SUBSTITUTE FOR

SENATE BILL NO. 633

A bill to provide for the establishment of a state-based health insurance exchange as a nonprofit corporation; to create the board of exchange 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. This act may be cited as the "Michigan health insurance exchange act". The exchange shall foster a competitive market for health insurance in this state and serve as a market facilitator to promote the purchase and sale of qualified health

plans and to disseminate information regarding qualified health plans to health benefit plan consumers.

Sec. 103. As used in this act:

(a) "Board" means the board created under section 201.

(b) "Conflict of interest" means that by taking any action or making any decision or recommendation on a matter within the authority of the board, a member of the board, or an immediate family member, or any entity with which the member is affiliated, or an immediate family member, would receive a pecuniary benefit or detriment, unless the pecuniary benefit or detriment would apply to the same degree to a class consisting of all persons within the particular class in this state.

(c) "Director" means the director of the department of insurance and financial services.

(d) "Enhanced direct enrollment" means a process by which an approved entity approved by the director can provide a comprehensive consumer experience including, the eligibility application, exchange enrollment, and postenrollment year-round customer service capabilities, for consumers and producers working on behalf of consumers, directly on the entity's own website.

(e) "Exchange" means the nonprofit corporation organized under section 203.

(f) "Executive director" means the executive director appointed by the governor under section 207.

(g) "Facilitate enrollment" means to perform an act that is only indirectly related to the sale, solicitation, or negotiation of a health insurance policy and is to inform an individual of the individual's eligibility for public assistance or to inform an individual that the individual can purchase a health insurance

policy through a producer, the marketplace, a carrier offering a qualified health plan, or another source, which act is in compliance with federal law, state law, and the purposes of this act.

(h) "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 any regulations promulgated under those acts.

(i) "Federally recognized Indian tribe" means any of the following:

(*i*) An Indian tribe as that term is defined in 25 USC 5130.

(*ii*) An Indian tribe as that term is defined in 25 USC 1603.

(*iii*) An Indian tribe, tribal organization, or inter-tribal consortium, as those terms are defined in 25 USC 5301 to 5423.

Sec. 105. As used in this act:

(a) "Health carrier" or "carrier" means any of the following entities that are subject to the insurance laws and regulations of this state or otherwise subject to the jurisdiction of the director:

(*i*) A health insurer operating under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

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

(*iii*) A health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iv*) A nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(*v*) Any other entity providing a plan of health insurance,

health benefits, or health services.

(b) "Health insurance policy" means an expense-incurred hospital, medical, or surgical policy, certificate, or contract. Health insurance policy does not include a policy that provides coverage only for excepted benefits as described in 42 USC 300gg-91.

(c) "Immediate family" means any relation by blood or affinity to the third degree.

(d) "Marketplace" means the platform operated by the exchange.

Sec. 107. As used in this act:

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

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

(c) "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, if the employer meets any of the following:

(*i*) 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.

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

(d) "Qualified health plan" means a health benefit plan that has been certified under section 215.

(e) "Qualified individual" means that term as defined in 42 USC 18032.

Sec. 109. As used in this act:

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

(b) "Small employer" means that term as defined in section 3701 of the insurance code of 1956, 1956 PA 218, MCL 500.3701.

(c) "State medical assistance program" means a program established in this state under title XIX of the social security act, 42 USC 1396 to 1396w-7, or under title XXI of the social security act, 42 USC 1397aa to 1397mm.

PART 2

EXCHANGE

Sec. 201. (1) A board consisting of 12 members is created to organize and govern the exchange. The board is the incorporator of the exchange for the purposes of the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192. The director and the director of the department of health and human services shall serve as voting ex officio members of the board.

(2) The governor shall appoint the remaining 10 voting members of the board as follows:

(a) One member, subject to advice and consent of the senate, from among the insurers that offer health insurance policies through the exchange that are a hospital plan corporation, a professional health services plan corporation, or a parent, affiliate, subsidiary, or other associated entity or successor of a hospital plan corporation or a professional health services plan.

