Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 356 (Substitute S-2 as passed by the Senate)
Senate Bill 357 (Substitute S-3 as passed by the Senate)
Senate Bill 358 (Substitute S-2 as passed by the Senate)
Sponsor: Senator Kevin Hertel (S.B. 356)
Senator Mary Cavanaugh (S.B. 357)
Senator Veronica Klinefelt (S.B. 358)
Committee: Health Policy

Date Completed: 9-18-23

RATIONALE

Some people are concerned that a Federal court could strike down specific provisions of the Affordable Care Act (ACA), a comprehensive Federal healthcare reform law that requires insurance providers to follow requirements similar to those proposed by the bill (see **BACKGROUND**). Affordable, accessible healthcare is important for keeping serious health conditions at bay. According to testimony before the Senate Committee on Health Policy, without healthcare coverage, people forego needed screenings. This allows health conditions to worsen and become more difficult to treat. People then must seek treatment in hospitals and emergency rooms, financially burdening them further. Accordingly, it has been suggested that specified requirements of the ACA be enacted in State law.

CONTENT

Senate Bill 356 (S-2) would amend Section 2212a of the Insurance Code to require insurers to provide to a consumer a summary of a health insurance policy that contained specified information, such as information that a consumer could use to compare health coverage and understand the terms of the consumer's coverage.

Senate Bill 357 (S-3) would amend Section 2213b and add Section 2213e to the Insurance Code to prohibit an insurer from rescinding coverage unless the insured individual committed fraud or made an intentional misrepresentation of material fact.

Senate Bill 358 (S-2) would add Section 3406z to the Insurance Code to prescribe the levels of coverage a health policy insurer would have to offer in the State. The bill also would prescribe how much a plan could deviate from its required actuarial value.

Senate Bill 356 (S-2)

Under the Code, an insurer that delivers, issues for delivery, or renews in the State a health insurance policy must provide a written form in plain English to the insured upon enrollment that describes the terms and conditions of the insurer's policies. The form must provide in a clear, complete, and accurate description the following as applicable:

-- The service area.
-- Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.
-- Emergency health coverages and benefits.

-- Out-of-area coverage and benefits.
-- An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.
-- Provisions for continuity of treatment if a provider's participation terminates during the course of an insured person's treatment by the provider.
-- The telephone number to call to receive information concerning grievance procedures.
-- How the covered benefits apply in the evaluation and treatment of pain.
-- A summary listing certain information about the insurer's network and the health care providers in that network.

Instead, under the bill, an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy would have to provide a written summary of the policy. The written summary would have to provide a clear, complete, and accurate description of all the following, if applicable:

-- Uniform definitions of standard insurance terms and medical terms so that a consumer could compare health coverage and understand the terms of, or exceptions to, the consumer's coverage, in accordance with the most recent guidance issued by the United States Department of Health and Human Services (USDHHS).
-- A description of the coverage, including cost sharing, for each category of benefits in the most recent guidance issued by the USDHHS.
-- The exceptions, reductions, and limitations of the health insurance policy.
-- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.
-- The renewability and continuation of coverage provisions.
-- Coverage examples.
-- A statement about whether the health insurance policy provided minimum essential coverage as defined under Federal law, and whether the health insurance policy's share of the total allowed costs of benefits provided under the health insurance policy met applicable requirements.
-- A statement that the summary is only a summary, and that the health insurance policy should be consulted to determine the governing contractual provisions of the coverage.
-- Contact information for questions.
-- An internet web address where a copy of the actual individual coverage policy or group certificate of coverage could be reviewed and obtained.
-- For insurers that maintained one or more networks of providers, instructions for obtaining a list of network providers.
-- For insurers that used a formulary in providing prescription drug coverage, instructions for obtaining information on prescription drug coverage.
-- Instructions for obtaining the uniform glossary and a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies were available.

An insurer, or a group health plan, to the extent the group health plan had contractually agreed to distribute the written summary, would have to provide the written summary as follows:

-- To the applicant not later than seven business days after the date of the receipt of the application.
-- By the first date of coverage if the information provided at the time of application had changed.
-- To the insured not later than 30 days after the effective date of a renewal of the policy.
-- On request of the insured, not later than seven days after the request.

The information required under the bill could be provided electronically.

Senate Bill 357 (S-3)

The bill would prohibit an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy with respect to an individual, including a group to which the individual belonged or a family coverage in which the individual was included, from rescinding coverage under the policy unless the following applied:

-- The individual or a person seeking coverage on behalf of the individual performed an act, practice, or omission that constituted fraud, or an individual made an intentional misrepresentation of material fact.
-- The insurer provided written notice to the individual at least 30 days before the recission.

With respect to an individual who sought coverage on behalf of an individual that performed an act of fraud, a person would not include an employee or authorized representative of the insurer or a producer.

The bill would define "rescind coverage" as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage would not be a recission if any of the following applied:

-- The cancellation or discontinuance of coverage had only a prospective effect.
-- The cancellation or discontinuance of coverage was effective retroactively, to the extent it was attributable to a failure to timely pay required premiums or contributions, including COBRA premiums, toward the cost of coverage. ("COBRA" would mean the Consolidated Omnibus Budget Reconciliation Act of 1985.)
-- The cancellation or discontinuance of coverage was initiated by the individual or by the individual's authorized representative and the sponsor, employer, plan, or issuer did not directly or indirectly take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual.
-- The cancellation or discontinuance of coverage was initiated by an exchange established under the ACA and any regulations promulgated thereunder.

