ACA Codification Package
Executive Summary & Preliminary Commentary

Rep. Rogers House Bill 4619: Amends Chapter 20 (Unfair & Prohibited Trade Practices and Frauds) of the Michigan Insurance Code to prohibit insurers from refusing to insure or limiting the amount of coverage to an individual based on their gender, gender identity/expression, or sexual orientation. It would also prohibit charging different rates for the same coverage based on race, color, creed, sex, national origin, gender, gender identity/expression, or sexual orientation.

MAHP Commentary:

- **Amendment #1 - Effective Date:** Currently, the ACA prohibits gender from being used as a factor in non-grandfathered, individual, and small-group insurance plans. The ACA does not provide this same restriction for grandfathered (those health plan policies issued before the ACA) large-group (more than 50 employees), employer self-insured (ERISA), and short-term-limited duration plans (less than one-year gap catastrophic coverage). HB 4619 would impose this restriction on grandfathered, large group, and short-term-limited duration plans. Employer self-insured plans are not governed by state law and are therefore exempt from this bill and the entire ACA codification package. If the desire is to impose this limitation on these additional groups that are not currently subject to this restriction under the ACA, MAHP would recommend an effective date of January 1, 2025, considering health plans have already filed rates with DIFS for the plan year 2024.

- **Amendment #2 - Exception for Grandfathered & Short-Term-Limited Duration Plans:** Because of their uniqueness and current exemption status under the ACA, MAHP would recommend exempting grandfathered and short-term-limited duration plans.

Rep. Miller House Bill 4622: Adds a new section (3406z) to the Michigan Insurance Code that would prohibit insurers from instituting annual and lifetime limits on the dollar value of benefits for the insured.

MAHP Commentary:

- **Amendment #3 - Definition of Benefits:** The ACA prohibits insurers from imposing annual and lifetime limits on coverage expenses for essential health benefits (*emphasis* on essential). However, the term "benefits" is not defined in House Bill 4622. As such, the prohibition under the bill would apply to all covered benefits, including non-essential health benefits. Many health plans will offer non-essential health benefits such as IVF treatment coverage to assist reproductive medical services. If plans are not allowed to impose some meaningful limitation for non-essential benefits, health plans may no longer offer these benefits because of the potential unsustainable costs of doing so. As such, MAHP would suggest adding a definition of "benefit" to mean essential health benefits as required under the ACA.

- **Amendment #4 - Exception for Grandfathered & Short-Term-Limited Duration Plans:** Because of their uniqueness and current exemption status under the ACA, MAHP would recommend exempting grandfathered and short-term-limited duration plans.

Rep. Koleszar House Bill 4623: Adds a new section (3406z) to the Michigan Insurance Code to codify the ten enumerated essential health benefits. For preventative and wellness services purposes, the bill delegates authority to the DIFS's director to establish by order annually the following benefits.

- Evidence-based items or services highly recommended by the director after recommendations issued by USPSTF.
- Any immunizations determined by the director after consideration of recommendations by the Advisory Committee on Immunizations Practices of the CDC.
- Preventative care and screenings for infants, children, or adolescents determined by the director based upon recommendations from the Health Resources and Services Administration or other organizations recognized by the Director.
- Preventive care and screenings for women that the director determines are supported by the Health Resources and Services Administration or other organizations recognized by the Director.

Cost sharing is also prohibited for preventative care and wellness essential health benefits under the bill.

MAHP Commentary:

- **Amendment #5 - Large Group Plans Clarification:** Large Group Plans (more than 50 employees) are not subject to all the ACA-enumerated essential health benefits. The Michigan Insurance Code currently mandates the services large group plans must cover, known as "basic health services". This list includes things like preventive care benefits but does not include prescriptions and habilitative care. HB 4623 would require large group plans to provide more benefits than currently required under the ACA, leading to increased premiums. As such, MAHP recommends that large-group plans be exempted from the bill or that the definition of essential health benefits for large-group plans reference the "basic health services" already defined in the Insurance Code.

- **Amendment #6 - Director Discretion:** While the enumerated ten essential health benefits are mostly consistent with federal law, the delegated language to the DIFS director on preventative care and wellness is very open-ended and concerning. Even the ACA requires proper due diligence and public input before additional preventive care and wellness services can be added as essential health benefits. See 42 USC 18022(3)&(4) for public notice, hearing, and required elements to consider any additional recommended medical services by the US Secretary. MAHP would recommend eliminating the Director's discretion or, at the very least, requiring the Director to follow the same due process and diligence as required of the US Secretary under the ACA.

- **Amendment #7 – USPSTF Recommendations**: Under the ACA (2590.715-2713(a)(1)), USPSTF recommendations for preventive care are limited to only recommendations of classification of "A" and "B". HB 4623 would allow for all recommendations from the USPSTF to be included. MAHP recommends that the list of recommendations from the USPSTF be limited to only "A" and "B" classifications.

- **Amendment # 8 - Out of Network Cost Sharing Clarification:** The ACA requires no cost-sharing for in-network preventive care services. However, it does allow a health plan to impose cost-sharing for out-of-network preventive services (when care is provided by an out-of-network provider) unless the

network is deemed inadequate (45 CFR 147.130(3)). HB 4623 expressly prohibits cost-sharing regardless of network classification. As such, MAHP recommends adopting the federal language allowing out-of-network cost-sharing.

