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Employment Law Summary

Michigan

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Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for insured health plans. Mandates can affect various parts of health insurance plans as follows:

- **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures. In some cases, however, benefit mandates only require issuers to offer coverage to employers for specific treatments, services or procedures.
- **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form of nondiscrimination mandates that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For example, in addition to many other federal mandates, the Affordable Care Act (ACA) requires non-grandfathered health plans in the small group and individual markets to provide coverage for certain items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains charts outlining Michigan's benefit, provider and person mandates for insured group health plans. Please keep in mind that the following charts do not address federal benefit mandates, such as those in the ACA. More information can be found on the Michigan Department of Insurance and Financial Services website, and the Michigan Department of Licensing and Regulatory Affairs website.

Benefit Mandates

BENEFIT MANDATE	DESCRIPTION
Autism spectrum disorders	Plans must cover the diagnosis and treatment of autism spectrum disorders to the same extent as covered physical illnesses in general. Treatment subject to this mandate includes medically necessary: • Behavioral treatment; • Pharmacy care; • Psychiatric and psychological care; and • Therapeutic care. This treatment coverage may be limited to individuals **under age 19** and may be subject to a **maximum annual benefit** of:

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	• **$50,000** for a child six years of age and younger; • **$40,000** for a child seven years of age through 12 years of age; • **$30,000** for a child 13 years of age through 18 years of age. Under this mandate, plans may not: • Limit the number of visits; or • Deny or limit coverage because a treatment is educational or habilitative in nature.
Breast cancer services and mammograms	Plans must cover or offer to cover breast cancer diagnostic services, outpatient treatment services and rehabilitative services to the same extent as covered physical illnesses in general. This coverage must include benefits for: • One mammography for women **ages 35-39**; and • A mammography every calendar year for women **ages 40 and older**.
Cancer treatment – antineoplastic therapy	Plans must cover a drug approved by the federal Food and Drug Administration (FDA), along with the reasonable cost of its administration, that is used in antineoplastic therapy. This coverage must include benefits for off-label drugs that are: • Ordered by a physician for the treatment of a specific type of neoplasm; • FDA-approved for use in antineoplastic therapy; • Used as part of an antineoplastic drug regimen; • Used as part of a treatment that is generally accepted by recognized oncology organizations; and • Used by a patient who has provided informed consent for the treatment regimen.
Diabetes	Plans must cover the following **equipment**, **supplies** and **educational training** for the treatment of diabetes (gestational diabetes, insulin-dependent diabetes and non-insulin-dependent diabetes), if medically necessary and prescribed by an allopathic or osteopathic physician: • Blood glucose monitors (including monitors for the legally blind); • Test strips for glucose monitors, visual reading and urine testing strips, lancets and spring-powered lancet devices; • Syringes; • Insulin pumps and related medical supplies; and • Self-management training. Plans that cover outpatient prescription drugs must include the following **drug coverage** for the treatment of diabetes, if determined to be medically necessary:

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	• Insulin prescribed by an allopathic or osteopathic physician; • Non-experimental medication for controlling blood sugar prescribed by an allopathic or osteopathic physician; and • Medications used in the treatment of foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes, if prescribed by an allopathic, osteopathic or podiatric physician. This coverage may not be subject to dollar limits, deductibles or copayment provisions that are greater than those for physical illness in general.
Emergency health services	Plans that cover emergency health services must cover medically necessary services provided to an insured for the sudden onset of an emergency medical condition, which is one that manifests itself by signs and symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in: • Serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. A plan may not: • Require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization; • Deny payment for emergency health services up to the point of stabilization based on the final diagnosis or because prior authorization was not given before emergency health services were provided.
Hospice care	Plans that cover inpatient hospital care must offer to cover hospice care.
Insulin – emergency supply	Plans that provide coverage for prescription drugs must cover any emergency supply of insulin that is covered under an insured's policy and that is dispensed to the insured by a pharmacist as provided in the Public Health Code.
Living donors, protections	Plans cannot deny or cancel coverage, refuse to issue a policy, determine the price or premium for a policy, or otherwise vary a term or condition of the policy based solely on an individual's status as a living donor.
Mastectomy – prosthetic devices	Plans must cover prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage must include: • Medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a

