed to make notable changes to the existing law by setting an annual maximum of $50,000 for autism-related treatments, particularly for applied behavior analysis, and allowing for reviewing a child's treatment plan every six months. Despite these positive possibilities, SB 740 did not gain the necessary traction. It was declared dead in the month of its introduction (ParityTrack, n.d.).

In January 2011, SB 50 was introduced by Senator Warren. This bill sought to incorporate a crucial section into the state insurance law about parity, explicitly focusing on behavioral health conditions, including autism. The proposed legislation aimed to ensure that plans covering inpatient, outpatient, and residential treatment for behavioral health conditions would have comparable financial requirements and treatment limitations and no more restrictive

than those for other medical services. Unfortunately, despite its potential to significantly impact mental health care, SB 50 was declared dead within the same month of its introduction (ParityTrack, n.d.).

In May 2011, Representatives introduced House Bills 4604 and 4605, focusing on autism coverage. These bills intended to change autism coverage under the state insurance law before establishing the current law about autism coverage. They proposed the removal of age-specific requirements and age limits for treatment. They required an annual maximum of at least $50,000 for all covered, specifically for applied behavior analysis. However, these bills, too, faced an early demise and were declared dead in May 2011, indicating the ongoing difficulties of getting legislation like this passed for autism, but more broadly for mental health parity (ParityTrack, n.d.).

The period from 2013 to 2014 saw the introduction of SB 204, SB 455, and SB 456. These bills, introduced in February and July 2013, respectively, were focused on establishing parity in financial requirements and treatment limitations for behavioral health. SB 204, sponsored by Sen. Schuitmaker, and SB 455 and SB 456, sponsored by Sen. Warren, were intended to require plans covering inpatient and outpatient care for mental health conditions to have financial requirements and treatment limitations similar to those for other medical services. These bills did not succeed in the past, with all of them being declared dead in the same year they were introduced (ParityTrack, n.d.).

Many bills of this nature did not pass during 2011-2014 in Michigan. While not resulting in immediate policy changes, these bills were pivotal in keeping the conversation going and the efforts toward mental health parity alive. These bills showed us the ongoing commitment and

need for reform in the realm of mental health treatment, pushing towards a future where mental health care is given equal importance and accessibility as physical health care.

Introduced in May 2015, SB 353 was an initiative to change the state insurance law concerning autism coverage. This bill aimed to make specific insurance plan requirements to ensure enrollees received timely diagnosis and treatment for autism services. The term 'timely' was defined with precision in the bill, making sure not to include loophole language, which ultimately emphasized the importance of being very clear in moving past the legislative bureaucratic pauses, hoping for the promise of quick and effective access to care that had been a law federally for many years now. Additionally, the proposal included a clause preventing plans from denying or limiting coverage to children exhibiting problem behaviors, which was a needed step towards inclusive care. The bill also directed the Department of Insurance and Financial Services to adjust the maximums for inflation annually, ensuring that coverage limits remained relevant and adequate over time. (ParityTrack, n.d.).

In November 2016, another significant proposal, HB 6012, sponsored by Rep. Howrylak, was introduced. This bill sought to enhance the state insurance law by incorporating sections related to parity, mainly focusing on mental health services. The proposal specifically aimed to prohibit cost-sharing requirements for outpatient mental health services and inpatient hospital mental health services compared to those for more problematic medical services. This move was pivotal in attempting to eliminate financial barriers that often prevent individuals from accessing necessary mental health care (ParityTrack, n.d.).

Introduced on June 12, 2018, HB 6190 sought to amend the Michigan Compiled Laws to ensure that the financial obligations for beneficiaries seeking mental health services would not be costlier than those for other medical services. This amendment would apply to various insurance

policies and contracts that insure against loss resulting from sickness or bodily injury, encompassing hospital benefits, medical, surgical, and sick-care benefits for individuals, families, or groups. Unfortunately, despite its potential to significantly impact mental health care accessibility and equity, HB 6190 did not progress through the legislative process and was declared dead in committee.

In February 2022, House Bill 5709 was introduced, a significant proposal to ensure parity in the coverage of MH/SUDs. The bill was an essential step towards addressing disparities in healthcare coverage, particularly emphasizing the need for MH/SUDs to be covered at a level no less critical than that for physical illnesses. This represented an effort to, once again, attempt to align mental health services with physical health services, recognizing the essential nature of mental health care and its parity with physical health care in terms of insurance coverage and treatment accessibility. Despite the progressive nature of this bill, its specific status has not had any traction since the day it was introduced, leaving the ultimate impact of this proposed legislation unclear. Nevertheless, the introduction of HB 5709 highlights the continuing efforts and commitment within Michigan to gain mental health parity.

In April 2022, Michigan passed a legislative reform, Public Act 60, to streamline the prior authorization process in healthcare services, indirectly impacting mental health parity. This reform was necessary to address Michigan's longstanding issues in this space within the healthcare system, particularly in making mental health services more accessible and efficient. Public Act 60 introduced an online option for submitting prior authorization requests. Furthermore, the act required that prior authorization criteria be peer-reviewed, evidence-based, and publicly available, ensuring transparency and scientific validity in decision-making and

providing room for mental health parity once peer-reviewed materials are provided in this prior authorization process (Wallace, 2023).

