PUBLIC EMPLOYEES HEALTH BENEFIT ACT (EXCERPT)
Act 106 of 2007

124.79 Public employer pooled plan; requirements; effect of insufficient reserves; authority of commissioner to take certain actions.

Sec. 9.

(1) In addition to other requirements as provided in this act, a public employer pooled plan established on or after October 1, 2007 shall do all of the following:

(a) Establish and maintain minimum cash reserves of not less than 25% of the aggregate contributions in the current fiscal year or in the case of new applicants, 25% of the aggregate contributions projected to be collected during its first 12 months of operation, as applicable; or not less than 35% of the claims paid in the preceding fiscal year, whichever is greater. As an alternative, a pooled plan that has operated for 5 years or more may elect to maintain minimum cash reserves in an amount equal to 2.5% of the immediately preceding year's claims plus its most recent designated reserve for incurred but not reported claims, as indicated in its financial statement filed with the commissioner under subdivision (b). Reserves established pursuant to this section must be maintained in a separate, identifiable account and must not be commingled with other funds of the pooled plan. The pooled plan shall invest the required reserve in the types of investments allowed under section 910, 912, or 914 of the insurance code of 1956, 1956 PA 218, MCL 500.910, 500.912, and 500.914. Except as otherwise provided in this subdivision, the pooled plan may satisfy up to 100% of the reserve requirement in the first year of operation, up to 75% of the reserve requirement in the second year of operation, and up to 50% of the reserve requirement in the third and subsequent years of operation, through an irrevocable and unconditional letter of credit. A pooled plan that elects the alternative minimum cash reserve may not satisfy any portion of the reserve requirement with a letter of credit. As used in this subdivision, "letter of credit" means a letter of credit that meets all of the following requirements:

(i) Is issued by a federally insured financial institution.

(ii) Is issued upon such terms and in a form as approved by the commissioner.

(iii) Is subject to draw by the commissioner, upon giving 5 business days' written notice to the pooled plan, or by the pooled plan for the member's benefit if the pooled plan is unable to pay claims as they come due.

(b) Within 90 days after the end of each fiscal year, file with the commissioner financial statements audited by a certified public accountant. An actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses, in accordance with subdivision (d), must be included in the audited financial statement. The opinion must be rendered by an actuary approved by the commissioner or who has 5 or more years of experience in this field.

(c) Within 60 days after the end of each fiscal quarter, file with the commissioner unaudited financial statements, affirmed by an appropriate officer or agent of the pooled plan.

(d) Within 60 days after the end of each fiscal quarter, file with the commissioner a report certifying that the pooled plan maintains reserves that are sufficient to meet its contractual obligations, and that it maintains coverage for excess loss as required in this act.

(e) File with the commissioner a schedule of premium contributions, rates, and renewal projections.

(f) Possess a written commitment, binder, or policy for excess loss insurance issued by an insurer authorized to do business in this state in an amount approved by the commissioner. The binder or policy must provide not less than 30 days' notice of cancellation to the commissioner.

(g) Establish a procedure, to the satisfaction of the commissioner, for handling claims for benefits in the event of dissolution of the pooled plan.

(h) Provide for administration of the plan using personnel of the pooled plan, provided that the pooled plan has within its own organization adequate facilities and competent personnel to service the medical benefit plan, or by awarding a competitively bid contract, to an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan.

(2) If the commissioner finds that a pooled plan's reserves are not sufficient to meet the requirements of subsection (1)(a), the commissioner shall order the pooled plan to immediately collect from any public employer that is or has been a member of the pooled plan appropriately proportionate contributions sufficient to restore reserves to the required level. The commissioner may take such action as he or she considers necessary, including, but not limited to, ordering the suspension or dissolution of a pooled plan, if the pooled plan is consistently failing to maintain reserves as required in this section; is using methods and practices that render further transaction of business hazardous or injurious to its members, employees, beneficiaries, or to the public; has failed, after written request by the commissioner, to remove or discharge an officer, director, trustee, or employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude; has failed or refused to furnish any report or statement required under this act; or if the commissioner, upon investigation, determines that it is conducting

business fraudulently or is not meeting its contractual obligations in good faith. Any proceedings by the commissioner under this subsection are governed by the requirements and procedures of sections 7074 to 7078 of the insurance code of 1956, 1956 PA 218, MCL 500.7074 to 500.7078.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007 ;-- Am. 2017, Act 55, Eff. Sept. 13, 2017