HOUSE BILL No. 5409

February 16, 2012, Introduced by Reps. Talabi, Cavanagh, Rutledge, Irwin, Ananich, Howze, Womack, Tlaib, Durhal, Stapleton, Townsend, Santana, Hovey-Wright, Bauer, Jackson and Oakes and referred to the Committee on Health Policy.

A bill to provide for the establishment of the MiHealth marketplace as a nonprofit corporation; to create the board of the MiHealth marketplace and prescribe its powers and duties; to provide for assessments and user fees; and to provide for the powers and duties of certain state and local governmental officers and agencies.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

PART 1

GENERAL PROVISIONS

Sec. 101. (1) This act shall be known and may be cited as the "MiHealth marketplace act". The marketplace under this act is a nonexclusive health insurance clearinghouse. The marketplace shall foster a competitive market for health insurance in this state.

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(2) For purposes of this act, the words and phrases defined in sections 103 to 109 have the meanings ascribed to them in those sections.

(3) A reference in this act to the federal act includes other provisions of the laws of the United States relating to health care coverage for all Americans.

Sec. 103. (1) "Board" means the MiHealth marketplace board created under section 201.

(2) "Commissioner" means the commissioner of the office of financial and insurance regulation.

(3) "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(4) "Executive director" means the executive director appointed by the board under section 207.

(5) "Federal act" means the federal patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152, and other federal acts, and any regulations promulgated under those acts.

Sec. 105. (1) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include any of the following:

(a) Coverage only for accident or disability income insurance,

or any combination of those coverages.

(b) Coverage issued as a supplement to liability insurance.

(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Worker's compensation or similar insurance.

(e) Automobile medical payment insurance.

(f) Credit-only insurance.

(g) Coverage for on-site medical clinics.

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to the health insurance portability and accountability act of 1996, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(i) A plan that provides the following benefits if those benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(*i*) Limited scope dental or vision benefits.

(*ii*) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits.

(*iii*) Other similar, limited benefits specified in federal regulations issued pursuant to the health insurance portability and accountability act of 1996, Public Law 104-191.

(j) A plan that provides the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the

provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor:

(*i*) Coverage only for a specified disease or illness.

(*ii*) Hospital indemnity or other fixed indemnity insurance.

(k) Any of the following if offered as a separate policy, certificate, or contract of insurance:

(*i*) A medicare supplemental policy as defined in section 1882(g)(1) of the social security act, 42 USC 1395ss.

(*ii*) Coverage supplemental to the coverage provided by the TRICARE program under 10 USC 1071 to 1110b.

(*iii*) Similar coverage supplemental to coverage provided under a group health plan.

(2) "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, but not limited to, any of the following:

(a) A health insurer operating pursuant to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(b) A health maintenance organization operating pursuant to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(c) A health care corporation operating pursuant to the nonprofit health care corporation reform act of 1980, 1980 PA 350,

MCL 550.1101 to 550.1704.

(d) Any other entity providing a plan of health insurance, health benefits, or health services.

(3) "Marketplace" or "MiHealth marketplace" means the nonprofit corporation organized under section 203.

(4) "Medicaid" means a program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5.

(5) "MIChild" means the children's health insurance program established under title XXI of the social security act, 42 USC 1397aa to 1397mm.

Sec. 107. (1) "Producer" means insurance producer as defined in section 1201 of the insurance code of 1956, 1956 PA 218, MCL 500.1201.

(2) "Qualified dental plan" means a limited scope dental plan that has been certified under section 215.

(3) "Qualified employer" means a small employer that elects to make its full-time employees eligible for 1 or more qualified health plans offered through the SHOP and, at the option of the employer, some or all of its part-time employees, provided that the employer meets any of the following:

(a) Has its principal place of business in this state and elects to provide coverage through the SHOP to all of its eligible employees, wherever employed.

(b) Elects to provide coverage through the SHOP to all of its eligible employees who are principally employed in this state.

(4) "Qualified health plan" means a health benefit plan that

has been certified under section 215.

(5) "Qualified individual" means an individual, including a minor, who meets all of the following requirements:

(a) Is seeking to enroll in a qualified health plan offered to individuals through the marketplace.

(b) Resides in this state.

(c) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

(d) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(e) Is eligible to participate in the MiHealth marketplace based upon the policies and procedures of the marketplace.

Sec. 109. (1) "Secretary" means the secretary of the United States department of health and human services.

(2) "SHOP" means the small business health options program established by the marketplace under section 211.