(b) One member, subject to advice and consent of the senate, from among the carriers that offer health insurance policies through the exchange that are not a hospital plan corporation, a professional health services plan corporation, or a parent, affiliate, subsidiary, or other associated entity or successor of a

hospital plan corporation or a professional health services plan.

(c) One member, subject to advice and consent of the senate, with experience in health care public education and consumer assistance activities.

(d) Two members, subject to advice and consent of the senate, who are consumer representatives.

(e) One member, subject to advice and consent of the senate, from a list of 3 candidates provided by the senate majority leader, who has relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(f) One member, subject to advice and consent of the senate, appointed from a list of 3 candidates provided by the senate minority leader, who has relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(g) One member, subject to advice and consent of the senate, appointed from a list of 3 candidates provided by the speaker of the house of representatives, who has relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(h) One member, subject to advice and consent of the senate, appointed from a list of 3 candidates provided by the minority

leader of the house of representatives, who has relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(i) One member, subject to advice and consent of the senate, representing a nonprofit mutual disability insurer formed under chapter 58 of the insurance code of 1956, 1956 PA 218, MCL 500.5800 to 500.5840.

(3) The governor shall consider the cultural, ethnic, economic, and geographical diversity of this state so that the board's composition reflects the communities of this state.

(4) A majority of the voting members of the board must not have a conflict of interest as set forth in section 1321 of the federal act and the regulations promulgated under that section. Other than the individuals listed in subsections (2)(a), (2)(b), and (2)(i), the voting members of the board listed in subsection (2) must not have a conflict of interest.

(5) Each member of the board shall meet the requirements of this act, the federal act, and all applicable state and federal laws and regulations, to serve the public interest as well as the interests of the individuals and small businesses seeking health care coverage through the exchange, and to ensure the operational well-being and fiscal solvency of the exchange.

(6) 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. For the initial members appointed under subsection (2), 2 members must be appointed for 2-year terms, 5 members must be appointed for 3-year terms, and 3

members must be appointed for 4-year terms. The length of the initial term of each initial member must be determined by the governor at the time of appointment.

(7) The executive director shall attend meetings of the board but shall not be a member, shall not vote, and must not be counted for purposes of establishing a quorum.

(8) The director shall call the first meeting of the board. The director or the director's designee shall serve as chairperson 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.

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

(10) Meetings of the board are subject to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. If there is a conflict between the provisions of this act and those of the open meetings act, 1976 PA 267, MCL 15.261 to 15.275, the provisions of the open meetings act, 1976 PA 267, MCL 15.261 to 15.275, control.

(11) 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. The exchange shall pay for the reimbursements of board members.

(12) The board shall adopt a code of ethics for its members and for the officers and employees of the exchange. 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.

(13) A board member shall comply with the code of ethics adopted under subsection (12) and declare any conflict of interest. The board shall require that any board member with a direct or indirect interest in any matter before the exchange 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 the board member's 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.

(14) The board may establish committees to obtain recommendations concerning the operation and implementation of the exchange in this state. Committees established by the board under this subsection must be given a specific charge and may include individuals who are not board members, including, but not limited to, representatives of health care consumers, carriers, and health care providers and other health industry representatives.

(15) There is no liability on the part of, and no cause of action arises against, any member of the board for any lawful action taken by the member in the performance of the member's 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 must be organized not later than 60 days after the first board meeting to provide an individual marketplace for qualified health plans in this state. Before formation of the exchange, the director may take any action

necessary to effect a timely transition from a federally administered exchange to the exchange established under this act, including, but not limited to, taking steps that are necessary to facilitate a state-based exchange on the federal platform that will operate until the director determines that the exchange organized under this act is adequately prepared to operate on the marketplace.

