Legislative Analysis

CODIFY AFFORDABLE CARE ACT PROVISIONS

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House Bill 4619 as enacted
Public Act 156 of 2023
Sponsor: Rep. Julie M. Rogers

House Bill 4620 as enacted
Public Act 157 of 2023
Sponsor: Rep. Kimberly Edwards

House Bill 4621 as enacted
Public Act 158 of 2023
Sponsor: Rep. John Fitzgerald

House Bill 4622 as enacted
Public Act 159 of 2023
Sponsor: Rep. Reggie Miller

House Bill 4623 as enacted
Public Act 160 of 2023
Sponsor: Rep. Matt Koleszar

House Committee: Insurance and Financial Services
Senate Committee: Health Policy
Complete to 10-26-23

SUMMARY:

House Bills 4619, 4620, 4621, 4622, and 4623 amend the Insurance Code to add various health insurance requirements and protections for insured individuals in Michigan.

House Bill 4619 adds various characteristics to those that are protected from certain practices.

The act prohibits an insurer from limiting the amount of coverage available to an individual or refusing to insure or continuing to insure an individual based on race, color, creed, marital status, sex, or national origin. The bill adds gender, gender identity or expression, and sexual orientation to the characteristics covered by this provision.

In addition, the act requires that 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 must be based on sound actuarial principles, a reasonable classification system, and be related to the actual and credible loss statistics or, in the case of new coverages, reasonably anticipated experience. The bill adds race, color, creed, national origin, gender, gender identity or expression, and sexual orientation to the characteristics covered by this protection.

MCL 500.2027

House Bill 4620 prohibits an insurer that delivers, issues for delivery, or renews 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 does not apply to any of the following:

- Grandfathered health plan coverage, as that term is defined in 45 CFR 147.140.[1]
- Insurance coverage that provides benefits for any of 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*** means a limitation or exclusion of benefits or a denial of coverage based the fact that on 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.

MCL 500.3406ii

House Bill 4621 requires health insurance policies that make dependent coverage available to offer the dependent coverage until a dependent has attained 26 years of age, at the option of the policyholder. The bill also requires that an insurer provide the same benefits, at the same rate or premium, for dependent children as for any other covered dependent.

The bill does not require an insurer to make dependent coverage available for the child of a child that is receiving dependent coverage.

MCL 500.3403

House Bill 4622 prohibits an insurer that delivers, issues for delivery, or renews a health insurance policy in Michigan from instituting annual or lifetime limits on the dollar value of benefits for essential health benefit coverage provided under section 3406bb(1), added by House Bill 4623. This does not apply to grandfathered health plan coverage, as that term is defined in 45 CFR 147.140, or to a short-term or one-time limited duration policy or certificate of up to six months.

The bill does not prevent an insurer from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that the limits are otherwise allowed under federal or state law.

MCL 500.3406z

[1] https://www.law.cornell.edu/cfr/text/45/147.140

House Bill 4623 requires an insurer that delivers, issues for delivery, or renews a health insurance policy in the individual or small group market in Michigan to provide coverage for all of 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.
- Preventive and wellness services and chronic disease management services identified by the director of the Department of Insurance and Financial Services (DIFS) as meeting one of the following requirements:
    - Evidence-based items or services if the U.S. Preventative Services Task Force has rated the item or service as "A" or "B" for the purposes of its recommendations currently in effect with respect to the individual involved.
    - For women, preventive care and screening not described above if the U.S. Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.
    - An immunization with routine use in children, adolescents, and adults if the Advisory Committee on Immunization Practices of the U.S. Centers for Disease Control and Prevention (CDC) has included the immunization for the purposes of its recommendations with respect to the individual involved.
    - For infants, children, and adolescents, evidence-informed preventive care and screenings if the U.S. Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.
- Pediatric services, including oral and vision care. Pediatric oral care is not required if the insured has dental insurance from another source and provides evidence of coverage to the insurer.

Any change to the items and services required under the bill will take effect for the plan year that begins on or after the date that is one year after the date the recommendation or guideline is issued.

The benefits required as described above are subject to all requirements applicable to those benefits under Chapter 34 (Disability Insurance Policies) of the act. The bill does not limit the requirements to provide additional benefits under that chapter.

The bill does not require an insurer to cover items of the U.S. Preventative Services Task Force that have been downgraded to a "D" rating, or any item or service during a plan year that is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service.

The bill does 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 are not specified in the relevant recommendation or guideline. An insurer may 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.

Out-of-network and cost sharing

Except as otherwise allowed under 45 CFR 147.130(a)(2)(i), (ii),and (iii),[2] the bill also prohibits an insurer from imposing any cost-sharing requirements for any of the required preventative and wellness services and chronic disease management services described above.

The bill does not require an insurer that has a network of providers to provide benefits for required items and services described above that are delivered by an out-of-network provider and does not preclude such an insurer from imposing cost-sharing requirements for those items or services if they are delivered by an out-of-network provider. An insurer that does not have a provider in its network that can provide the required items or services must cover them with an out-of-network provider without imposing cost sharing.

Exclusions

The bill does not apply to grandfathered health plan coverage, as that term is defined in 45 CFR 147.140, or to a short-term or one-time limited duration policy or certificate of not longer than six months, as described in House Bill 4622.

Complementary changes

The bill also makes complementary changes to the definition of ***basic health services*** as that term is used in Chapter 35 (Health Maintenance Organizations) of the act. Under the bill, the term means medically necessary health services that health maintenance organizations must offer to large employers in at least one health maintenance contract, including all of the following:

- Physician services including primary care and specialty care.
- Ambulatory patient services.
- Hospitalization services.
- Emergency health services.
- Mental health and substance use disorder services, including behavioral health treatment.
- Laboratory services.
- Home health services.
- Preventive, wellness, and chronic disease management health services.
- Pregnancy, maternity, and newborn care.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.

MCL 500.3501 and MCL 500.3406bb

[2] https://www.law.cornell.edu/cfr/text/45/147.130

BACKGROUND AND BRIEF DISCUSSION:

According to committee testimony, the bills were intended to codify various provisions of the federal Patient Protection and Affordable Care Act (ACA), including some provisions that have been challenged in federal court. Specifically, a March 2023 federal decision in *Brainwood Management Inc. v Becerra* struck down an ACA provision requiring health insurance to fully cover certain preventive care measures.[3]

Supporters of the bills argued that these provisions are critical to protecting the health of Michigan residents and that acting proactively to protect them as the ACA is challenged in federal court is critical to ensuring that residents do not lose them. According to committee testimony, at least 15 other states have already codified at least some ACA protections into state law.[4]

FISCAL IMPACT:

The bills will not have a fiscal impact on the state or local governments.

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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.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/
[4] https://www.commonwealthfund.org/blog/2022/aca-preventive-services-benefit-jeopardy-what-can-states-do