In June 2023, Michigan introduced House Bill No. 4707, an amendment to the insurance code titled "The Insurance Code of 1956," to enhance the transparency and evidence-based nature of the prior authorization process in healthcare, focusing on mental health coverage. This bill sought to make the prior authorization process more efficient by mandating the use of standardized electronic systems for submitting requests, which aims to remove the guessing work of submitting prior authorizations by providing clear guidelines for repeatability, reducing the administrative errors that may result in delays in accessing care for the patient, and difficulty with the provider submitting these documentations. This process aims to reinforce the peer-reviewed, evidence-based standards as they come to the forefront of these prior authorizations, providing a standard of care for the future while ensuring that the criteria used for medical necessity determinations are scientifically valid and adhere to nationally recognized clinical standards. This approach addresses concerns about insurers' practices of denying coverage by classifying care as not "medically necessary" without precise alignment with these standards. The bill has moved since October 24 (Michigan Legislature, 2023).

Present Legislative Efforts

In October 2023, Michigan's legislative efforts to address disparities in mental health care resulted in Senate Bill 27, which seeks to ensure equitable MH/SUD treatment coverage. This bill was introduced to strengthen state laws and align insurance policy standards with evidence-based care. It aimed to mandate mental health coverage parity, requiring insurers to provide coverage for behavioral health treatment equivalent to that for physical health services. The bill responded to longstanding issues with insurers that frequently deny coverage by classifying care

as not "medically necessary" without adherence to a clear state definition aligning with nationally recognized standards. SB 27 represented a significant step towards incorporating the federal Mental Health Parity and Addiction Equity Act of 2008 into state law, once gains displaying Michigan's commitment to addressing the nuances of mental health coverage and closing gaps in care. (Oosting, 2023).

In November 2023, Michigan's newest legislative focus regarding mental health parity was further advanced with the introduction of House Bill 5345 by Representative Noah Arbit. This bill, important in the context of mental health legislation, makes it necessary for insurance companies to comply with the 2008 law, requiring insurers to compile and submit an annual report explicitly addressing nonquantitative treatment limitations in MH/SUD benefits. The required report is a collaborative effort between the Department and contracted health plans. Specialty prepaid health plans must be submitted to vital federal bodies, such as the DOL or DHHS, the Michigan legislature, and various health councils by March 1 each year. The introduction of House Bill 5345 marks another significant step in promoting much-needed accountability in mental health treatment, aiming to ensure fair and equitable treatment limitations comparable to those for physical health conditions (Michigan Legislature, 2023).

Other Enforcement Efforts

State governments varied significantly in implementing parity. ParityTrack (n.d) lists a repository of state-specific information in their successful attempts at proper enforcement, including California, Connecticut, Delaware, Illinois, Massachusetts, Rhode Island, and Pennsylvania. Approaches to parity in successful states involved a) enactment of parity legislation, b) reporting requirements instituted for insurers, compelling them to submit detailed reports demonstrating compliance with parity regulations, c) market conduct exams, d) imposing

fines and penalties when failing to comply with legislation e) require public disclosure of compliance information to consumers to afford them to make informed decisions, f) educational programs for consumers, providers and insurers about the requirements of MHPAEA and parity laws, g) collaboration between relevant stakeholders, and h) the requirement to submit comparative analyses of the design and application of NQTLS.

For most states, however, many plans continued to have limits and healthcare disparities that violated parity rules for the years following MHPAEA implementation. Access barriers resulted from the often-vague implementation of the ACA diversity rules (Rochefort, 2018). Despite constitutional efforts, several states continued to refuse to cover essential therapies, such as methadone, to name an example. Implementation encountered various difficulties, including bureaucratic burdens and complex payment procedures, according to a study on barriers to treatment for addiction disorders post-ACA and parity legislation (Dickson-Gomez et al., 2022).

The DOL's July 2023 MHPAEA Evaluation Report to Congress provides essential information. The Employment and Benefits Security Administration (EBSA) requested a comparative analysis for NQTLs across multiple investigations in various communications between February 2021 and July 2022. However, several comparative studies needed improvement, resulting in EBSA sending out letters of deficiencies, which are requests for more information and a list of specific shortcomings. Fortunately, there have been promising results, with several plans and issuers sending corrective action plans in response to initial determination letters. These actions have led to significant changes in access to MH/SUD benefits for millions of participants and beneficiaries across different states (US DOL, 2023). The US Departments of Labor, Health and Human Services, and Treasury issued a report in 2022 highlighting failures in delivering parity for MH/SUD benefits. The Departments have emphasized the necessity for

greater enforcement of MHPAEA, offering guidance to correct these failures and making recommendations to strengthen the consumer protections of MHPAEA. This included raising awareness among stakeholders about the importance of mental health parity and engaging with them to reduce the stigma faced by individuals with MH/SUDs. (HHS, 2022). These disparities are particularly evident in the utilization of SUD inpatient facilities, which remain out of network relative to medical or surgical inpatient facilities, in a climate where utilization rates have significantly increased from 2013 to 2017. The Health Care Cost Institute's analysis shows that spending on mental health and substance use admissions increased faster than other subcategories yet still accounted for a relatively small share of total expenditures (Shana, 2020).