(3) "Small employer", until January 1, 2016, means both a sole proprietor and small employer as those terms are defined in section 3701 of the insurance code of 1956, 1956 PA 218, MCL 500.3701. Effective January 1, 2016, "small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year. Effective January 1, 2016, all of the following apply to an employer to determine if it is a small employer under this act:

(a) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the internal revenue code of 1986, 26

USC 414, shall be treated as a single employer.

(b) An employer and any predecessor employer shall be treated as a single employer.

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

(d) If an employer was not in existence for the entire preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP, and would cease to be a small employer because of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this act as long as it continuously makes enrollment through the SHOP available to its employees.

PART 2

MIHEALTH MARKETPLACE

Sec. 201. (1) The MiHealth marketplace board consisting of 7 voting members is created to organize and govern the MiHealth marketplace. The board is the incorporator of the marketplace for the purposes of the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192. The commissioner shall serve as a nonvoting ex officio member of the board.

(2) The governor shall appoint 5 of the initial voting members of the board with the advice and consent of the senate, including

at least 1 who is a member of the general public and who is medicaid-eligible. The senate majority leader and the speaker of the house of representatives shall each appoint 1 of the initial voting members of the board. Except as otherwise provided in this subsection, a vacancy in the board after the initial appointment under this subsection shall be filled in the manner specified in the marketplace's articles of incorporation or bylaws. A board member shall not serve more than 2 consecutive terms of office.

(3) A board member shall not be employed, directly or indirectly, by a carrier, a producer, a health care provider, or any other entity, affiliate, or subsidiary of a health benefit plan.

(4) The members first appointed to the board shall be appointed within 30 days after the effective date of this act. Except as otherwise provided in this subsection, an appointed board member shall serve for a term of 4 years or until a successor is appointed, whichever is later. The following apply to the members first appointed under subsection (2):

(a) For the members appointed by the governor, 1 member shall serve for 1 year, 1 member shall serve for 2 years, 2 members shall serve for 3 years, and 1 member shall serve for 4 years.

(b) For the member appointed by the senate majority leader, the member shall serve for 4 years.

(c) For the member appointed by the speaker of the house of representatives, the member shall serve for 2 years.

(5) The first meeting of the board shall be called by the commissioner. A chairperson shall be elected at the first meeting

of the board. After the first meeting, the board shall meet at least quarterly, or more frequently at the call of the chairperson or if requested by 4 or more members.

(6) Four members of the board constitute a quorum for the transaction of business at a meeting of the board. An affirmative vote of 4 board members is necessary for official action of the board.

(7) The business that the board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, the board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days or more before but not more than 60 days before a meeting, the board shall provide public notice of its meeting at its principal office and on its internet website. The board shall include in the public notice of its meeting the address where board minutes required under subsection (8) may be inspected by the public. The board may meet in a closed session for any of the following purposes:

(a) To consider the hiring, dismissal, suspension, or disciplining of board members or its employees or agents.

(b) To consult with its attorney.

(c) To comply with state or federal law, rules, or regulations regarding privacy or confidentiality.

(8) The board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the board shall make the minutes available at the address designated on the public

notice of its meeting under subsection (7). The board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. The board shall include all of the following in its board minutes:

(a) The date, time, and place of the meeting.

(b) Board members who are present and absent.

(c) Board decisions made at a meeting open to the public.

(d) All roll call votes taken at the meeting.

(9) Board members shall serve without compensation. However, board members may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

(10) The board shall adopt a code of ethics for its members, employees, and agents and for the directors, officers, and employees of the marketplace pursuant to federal law, state law, and the standard of practice applicable to nonprofit corporations. The board shall include in the code of ethics policies and procedures requiring the disclosure of relationships that may give rise to a conflict of interest.

(11) In addition to complying with the code of ethics under subsection (10), a board member shall declare any conflicts of interest. The board shall require that any board member with a direct or indirect interest in any matter before the marketplace disclose the member's interest to the board before the board takes any action on the matter. If a board member or a member of his or her immediate family, organizationally or individually, would derive direct and specific benefit from a decision of the board,

that member shall recuse himself or herself from the discussion and vote on the issue.

(12) The board may establish committees as the board considers appropriate to obtain recommendations concerning the operation and implementation of the marketplace in this state. Committees established by the board under this subsection shall be given a specific charge and may include individuals who are not board members, including, but not limited to, representatives of consumer groups, carriers, health care providers, and other health industry representatives.

(13) There is no liability on the part of, and no cause of action shall arise against, any member of the board for any lawful action taken by him or her in the performance of his or her powers and duties under this act.

Sec. 203. (1) The initial board appointed under section 201 shall organize a nonprofit corporation, on a nonstock, directorship basis, under the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192. The nonprofit corporation shall be known as the MiHealth marketplace and is organized to provide both an individual and SHOP marketplace for qualified health plans in this state.

