HOUSE BILL NO. 4464

May 06, 2025, Introduced by Rep. Harris and referred to Committee on Insurance.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3403, 3406z, 3406bb, 3406hh, and 3406ii (MCL 500.3403, 500.3406z, 500.3406bb, 500.3406hh, and 500.3406ii), section 3403 as amended by 2023 PA 158, section 3406z as added by 2023 PA 159, section 3406bb as added by 2023 PA 160, section 3406hh as added by 2024 PA 41, and section 3406ii as added by 2023 PA 157.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3403. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that makes

dependent coverage available under the health insurance policy shall do all of the following:

(a) Make available dependent coverage, at the option of the policyholder, until the dependent has attained 26 years of age.

(b) Provide the same health insurance benefits to a dependent child that are available to any other covered dependent.

(c) Provide health insurance benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

(d) Include both of the following provisions in the health insurance policy:

(*i*) That the health insurance benefits applicable for children are payable with respect to a newly born child of the insured from the moment of birth.

(*ii*) That the coverage for newly born children consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(2) A health insurance policy that offers dependent coverage shall not deny enrollment to an insured's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the insured's federal income tax return.

(c) The child does not reside with the insured or in the insurer's service area.

(3) This section does not require an insurer or plan to make coverage available for a child of a child receiving dependent coverage.

(4) This section does not apply to retiree-only health

insurance coverage.

Sec. 3406z. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not institute either of the following:

(a) Lifetime limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(b) Annual limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(2) This section does not prevent an insurer from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that the limits are otherwise permitted under applicable federal or state law.

(3) This section does not apply to grandfathered health plan coverage, as that term is defined in 45 CFR 147.140, **retiree-only health insurance coverage**, or ~~to~~ a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

Sec. 3406bb. (1) An insurer that delivers, issues for delivery, or renews in the individual or small group market in this state a health insurance policy shall provide coverage for all of the following:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Pregnancy, maternity, and newborn care.

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

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management identified by the director as meeting a requirement under this subdivision. Coverage for an item or service is not required under this subdivision unless the item or service is 1 or more of the following:

(*i*) Evidence-based items or services if the United States Preventive Services Task Force has rated the item or service as "A" or "B" for the purposes of its recommendations currently in effect with respect to the individual involved.

(*ii*) An immunization with routine use in children, adolescents, and adults if the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention has included the immunization for the purposes of its recommendations with respect to the individual involved.

(*iii*) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(*iv*) With respect to women, preventive care and screenings not described in subparagraph (*i*) if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(j) Pediatric services, including oral and vision care. Pediatric oral care, as required under this subdivision, is not required if an insured has dental insurance from another source and provides evidence of the coverage to the insurer.

(2) Except as otherwise allowed under 45 CFR 147.130 (a)(2)(*i*),(*ii*), and (*iii*), an insurer that delivers, issues for

delivery, or renews in this state a health insurance policy shall not impose any cost-sharing requirements for benefits provided under subsection (1)(i).

(3) Benefits provided under subsection (1) are subject to all requirements applicable to those benefits under this chapter.

(4) This section does not limit the requirements to provide additional benefits under this chapter.

(5) This section does not require an insurer that has a network of providers to provide benefits for items or services described in subsection (1) that are delivered by an out-of-network provider or preclude an insurer that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (1) that are delivered by an out-of-network provider. If an insurer does not have in its network a provider who can provide an item or service described in subsection (1), the insurer must cover the item or service when performed by an out-of-network provider, and may not impose cost sharing with respect to the item or service.

(6) This section does not prevent an insurer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (1) to the extent not specified in the relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, an insurer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(7) This section does not require an insurer to cover items of

the United States Preventive Services Task Force that have been downgraded to a "D" rating, or any item or service during the plan year that is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service.

(8) This section does not apply to a short-term or 1-time limited duration policy or certificate of not more than 6 months as described in section 2213b, ~~or to a~~ grandfathered **health** plan **coverage** as that term is defined in 45 CFR 147.140, **non-grandfathered health plan coverage, or retiree-only health insurance coverage.**

(9) Any changes to the items and services required under subsection (1)(i) must take effect for the plan year that begins on or after the date that is 1 year after the date the recommendation or guideline is issued.