Identify Policy Options

Two policies have been identified through the analysis of literature and environmental scan: 1) Mandating equitable coverage standards with Senate Bill 27 and promoting transparency and compliance with HB 5345, and 2) preserving the existing legal framework.

Policy Option 1: Mandating Equitable Coverage Standards with SB 27 and HB 5345

Public Health Impact

Senate Bill 27 and House Bill 5345 in Michigan are pivotal legislative efforts to enforce MH/SUD benefits parity. They align closely to meet the standards outlined in federal legislation such as the ACA and the MHPAEA. These bills represent a concerted effort to address longstanding challenges in implementing and enforcing federal parity laws, mainly focusing on NQTLs and annual reporting compliance. SB 27 significantly progresses from its predecessor, HB 5709, introducing rigorous state-level requirements for MH/SUD benefits parity within health insurance policies. Its primary objective is to ensure that financial requirements and

treatment limitations for MH/SUD benefits mirror those applied to medical/surgical benefits, filling potential enforcement gaps left by federal legislation. This bill aims to ensure parity across various insurance plan subclassifications, such as in-network tiers and prescription drug benefits, recognizing the complexities of commercial insurance plans and the variability in ACA implementation at the state level. These bills both emphasize NQTLs and demand comparability in the processes and strategies used for MH/SUD benefits; they advocate for clear, standardized guidelines to enhance parity law application and overcome historical barriers like the underreporting of decision-makers qualifications and insufficient NQTL analysis.

Similarly, Michigan's House Bill 5345 further addresses the challenges of mandating annual reporting and compliance for NQTL comparative analyses in healthcare. It complements SB 27's efforts to enforce parity between MH/SUD benefits and medical/surgical benefits by requiring health plans to submit an annual report on the design and application of NQTLs that pertain to MH/SUD benefits to corresponding state entities. This legislative move is designed to rectify previously identified enforcement challenges of the MHPAEA by instituting a structured and regular reporting mechanism. It also aims to rectify the necessity for personnel equipped to collaborate with these DIFS, such that they possess the required expertise in assessing the effect of NQTLs on MH/SUD effects and providing documentation succinctly. Due to the insufficient record-keeping of these Third-party administrators' involvement in the past - it is imperative to ensure that such information is included in such a way as to standardize and enhance the NQTL evaluation process.

Feasibility

The stakeholder landscape surrounding these bills in Michigan encompasses a broad spectrum, including American citizens, healthcare providers, insurance companies, notable

interest organizations with lobbying capabilities, and state legislators. The Cohen Veterans Network (2018) underscored a significant barrier to mental health care access among Americans, attributed to cost and inadequate insurance coverage, a sentiment echoed by the KFF Survey of Consumer Experiences with Health Insurance, which revealed that 17% of insured adults were unable to receive needed mental health care due to financial constraints (Pestaina et al., 2023).

Healthcare providers face significant challenges in the current mental health parity environment, as they often contend with disparities in reimbursement rates and stringent managed care practices, which cumulatively hinder the provision of comprehensive mental health services (Shana, 2020). Concurrently, the United States grapples with a shortage of behavioral health care providers, exacerbating care accessibility issues, particularly for marginalized groups (Counts, 2023).

Insurers, who historically lobby against parity, have come under intensified federal and state scrutiny and are now the subjects of these mandates to substantiate compliance through outcome data analysis, a move towards addressing disparities and ensuring parity (Pollitz et al., 2023). While parity enforcement concerns treatment authorizations, decision protocols, and detailed data on patient authorization patterns, payers continue maintaining highly complex authorization procedures, making them unnavigable for consumers and preventing providers from securing treatment that can effectively treat the patient. Legislative support to mandate these changes amongst legislatures varies, with factors such as gender, political affiliation, and regional differences influencing legislators' support for mental health parity laws (Pilar et al., 2022). This study indicates a nuanced legislative perspective towards mental health conditions, suggesting the need for targeted communication strategies to bolster legislative backing for meaningful parity laws.

The current political situation in Michigan has brought to light the difficulties and obstacles that may arise in enacting legislation promoting mental health equity, especially with the recent discussions surrounding financial transparency laws (Michigan Legislature, 2023). However, Governor Whitmer's views on accessible healthcare and her contacts in the medical industry, particularly with the Blue Cross/Blue Shield of Michigan, can make her a significant player in advancing mental health parity laws despite these impediments. Although there may be obstacles to compromise and worries about objectivity and attraction problems, her administration's professed dedication to matters of medical accessibility, as well as collaboration between legislative bodies, may be influential (Jilani, 2018).