(2) The marketplace has the following powers and duties as a nonprofit corporation:

(a) To contract with others, public or private, for the provision of all or a portion of services necessary for the management and operation of the marketplace.

(b) To make contracts, give guarantees, incur liabilities,

borrow money at such rates of interest as the marketplace may determine, issue its notes, bonds, and other obligations, and secure any of its obligations by mortgage or pledge of any of its property or an interest in the property, wherever situated.

(c) To sue and be sued in all courts and to participate in actions and proceedings judicial, administrative, arbitrative, or otherwise, in the same manner as a natural person.

(d) To have a corporate seal, and to alter the seal, and to use it by causing it or a facsimile to be affixed, impressed, or reproduced in any other manner.

(e) To adopt, amend, or repeal bylaws, including emergency bylaws, relating to the purposes of the marketplace, the conduct of its affairs, its rights and powers, and the rights and powers of its board members, directors, or officers.

(f) To elect or appoint officers, employees, and other agents of the marketplace, to prescribe their duties, to fix their compensation and the compensation of directors, and to indemnify corporate directors, officers, employees, and agents.

(g) To purchase, receive, take by grant, gift, devise, bequest, or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use, and otherwise deal in and with, real or personal property, or an interest in real or personal property, wherever situated, either absolutely or in trust and without limitation as to amount or value.

(h) To sell, convey, lease, exchange, transfer, or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest in the property, wherever

situated.

(i) To purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares or other securities or interests or memberships issued by others, whether engaged in similar or different business, governmental, or other activities, including banking corporations or trust companies. The marketplace shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.

(j) To make contracts, give guarantees, and incur liabilities, borrow money at rates of interest as the marketplace may determine, issue its notes, bonds, and other obligations, and secure any of its obligations by mortgage or pledge of any of its property or an interest in the property, wherever situated.

(k) To invest and reinvest its funds, and take and hold real and personal property as security for the payment of funds loaned or invested.

(*l*) To establish and carry out savings, thrift, and other incentive, and benefit plans, trusts, and provisions for any of its directors, officers, and employees. The marketplace shall not establish and carry out pension or retirement benefit plans.

(m) To purchase, receive, take, otherwise acquire, own, hold, sell, lend, exchange, transfer, otherwise dispose of, pledge, use, and otherwise deal in and with its own shares, bonds, and other securities.

(n) To cease its corporate activities and dissolve pursuant to the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, and the affordable care act, except that upon dissolution the assets of the marketplace shall be distributed as follows:

(*i*) All liabilities shall be paid and discharged.

(*ii*) Assets remaining after subparagraph (*i*) is fulfilled shall be distributed as provided in a plan of action developed and adopted by the board and approved by the commissioner.

(o) To conduct its affairs, carry on its operations, and have offices and exercise the powers granted by this act in any jurisdiction within this state, and, for the transaction of business, the receipt and payment of money, the care and custody of property, and other incidental business matters, to transact business, receive, collect, and disburse money, and to engage in other incidental business matters as are naturally or properly within the scope of its articles.

(3) Other than a power or duty under section 261 of the nonprofit corporation act, 1982 PA 162, MCL 450.2261, the marketplace has the powers and duties of a nonprofit corporation under the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192. Subsection (2) controls regarding the powers and duties of the marketplace in lieu of section 261 of the nonprofit corporation act, 1982 PA 162, MCL 450.2261. If a conflict between a power or duty of the marketplace under this act conflicts with a power or duty under other state law, this act controls.

Sec. 204. Beginning on the effective date of this act, an entity shall not incorporate, file, register, or otherwise form in

this state using a name that is the same as or deceptively or confusingly similar to the name "MiHealth marketplace".

Sec. 205. The board shall develop criteria for rating each qualified health plan offered through the marketplace based on relative value and quality. The criteria developed by the board shall be in compliance with federal law, state law, and the purposes of this act. The board shall consult with the commissioner and the medical services administration for the department of community health on the development of the rating criteria.

Sec. 207. (1) The board shall appoint an executive director to manage the marketplace. The executive director shall be independent and have no material relationship with the marketplace. The executive director may appoint staff as necessary.

(2) The executive director may contract with others, public or private, to provide all or a portion of the services necessary to manage and operate the marketplace.

(3) To ensure efficient operation of the marketplace, the executive director may seek assistance and support as may be required in the performance of his or her duties from appropriate state departments, agencies, and offices. Upon request of the executive director, the state department, agency, or office may provide assistance and support to the executive director.

(4) The executive director shall display on the marketplace internet website information relevant to the public, as defined by the board, concerning the marketplace's operations and efficiencies, as well as the board's assessments of those activities.

