The following publication is a summary of pending health care legislation in the Michigan Legislature as of February 28, 2026. This publication is intended to serve as a preliminary research tool for attorneys. It is not intended to be used as the sole basis for making critical business or legal decisions. This document does not constitute, and should not be relied upon, as legal advice.

Summary of ILMC and Scope of Practice Bills

House Bill 4399—Nurse Practitioner Scope of Practice

On April 29, 2025, Representative David Prestin introduced House Bill 4399, which if enacted, would allow nurse practitioners to practice independently without physician supervision or collaboration. Under a proposed H-1 substitute of the bill, in addition to the duties of the practice of nursing, the bill would codify the scope of practice for nurse practitioners currently set forth in by rule to allow nurse practitioners to perform the following tasks:

- Performing comprehensive assessments, providing physical examinations and other health assessments, and screening activities.
- Diagnosing, treating, and managing patients with acute and chronic illnesses and diseases.
- Ordering, performing, supervising, and interpreting laboratory and imaging studies.
- Prescribing pharmacological and nonpharmacological interventions and treatments that are within the registered professional nurse's specialty role.
- Engaging in health promotion and disease prevention.
- Providing health education.
- Counseling patients and families with potential, acute, and chronic health disorders.

The bill would additionally allow nurse practitioners to be certified to prescribe and dispense controlled substances without delegation if they have 1,000 hours of experience working as a nurse practitioner, complete at least 15 hours of continuing education per renewal cycle in pharmacology, therapeutics or prescribing, and meet any other requirements established by LARA in consultation with the board. Nurse practitioners without the separate certification could still prescribe and dispense controlled substances as a delegated act of a physician or a nurse practitioner with the new certification (under the newly defined term "qualified delegating practitioner"). Supporters of HB 4399 have stated that allowing full practice authority for nurse practitioners would help improve access to care in rural and underserved areas and reduce the provider shortages in primary care and mental health. Opponents of the bill have stated that the bill fails to address the root cause of health professional shortages which would not be cured through expanded scope of practice, and identified risks posed by the bill in the absence of physician-led care teams.

Substitute H-1 of the bill was reported with recommendation for referral to the Committee on Rules on November 5, 2025.

House Bill 5299--Physician's Assistant Scope of Practice

On February 18, 2026, Representative Luke Meerman and several other representatives introduced House Bill 5299, which if enacted, would allow physician's assistants to delegate and supervise acts and tasks to other health professionals consistent with Section 16215 of the Public Health Code and, beginning January 1, 2027, allow physician's assistants with at least 1,000 hours of experience to practice medicine, osteopathic medicine and surgery, and podiatric medicine and surgery without a practice agreement or other delegation or supervision by a physician or podiatrist. Also beginning January 1, 2027, the bill would allow physician's assistants with fewer than 1,000 hours of experience to practice medicine, osteopathic medicine and surgery, or podiatry pursuant to a practice agreement with either a physician, podiatrist or a physician's assistant with more than 1,000 hours of experience.

The bill has been referred to the Committee on Health Policy.

Interstate Medical Licensure Compacts

The Interstate Medical Licensure Compact Commission (IMLCC) is an agreement among multiple states which allow physicians in a participating state to more easily become licensed in another state. Michigan joined the IMLCC at the end of 2018. The compact was set to be repealed in 2022 which was extended by an additional three years to March 28, 2025. House Bill 4032 and Senate Bill 60 were introduced in the House and Senate to eliminate the "sunset date" to keep Michigan in the IMLCC, but each were not timely passed. Accordingly, Michigan has started the process of withdrawing from the IMLCC, which will be effective March 28, 2026 absent legislative action.

In response to this, on May 14, 2025, Senate Bill 303 was introduced by Senator Roger Hauck to reenter Michigan into the IMLCC which passed the Senate on May 21, 2025. A similar bill, House Bill 5455 was introduced by Representative Rylee Linting on January 15, 2026 and passed the House on February 4, 2026. In order for physicians in Michigan who practice under a compact license to remain recognized, either Senate Bill 303 or House Bill 5455 will need to be signed by the Governor before March 28, 2026. If neither the House nor Senate Bill is passed, it is estimated that over 8,000 licensed physicians in Michigan will be impacted.