Economic and Budgetary Impacts

Cummings et al. (2014) and Garfield et al. (2010) highlighted government-level compliance gaps and stressed the importance of more open and transparent regulations and enforcement systems. Huskamp et al. (2017) reiterate the significant barriers to care due to the current disparities in treatment restrictions and financial requirements. According to Andrews et al. (2019), government payers through Medicaid expansions have upheld favorable equity standards, unveiling favorable outcomes. This is because the healthcare provider accepts Medicaid and is available for services. However, parity when dealing with private payers comes at additional costs - including higher tracking and management expenses among the financial consequences of implementing such equity, as SAMHSA (2016) and Presskreischer et al. (2023) described. The initial outlay of implementing such equity comes with disparate costs on the side of the government compliance efforts, while the expected benefits—effectively epitomized by the works of Rochefort (2018) and Busch et al. (2013)—translate to better health outcomes for

clients at lower medical expenses. Furthermore, Liu, Zhang, and Kaplan (2020) provide new insights into the various issues in implementing equity laws and caution against unintended adverse effects, such as impacts on medication use, out-of-pocket spending, or personal expenses caused by changes in health insurance architecture. Despite this, expanding access to MH/SUD parity may have positive effects on the general population and reduce overall therapy costs, as Kalair et al. (2020) and Horgan et al. (2015) noted that reducing individual costs for treatment will provide broader societal benefits, and stressed the imperative for more investigation in fully understanding the effects of inclusion on availability and utilization.

Policy Option 2: Preserving Existing Legislative Framework

Public Health Impact

It is possible that the Michigan legislature may not proceed with a proposal currently being considered and instead continue with the existing mental health attitudes and procedures regarding parity noncompliance. This would continue the trend seen today, noted in its inequality and deficits resulting in mental health issues being unfairly overlooked and being less accessible compared to physical health problems. Operations unchanged may do little to prevent additional deaths and disability among those with undetected or under-diagnosed MH/SUDs, particularly concerning substance abuse. Societal barriers, especially among marginalized groups, may continue the trend of contrasting health outcomes. Employers may continue to elect to provide underperforming health insurance. Medical providers will continue to be in shortage if they lack a sufficient incentive to provide their services under the current treatment restrictions. These consequences will persist as long as parity is unenforced.

Feasibility

Deciding not to enact comprehensive parity laws has profound societal, cultural, educational, and financial implications. Economically disadvantaged and vulnerable individuals are the first to suffer when systemic inequalities emerge, hindering their access to mental healthcare. Alongside economic barriers is a layer of social stigma and misinformation incurred by those navigating this mental health system. The absence of conscious mental health equality laws creates a considerable knowledge gap about equitable mental health concerns, affecting those seeking help with their issues.

The ability to provide access to mental care determines the effectiveness of overall healthcare. As Michigan insurance companies have opposed behavioral health equality out of concern for higher premiums and more complicated paperwork, this ability is put into question as prioritizing profit from the current uncertainty in the law continues to allow payers to choose the extent of insurance coverage and the prices at which mental health services are reimbursed. While some medical experts and advocates are more concerned about the justice system, Insurance companies' organizational level prioritizes risk assessment and cost management rather than fair access to quality care. Therefore, it is paramount that state officials balance these conflicting goals so that any laws generated are protective and beneficial for all affected parties.

Economic and budgetary impacts

Ensuring equality in mental illness protection necessitates regulatory monitoring, with possible subsidies as the primary expenses for public entities such as the government, states, and municipalities to function in this capacity. Continuous benefits not present in existing structures include lower healthcare costs from timely, available mental health treatments and averting more severe and expensive health problems. Also absent would be the unintended financial advantages such as greater efficiency and lower social security expenses.

Although rising demands for mental healthcare may result in a preliminary expense increase for individuals, especially corporations and carriers, the benefits of increased worker health and efficiency and lower turnover and absences may more than offset these expenses. Organizations that promote their employees' mental health, engagement, and productivity may get a sizable return on investment by aligning these advantages with their purported values. Additionally, organizations may benefit from reduced expenses due to fewer seeking of emergent mental health crises as a byproduct of regular outpatient visits, increased efficiency, and promoting a more positive and productive workplace.

Quantifying the precise return on investments and long-term cost reductions takes time and effort. The lack of complex data emphasizes the necessity for more thorough investigation and analysis. Despite these obstacles, future financial advantages such as lower costs, increased output, and a healthier populace indicate that enacting parity laws in Michigan offers a beneficial cost-effectiveness ratio.

Domain 2B: Assessing Policy Options

Enacting Policy Option 1, Including SB 27 and HB 5345

Table 2 presents a scoring system for regulations based on their healthcare impact, practicality, and financial factors. The standards range from "low" to "high" in terms of influence and potential and from "less favorable" to "more favorable" for financial and economic consequences. This information is derived from the Centres for the Prevention and Control of Diseases (2013). The scoring is based on their potential impact on public health, the feasibility of enactment, and economic implications.

SB 27/HB 5345 significantly affects the public's access to more favorable mental health equity in their insurance plans. As these measures require mental health insurance parity, addressing such would result in enduring treatment gaps in the current environment.