(10) As used in this section, "non-grandfathered health plan coverage" means individual and small group transitional insurance plans that have been afforded additional time to comply with certain market reform provisions of the affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and as specified annually by the director, until the Centers for Medicare and Medicaid Services requires these plans to come into full compliance with the affordable care act.

Sec. 3406hh. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for mental health and substance use disorder services. All of the following apply to the coverage required under this subsection:

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

(b) Except as otherwise provided in subsections (3) and (4), nonquantitative treatment limitations may be imposed on mental health or substance use disorder benefits in any classification only if the processes, strategies, evidentiary standards, or other factors used in developing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the same classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in developing and applying the limitation with respect to medical/surgical benefits in the same classification.

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

(*i*) Office visits, such as physician visits.

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

(2) Benefits provided under subsection (1) must meet all applicable federal parity requirements, including, but not limited to, 42 USC 300gg-26 and the regulations promulgated under that

section. An insurer that meets the federal parity requirements described in this subsection is considered to meet the requirements under subsection (1) if the federal parity requirements are not less stringent than the requirements under subsection (1).

(3) If a health insurance policy provides benefits through multiple tiers of in-network providers, including an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers, the health plan may divide its benefits provided on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements for nonquantitative treatment ~~limits~~ **limitations** and without regard to whether a provider provides services with respect to medical and surgical benefits or mental health or substance use disorder benefits. After the subclassifications are established, the health insurance policy must not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits in the subclassification.

(4) If a health insurance policy applies different levels of financial requirements to different tiers of prescription drug benefits that are based on reasonable factors determined in accordance with the requirements for nonquantitative treatment ~~limits~~ **limitations** and without regard to whether a drug is generally prescribed with respect to medical and surgical benefits or with respect to mental health or substance use disorder

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

(5) This section does not apply to retiree-only health insurance coverage.

(6) ~~(5)~~ As used in this section:

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

(*i*) Inpatient in-network.

(*ii*) Inpatient out-of-network.

(*iii*) Outpatient in-network.

(*iv*) Outpatient out-of-network.

(*v*) Emergency services.

(*vi*) Prescription drugs.

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

(c) "Nonquantitative treatment limitations" means those limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a health insurance policy or coverage and includes, but is not limited to, the limitations described under 45 CFR 146.136. Nonquantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

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

(e) "Quantitative treatment limitations" includes limitations that are expressed numerically, such as limits on benefits based on the frequency of treatment, number of visits, days of coverage,

days in a waiting period, or other similar limits on the scope or duration of treatment, and includes, but is not limited to, the limitations described under 45 CFR 146.136. Quantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

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

Sec. 3406ii. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on the individual.

(2) This section does not apply to any of the following:

(a) Grandfathered health plan coverage, as that term is defined in 45 CFR 147.140.

(b) Insurance coverage that provides benefits for any of the following:

(*i*) Hospital confinement indemnity **or other fixed indemnity as that term is described in 45 CFR 148.220(b)(4).**

(*ii*) Disability income.

(*iii*) Accident only.

(*iv*) Long-term care.

(*v*) Medicare supplemental.

(*vi*) Limited benefit health.

(*vii*) Specified disease indemnity.

(*viii*) Sickness or bodily injury, or death by accident, or both.

(*ix*) Retiree-only health insurance coverage.

(*x*) Stand-alone dental plans.

(*xi*) Stand-alone vision plans.

(*xii*) Other limited benefit policies.

(*xiii*) A short-term or 1-time limited duration policy or certificate of not longer than 6 months as described in section 2213b.

(c) Non-grandfathered health plan coverage as that term is defined in section 3406bb.

(3) As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits or a denial of coverage based on the fact that a physical or mental condition was present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care, or treatment was recommended or received for the condition before the date of coverage or denial of coverage.