Senate Fiscal Agency
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BILL ANALYSIS

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House Bill 4619 (as passed without amendment)
House Bill 4620 (Substitute H-1 as passed by the House)
House Bill 4621 (Substitute H-2 as passed by the House)
House Bill 4622 (Substitute H-3 as passed by the House)
House Bill 4623 (Substitute H-2 as passed by the House)
Sponsor: Representative Julie Rogers (H.B. 4619)
Representative Kimberly Edwards (H.B. 4620)
Representative John Fitzgerald (H.B. 4621)
Representative Reggie Miller (H.B. 4622)
Representative Matt Koleszar (H.B. 4623)
House Committee: Insurance and Financial Services
Senate Committee: Health Policy

Date Completed: 9-12-23

INTRODUCTION

Generally, the bills would codify provisions of the Affordable Care Act in the Insurance Code. These provisions would include prohibitions against discriminatory insurance practices based on gender, gender identity or expression, and sexual orientation; prohibitions against exclusion of coverage due to a pre-existing condition; a requirement that dependents qualify for health insurance until the age of 26; prohibitions against lifetime or annual limits on specific coverage; and requirements of insurers to provide coverage for specific services, such as emergency services, pregnancy, and prescription drugs, among other services.

FISCAL IMPACT

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

MCL 500.2027 (H.B. 4619)
Proposed MCL 500.3406aa (H.B. 4620)
MCL 500.3403 (H.B. 4621)
Proposed MCL 500.3406z (H.B. 4622)
Proposed MCL 500.3606bb (H.B. 4623)

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CONTENT

House Bill 4619 would amend Chapter 20 (Unfair and Prohibited Trade Practices and Frauds) of the Insurance Code to do the following:

- **Prohibit an insurer from refusing to insure an individual based on gender, gender identity or expression, and sexual orientation, in addition to characteristics currently covered by this prohibition.**
- **Prohibit an insurer from charging an individual a different rate for the same coverage based on race, color, creed, national origin, gender, gender identity or expression, and sexual orientation, in addition to characteristics currently covered by this prohibition.**

House Bill 4620 (H-1) would amend Chapter 34 (Disability Insurance Policies) of the Insurance Code to prohibit an insurer that delivered, issued for delivery, or renewed a health insurance policy in Michigan from limiting or excluding coverage for an individual by imposing a preexisting condition exclusion on the individual. The bill also would prescribe exemptions to its prohibition.

House Bill 4621 (H-2) would amend Chapter 34 of the Insurance Code to require health insurance policies that offered dependent coverage to make that coverage available for a dependent until the dependent was 26 years old. Additionally, the bill would prescribe additional provisions related to dependent coverage.

House Bill 4622 (H-3) would amend Chapter 34 of the Insurance Code to prohibit an insurer that delivered, issued for delivery, or renewed a health insurance policy in Michigan from instituting lifetime or annual limits on the dollar value of specified essential health benefit coverage, such as emergency services, hospitalization, and pregnancy, among other things. It also would provide exemptions to the prohibition.

House Bill 4623 (H-2) would require an insurer that delivered, issued for delivery, or renewed a health insurance policy in the individual or small group market in Michigan to provide coverage for a specified services, such as emergency services, hospitalization, and pregnancy, among other things. Additionally, the bill would prohibit an insurer from imposing cost-sharing requirements for preventative and wellness services and require an insurer without a specific in-network service provider to provide the service with an out-of-network provider without imposing cost sharing.

House Bill 4622 is tie-barred to House Bill 4623.

House Bill 4619

The Insurance Code prohibits an insurer from limiting the amount of coverage available to an individual, refusing to insure an individual, or refusing to continue to insure an individual based on race, color, creed, marital status, sex, or national origin, except that marital status may be used to classify individuals or risks for the purpose of insuring family units.

The bill would add gender, gender identity or expression, and sexual orientation to the individual characteristics covered by this provision.

Additionally, the Code prohibits an insurer from charging a different rate for the same coverage based on an individual's sex, marital status, age, residence, location of risk, disability, or lawful occupation, unless the rate is based on legitimate information.

The bill would add race, color, creed, national origin, gender, gender identity or expression, and sexual orientation to the characteristics covered by this provision.

House Bill 4620 (H-1)

The bill would amend the Code to prohibit an insurer that delivered, issued for delivery, or renewed a health insurance policy in Michigan from limiting or excluding coverage for an individual by imposing a preexisting condition exclusion on the individual.

The prohibition would not apply to any grandfathered healthcare plan coverage as that term is defined under Federal law or to insurance coverage that provided benefits for the following:

-- Hospital confinement indemnity.
-- Disability income.
-- Accident only.
-- Long-term care.
-- Medicare supplement.
-- Limited benefit health.
-- Specified disease indemnity.
-- Sickness or bodily injury, or death by accident, or both.
-- Retiree-only health insurance coverage.
-- Stand-alone dental plans.
-- Stand-alone vision plans.
-- Other limited benefit policies.