- **Amendment #9 – Reasonable Medical Management Techniques**: The ACA expressly allows health plans to use clinical evidence-based medical management techniques to determine preventive care services' frequency, method, and treatment. HB 4623 does not provide for this flexibility. MAHP would recommend adding this language from the ACA, specifically 45 CFR 147.130(4).

- **Amendment #10 - Pediatric Dental Stand-Alone Coverage:** Under the ACA, all plans sold on the exchange must include pediatric dental benefits as an essential health benefit. However, in the large group market and others outside the exchange, a policy may exclude dental coverage from the plan if they are "reasonably sure" the consumer has purchased a stand-alone dental plan with pediatric dental coverage. The health plan must offer the coverage, but the pediatric dental coverage may be carved out for a consumer that attests that they have purchased the stand-alone coverage elsewhere. As such, MAHP recommends adding language to allow consumers to opt-out if they can attest that they have purchased stand-alone coverage elsewhere.

- **Amendment #11 - Implementation Date:** The current ACA allows health plans to implement preventive coverage changes at the first renewal one year after the preventive service is recommended (See 45 CFR 147.140 (b)). MAHP recommends including the same implementation date for HB 4623.

- **Amendment #12 - Exception for Grandfathered & Short-Term-Limited Duration Plans:** Because of their uniqueness and current exemption status under the ACA, MAHP would recommend exempting grandfathered and short-term-limited duration plans.

Rep. Edwards House Bill 4620: Adds a new section (3406z) to the Michigan Insurance Code to prohibit an insurer from limiting or excluding coverage for an individual based on a preexisting condition. Grandfathered health plans providing individual health insurance coverage and insurance coverage providing the following specific benefits would be excluded. (Hospital confinement indemnity, disability income, accident only, long-term care, Medicare supplement, limited benefit health, specified disease indemnity, sickness, or bodily injury, and or death by accident, and other limited benefit policies)

MAHP Commentary:

- **Amendment #13 - Definition of Preexisting Condition:** The ACA definition of a "preexisting condition" differs from the definition used in HB 4620. For consistency and uniformity, MAHP recommends using the federal definition (45 CFR 114.103), which is more detailed.

Rep. Fitzgerald House Bill 4621: Amends Section 3403 of Chapter 34 of the Michigan Insurance Code to require insurers to offer dependent coverage until the dependent is 26. The insurer would also have to provide the same coverage, benefits, and rates to the dependent available to other dependents. Furthermore, concerning a dependent child with a disability, the insurer shall offer dependent coverage regardless of age.

MAHP Commentary:

- **Amendment #14 – Remove Duplicate Disabled Coverage:** Michigan law (MCL 500.2264) already expressly allows a disabled individual to remain a dependent on an insurance policy. MAHP would encourage removing this language from HB 4621 to avoid confusion and duplication.

Senator Hertel Senate Bill 356: Amends Section 2212a of Chapter 22 (Insurance Contracts) of the Michigan Insurance Code to remove language requiring insurers to provide written forms to the insured about the terms and conditions of the policy. In the place of providing such information, the director of DIFS is given the authority to prescribe forms that insurers must provide applicants and the insured at the time of application, issuance, and renewal.

MAHP Commentary:

- **Clarification of Intent:** There is a level of confusion regarding the intent of SB 356. Some MAHP members believe this language intends to "codify" the "Summary of Benefits and Coverage" required at the federal level to explain benefit coverages. Others believe this is an intent to change individual health plan "certificates of coverage" forms. If indeed the bill intends to empower DIFS to codify Summary of Benefits and Coverages, MAHP would likely oppose the bill as the current federal multi-year process that health plans painstakingly when through is not something members want to be replicated at the state level. If the intent is to make individual health plan certificates of coverage forms more uniform, further conversation about consumer complaints and departmental intent for uniformity would be appreciated.

Senator Klinefelt Senate Bill 358: Adds a new section (3406z) to the Michigan Insurance Code to require insurers to provide at least one level (60%, 70%, 80%, or 90% of full actuarial value) of coverage. The insurer shall also offer coverage at that level as child-only coverage.

MAHP Commentary:

- **Amendment #15 – De minimis variation & AV Calculator:** Under the ACA (45 CFR 156.140) health plans can meet the actuarial value of coverage by a 2% plus or minus de minimis variation. Furthermore, CMS approves an AV Calculator used by health plans to formulate actuarial values. SB 358 provides neither a de minimis variation nor an AV calculator standard. As such, MAHP would recommend adding language allowing for the 2% de minimis variation and delegating the CMS federally approved AV calculator to be used.

Senator Cavanagh Senate Bill 357: Amends Section 2213b and adds a new section (2213e) of Chapter 22 (Insurance Contracts) of the Michigan Insurance Code to prohibit insurers from rescinding coverage unless the insured performs an act of fraud or makes an intentional misrepresentation of material fact. The insurer would have to give written notice to the insured at least 30 days before the rescission.

MAHP Commentary:

- **Amendment #16 - ACA Prohibition on Rescission:** The conditions placed on a health plan for when a policy can be rescinded are not entirely consistent with the federal conditions outlined here. For example, permission to rescind/cancel based on the originating requestor to rescind (individual/employer) or cancellation from the federal exchange. MAHP would recommend adding the following provisions of 147.128(2) from the code of federal regulations for consistency.