PRUDENT PURCHASER ACT
Act 233 of 1984

AN ACT to authorize certain organizations to enter into prudent purchaser agreements with health care providers; to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care; to provide for the regulation of certain organizations, health care providers, health care facilities, and prudent purchaser arrangements; to establish a joint legislative committee to investigate the degree of competition in the health care coverage market in this state; and to provide for the powers and duties of certain state officers and agencies.

History: 1984, Act 233, Eff. Dec. 20, 1984.

The People of the State of Michigan enact:

550.51 Short title.

Sec. 1. This act shall be known and may be cited as the “prudent purchaser act”.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.52 Definitions.

Sec. 2. As used in this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Dental care corporation" means a dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(c) "Health care corporation" means a health care corporation incorporated under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(d) "Health care provider" means a health facility or a person licensed, certified, or registered under part 62 or parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251 and 333.16101 to 333.18237, and chapter 2A of the mental health code, 1974 PA 258, MCL 330.1260 to 330.1287. Health care provider does not include a pharmacist or pharmacy engaged in the retail sale of drugs, until January 1, 1987.

(e) "Health facility" means:

(*i*) A facility or agency licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e, or a licensed part of that facility or agency. Health facility does not include an ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(*ii*) A mental hospital, psychiatric hospital, psychiatric unit, or other facility defined in 42 USC 1396d(d) operated by the department of community health or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a freestanding hemodialysis unit.

(*v*) An organized ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance abuse treatment program licensed under part 62 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251, or chapter 2A of the mental health code, 1974 PA 258, MCL 330.1260 to 330.1287.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(f) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(g) "Hospital service corporation" means a hospital service corporation incorporated under former 1939 PA 109.

(h) "Insurer" means an insurer as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.

(i) "Medical care corporation" means a medical care corporation incorporated under former 1939 PA 108.

(j) "Organization" means an insurer, a dental care corporation, hospital service corporation, medical care corporation, health care corporation, or third party administrator.

(k) "Provider panel" means a panel of health care providers providing health care services under a prudent

purchaser agreement.

(*l*) "Prudent purchaser agreement" means an agreement between an organization and a health care provider under section 3.

(m) "Third party administrator" means an administrator operating under a certificate of authority issued by the commissioner pursuant to the third party administrator act.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 2014, Act 74, Imd. Eff. Mar. 28, 2014.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53 Prudent purchaser agreement; number; location of health care provider; membership on provider panel; written standards; notice procedures; provider application period; providing standards on request; notice of acceptance or rejection; reasons for termination; professional review program; evaluation; 2 or more classes of health care providers providing same health care service; removal from provider panel; membership in more than 1 provider panel; provider panel including health care providers and facilities outside Michigan; required information; emergency episode of illness or injury; limiting number of prudent purchaser agreements; benefits for services within scope of practice of optometry or chiropractic.

Sec. 3. (1) An organization may enter into a prudent purchaser agreement with 1 or more health care providers of a specific service to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The organization may limit the number of prudent purchaser agreements entered into pursuant to this section if the number of agreements is sufficient to assure reasonable levels of access to health care services for recipients of those services. The number of prudent purchaser agreements authorized by this section that are necessary to assure reasonable levels of access to health care services for recipients shall be determined by the organization. However, the organization shall offer a prudent purchaser agreement, comparable to those agreements with other members of the provider panel, to at least 1 health care provider that provides the applicable health care services and is located within a reasonable distance from the recipients of those health care services, if a health care provider that provides the applicable health care services is located within that reasonable distance.

(2) An organization shall give all health care providers that provide the applicable health care services and are located in the geographic area served by the organization an opportunity to apply to the organization for membership on the provider panel.

(3) A prudent purchaser agreement shall be based upon the following written standards which shall be filed by the organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner before the initial provider panel is formed:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the organization.