Sec. 209. (1) The marketplace shall make qualified health plans available through its internet website for review, purchase, and enrollment by qualified individuals and qualified employers beginning on or before January 1, 2014 or as otherwise provided for by federal law, rule, or regulation.

(2) The marketplace shall not make available any health benefit plan that is not a qualified health plan. However, the marketplace shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the internal revenue code of 1986, 26 USC 9832, through the marketplace, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal act.

(3) The marketplace or a carrier offering health benefit plans through the marketplace shall not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the internal revenue code of 1986, 26 USC 36B.

Sec. 211. The marketplace shall do all of the following:

(a) Perform all duties and obligations of an exchange required by federal law, state law, and the purposes of this act.

(b) Implement procedures consistent with section 215 for the certification, recertification, and decertification of health

benefit plans as qualified health plans.

(c) Make available in the marketplace all qualified health plans consistent with section 215.

(d) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(e) Provide for enrollment periods, as provided under section 1311(c)(6) of the federal act.

(f) Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on the plans. At the direction of the board, the marketplace shall also include on the internet website information relative to individual health and wellness.

(g) Assign a rating to each qualified health plan offered through the marketplace pursuant to the rating criteria developed by the board under section 205.

(h) Use a standardized format for presenting health benefit options in the marketplace, including the use of the uniform outline of coverage established under section 2715 of the public health service act, 42 USC 300gg-15.

(i) Inform individuals of eligibility requirements for medicaid, MIChild, or any applicable health subsidy program pursuant to the federal act. If through screening an application the marketplace determines that an individual is eligible for medicaid, the marketplace shall enroll the individual in the medicaid program. If through screening an application the marketplace determines that an individual is potentially eligible for any other health subsidy program described in this subdivision,

the marketplace shall provide the individual with information about the program. If requested by the individual, the marketplace shall enroll the individual in the program, if applicable, or direct that individual to the appropriate authority for final eligibility determination and enrollment.

(j) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the internal revenue code of 1986, 26 USC 36B, and any cost-sharing reduction under section 1402 of the federal act.

(k) Establish a small business health options program through which qualified employers may access coverage for their employees. The SHOP shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP at the specified level of coverage.

(*l*) Notify employees using the SHOP of potential eligibility for medicaid or MIChild.

(m) Grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the internal revenue code of 1986, 26 USC 5000A, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of any of the following:

(*i*) There is no affordable qualified health plan available through the marketplace, or the individual's employer, covering the individual.

(*ii*) The individual meets the requirements for any other

exemption from the individual responsibility requirement or penalty.

(n) Contract with the office of financial and insurance regulation to certify health benefit plans as qualified health plans consistent with section 215.

(o) Transfer to the federal secretary of the treasury all data and information required to be transferred under regulations promulgated under the federal act.

(p) Provide to each employer defined in this subdivision the name of each employee of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation. As used in this subdivision, "employer" includes all of the following:

(*i*) An employer that did not provide minimum essential coverage.

(*ii*) An employer that provided the minimum essential coverage, but the coverage was determined under section 36B(c)(2)(C) of the internal revenue code of 1986, 26 USC 36B, to either be unaffordable to the employee or not provide the required minimum actuarial value.

(q) Perform duties required of the marketplace by the secretary or the federal secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(r) Select entities qualified to serve as navigators pursuant to the federal act, and standards developed by the secretary. The marketplace shall give consideration to community organizations and

grassroots organizations when making the selections under this subdivision and shall award grants to enable navigators to do all of the following:

(*i*) Conduct public education activities to raise awareness of the availability of qualified health plans.

(*ii*) Distribute fair, accurate, and impartial information concerning qualified health plans and acknowledge other health plans.

(*iii*) Facilitate enrollment in qualified health plans and in medicaid, as applicable. A navigator shall not engage in any activity that constitutes the sale or negotiation of insurance.

(*iv*) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman program established under section 2793 of the public health service act, 42 USC 300gg-93, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan or coverage or a determination under that plan or coverage.

(*v*) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the marketplace.

(s) Review the rate of premium growth within the marketplace and outside the marketplace and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(t) Permit producers to do all of the following:

(*i*) Subject to subdivision (r), serve as navigators.

(*ii*) Receive grants from the marketplace as described in subdivision (r).

(*iii*) Facilitate enrollment and enroll qualified individuals, qualified employers, and qualified employees in qualified health plans.

(*iv*) Assist individuals in applying for advance payments of premium tax credits under section 36B of the internal revenue code of 1986, 26 USC 36B, and cost-sharing reductions under section 1402 of the federal act.