SB 27's feasibility is rated as medium. This evaluation considers several variables, such as politics, stakeholder interests, and the background of Michigan's mental health laws. The bill's moderate practicality ranking indicates that, although there are factors in favor of its passage and execution, obstacles and opposition could prevent it from moving further. These can include resistance from specific insurance firms, administrative roadblocks, and the requirement for significant adjustments to how the financial services sector operates now to meet the new parity specifications.

SB 27 has less favorable budgetary impacts in the immediate sense but more favorable in the long-term. To implement parity, the state must commit many resources to enforce the NQTLs uniformly. Throughout searches, this entails handling copious amounts of data through insurance providers that might cause a significant operational and financial strain on the state. Expanding covering standards may also increase insurers' costs, forcing them to modify their rate designs or other economic choices. Nevertheless, the long-term benefits of better mental healthcare performance and availability must be evaluated against this cost. These advantages include lower costs for different medical conditions and improved public safety.

Due to the state's expenditure on implementing NQTLs and handling vast amounts of data from insurance firms, the short-term financial and fiscal ramifications of SB 27 may seem less favorable. However, the long-term economic benefits are more significant, altering benefit availability. Improved services may also lessen the load on the court system along with social welfare agencies, which frequently foot the bill for unaddressed mental health conditions.

Individuals who do not receive adequate mental health treatment are more inclined to call 911 or have recurrent hospitalizations due to mental health emergencies, resulting in more effective use of medical resources.

Finally, states with superior services might attract more enterprises and highly qualified labor, promoting stability and economic progress. The perceived value of life and the accessibility of complete medical treatment, particularly mental healthcare, may contribute to the state's overall prosperity.

Policy #2 Status Quo

The current state of mental healthcare in Michigan is likely to continue if the present legal structure is kept in place and the planned equitable mental healthcare measures are not put into action. This lack of response could keep the system's shortcomings and inequities in place. Maintaining the status quo could lead to ongoing difficulties with fairness, effectiveness, and accessibility to mental health services compared to medical services. The possibility that disparities in the rates of death and morbidity linked to untreated or insufficiently treated mental health conditions—particularly those resulting from substance abuse—will worsen is especially problematic. Long-lasting obstacles to mental health treatment, especially for underprivileged groups, may contribute to enduring differences in health and quality of life, contributing to a rise in morbidity and mortality rates as a result of a lower quality of life.

Maintaining the current structure demonstrates medium feasibility. Michigan insurance businesses have shown reluctance to establish parity, primarily because of worries about higher premiums and more complicated administration. They profit from the existing uncertainty in the law, which gives them freedom to choose the extent of protection and the prices at which mental health services are reimbursed. Often, this does not lead to a fair provision of money for mental

health, and medications for mental illnesses become less than adequate. This results in the inadequately effective and available mental health care in the state. The state government has to choose between the public welfare and particular interest groups that represent the diverse views of the general population and consider the difficulty and affordability of those concerned. Opting out of parity programs nationwide initially has neutral economic effects due to the absence of an alteration of the present system. While the immediate neutral figures may seem appealing, these numbers outweigh the likelihood of increasing long-term costs, which in the long term are unfavorable. A general lack of knowledge about mental health issues, the possibility of underdiagnosis and inadequate treatment of MH/SUD, and the maintenance of existing social norms – all contribute to the potential disapproval by lawmakers to enact mental health parity laws. Similar to other severe physical health issues, insufficient mental health treatment has a detrimental effect on the treatment and results of these interrelated health problems. Maintaining the current legal framework, or Policy Option 2, harms public health due to the continuous exacerbation of existing gaps and insufficiencies in mental health services. Due to the diverse points of view of the significant stakeholders, its viability is rated as medium. In terms of the economy and budget, it has little current effect. However, it could have substantial effects in the future due to the high costs and unfavorable effects of providing insufficient treatment for mental illnesses.

Domain 2C: Prioritize Policy Options

These legislative initiatives could significantly improve Michigan's mental health parity. By implementing strict guidelines for the annual submission of NQTL comparison analyses and the requirement for fair coverage standards, these initiatives aim to significantly enhance treatment availability, quality, and equity for MH/SUD. This stands in sharp contrast to the

current legal framework, which is likely to continue to perpetuate disparities in mental health care access and outcomes. Unless the current status quo is changed, systemic barriers that impede mental health equity will continue to be ignored.

Michigan's social and political environment recognizes mental health as a critical public health concern, which increases the likelihood of passing and implementing SB 27 and HB 5345. The current political will and social advocacy support parity legislation despite expected opposition from specific business sectors and the inherent difficulties in implementing complete parity criteria. On the other hand, maintaining the current framework would face little organizational or political resistance since it does not require changing the current system. However, this approach does not address the urgent need for legislative reform regarding parity in mental health care.

State Senator Anthony, who represents Michigan's 21st district, credits several essential elements for the possible passage of these bills, including efficient coordination with the House Panel on Coverage and Financial Services, robust backing from a broad range of stakeholders documented in the minutes of the Senate Health Policy Committee, and alignment with House partners in their support of HB 5345, calling for the establishment of required yearly reporting on mental health and drug abuse treatment offerings. All these factors increase the likelihood that the measure is on a pathway for success to improve healthcare access in Michigan.