(2) Subject to subsection (3), the exchange shall exercise all the powers and duties necessary and appropriate to provide a marketplace for qualified health plans in this state, including, without limitation, the following:

(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 exchange.

(b) To enter into contracts, give guarantees, incur liabilities, borrow money at rates of interest as the exchange 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, to alter the seal, and to use the seal 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 exchange, the conduct of its affairs, its rights and powers, and the rights and powers of its board members, corporate directors, or officers.

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

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

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

(k) To establish and carry out savings, thrift, and other incentive and benefit plans, trusts, and provisions for any of its

corporate directors, officers, and employees. The marketplace shall not establish and carry out pension plans.

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

(m) To cease its corporate activities and dissolve under this subdivision, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, and the federal act. Not earlier than 12 months and not later than 15 months after publication of the public notice by the board, the exchange shall initiate steps to cease operation of the marketplace and shall cease operations. On dissolution, the assets of the exchange must be distributed as follows:

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

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

(n) 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 of incorporation.

(3) Other than a power or duty under section 261 of the nonprofit corporation act, 1982 PA 162, MCL 450.2261, the exchange 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 exchange instead of section 261 of the nonprofit corporation act, 1982 PA 162, MCL 450.2261. If a conflict between a power or duty of the exchange 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 of the exchange.

Sec. 207. The governor shall appoint an executive director to manage the exchange. The executive director must be independent and have no material relationship with the exchange.

Sec. 209. (1) The exchange shall make qualified health plans available through its internet website and its toll-free telephone hotline for review, purchase, and enrollment by qualified individuals and qualified employers beginning on or before January 1, 2026.

(2) The exchange shall implement an enhanced direct enrollment by the first open enrollment period in which the exchange's state-based platform is operational.

(3) The exchange shall allow health insurance carriers or web brokers to provide for automatic re-enrollment in a qualified health plan. Health insurance carriers or web brokers, as applicable, shall make a reasonable effort to notify enrollees before automatic re-enrollment. Auto-enrollees may choose a different qualified health plan during open enrollment, but have until December 15 to choose a different qualified health plan with no interruption in coverage.

(4) The exchange shall not make available any health benefit plan that is not a qualified health plan. However, the exchange shall allow a health carrier to offer a qualified dental 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. The exchange shall allow an individual to purchase a qualified dental plan independently without that individual needing to purchase a qualified health plan.

(5) The exchange or a carrier offering health benefit plans and qualified dental plans through the marketplace shall not charge an individual a fee or penalty for termination of coverage. This subsection does not prohibit the exchange or a carrier from refusing to re-enroll an individual whose coverage has been terminated for nonpayment of premiums if the individual premium is at least 90 days past due.

(6) A carrier shall not offer in any service area more than 4 nonstandardized plan options per any of the following:

(a) Network type.

(b) Metal level other than catastrophic plans.

(c) Inclusion of dental benefit coverage or vision benefit coverage, or both.

Sec. 211. (1) The exchange 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. The exchange shall do both of the following:

(*i*) Contract with the department of insurance and financial services to certify health benefit plans as qualified health plans consistent with section 215.

(*ii*) Contract with qualified vendors to provide technology, implementation, maintenance, and enhancement services needed to operate the exchange. The exchange may coordinate as necessary with the department of health and human services to meet the requirement of this subparagraph.

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

(d) Provide for the operation of a toll-free telephone hotline, postal address, email address, or other means of communication to accept complaints and grievances and respond to requests for assistance in a manner that is linguistically appropriate to the needs of the population being served. The exchange shall work with carriers to establish a system to track complaints and grievances.

(e) Any of the following for an enrollment period, but an enrollment period must not be continuous:

(*i*) Provide at the least an annual enrollment period beginning on November 1 and ending on January 15.

(*ii*) Provide a special enrollment period in accordance with 42 USC 18031, and any regulations promulgated under that section.

