Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bills 356 through 358 (as enacted) **PUBLIC ACTS 161-163 of 2023**
Sponsor: Senator Kevin Hertel (S.B. 356)
Senator Mary Cavanaugh (S.B. 357)
Senator Veronica Klinefelt (S.B. 358)
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 11-29-23

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 offer specific levels of coverage and maintain that coverage. 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; newly sold insurance plans must be at one of four actuarial level values; and plans and issuers are prohibited from canceling or discontinuing coverage that has a retroactive effect, except in certain circumstances.

If a Federal court struck down these provisions, it could lead to a decrease in the quality of some individuals' coverage or to individuals losing their existing healthcare coverage. 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 was suggested that specified requirements of the ACA be enacted in State law.

CONTENT

Senate Bill 356 amends Section 2212a of the Insurance Code to require insurers to provide to a consumer a summary of a health insurance policy that contains specified information, such as information that a consumer may use to compare health coverage and understand the terms of the consumer's coverage.

Senate Bill 357 amends Section 2213b and adds Section 2213e to the Insurance Code to prohibit an insurer from rescinding coverage unless the insured individual commits fraud or makes an intentional misrepresentation of material fact.

Senate Bill 358 adds Section 3406ee to the Insurance Code to prescribe the levels of coverage a health policy insurer must offer in the State. The bill also prescribes how much a plan may deviate from its required actuarial value.

Each bill will take effect February 13, 2024.

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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 delivers, issues for delivery, or renews in the State a health insurance policy must provide a written summary of the policy. The written summary must 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 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 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 provides 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 meet 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 may 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 and a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

An insurer, or a group health plan, to the extent the group health plan has contractually agreed to distribute the written summary, must 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 has 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 may be provided electronically.

Senate Bill 357

The bill prohibits an insurer that delivers, issues for delivery, or renews in the State a health insurance policy with respect to an individual, including a group to which the individual belongs or a family coverage in which the individual is 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 does not include an employee or authorized representative of the insurer or a producer.

The bill defines "rescind coverage" as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a recission 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. ("COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.)[1]
-- 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 ACA and any regulations promulgated thereunder.

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

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[1] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives workers and their families who lose health benefits the right to continue group health benefits provided by their group health plan for limited periods of time under circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, and divorce. This temporary extension of health coverage required by COBRA is often referred to as "continuation coverage."

The bill requires an insurer that delivers, issues for delivery, or renews in the State a health insurance policy in the individual or small group market to offer health insurance policies that 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 (a Bronze plan).
-- Coverage designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the policy (a Silver plan).
-- Coverage designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the policy (a Gold plan).
-- Coverage designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the policy (a Platinum plan).

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 is the de minimis variation as described in Federal law.[2]

For purposes of determining compliance with the bill's requirements above, an insurer described above must use the actuarial calculator developed and made available by the USDHHS for the applicable plan year. Subject to the in-network cost sharing limitations below, if the USDHHS did not develop and make available the calculator, an insurer described above may use the most recently issued calculator. If a health insurance policy's design is not compatible with the calculator, the insurer must 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 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 may include only in-network cost-sharing, including multitier networks.

[2] Generally, the de minimis variation in 45 CFR 156.140 describes the allowable variation in the AV (actuarial value, or anticipated covered medical spending) of a health plan that does not result in a material difference in the true dollar value of the health plan. For plan years beginning between January 1, 2018 and December 31, 2022, the AV is -4 percentage points and +2 percentage points. For plan years beginning January 1, 2023 and after, the AV is -2 percentage points and +2 percentage points. Special AVs apply for bronze plans that meet certain criteria.

This bill specifies that it does not apply to a short-term or one-time limited duration policy or certificate of up to six months as described in Senate Bill 357, to a grandfathered plan as that term is defined in Federal law,[3] or to a catastrophic plan as defined in Federal law.[4]

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

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.[5] 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. Codifying ACA provisions in State law will ensure that people are provided with needed information about health plans before and after they enroll, that insurers within the State do not deny access to affordable coverage to individuals with pre-existing conditions as they reportedly did to 1.8 million Michigan residents before the passage of the ACA, and that Michigan residents' insurance coverage could not be discontinued with retroactive effect. This court case shows the importance of enshrining protections of the ACA in State law.

Legislative Analyst: Alex Krabill

FISCAL IMPACT

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

Fiscal Analyst: Elizabeth Raczkowski

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[3] Generally, grandfathered health plan coverage, as defined in 45 CFR 147.140, refers to health insurance coverage provided to an individual by a group health plan or a group/individual health insurance issuer before the Affordable Care Act was signed into law on March 23, 2010.

[4] Generally, catastrophic healthcare plans, as defined in 45 CFR 156.155, refer to health plans that have low monthly premiums, but a high deductible. In most situations, catastrophic plans must only be offered in the individual market, must provide coverage for at least three primary care visits per year before reaching the deductible, and must be initially purchased by an individual who is younger than 30 unless that individual has received a certificate of exemption.

[5] 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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