(u) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

(*i*) Educated health care consumers who are enrollees in qualified health plans.

(*ii*) Individuals and entities with experience in facilitating enrollment in qualified health plans.

(*iii*) Representatives of small businesses and self-employed individuals.

(*iv*) The medical services administration of the department of community health.

(*v*) Advocates for enrolling hard-to-reach populations.

(*vi*) Federally recognized tribes, as defined in the federally recognized Indian tribe law of 1994, 25 USC 479a.

(v) Widely advertise the availability of qualified health plans through the marketplace by utilizing all media outlets available.

Sec. 213. (1) The board shall appoint an audit committee. The

audit committee shall contract with an external auditor for the preparation of at least 1 audit of the financial statements of the marketplace in every fiscal year. The audit committee shall be independent of the marketplace and shall not have contractual relationships with the marketplace or the external auditor other than for the marketplace audit.

(2) The executive director shall do all of the following:

(a) Review and certify the reports of the external auditor.

(b) Make the external auditor reports available to the board and the general public.

(3) The marketplace shall meet all of the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the secretary, the governor, the commissioner, and the senate and house of representatives appropriations committees and standing committees on insurance issues a report concerning those accountings.

(b) Fully cooperate with any investigation conducted by this state or a federal agency pursuant to authority under federal or state law, to do any of the following:

(*i*) Investigate the affairs of the marketplace.

(*ii*) Examine the properties and records of the marketplace.

(*iii*) Require periodic reports in relation to the activities undertaken by the marketplace.

(c) In carrying out its activities under this act, not use any money intended for the administrative and operational expenses of the marketplace for staff retreats, promotional giveaways,

excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Sec. 215. (1) The marketplace shall contract with the office of financial and insurance regulation to certify health benefit plans under this section. Subject to subsection (2), the commissioner shall certify a health benefit plan as a qualified health plan if either of the following requirements is met:

(a) The health benefit plan meets the requirements of federal law, state law, and the purposes of this act.

(b) If, as determined by the commissioner, the requirements of the federal act have changed substantially after the effective date of this act, and the health benefit plan is offered by a carrier that is licensed or has a certificate of authority under the laws of this state and is in good standing to offer the health benefit plan to all residents of this state.

(2) The commissioner shall not certify a health benefit plan as a qualified health plan unless the premium rates and contract language have been approved by the commissioner.

(3) The commissioner shall not exclude a health benefit plan as a qualified health plan as follows:

(a) On the basis that the plan is a fee-for-service plan.

(b) Through the imposition of premium price controls in the marketplace.

(c) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the commissioner determines are inappropriate or too costly.

(4) The commissioner shall require each carrier seeking

certification of a health benefit plan as a qualified health plan to do all of the following:

(a) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its internet website. The commissioner shall take this information into consideration when determining whether to allow the carrier to make plans available through the marketplace.

(b) Make available to the public, in plain language, as that term is defined in section 1311(e)(3)(B) of the federal act, and submit to the marketplace, the secretary, and the commissioner accurate and timely disclosure of all of the following:

(*i*) Claims payment policies and practices.

(*ii*) Periodic financial disclosures.

(*iii*) Data on enrollment.

(*iv*) Data on disenrollment.

(*v*) Data on the number of claims that are denied.

(*vi*) Data on rating practices.

(*vii*) Information on cost-sharing and payments with respect to any out-of-network coverage.

(*viii*) Information on enrollee and participant rights under title I of the federal act.

(*ix*) Other information as determined appropriate by the secretary.

(c) Permit individuals to determine, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the

individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an internet website and through other means for individuals without access to the internet.

(4) The provisions of this act that are applicable to qualified health plans apply to the extent relevant to qualified dental plans except as modified in this subsection or by the board as permitted by the federal act. A carrier offering a qualified dental plan shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits. The qualified dental plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary under section 1302(b)(1)(J) of the federal act, and any other dental benefits the board or the secretary specify. Carriers may jointly offer a comprehensive plan through the marketplace in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same price.

Sec. 217. (1) This act does not authorize the expending of any state money by the marketplace.

(2) The marketplace may charge assessments or user fees to

health carriers or otherwise may generate funding necessary to support its operations under this act.

(3) The marketplace shall publish the average costs of fees and any other payments required by the marketplace, and the administrative costs of the marketplace, on its internet website. The marketplace shall include information on money lost to waste, fraud, and abuse.

Sec. 219. (1) This act does not preempt or supersede the authority of the commissioner to regulate the business of insurance within this state or of the single state agency to administer medicaid.

(2) Except as expressly provided to the contrary in this act, all carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules promulgated and orders issued by the commissioner.