(*iii*) If the governor declares a state of emergency or state of disaster under the emergency management act, 1976 PA 390, MCL 30.401 to 30.421, provide an enrollment period that a majority of the board determines is necessary as a result of the declaration of

a state of emergency or state of disaster.

(*iv*) By a 3/4 vote of the board members then serving, provide for not more than one 45-day enrollment period in addition to those required under subparagraphs (*i*) to (*iii*) in a calendar year.

(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 exchange shall also include on the internet website information relative to individual health and wellness. The exchange shall not modify the website information relative to individual health and wellness more than quarterly and during an open enrollment period.

(g) Assign a rating under the federal act to each qualified health plan offered through the marketplace.

(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) Provide 1 standard application for insurance coverage to all individuals applying for insurance coverage.

(j) Determine each individual applicant's eligibility for any applicable health subsidy program, assess each individual applicant's potential eligibility to enroll in a state medical assistance program, and inform the applicant of the determination and assessment.

(k) Share application enrollment information with a state medical assistance program or any applicable health subsidy program under the federal act and state law.

(*l*) 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.

(m) Adopt an annual operating revenue and expense budget before the start of each fiscal year and make the budget available on its website.

(n) Transfer all data and information required to be transferred in compliance with federal and state law.

(o) Perform duties required of the exchange in compliance with federal and state law related to determining eligibility for premium tax credits or reduced cost-sharing.

(p) Select entities qualified to serve as navigators in compliance with applicable law and award grants to enable navigators to perform the duties established in section 1262(3) of the insurance code of 1956, 1956 PA 218, MCL 500.1262.

(q) Enroll individuals in qualified health plans and coordinate with the department of health and human services to refer individuals to state medical assistance programs.

(r) Subject to subsection (3), permit producers to do all of the following:

(*i*) Receive commissions or other remuneration from a carrier for enrolling consumers in a qualified health plan.

(*ii*) Enroll qualified individuals and qualified employers in any qualified health plan. Upon enrollment by a producer under this subparagraph, the exchange shall verify that enrollment with the individual enrolled.

(*iii*) 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.

(s) Subject to terms and conditions determined by the exchange, allow a federally recognized Indian tribe to pay premiums for qualified health plans on behalf of tribal members who are qualified individuals enrolled in a qualified health plan.

(t) Consult with stakeholders relevant to carrying out the activities required under this act. Stakeholders include, but are not limited to, the following:

(*i*) Consumer representatives.

(*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 health and human services.

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

(*vi*) Federally recognized Indian tribes.

(*vii*) Federally qualified health centers.

(u) Match, to the extent reasonably practicable, the reconciliation standards established by the Centers for Medicare and Medicaid Services for a health insurance exchange website operated by the federal government.

(v) Educate consumers, including through outreach, a navigator program and postenrollment support.

(w) If the exchange establishes a SHOP under subsection (2), notify employees using the SHOP of potential eligibility for a state medical assistance program.

(x) Ensure that all enrollee information possessed by any

person associated with the exchange is protected as required by the health insurance portability and accountability act of 1996, Public Law 104-191.

(y) Protect personally identifiable health and financial information in accordance with all applicable federal and state laws and regulations, including any rules that the director may promulgate to implement this act.

(2) The exchange may establish a small business health options program through which qualified employers may access coverage for their employees and federally recognized Indian tribes may access coverage for their tribal members. If established, the SHOP must do all of the following:

(a) Enable any qualified employer or federally recognized Indian tribe to specify a level of coverage so that any of its employees or tribal members may enroll in any qualified health plan offered through the SHOP at the specified level of coverage.

(b) Provide a qualified employer or federally recognized Indian tribe with the opportunity to establish a defined contribution arrangement for the SHOP's employees or tribal members to purchase a health benefit plan.

(3) Subsection (1)(r) does not require a qualified individual or qualified employer to utilize a producer for any of the services described in subsection (1)(r). However, a qualified individual or qualified employer must not be penalized, either by premium cost or coverage under a health benefit plan, for choosing to use the services of a producer.