Other Interstate Licensure Compacts

Multiple bills have been introduced in the Michigan House of Representatives and Senate to enter Michigan into multiple interstate licensure compacts for other health professions, including the following:

- House Bill 4101/Senate Bill 501—This bill was introduced by Representative Matt Bierlein to enter Michigan into the Physical Therapy Licensure Compact. The bill was

passed by the Michigan House with immediate effect on May 22, 2025 and a substitute version of the bill was passed by the Michigan Senate on September 9, 2025.

Senate Bill 501, which is tie barred with House Bill 4101 would authorize an individual who held a compact privilege to practice physical therapy to engage in the practice of physical therapy. The bill would additionally allow individuals with a compact privilege to practice physical therapy as a physical therapist assistant under the supervision of a physical therapist. Senate Bill 501 also passed the Senate on September 9, 2025. Senate Bill 501 was referred to the House Committee on Health Policy where it was voted out favorably on January 21, 2026.

- House Bill 4103—This bill was introduced by Representative Julie Rogers to enter Michigan into the Occupational Therapy Licensure Compact. The bill was passed by the Michigan House with immediate effect on May 13, 2025 and referred to the Senate Committee on Health Policy, which reported favorably a substitute version of the bill on September 11, 2025.

- House Bill 4246—This bill was introduced by Representative Phil Green to enter Michigan into the Nurse Licensure Compact. The bill was was passed by the Michigan House with immediate effect on June 12, 2025 and was referred to the Senate Committee on Regulatory Affairs.

- House Bill 4309—This bill was introduced by Representative David Prestin to enter Michigan into the Physician's Assistants Licensure Compact. The bill was passed by the Michigan House on May 13, 2025 and referred to the Senate Committee on Health Policy, which reported favorably without amendment on November 12, 2025.

- House Bill 4509—This bill was introduced by Representative Luke Meerman on May 21, 2025 to enter Michigan into the Audiology and Speech-Language Pathology Interstate Licensure Compact. The bill passed the House on October 28, 2025 and referred to the Senate Committee on Health Policy.

Each of these bills remain pending as of the date of this publication.

340B Advocacy: Moving to the States

The 340B program allows covered safety net hospitals and other community care organizations to access certain outpatient prescription drugs at discounted prices. The benefit realized from program participation allows for covered entities to support access to healthcare and affordable drugs for patients and communities. Created by Congress in 1992 to stretch scarce resources in healthcare without any state or federal tax dollars, the program requires drug manufacturers to

offer certain eligible healthcare entities discounted prices on identified outpatient drugs as a condition of participation in Medicaid and Medicare Part B. Efforts to alter, expand and govern the program were the sole purview of the Congress until recently, when states have taken up the mantle of 340B advocacy and policy over the last five years.

Legislation is pending in Michigan, along with 12 other pending states and 19 states that have enacted laws, addressing specific elements of the 340B program not contemplated by federal law. Specifically, the breadth and depth of contract pharmacy relationships with covered entities. Senate Bill 94, sponsored by Sen. Sam Singh (D-East Lansing), prohibits drug manufacturers, wholesalers and wholesale distributor-brokers from limiting the acquisition of 340B drugs based on a covered entity's contracting with independent or retail pharmacies authorized to receive those drugs on behalf of the 340B covered entity. In addition to 340B program protections contained in SB 94, the bill includes new language requiring covered entities to report on compliance and impact of the program and requires drug manufacturers to report on elements contributing to the high cost of drugs.

In addition to Senate Bill 94, House Bill 4878 sponsored by Representative Curt VanderWall (R-Ludington) addresses substantially similar contract pharmacy issues while including increased reporting and transparency requirements for 340B covered entities. Both the House and Senate legislation reiterate the evolving trend of state action in a traditionally federal space.

The specific 340B issue addressed in both bills is a current practice drug manufacturers employ designed to limit the number of permissible contracted pharmacies a covered entity can work with. Individual drug manufacturers are deploying varying compliance policies, including blanket prohibitions on the number of pharmacies a covered entity may contract with, restrictions based on pharmacy distance from the covered entity and data submission requirements. The result is a patchwork of program requirements not contemplated by federal law. The impact of this litany of manufacturer contract pharmacy restrictions is reduced program savings, increased administrative costs and risk of reduced access to needed healthcare services in communities throughout Michigan.