"Preexisting condition exclusion" would mean a limitation or exclusion of benefits or a denial of coverage based on the fact that a physical or mental condition was present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of the coverage or denial of coverage.

House Bill 4621 (H-2)

The Code requires an insurer that delivers or renews in the State a health insurance policy that offers dependent coverage to include provisions in the policy that generally provide coverage for newborn children. It also prohibits a health insurance policy that offers dependent coverage from denying enrollment to an insured's child on specified grounds, such as the child being born out of wedlock.

In addition, the bill would require a health insurance policy that offered dependent coverage to do the following:

-- Make available dependent coverage, at the option of the policyholder, until the dependent was 26 years old.
-- Provide the same benefits at the same rate or premium for a dependent child as provided for any other covered dependent.

The bill also specifies that it would not require an insurer to make dependent coverage available for a child of a child who was receiving dependent coverage.

House Bill 4622 (H-3)

The bill would prohibit an insurer that delivered, issued for delivery, or renewed a health

insurance policy in Michigan from instituting lifetime or annual limits on the dollar value of essential health benefit coverage required by House Bill 4623 (H-2) (see below).

The bill specifies that these prohibitions would not apply to grandfathered health plan coverage as that term is defined under Federal law or to a short-term or one-time limited duration policy or certificate of 6 months or shorter.

The bill also specifies that it would not prevent an insurer from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that were not essential health benefits to the extent that the limits were otherwise permitted under applicable Federal or State law.

House Bill 4623 (H-2)

The bill would require an insurer that delivered, issued for delivery, or renewed in the individual or small group market a health insurance policy in Michigan to provide coverage for all the following:

-- Ambulatory patient services.
-- Emergency services.
-- Hospitalization.
-- Pregnancy, maternity, and newborn care.
-- Mental health and substance use disorder services, including behavioral health treatment.
-- Prescription drugs.
-- Rehabilitative and habilitative services and devices.
-- Laboratory services.
-- Pediatric services, including oral and vision care; this care would not be required if an insured had dental insurance from another source and provided evidence of the coverage to the insurer.

Additionally, insurers would be required to cover preventative and wellness services and chronic disease management identified by the Director of the Department of Insurance and Financial Services. Coverage for an item or service would not be required under the bill unless an item or service was one or more of the following:

-- Evidence-based items or services if the United States Preventive Services Task Force (USPSTF) had rated the item or service as "A" or "B" (ratings indicating that the USPSTF *recommended* the item or service)[1] for the purposes of its recommendations in effect at the time with respect to the individual involved.
-- An immunization with routine use in children, adolescents, and adults if the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention had included the immunization for the purposes of its recommendations with respect to the individual involved.
-- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings if the United States Health Resources and Services Administration had included the care or screening for the purposes of its guidelines.
-- With respect to women, preventive care and screenings not rated as "A" or "B" as described above if the United States Health Resources and Services Administration had included the care or screening for the purposes of its guidelines.

[1] United States Preventative Services Task Force, *What Grades Mean and Suggestions for Practice*, June 2018.

Any change to the preventive and wellness services and chronic disease management services required as described above would have to take effect for the plan year that began on or after the date that is one year after the date the recommendation or guideline was issued. An insurer could not impose any cost-sharing requirements for any of those services, except as otherwise allowed under Federal law.

Benefits required as described above would be subject to all requirements applicable to those benefits under Chapter 34 of the Code. However, the bill would not limit the requirements to provide additional benefits under Chapter 34.

The bill would not require an insurer to cover items of the USPSTF that were downgraded to a "D" (a rating indicating that the USPSTF *recommended against* the item or service)[2] rating or any item or service during a plan year that was subject to a safety recall or was otherwise determined to pose a significant safety concern by a Federal agency authorized to regulate the item or service.

The bill would not prevent an insurer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a required item or service to the extent they were not specified in the relevant recommendation or guideline. An insurer could rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting of a recommended preventative health service.

Cost Sharing

Under the bill, except for separately billed items or services in office visits for which insurers may impose cost-sharing requirements under Federal law, an insurer could not impose any cost-sharing requirements for benefits provided as preventative and wellness services and chronic disease management described above.

Out-of-Network and Cost Sharing

The bill would not require an insurer that had a network of providers to provide benefits for required items and services described above that were delivered by an out-of-network provider and would not preclude such an insurer from imposing cost-sharing requirements for these items or services if they were delivered by an out-of-network provider. An insurer that did not have a provider in its network that could provide the required items or services would have to cover them with an out-of-network provider without imposing cost sharing.

Exclusions

The bill would not apply to grandfathered health plan coverage as that term is defined in Federal law or to a short-term or one-time limited duration policy or certificate of six months or shorter.

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[2] *Id.*

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.