Sec. 213. (1) The board shall appoint from the board's members 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 exchange in every fiscal year. The audit committee members shall not have contractual relationships with the external auditor other than for the exchange audit.

(2) The audit committee shall do all of the following:

(a) Review the reports of the external auditor.

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

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

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

(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 exchange.

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

Sec. 215. (1) As provided in section 211, the exchange shall contract with the department of insurance and financial services to certify health insurance policies under this section. Subject to subsection (2), the director shall certify a health insurance policy as a qualified health plan if the health benefit plan meets the requirements of federal law, state law, and the purposes of this act.

(2) The director shall not certify a health insurance policy

as a qualified health plan unless the premium rates and contract language have been approved by the director.

(3) The director shall require each carrier seeking certification of a health insurance policy as a qualified health plan to do all of the following:

(a) 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 exchange and the director 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 required to be in compliance with federal law, state law, and the purposes of this act.

(b) Permit determination, in a timely manner on the request of the individual, the level 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 must be made available to the individual through a 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 must be licensed to offer dental coverage, but need not be licensed to offer other health benefits. The qualified dental plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and must include, at a minimum, the essential pediatric dental benefits required under section 1302(b)(1)(J) of the federal act, and any other dental benefits specified in compliance with federal law, state law, and the purposes of this act. 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) Subject to section 221, the exchange shall charge assessments or user fees and collect fees from carriers to support the operation of the exchange under this act and the reinsurance program established under section 3406nn of the insurance code of 1956, 1956 PA 218, MCL 500.3406nn, except that the exchange shall not assess or collect any form of obligation other than an exchange user fee on total monthly premiums for exchange policies and unless approved by unanimous consent of the board, the fee must not exceed the user fee for the federally facilitated marketplace plus or minus 1% of total monthly premiums for on-exchange policies. By majority vote, the board may decrease

the fee under this section. By a 3/4 vote, the board may increase the fee under this section. The exchange may generate funding necessary to support its operations under this act. An assessment or user fee charged to carriers under this section is considered a licensing or regulatory fee for the purpose of determining compliance with the medical loss ratio requirements of the federal act. An assessment of a user fee may be used only for the purposes directly related to the operation of the exchange or any reinsurance program established under the law of this state.

(2) The exchange shall publish on its internet website the financial information as required under the federal act.

(3) The board must approve by a majority vote any assessment or user fee.

Sec. 218. (1) The exchange fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the fund. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(3) Money in the fund at the close of the fiscal year must remain in the fund and must not lapse to the general fund.

(4) The department of insurance and financial services is the administrator of the fund for auditing purposes.

(5) The department of insurance and financial services shall expend money from the fund to do either of the following:

(a) Operate the exchange.

(b) On appropriation and from money, other than money received from fees under this act, assist health carriers for transition costs in the first year the exchange operates.

Sec. 219. (1) This act does not preempt or supersede the authority of the director to regulate the business of insurance within this state or of the department of health and human services to administer a state medical assistance program.

(2) Except as otherwise expressly provided 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 director.

(3) Any standard or requirement adopted by the exchange under the federal act or this act must be applied uniformly to all carriers and health benefit plans in each insurance market to which the standard or requirement applies.

(4) A carrier aggrieved by an action or decision of the exchange may appeal to the director not more than 30 days after the action or decision. After a hearing held on not less than 10 days' written notice to the aggrieved carrier and the exchange, the director shall issue an order approving the action or decision, disapproving the action or decision, or directing the exchange to give further consideration to the matter. Proceedings under this subsection are subject to judicial review under the administrative procedures act of 1969, 1969 PA 306, MCL 24.301 to 24.306.

Sec. 221. The director may promulgate rules that the director determines are necessary to implement this act.

Enacting section 1. This act does not take effect unless Senate Bill No. 637 of the 102nd Legislature is enacted into law.