The bill's contents would apply to a health insurance policy delivered, issued for delivery, or renewed in Michigan before, on, or after the bill's effective date.

Senate Bill 358 (S-2)

The bill would require an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy in the individual or small group market to offer health insurance policies that provided at least one of the following levels of coverage:

-- Coverage designed to provide benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the policy.
-- Coverage designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the policy.
-- Coverage designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the policy.
-- Coverage designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the policy.

For plan years beginning after the bill's effective date, the allowable variation in the actuarial value of a health insurance policy that does not result in a material difference in the true dollar value of the health insurance policy would be −2% and +2%. However, if a health insurance policy with benefits actuarially equivalent to 60% of the full actuarial value of the

benefits provided covered and paid for at least one major service other than preventive services before the deductible, or met the requirements to be a high deductible health plan within the meaning of Federal law, the allowable variation in actuarial value for the health insurance policy would be −2% and +5%.

For purposes of determining compliance with the bill's requirements above, an insurer described above would have to use the actuarial calculator developed and made available by the Federal Department of Health and Human Services for the applicable plan year. Subject to the in-network cost sharing limitations below, if the Federal Department of Health and Human Services had not developed and made available the calculator, an insurer described above could use the most recently issued calculator. If a health insurance policy's design were not compatible with the calculator, the insurer would have to submit an actuarial certification from an actuary, who was a member of the American Academy of Actuaries, using one of the following methodologies:

-- Calculate the health insurance policy's actuarial value by estimating a fit of its plan design into the parameters of the calculator or by having the actuary certify that the plan design fits appropriately in accordance with generally accepted actuarial principles and methodologies.
-- Use the calculator to determine the actuarial value for the health insurance policy provisions that would fit within the calculator parameters and have the actuary calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the actuarial value identified by the calculator, for plan design features that deviate substantially from the parameters of the calculator.

These calculation methods could include only in-network cost-sharing, including multitier networks.

This bill specifies that it would not apply to a short-term or one-time limited duration policy or certificate of up to six months as described Senate Bill 357 (S-3), or to a grandfathered plan as that term is defined in Federal law.

MCL 500.2212a (S.B. 356)
MCL 500.2213b et al. (S.B. 357)
Proposed MCL 500.3406z (S.B. 358)

BACKGROUND

The ACA is a comprehensive healthcare reform law that was enacted in March 2010 under the Obama administration. Among other provisions of the ACA, insurance and health care providers must provide consumers with standardized and easy-to-read information about a plan using a common form that is intended to make it easier for consumers to compare plans. Additionally, under the ACA, newly sold insurance plans must be at one of four actuarial level values: 60% (a bronze plan); 70% (a silver plan); 80% (a gold plan); or 90% (a platinum plan). Under the ACA, plans and issuers are prohibited from canceling or discontinuing coverage that has a retroactive effect, except because of failure to pay timely premiums toward coverage, the presence of fraud, or an intentional misrepresentation of material fact.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Congress and the Federal court system have shown actionable disagreement toward the ACA and its health care access. This, in conjunction with the *Braidwood Management Inc. v. Becerra* case currently on the U.S. Fifth Circuit Court of Appeals' docket, could put 2.1 million

residents of Michigan at risk of losing full coverage of preventative services. In *Braidwood Management Inc. v. Becerra*, the requirement that most private insurance plans cover recommended preventative care services without cost sharing could be struck down.[1] On March 30, 2023, Judge Reed O'Connor at the U.S. District Court in the Northern District of Texas struck down a provision of the ACA that requires most private health plans to cover a range of preventative services without any cost sharing for their enrollees on the grounds that the requirement to cover preexposure prophylaxis (PrEP) medications (medication designed to lower the chances of getting HIV from sex or injection drug use) violates the rights of the plaintiffs who have religious objections to PrEP. The Federal government appealed this decision and on May 15, 2023, the Fifth Circuit Court of Appeals issued an administrative stay of the district court's ruling, allowing the Federal government to continue enforcing the preventative services requirement while the Fifth Circuit considers the Federal government's motion. This court case illuminates the importance of enshrining protections of the ACA in State law. Michigan residents with pre-existing conditions, women, seniors, low-income residents, and families would all benefit from the bills' provisions.

Supporting Argument

Codifying ACA proposals in State law would ensure people are provided with needed information about health plans before and after they enroll. This could lead to an easier-to-navigate healthcare system and more transparency regarding rates and provider availability between insurers and consumers. Senate Bill 358 would give Michigan residents the security of knowing they will continue to have that transparency when they choose and enroll in their health insurance coverage in the future.

Supporting Argument

According to testimony before the Senate Committee on Health Policy, 1.8 million Michigan residents were denied access to affordable coverage because of a pre-existing condition before the passage of the ACA. Codifying Senate Bill 357 into State law would ensure that a person's coverage could only be rescinded if a person committed insurance fraud or intentionally misrepresented material fact. This would provide Michigan residents security because insurance coverage could not be discontinued with retroactive effect.

Legislative Analyst: Alex Krabill

FISCAL IMPACT

The bills would have no fiscal impact on State or local government.

Fiscal Analyst: Elizabeth Raczkowski

[1] Laurie Sobel et al., Kaiser Family Foundation, *Explaining Litigation Challenging the ACA's Preventative Services Requirements: Braidwood Management Inc. v. Becerra*, May 15, 2023.

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