340B covered entities include federally qualified health centers (FQHCs), tribal health centers, Ryan White HIV/AIDS clinics, and certain non-profit hospitals, including critical access hospitals, rural referral centers, children’s hospitals, cancer hospitals, sole community hospitals and hospitals that serve a disproportionate share of Medicaid patients. For these safety net providers, the 340B benefit is integral to supporting community-based care. Action in the state Legislature will protect the program from erosion and maintain patient access to necessary care.

The state Senate took action on Senate Bill 94 in early March, and its tie-barred companion bill Senate Bill 95, sponsored by Sen. Jonathan Lindsey (R-Coldwater). The bills passed 33-3 with overwhelming bipartisan support. The state House Health Policy Committee, reported House Bill 4878 with an H-3 substitute on January 28, 2026. House Bill 4878 has been referred to the House Rules Committee for next steps. Should Michigan move either Senate Bill 94 or House Bill 4878

forward, it will join 19 other states in exercising state authority to protect the intent of the 340B program.

Surrogate Decision-Making in Health Care Legislation: Michigan House Bill 4418

House Bill 4418 creates a legal framework governing surrogate decision-making for health care decisions when an adult patient is deemed incapacitated and therefore unable to make medical decisions, and does not have a guardian or an existing patient advocate designation completed pursuant to a Durable Power of Attorney for Healthcare (DPOAH).

The bill defines key terms such as "health care", "health care decision", "surrogate" and "reasonably available", ensuring clarity for patients, families, and health care providers. It broadly defines "health care decisions" to include selecting providers and facilities, approving tests and directing medical care, while limiting treatment decisions that could result in the patient's death. The bill also allows the surrogate to make mental health treatment decisions that the patient would be able to make for themselves if they had capacity.

Under the bill, a surrogate may act only when the patient lacks decision-making capacity and no patient advocate, equivalent designation, or guardian is reasonably available. A surrogate's authority automatically ends if the patient regains capacity. Importantly, patients with capacity who are admitted to a health care facility may proactively designate a surrogate, either in writing or through witnessed verbal communication, that is then documented in the patient's medical record.

If no surrogate is designated by the patient or the patient is unable to designate a surrogate, the bill establishes a priority list to determine who may act as surrogate in the following order: a patient's spouse, adult children, domestic partners, parents, siblings, cohabitants, and other adults who have demonstrated special care and familiarity with the patient and their values. When multiple individuals share the same priority level, a single surrogate must be selected by majority vote of all the individuals in that priority level. It is, however, unclear what happens if a majority decision cannot be reached, and whether individuals are able to abstain from voting.

The bill includes surrogate safeguards to protect patients. Individuals subject to personal protection orders, involved in abuse-related criminal proceedings, or found by a court to pose a danger to the patient are automatically disqualified from serving as surrogates. Patients may also disqualify any potential surrogate at any time, even if they no longer have capacity, similar to a patient's ability to revoke a DPOAH at any time. Any disqualification is documented in the patient's medical record.

In regard to mental health treatment decisions, the bill differs from the Patient Advocate Designation Statute, MCL 700.5506, in one important way: the bill does not provide an optional 30-day delay for the disqualification to take effect, unlike the Patient Advocate Designation Statute, which gives patients the ability to delay their revocation by 30 days for mental health treatment decisions.

Surrogates must formally accept their role in writing and are held to fiduciary standards, requiring them to act in the patient's best interests and in accordance with known patient preferences and values, and have access to the patient's medical record. There are also limits on a surrogate's authority to make decisions. For example, surrogates are prohibited from receiving compensation, withdrawing or withholding life-sustaining treatment that would result in the patient's death, or relocating patients out of state without court approval. They are also required to notify other family members of their assumption of authority and provide written notice if their role continues beyond seven days. Importantly, though, the proposed legislation does not limit the authority of a surrogate to withhold or withdraw care when they are acting under the Death with Dignity Act, MCL 333.5652.

The bill provides clear guidance for health care providers, directing them to document capacity determinations, surrogate designations, and changes in authority in the medical record. However, from a practical standpoint, it may be difficult for health care providers to pass this information to another facility if designations, acceptances, and disqualifications may be documented in multiple places throughout the record. Health care decisions made by a surrogate are effective without court approval, offering health care providers legal clarity and reducing the need for court intervention.

House Bill 4418 aims to balance patient autonomy, family involvement, and clinical considerations by creating a structured, legal sanctioned process for surrogate decision-making when patients cannot make decisions for themselves.