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	prosthetic device after the individual's physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment; and • The cost and fitting of a prosthetic device following a mastectomy.
Prescription drugs – non-formulary alternatives	Plans that cover prescription drugs and limit those benefits to drugs included in a formulary must provide exceptions to the formulary limitation when a non-formulary alternative is a medically necessary and appropriate alternative.
Prescription drugs – off-label use	Plans that cover prescription drugs must cover off-label use of an FDA-approved drug and the reasonable cost of supplies that are medically necessary to administer it, if the drug: • Is prescribed by an allopathic or osteopathic physician for the treatment of a life-threatening condition or a chronic and seriously debilitating condition; and • Has been recognized for treatment for the condition for which it is prescribed by certain medical authorities. Any copayment, deductible, prior approval or drug utilization review program may not be more restrictive than for prescription coverage in general.
Prescription eyedrops	Plans that cover prescription eyedrops cannot deny coverage for a refill if all of the following apply: • For a 30-day supply, the amount of time has passed within which the insured should have used 75% of the dosage units of the drug according to the prescriber's instructions, or 23 days have passed after either the original date the prescription was distributed or the date the most recent refill was distributed; • The prescriber indicates on the original prescription that additional quantities are needed; • The prescription eye drops prescribed are covered under the health plan.
Substance abuse coverage	Plans must cover intermediate and outpatient care for substance use disorder. The charges, terms and conditions for this coverage cannot be less favorable than the maximums for any other comparable service.
Telemedicine services	Plans may not require face-to-face contact between a health care professional and a patient for coverage of services appropriately provided through telemedicine. To be considered telemedicine, a health care professional must be able to examine the patient via a HIPAA-compliant,

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	secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

Provider Mandates

PROVIDER MANDATE	DESCRIPTION
Chiropractors **Dentists** **Optometrists** **Podiatrists** **Psychologists**	Nondiscrimination mandates: If a plan covers services within the scope of these providers' licenses and practices, the plan must cover the services when legally performed by these providers within their scopes.
Mental health providers	Plans that cover mental health services must cover these services when provided by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board if: • Appropriate mental health services cannot be delivered otherwise; or • The provider is designated by court order and meets the plan's standards for all other providers of the same type.
Nurse midwife	Plans that cover obstetrical and gynecological services must cover these services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification. Alternatively, a plan must offer to cover the following regardless of whether it is performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification: • Obstetrical and gynecological services; and/or • Maternity and gynecological services.
Obstetrician-gynecologist – direct access	Plans that cover annual well-woman examinations and routine obstetrical and gynecologic services and require an insured to designate a participating primary care provider must permit a female insured to access an obstetrician-gynecologist for these services without prior authorization or a referral from a participating provider.
Pediatrician – direct access	Plans that cover dependents and require an insured to designate a participating primary care provider must permit a dependent child to select and access a pediatrician for general pediatric care services without prior authorization or a referral from a participating provider.

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Person Mandates

PERSON MANDATE	DESCRIPTION
Conversion coverage	If an individual has been continuously covered under a plan for **at least three months**, the member and his or her covered spouse and dependents may elect coverage under an individual conversion policy, without evidence of insurability, when coverage terminates due to certain events, such as: • Discontinuance of a plan in its entirety or with respect to an insured class; • Termination of employment (other than because of gross misconduct); • For a surviving spouse or dependent, death of the covered member; or • An event that causes a spouse or dependent to no longer be a qualified family member.
Dependent coverage	Effective **Feb. 13, 2024**, plans that make dependent coverage available must do all of the following: • Make available dependent coverage, at the option of the policyholder, until the dependent has attained 26 years of age; • Provide the same health insurance benefits to a dependent child that are available to any other covered dependent; • Provide health insurance benefits to a dependent child at the same rate or premium applicable to any other covered dependent; and • Comply with the newborn children mandates and non-custodial children mandates below.
Dependent coverage – non-custodial children	Plans that offer dependent coverage may not deny enrollment to an insured's child because the child: • Was born out of wedlock; • Is not claimed as a dependent on the insured's federal income tax return; or • Does not reside with the insured or in the insurer's service area.
Incapacitated dependent child	Plans that offer dependent coverage up to a specified age must continue coverage past the limiting age for an unmarried child who is: • Incapable of self-support due to developmental disability or physical disability; and • Dependent upon the insured employee for support and maintenance.
Newborn children	Plans that provide family coverage must cover a newly born child of an insured from the moment of birth. This coverage must include benefits for

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	necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
Student – medical leave of absence	Plans that cover dependent children must continue coverage for a covered dependent student who takes a leave of absence from school due to illness or injury. This coverage must continue for the shorter of either 12 months or until the dependent reaches the age at which coverage would otherwise terminate.

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