(4) An organization shall develop and institute procedures that are designed to notify health care providers located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to providers of the service upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period. An organization shall provide for an initial 60-day provider application period during which providers of the service may apply to the organization for membership on the provider panel. An organization that has entered into a prudent purchaser agreement concerning a particular health care service shall provide, at least once every 4 years, for a 60-day provider application period during which providers of that service may apply to the organization for membership on the provider panel. Notice of this provider application period shall be given to providers of the service upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. The initial 60-day provider application period and procedures and the 4-year 60-day provider application periods and procedures required under this subsection do not apply to organizations whose provider panels are open to application for membership at any time. Upon receipt of a request by a health care provider, the organization shall provide the written standards described in subsection (3) to the health care provider. Within 90 days after the close of

a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, an organization shall notify an applicant in writing as to whether the applicant has been accepted or rejected for membership on the provider panel. If an applicant has been rejected, the organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(5) A health care provider whose membership on an organization's provider panel is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(6) An organization that enters into a prudent purchaser agreement shall institute a program for the professional review of the quality of health care, performance of health care personnel, and utilization of services and facilities under the prudent purchaser agreement. At least every 2 years, the organization shall provide for an evaluation of its professional review program by a professionally recognized independent third party.

(7) If 2 or more classes of health care providers may legally provide the same health care service, the organization shall offer each class of health care providers the opportunity to apply to the organization for membership on the provider panel.

(8) Each prudent purchaser agreement shall state that the health care provider may be removed from the provider panel before the expiration of the agreement if the provider does not comply with the requirements of the contract.

(9) This act does not preclude a health care provider or health care facility from being a member of more than 1 provider panel.

(10) A provider panel may include health care providers and facilities outside Michigan if necessary to assure reasonable levels of access to health care services under coverage authorized by this act.

(11) When coverage authorized by this act is offered to a person, the organization shall give or cause to be given to the person the following information:

(a) The identity of the organization contracting with the provider panel.

(b) The identity of the party sponsoring the coverage including, but not limited to, the employer.

(c) The identity of the collective bargaining agent if the coverage is offered pursuant to a collective bargaining agreement.

(12) If a person who has coverage authorized by this act is entitled to receive a health care service when rendered by a health care provider who is a member of the provider panel, the person is entitled to receive the health care service from a health care provider who is not a member of the provider panel for an emergency episode of illness or injury that requires immediate treatment before it can be obtained from a health care provider who is on the provider panel.

(13) Subsections (2) to (12) do not limit the authority of organizations to limit the number of prudent purchaser agreements.

(14) If coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, this act does not require that coverage or reimbursement be provided for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(15) If coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, this act does not require that coverage or reimbursement be provided for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 1994, Act 439, Eff. Mar 30, 1995;—Am. 1996, Act 518, Eff. Oct. 1, 1997;—Am. 2009, Act 224, Imd. Eff. Jan. 5, 2010.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53a Disclosure of financial relationships between organization and participating health care providers, health care facilities, or other entities.

Sec. 3a. An organization that establishes a prudent purchaser agreement shall disclose in writing to all purchasers of its coverage and to all covered members of its plans upon request the financial relationships between the organization and its participating health care providers, health care facilities, or other similar entities, including all of the following as applicable:

(a) Whether a fee-for-service arrangement exists, under which the provider is paid a specified fee for each particular covered service rendered to each covered individual.

(b) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services rendered to each covered individual.

(c) Whether payments to providers are made according to how well the provider meets criteria regarding costs, quality, patient satisfaction, or other criteria.

History: Add. 1996, Act 518, Eff. Oct. 1, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53b Prudent purchaser agreement services; providing requested information to insurer.

Sec. 3b. An organization that is providing prudent purchaser agreement services to an insurer shall provide the insurer on a timely basis with information requested by the insurer that the organization has and that the insurer needs to comply with section 2212 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.2212 of the Michigan Compiled Laws.

History: Add. 1996, Act 518, Eff. Oct. 1, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.54 Discrimination prohibited; complaint of violation; hearing; penalty.

Sec. 4. An organization shall not refuse to enter into a prudent purchaser agreement with a health care provider on the basis of religion, race, color, national origin, age, sex, or marital status. Upon receipt of a complaint of a violation of this section, in a form satisfactory to the commissioner, and if the commissioner has probable cause to believe that such a violation has occurred, the commissioner shall conduct a hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws. If after such hearing the commissioner determines the organization has violated this section, the commissioner may do 1 or more of the following:

(a) Issue a cease and desist order requiring the organization to cease and desist from engaging in the conduct prohibited by this section.

(b) Issue a cease and desist order requiring the organization to enter into a prudent purchaser agreement with a health care provider.

(c) Impose a fine of not more than $500.00 for each violation, but not to exceed an aggregate fine of $5,000.00, unless the organization knew or reasonably should have known it was violating this section, in which case the fine shall not be more than $2,500.00 for each violation and shall not exceed an aggregate fine of $25,000.00 for all violations committed in a 6-month period.