The financial and economic picture for putting SB 27 and HB 5345 into effect long-term is advantageous. The expected long-term benefits outweigh the initial expenses of enacting legislation and prospective increases in insurers' claims expenditures. These benefits include better mental health outcomes, lower healthcare costs due to early intervention techniques, and higher social productivity due to better mental healthcare accessibility. On the other hand,

keeping the current regulatory structure in place would save money on execution expenses. However, it will likely result in higher long-term costs for the economy and society due to the ongoing shortcomings in the delivery of mental health treatment and the effects it will have on employment and public health.

Domain 3: Strategy and Policy Development

It is crucial to have practical procedures in Michigan to ensure mental health equity, primarily through the Department of Insurance and Financial Services. Senate Bill 27 enforces this by requiring insurers to include MH/SUD treatment without imposing more restrictive guidelines than those for medical/surgical benefits. DIFS ensures that insurers comply with this requirement by establishing a robust structure for compliance assessments. To comply with the parity criteria, insurers must submit comprehensive plans with a standardized evaluation mechanism for applying statistical and NQTLs throughout behavioral health and medical/surgical coverage. Additionally, DIFS should develop a systematic approach for the annual reporting requirements about NQTL evaluations as proposed by House Bill 5345. This involves specifying the methodologies for these analyses, criteria for evaluation, and establishing clear expectations for transparency in reporting outcomes. There may be room for optimization to specify an additional framework to enforce this data sharing with federal agencies, which could further align state enforcement mechanisms with federal oversight and best practices.

Establishing formal partnerships with federal agencies such as SAMHSA and the DHHS would grant Michigan access to a wealth of federal expertise, guidance on best practices, and technical support. This is critical for aligning the state's parity efforts with national standards, especially considering the working with these agencies to materialize the objectives listed in the 2023 Department of Labor guidelines, which provide a model for strengthening enforcement of

the MHPAEA. Additionally, tasking lawmakers to actively seek federal grants designed to support state enforcement of mental health parity laws is essential, as the biggest challenge to enforcement is upfront efforts to perform market conduct examinations. By identifying and applying for relevant funding opportunities offered by federal entities like SAMHSA and HHS, Michigan can support crucial initiatives that most notably target the development of data management systems for parity compliance monitoring.

Collaboration with federal agencies like SAMHSA and NIMH may happen directly through a channel established within DIFS. Additionally, DIFS may create a task force for participation in research consortia, such as the Mental Health Research Network, which may serve as a nationwide forum for collaboration amongst different states in the realm of strategies to discuss the application of parity. Multi-state collaboration and state-federal partnerships can enable Michigan to contribute its specific data and insights to refine its parity enforcement strategies. Furthermore, by drawing upon the DOL guidelines, Michigan can ensure that its efforts to test and evaluate innovative approaches to mental health parity are precisely aligned with the specific federal requests to streamline specificity in compliance outlined in the report, forgoing the old system of incorrect and voluminous submission strategies by insurance companies.

Conclusion

This detailed analysis uncovers the necessity for robust frameworks like Senate Bill 27 and House Bill 5345, highlighting their potential to significantly enhance parity compliance and ensure equitable access to MH/SUD treatments. Furthermore, the pivotal role of federal guidance and support, as demonstrated by federal reporting, necessitates guidance in which States may model their strengthening enforcement efforts, thereby facilitating a cohesive effort towards

achieving true mental health parity, reflecting an informed and strategic response to the complex challenge of parity enforcement. A three-step approach is proposed to disseminate these findings and engage critical stakeholders effectively. First, a comprehensive PowerPoint presentation will be developed, briefly summarizing the analysis and recommendations. This presentation aims to inform state senators about the critical issues and potential solutions identified. Second, the presentation will be distributed via direct email to state senators, with a brief message explaining its relevance to ongoing legislative efforts in mental health parity. This step seeks to inform and generate interest among senators. Third, the initial dissemination will include an offer for more detailed follow-up presentations, providing an invite link for interested parties to engage in deeper discussions. This structured approach facilitates meaningful dialogue and potential legislative progress addressing mental health parity in Michigan.

