Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 356 through 358 (as introduced 5-24-23)
Sponsor: Senator Kevin Hertel (S.B. 356)
Senator Mary Cavanaugh (S.B. 357)
Senator Veronica Klinefelt (S.B. 358)
Committee: Health Policy

Date Completed: 6-6-23

INTRODUCTION

Taken together, the bills would codify certain provisions of the Affordable Care Act (ACA), such as the requirement that health care insurers provide a form with specific information to an applicant or an insured person at certain times and the prohibition against the rescission of coverage unless there was fraud. Additionally, the bills would prescribe four tiers of health care coverage an insurer would have to offer.

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

FISCAL IMPACT

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

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CONTENT

Senate Bill 356 would amend the Insurance Code to modify the form an insurer would have to provide to an applicant or an insured person and the timeline for the form to be provided.

Senate Bill 357 would amend 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 would amend the Insurance Code to add Section 3406z to prescribe the levels of coverage a health policy insurer would have to offer in the State.

Senate Bill 356

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 form prescribed by the Director of the Department of Insurance and Financial Services to insured that described the terms and conditions of the policy. An insurer also would have to provide the form as follows:

-- To the applicant at the time of the application.
-- To the insured at the time the insurer issues the policy.
-- To the insured within 30 days after the renewal policy's effective date.
-- Upon request of the insured, within seven days of the request.

Senate Bill 357

The bill would add Section 2213e, which 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.

Senate Bill 358

The bill would amend the Insurance Code to add Section 3406z to require an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy 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.

In addition, the insurer also would have to provide coverage at that level as child-only coverage.

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 insurances 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 to the extent attributable to a failure to pay timely premiums toward coverage, unless there is fraud, or the individual makes an intentional misrepresentation of material fact.

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