

**SUBSTITUTE FOR
SENATE BILL NO. 135**

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:

1 Sec. 3403. (1) An insurer that delivers, issues for delivery,
2 or renews in this state a health insurance policy that makes
3 dependent coverage available under the health insurance policy
4 shall do all of the following:

5 (a) Make available dependent coverage, at the option of the

1 policyholder, until the dependent has attained 26 years of age.

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

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

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

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

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

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

18 (a) The child was born out of wedlock.

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

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

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

26 **(4) This section does not apply to retiree-only health**
27 **insurance coverage.**

28 Sec. 3406z. (1) An insurer that delivers, issues for delivery,
29 or renews in this state a health insurance policy shall not

1 institute either of the following:

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

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

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

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

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

19 (a) Ambulatory patient services.

20 (b) Emergency services.

21 (c) Hospitalization.

22 (d) Pregnancy, maternity, and newborn care.

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

25 (f) Prescription drugs.

26 (g) Rehabilitative and habilitative services and devices.

27 (h) Laboratory services.

28 (i) Preventive and wellness services and chronic disease
29 management identified by the director as meeting a requirement

1 under this subdivision. Coverage for an item or service is not
2 required under this subdivision unless the item or service is 1 or
3 more of the following:

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

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

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

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

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

25 (2) Except as otherwise allowed under 45 CFR 147.130

26 (a) (2) (i), (ii), and (iii), an insurer that delivers, issues for
27 delivery, or renews in this state a health insurance policy shall
28 not impose any cost-sharing requirements for benefits provided
29 under subsection (1) (i).

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

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

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

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

26 (7) This section does not require an insurer to cover items of
27 the United States Preventive Services Task Force that have been
28 downgraded to a "D" rating, or any item or service during the plan
29 year that is subject to a safety recall or is otherwise determined

1 to pose a significant safety concern by a federal agency authorized
2 to regulate the item or service.

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

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

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

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

27 (a) Any financial requirements or quantitative treatment
28 limitations applicable to mental health and substance use disorder
29 benefits in any classification must be no more restrictive than the

1 predominant financial requirements or quantitative treatment
2 limitations applied to substantially all benefits provided for
3 medical/surgical benefits in the same classification and there must
4 be no separate cumulative financial requirements that are
5 applicable only with respect to mental health or substance use
6 disorder benefits.

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

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

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

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

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

1 less stringent than the requirements under subsection (1).

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

20 (4) If a health insurance policy applies different levels of
21 financial requirements to different tiers of prescription drug
22 benefits that are based on reasonable factors determined in
23 accordance with the requirements for nonquantitative treatment
24 ~~limits~~**limitations** and without regard to whether a drug is
25 generally prescribed with respect to medical and surgical benefits
26 or with respect to mental health or substance use disorder
27 benefits, the health plan satisfies the parity requirements of this
28 section with respect to prescription drug benefits. As used in this
29 subsection, "reasonable factors" include cost, efficacy, generic

1 versus brand name drugs, and mail order versus pharmacy pick-up.

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

4 **(6)** ~~(5)~~—As used in this section:

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

6 (i) Inpatient in-network.

7 (ii) Inpatient out-of-network.

8 (iii) Outpatient in-network.

9 (iv) Outpatient out-of-network.

10 (v) Emergency services.

11 (vi) Prescription drugs.

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

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

22 (d) "Predominant" means that term as defined in 45 CFR
23 146.136.

24 (e) "Quantitative treatment limitations" includes limitations
25 that are expressed numerically, such as limits on benefits based on
26 the frequency of treatment, number of visits, days of coverage,
27 days in a waiting period, or other similar limits on the scope or
28 duration of treatment, and includes, but is not limited to, the
29 limitations described under 45 CFR 146.136. Quantitative treatment

1 limitations do not include a complete exclusion of all benefits for
2 a certain condition or disorder.

3 (f) "Substantially all" means that term as defined in 45 CFR
4 146.136.

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

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

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

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

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

16 (ii) Disability income.

17 (iii) Accident only.

18 (iv) Long-term care.

19 (v) Medicare supplemental.

20 (vi) Limited benefit health.

21 (vii) Specified disease indemnity.

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

23 (ix) Retiree-only health insurance coverage.

24 (x) Stand-alone dental plans.

25 (xi) Stand-alone vision plans.

26 (xii) Other limited benefit policies.

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

1 **2213b.**

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

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