# Legislative Analysis

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**CODIFYING ACA PROVISIONS**

**Senate Bill 356 (S-2) as passed by the Senate**
**Sponsor: Sen. Kevin Hertel**

**Senate Bill 357 (S-3) as passed by the Senate**
**Sponsor: Sen. Mary Cavanagh**

**Senate Bill 358 (S-2) as passed by the Senate**
**Sponsor: Sen. Veronica Klinefelt**

**House Committee: Insurance and Financial Service**
**Senate Committee: Health Policy**
**Complete to 9-13-23**

**SUMMARY:**

Senate Bills 356, 357, and 358 would amend the Insurance Code to codify various provisions of the federal Affordable Care Act (ACA) in state law relating to the summary of insurance benefits provided to insured individuals, the circumstances in which a policy can be rescinded, and the acceptable levels of coverage an insurer can offer.

**Senate Bill 356** would modify the summary of health insurance benefits that an insurer must provide to an insured individual. Currently, the act requires such information to be included in this summary as the service area, covered benefits, and emergency and out-of-area coverages and benefits. The bill would replace the current requirements with the following:

- Uniform definitions of standard insurance terms and medical terms so that a consumer may 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 U.S. Department of Health and Human Services.
- A description of the coverage, including cost sharing, for each category of benefits in the most recent guidance issued by the U.S. Department of Health and Human Services.
- 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 provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code[1] and whether the health insurance policy's share of the total allowed costs of benefits provided under the health insurance policy meets applicable requirements.
- A statement that the summary is only a summary and that the policy itself should be consulted to determine the governing contractual provisions of the coverage.
- Contact information for questions.

[1] https://www.law.cornell.edu/uscode/text/26/5000A

- An internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.
- For insurers that maintain one or more networks of providers, instructions for obtaining a list of network providers.
- For insurers that use a formulary in providing prescription drug coverage, instructions for obtaining information on prescription drug coverage.
- Instructions for obtaining the uniform glossary, a contact phone number to get a paper copy of the uniform glossary, and a disclosure that paper copies are available.

The bill would also require an insurer or group health plan that has contractually agreed to distribute a written summary to distribute it 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 has changed.
- To the insured not later than 30 days after the effective date of a renewal of the policy.
- Upon request of the insured, not later than seven days after the request.

Finally, the bill would allow the summary to be provided electronically.

MCL 500.2212a

**Senate Bill 357** would prohibit an insurer from ***rescinding coverage*** under a health insurance policy in Michigan unless both of the following apply:

- Either of the following:
  - The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud. For purposes of the bill, a person seeking coverage on behalf of an individual does not include an employee or authorized representative of the insurer or a producer.
  - The individual makes an intentional misrepresentation of material fact.
- The insurer provides written notice to the individual at least 30 days before the recission.

  ***Rescind coverage*** would mean a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage would not be a rescission if any of the following apply:
  - The cancellation or discontinuance of coverage has only a prospective effect.
  - The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions, including ***COBRA*** premiums, toward the cost of coverage.
  - The cancellation or discontinuance of coverage is initiated by the individual or by the individual's authorized representative and the sponsor, employer, plan, or issuer does 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 is initiated by an exchange established under the federal Patient Protection and Affordable Care Act

(ACA), as amended by the Health Care and Education Reconciliation Act of 2010, and any regulations promulgated under those acts.

***COBRA*** would mean the Consolidated Omnibus Budget Reconciliation Act of 1985.

The bill would apply to any health insurance policy delivered, issued for delivery, or renewed in Michigan before, on, or after the date bill takes effect.

MCL 500.2213b and proposed MCL 500.2213e

**Senate Bill 358** would require health insurance policies in the individual or small group markets to provide 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 did not result in a material difference in the true dollar value of the policy would be ±2 percentage points. However, if the policy provides benefits equal to 60% of the full actuarial value of the benefits provided covered and paid for at least one major service, other than preventative services, before the deductible or met the requirements to be a high deductible health plan,[2] the allowable variation would be -2 percentage points to +5 percentage points.

To determine compliance with the bill, an insurer would have to use the actuarial calculator developed and made available by the U.S. Department of Health and Human Services for the applicable plan year. If the department does not develop and make a calculator available, the insurer could use the most recently issued calculator. If a policy's design is not compatible with the calculator, the insurer would have to submit an actuarial certification from an actuary who is a member of the American Academy of Actuaries using one of the following methodologies:

- Calculating the health insurance policy's actuarial value by:
  - Estimating a fit of its plan design into the parameters of the calculator.
  - Having the actuary certify that the plan design fits appropriately in accordance with generally accepted actuarial principles and methodologies.
- Using the calculator to determine the actuarial value for the health insurance policy provisions that 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.

[2] See https://www.law.cornell.edu/uscode/text/26/223

The calculation methods required by the bill would only include in-network cost-sharing, including multitier networks.

The bill would not apply to a short-term or one-time limited duration policy or certificate of not longer than six months as described in section 2213b or to a grandfathered plan as that term is defined in 45 CFR 147.140.[3]

Proposed MCL 500.3406z

**FISCAL IMPACT:**

The bills would have no fiscal impact on the state or local units of government.

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.

[3] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.140