(d) Suspend, limit, or revoke the organization's license or certificate of authority.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.55 Notice of membership in provider panels; display.

Sec. 5. A health care provider which is a member of a provider panel shall display a notice in a conspicuous place at the entrance of the health care provider's facility indicating those provider panels to which the health care provider is a member.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.56 Reporting certain information on standard forms required; availability of information to appropriate state agencies; confidentiality.

Sec. 6. (1) An organization which enters into prudent purchaser agreements with health care providers under this act shall report with its annual statement, or on a date set by the commissioner, on standard forms prescribed by the commissioner the following information:

(a) The number of natural persons receiving health care benefits under prudent purchaser agreements.

(b) The number of individual and group contracts providing health care services pursuant to prudent purchaser agreements.

(c) The dollar volume of business conducted under prudent purchaser agreements.

(2) Information received by the commissioner pursuant to this section shall be made available to appropriate state agencies for purposes of reviewing and evaluating this act.

(3) The commissioner and state agencies shall ensure the confidentiality of information containing data

which may be associated with a particular organization. Information pertaining to the diagnosis, treatment, or health of any person receiving health care benefits under prudent purchaser agreements shall be confidential and shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes of this act; upon the express consent of the person; pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim examination or litigation between the person and the organization, to the extent that the data or information is pertinent.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 1988, Act 282, Imd. Eff. July 27, 1988.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.57 Agreements between health care providers and purchasers of health care services.

Sec. 7. Nothing in this act shall preclude 1 or more health care providers from entering into agreements with purchasers of health care services for the provision of health care services. Such agreements between 1 or more health care providers and purchasers of health care services shall not be considered to be per se violations of Michigan law prohibiting unreasonable restraint of trade. However, such agreements shall be fully subject to Michigan law regarding monopolization or attempted monopolization.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.58 Organization subject to enabling act; financial records.

Sec. 8. (1) An organization which provides or administers health care benefits or coverage under a prudent purchaser agreement shall remain subject to all of the provisions of its enabling act.

(2) An organization shall maintain financial records for its prudent purchaser agreements and activities in a form separate or separable from the financial records of other operations and activities carried on by the organization.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.59 Report on competition in retail pharmacy industry.

Sec. 9. The department of management and budget shall contract with an independent third party for a report which shall determine the extent of competition in the retail pharmacy industry, whether such competition results in maximum economic efficiency and the lowest possible costs for consumers, and the potential effects of this act on the retail pharmacy industry. Such report shall be submitted to the legislature before June 1, 1986.

History: 1984, Act 233, Eff, Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.60 Repealed. 2005, Act 203, Imd. Eff. Nov. 10, 2005.

Compiler's note: The repealed section pertained to creation of a joint committee to investigate competition in the health care coverage market.

550.61 Repealed. 1988, Act 282, Imd. Eff. July 27, 1988.

Compiler's note: The repealed section pertained to applicability of act.

550.62 Provisions inapplicable to certain contracts and renewal thereof.

Sec. 12. Nothing in this act shall apply to any contract which is in existence before the effective date of this act, or the renewal of such contract.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.63 Conditional effective date.

Sec. 13. This act shall not take effect unless all of the following bills of the 82nd Legislature are enacted

into law:

(a) Senate Bill No. 714.

(b) House Bill No. 4799.

(c) House Bill No. 4800.

(d) House Bill No. 4801.

(e) House Bill No. 5067.

(f) House Bill No. 5068.

(g) House Bill No. 5141.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: The bills referred to in this section were enacted into law as follows:

Senate Bill No. 714, filed with the Secretary of State December 20, 1984, became P.A. 1984, No. 280, Imd. Eff. Dec. 20, 1984;

House Bill No. 4799, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 230, Imd. Eff. July 30, 1984;

House Bill No. 4800, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 231, Imd. Eff. July 30, 1984;

House Bill No. 4801, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 232, Imd. Eff. July 30, 1984;

House Bill No. 5067, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 235, Imd. Eff. July 30, 1984;

House Bill No. 5068, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 234, Imd. Eff. July 30, 1984; and

House Bill No. 5141, filed with the Secretary of State July 13, 1984, became P.A. 1984, No. 218, Imd. Eff. July 13, 1984.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.