House
Legislative
Analysis
Section

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MEDICAL CHILD SUPPORT

House Bills 5166 and 5168
Sponsor: Rep. John Llewellyn

House Bill 5171
Sponsor: Rep. Edward LaForge

House Bill 5174
Sponsor: Gregory E. Pitoniak

Committee: Insurance

Complete to 10-30-95

A SUMMARY OF HOUSE BILL 5166, 5168, 5171, AND 5174 AS INTRODUCED 9-28-95

The bills would import into Michigan statutes requirements from the federal Omnibus Budget Reconciliation Act (OBRA) of 1993 regarding medical child support and the coordination of private insurance benefits with Medicaid.

House Bill 5166 would amend the Nonprofit Health Care Corporation Act (MCL 550.1419 et al.) and apply to Blue Cross and Blue Shield of Michigan. House Bill 5168 would create a new act, the Group Health Plan Act, and would apply to group health plans under the federal Employee Retirement Income Security Act of 1974 (ERISA). House Bill 5171 would amend the Insurance Code (MCL 340.3406g) and would apply to commercial health insurance companies. House Bill 5174 would amend the Public Health Code (MCL 333.21054v et al.) and apply to health maintenance organizations (HMOs). The term "insurer" is used in the summary for each kind of entity. Each bill contains the following provisions.

Prohibited as grounds for denial of coverage. An insurer (or similar entity) would be prohibited from denying coverage in a policy (or certificate or contract) that offers dependent coverage to an insured's child on the grounds that the child 1) was born out of wedlock; 2) was not claimed as a dependent on the insured's federal income tax return; or 3) did not reside with the insured or in the insured's service area. (For HMOs, House Bill 5174 would specify that enrollment outside of the service area "does not change any of the provisions of the health maintenance contract including costs and benefits.")

Coverage of children under a court order. If a parent was required by a court or administrative order to provide health coverage to a child and the parent was eligible for dependent coverage, the insurer would be required to permit the parent or legal custodian to enroll a child eligible for coverage without regard to any enrollment season restrictions.

If a parent was enrolled but failed to apply for coverage for a child, the insurer would be required to enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

An insurer would be prohibited from eliminating the child's health coverage (provided necessary premiums were paid) unless the insurer was provided with satisfactory written evidence that either 1) the court order or administrative order was no longer in effect or 2) that the child was or would be enrolled in comparable health coverage through another insurer (or health care corporation, health maintenance organization, or self-funded health plan) that would take effect not later than the effective date of the cancellation of existing coverage.

Noncustodial parent coverage. If a child had health coverage through an insurer of a noncustodial parent, the insurer would be required to:

1) provide the custodial parent with information necessary for the child to obtain benefits through that coverage;

2) permit the custodial parent or, with the custodial parent's or legal custodian's approval, the health care provider to submit claims for covered services without the noncustodial parent's approval; and

3) if applicable, reimburse or make payment on claims submitted by the custodial parent or medical provider.

(The provisions above would apply only if a parent was required by a court or administrative order to provide health coverage for a child, and the insurer was notified of the court order and administrative order.)

Related medical support provisions. Insurers would be prohibited from considering whether an individual was eligible for Medicaid in this or another state when considering eligibility for coverage or making payments under its health plan for eligible insureds. If an insurer had a legal liability to make payments, and payments had been made by Medicaid for covered expenses for medical goods or services furnished to an individual, the Department of Social Services would acquire the rights of the individual to payment by the insurer to the extent payment had been made by DSS for those goods or services. An insurer could not impose requirements on the DSS different from requirements that applied to an agent or assignee of any other covered insured.