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Table 1

Literature Table

Author	Title	Design	Purpose	Methods	Results	Interpretation	Relation to Project/Policy Implications
Alvarez et al., 2014	Pregnancy-enhanced changes in membrane potential are not driven by pregnancy-enhanced Ca2+ signaling in uterine artery endothelial cells (UAEC)	Literature Review	Examine access to mental health care services post-MHPAEA	Review of literature and policies	Access barriers persist for depression diagnosis and treatment without mandatory mental health coverage.	Absence of mandatory coverage leads to continued access barriers, despite MHPAEA.	Highlights the necessity of mandatory mental health coverage in insurance plans for comprehensive access to care
Andrews et al., 2019	Medicaid Coverage in Substance Use Disorder Treatment and Care	Observational	Assess the impact of Medicaid expansion on SUD treatment coverage	Utilized data from the IBM MarketScan Commercial Database, applying population-level interrupted time series regressions to assess the impact of the MHPAEA on utilization and spending outcomes, distinguishing between pre-and post-MHPAEA implementation periods.	Found increased insurance coverage for SUD treatment post-Medicaid expansion.	Indicates that Medicaid expansion significantly improves access to SUD treatment.	Supports the expansion of public insurance programs for MH/SUD parity.
Busch et al., 2013	The effects of federal parity on substance use disorder treatment	Difference-in-differences Design	Examine the effects of MHPAEA on substance use disorder treatment	Insurance claims data analysis comparing pre- and post-MHPAEA implementation	There were no significant changes in the proportion of enrollees using treatment; modest increase in spending per enrollee	The inclusion of substance use disorder services in MHPAEA did not significantly increase health plan spending	Suggests that concerns over increased costs due to parity for substance use disorders may be unfounded
Byrd & Douglas, 2019	TEN YEARS SINCE THE FEDERAL PARITY LAW: WHAT NEXT IS NEEDED	Policy Discussion	To reflect on MHPAEA's impact and discuss future directions.	Collaboration between various organizations to evaluate impact and future needs.	Identified were enforcement and regulatory activity gaps.	Calls for more robust regulatory and enforcement measures to realize MHPAEA's goals.	Points out necessity for enhanced policy efforts and enforcement for effective parity.
Drake et al., 2019	The Effects of Federal Parity on Mental Health Services Use and Spending	Observational	Evaluate the effects of MHPAEA on mental health services use and spending	Employed data from the 2005-2013 Medical Expenditure Panel Survey, using a difference-in-differences study design to compare changes in mental health services use and spending between affected and unaffected insurance plans by the MHPAEA.	There are no significant changes in use or spending, the marginal shift towards specialty services among users.	Suggests MHPAEA had, at most, minor effects on patterns of mental health services use and spending, indicating the need for further research and potentially more robust enforcement.	Calls for further research and potentially more robust enforcement of parity laws.
Hodgkin et al., 2018	Federal Parity and Access to Behavioral Health Care in Private Health Plans	Survey Study	Determine changes in behavioral health coverage and management post-MHPAEA	A nationally representative survey of commercial health plans	Expansion of behavioral health coverage; elimination of exclusion for eating disorder coverage; no widespread noncompliance found	Continued improvement in behavioral health coverage post-MHPAEA implementation	Supports the effectiveness of MHPAEA in enhancing behavioral health care access, with policy implications for enforcement and compliance

Horgan et al., 2015	Health Plans' Early Response to Federal Parity Legislation for Mental Health and Addiction Services	Survey Study	Examine private health plans' responses to MHPAEA regarding coverage and management of services.	A nationally representative survey of commercial health plans	Elimination of annual limits specific to behavioral health care; slight increase in copayments; increased size of behavioral health provider network	MHPAEA led to improvements in behavioral health coverage without unintended negative consequences	Indicates positive impact of MHPAEA on insurance practices and suggests continued monitoring for full compliance
Huskamp et al., 2017	Mental Health Spending and Intensity of Service Use Among Individuals With Diagnoses of Eating Disorders Following Federal Parity	Observational Study	Examine changes in mental health service use and spending post-MHPAEA among individuals with eating disorders.	Analysis of insurance claims data from 2007 to 2012	Slight increase in mental health spending; an increased number of outpatient visits, and no significant change in out-of-pocket spending	MHPAEA is associated with increased outpatient service use without increasing out-of-pocket costs, suggesting improved access and financial protection	Highlights MHPAEA's effectiveness in improving service utilization without additional financial burden on patients
Kalair et al., 2020	Medical Necessity Standards for Mental Health Parity in California	Policy analysis	Explore the effects of mental health parity laws in California	Conducted a thorough review of existing literature, legal documents, and policy analyses to examine the effects and implications of mental health parity laws in California, focusing on changes in individual costs for mental health and substance use disorder treatment.	Parity laws led to reductions in individual costs for MH/SUD treatment.	Demonstrates that mental health parity laws can significantly benefit marginalized populations by reducing health disparities.	Advocates for enforcing mental health parity in insurance coverage.
Liu et al., 2020	Differential Effects by Mental Health Status of Filling the Medicare Part D Coverage Gap	Observational	Investigate the impact of Medicare prescription drug coverage gap closure on mental health.	Analyzed data using statistical models to evaluate the impact of closing the Medicare Part D coverage gap on mental health, specifically looking at shifts in service utilization towards mental health specialty services compared to primary care services.	Marginal shift towards more mental health specialty services among users.	Closure of the Medicare Part D coverage gap has nuanced effects, suggesting the need for policy adjustments.	Highlights the need for policy adjustments in Medicare for MH/SUD.
Malekoff, 2020	Project Access: a small group effort to improve access to mental health care in the US.	Action Research	To address noncompliance with MHPAEA and improve access to care.	Organized stakeholders for action research to address compliance and enforcement issues.	Identified systemic barriers to compliance and practical steps for enforcement.	Demonstrates the importance of collaborative efforts in addressing compliance gaps.	Highlights the need for grassroots and stakeholder-driven efforts to enforce MHPAEA compliance.
Mulvaney-Day et al., 2019	Mental Health Parity and Addiction Equity Act and the Use of Outpatient Behavioral Health Services	Observational	Assess the impact of MHPAEA on mental and substance use disorder services	Analyzed data from the IBM MarketScan Commercial Database using interrupted time series regressions, similar to Andrews et al., to determine changes in utilization and spending on mental health services post-MHPAEA.	Positive association with increased utilization of outpatient MH/SUD services post-MHPAEA.	MHPAEA improves access to behavioral health services, underscoring the policy's long-term relationship with behavioral health service utilization.	Supports the continuation and expansion of mental health parity laws.
Presskreischer et al., 2022	Factors Affecting State-Level Enforcement of the Federal Mental Health Parity and Addiction Equity Act	Multiple-Case Study	Explore factors influencing state insurance offices' enforcement of MHPAEA	Interviews with individuals representing various stakeholders	Influence of insurance office relationships, policy complexity, and political priorities on enforcement	Enforcement variation influenced by state-specific factors, posing challenges to uniform enforcement	Emphasizes the need for strategies to address enforcement inconsistencies at the state level for effective parity implementation

