SUBSTITUTE FOR

HOUSE BILL NO. 4623

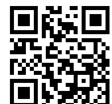
A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 3501 (MCL 500.3501), as amended by 2016 PA 276, and by adding section 3406bb.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 **Sec. 3406bb. (1) An insurer that delivers, issues for**
2 **delivery, or renews in the individual or small group market in this**
3 **state a health insurance policy shall provide coverage for all of**
4 **the following:**
5 **(a) Ambulatory patient services.**
6 **(b) Emergency services.**
7 **(c) Hospitalization.**
8 **(d) Pregnancy, maternity, and newborn care.**



1 **(e) Mental health and substance use disorder services,**
2 **including behavioral health treatment.**
3 **(f) Prescription drugs.**
4 **(g) Rehabilitative and habilitative services and devices.**
5 **(h) Laboratory services.**
6 **(i) Preventive and wellness services and chronic disease**
7 **management identified by the director as meeting a requirement**
8 **under this subdivision. Coverage for an item or service is not**
9 **required under this subdivision unless the item or service is 1 or**
10 **more of the following:**
11 **(*i*) Evidence-based items or services if the United States**
12 **Preventive Services Task Force has rated the item or service as "A"**
13 **or "B" for the purposes of its recommendations.**
14 **(*ii*) An immunization with routine use in children, adolescents,**
15 **and adults if the Advisory Committee on Immunization Practices of**
16 **the United States Centers for Disease Control and Prevention has**
17 **included the immunization for the purposes of its recommendations**
18 **with respect to the individual involved.**
19 **(*iii*) With respect to infants, children, and adolescents,**
20 **evidence-informed preventive care and screenings if the United**
21 **States Health Resources and Services Administration has included**
22 **the care or screening for the purposes of its guidelines.**
23 **(*iv*) With respect to women, preventive care and screenings not**
24 **described in subparagraph (*i*) if the United States Health Resources**
25 **and Services Administration has included the care or screening for**
26 **the purposes of its guidelines.**
27 **(j) Pediatric services, including oral and vision care.**
28 **(2) An insurer that delivers, issues for delivery, or renews**
29 **in this state a health insurance policy shall not impose any cost-**

1 sharing requirements for benefits provided under subsection (1)(i).
2 (3) Benefits provided under subsection (1) are subject to all
3 requirements applicable to those benefits under this chapter.
4 (4) This section does not limit the requirements to provide
5 additional benefits under this chapter.
6 (5) This section does not require an insurer that has a
7 network of providers to provide benefits for items or services
8 described in subsection (1) that are delivered by an out-of-network
9 provider or preclude an insurer that has a network of providers
10 from imposing cost-sharing requirements for items or services
11 described in subsection (1) that are delivered by an out-of-network
12 provider. If an insurer does not have in its network a provider who
13 can provide an item or service described in subsection (1), the
14 insurer must cover the item or service when performed by an out-of-
15 network provider, and may not impose cost sharing with respect to
16 the item or service.
17 (6) This section does not prevent an insurer from using
18 reasonable medical management techniques to determine the
19 frequency, method, treatment, or setting for an item or service
20 described in subsection (1) to the extent not specified in the
21 relevant recommendation or guideline. To the extent not specified
22 in a recommendation or guideline, an insurer may rely on the
23 relevant clinical evidence base and established reasonable medical
24 management techniques to determine the frequency, method,
25 treatment, or setting for coverage of a recommended preventive
26 health service.
27 (7) This section does not apply to a short-term or 1-time
28 limited duration policy or certificate of not more than 6 months as
29 described in section 2213b, or to a grandfathered plan as that term

is defined in 45 CFR 147.140.

(8) Any changes to the items and services required under subsection (1)(i) must take effect for the plan year immediately following the calendar year in which the items or services are newly recommended.

Sec. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person that has entered into a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee. Affiliated provider includes a person described in this subdivision that has entered into a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(b) "Basic health services" means medically necessary health services that health maintenance organizations must offer to large employers in at least 1 health maintenance contract. Basic health services include all of the following:

(*i*) Physician services including primary care and specialty care.

(*ii*) Ambulatory **patient** services.

(*iii*) ~~Inpatient hospital~~ **Hospitalization** services.

(*iv*) Emergency health services.

(*v*) Mental health and substance use disorder services, **including behavioral health treatment.**

(*vi*) ~~Diagnostic laboratory and diagnostic and therapeutic radiological~~ **Laboratory** services.

(*vii*) Home health services.

(*viii*) Preventive**, wellness, and chronic disease management** health services.

(*ix*) Pregnancy, maternity, and newborn care.

(*x*) Prescription drugs.

(*xi*) Rehabilitative and habilitative services and devices.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating the health professional when the health professional applies to become a participating provider with a health maintenance organization.

(d) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers to provide or arrange for the provision of health services within the health maintenance organization's service area. Health maintenance contract includes a prudent purchaser agreement under section 3405.

(e) "Health maintenance organization" means a person that, among other things, does the following:

(*i*) Delivers health services that are medically necessary to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health services provided.

(f) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in ~~his or her~~ **the individual's** respective state.

1 (g) "Health services" means services provided to enrollees of
2 a health maintenance organization under their health maintenance
3 contract.
4 (h) "Service area" means a defined geographical area in which
5 covered health services are generally available and readily
6 accessible to enrollees and where health maintenance organizations
7 may market their contracts.