Roberts et al., 2022	Reconceptualising the Treatment Gap for Common Mental Disorders	Review	Analyze the treatment gap for CMDs and potential policy interventions	Performed a systematic review of existing studies to analyze the treatment gap for common mental disorders, focusing on the utilization of mental health services among young adults and identifying factors contributing to this gap.	Identified significant treatment gaps, especially among young adults, less than 20% utilizing MH services despite high prevalence.	Stresses the importance of targeted policies to address the treatment gap in CMDs.	Underlines the importance of policy-driven approaches to CMD treatment.
Smith-East & Neff, 2020	Mental Health Care Access Using Geographic Information Systems: An Integrative Review	Integrative Review	To discuss GIS approaches to improving access to mental health care services.	Systematic search and synthesis of literature on GIS and mental health access.	Highlighted the potential of GIS to improve access and addressed the MHPSA issue.	Emphasizes innovative use of GIS to tackle access issues.	Indicates ongoing challenges in accessing mental health services post-MHPAEA and suggests GIS as a solution.
Solomon, 2022	State Mental Health Insurance Parity Laws and College Educational Outcomes	Observational	Examine the effect of state-level full parity mental illness law on college outcomes	Analyzed administrative data on suicides and GPA, along with survey data on mental health and college dropout decisions, to evaluate the impact of state-level mental health insurance parity laws on college students' outcomes using a DD analysis.	Suicide rate reductions, GPA increases post-law implementation.	State-level parity laws have positive educational and mental health outcomes, highlighting the laws' benefits on suicide rates and GPA among college-aged individuals.	Advocates for state-level mental health parity laws.
Thalmayer et al., 2017	The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits	Observational Study	Assess MHPAEA's effect on the prevalence of behavioral health QTLs	Analysis of specialty behavioral health benefit design data from 2008-2013	QTLs almost entirely disappeared post-MHPAEA	Effective elimination of QTLs by MHPAEA, suggesting increased access to care	Demonstrates MHPAEA's success in removing restrictive limits, potentially leading to broader access to behavioral health services

Table 2

Policy Options Assessment Table

CRITERIA	*PUBLIC HEALTH IMPACT*	*FEASIBILITY*	*ECONOMIC AND BUDGETARY IMPACT*	
Scoring Definitions	**Low:** small reach, effect size, and impact on disparate populations **Medium:** small reach with large effect size or large reach with small effect size **High:** large reach, effect size, and impact on disparate populations	**Low:** No/small likelihood of being enacted **Medium:** Moderate likelihood of being enacted **High:** High likelihood of being enacted	**Less favorable:** High costs to implement. **Favorable:** Moderate costs to implement **More favorable:** Low costs to implement	**Less favorable:** costs are high relative to benefits **Favorable:** costs are moderate relative to benefits (benefits justify costs) **More favorable:** costs are low relative to benefits
			BUDGET	*ECONOMIC*
Mandating Equitable Coverage Standards (SB 27 + HB 5345)	• Low • Medium • **High** Concerns about the amount or quality of data? (Yes / No)	• Low • **Medium** • High Concerns about the amount or quality of data? (Yes / No)	• **Less favorable** • Neutral • More favorable Concerns about the amount or quality of data? (Yes / No)	• Less favorable • Neutral • **More favorable** Concerns about the amount or quality of data? (Yes / No)
Preserving Status Quo	• Low • Medium • **High** Concerns about the amount or quality of data? (Yes / **No**)	• Low • **Medium** • High Concerns about the amount or quality of data? (Yes / **No**)	• Less favorable • **Neutral** • More favorable Concerns about the amount or quality of data? (Yes / **No**)	• Less favorable • **Neutral** • More favorable Concerns about the amount or quality of data? (Yes / **No**)