Kansas KS§ 65-4978

65-4978. Medical retainer agreement; definitions; requirements; notice. (a) As used in this section:

(1) "Health care provider" means a person licensed under the healing arts act as specified by K.S.A. 65-2802(d), and amendments thereto. Health care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(2) "Medical retainer agreement" means a contract between a health care provider and an individual patient or patient's legal representative in which the health care provider agrees to provide routine health care services to the individual patient for an agreed-upon fee and period of time.

(3) "Routine health care service" means only the following:

(A) Screening, assessment, diagnosis and treatment for the purpose of promotion of health or the detection and management of disease or injury;

(B) medical supplies and prescription drugs that are dispensed in a health care provider's office or facility site;

(C) laboratory work including routine blood screening or routine pathology screening performed by a laboratory that meets either of the following requirements:

(i) Is associated with the health care provider that is a party to the medical retainer agreement; or

(ii) if not associated with the health care provider, has entered into an agreement with the health care provider that is a party to the medical retainer agreement to provide the laboratory work without charging a fee to the patient for the laboratory work.

(b) (1) A medical retainer agreement is not insurance and shall not be subject to any provisions of chapter 40 of the Kansas Statutes Annotated, and amendments thereto. Entering into a medical retainer agreement is not the business of insurance and is not subject to any provisions of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(2) A health care provider or agent of a health care provider is not required to obtain a certificate of authority or license under chapter 40 of the Kansas Statutes Annotated, and amendments thereto, to market, sell or offer to sell a medical retainer agreement.

(3) To be considered a medical retainer agreement for the purposes of this section, the agreement must meet all of the following requirements:

(A) Be in writing;

(B) be signed by the health care provider or agent of the health care provider and the individual patient or such patient's legal representative;

(C) allow either party to terminate the agreement on written notice to the other party;

(D) describe and quantify the specific routine health care services that are included in the agreement;

(E) specify the fee for the agreement;

(F) specify the period of time under the agreement;

(G) prominently state in writing that the agreement is not health insurance;

(H) prohibit the health care provider and the patient from billing an insurer or other third party payer for the services provided under the agreement; and

(I) prominently state in writing that the individual patient must pay the provider for all services not specified in the agreement and not otherwise covered by insurance.

(c) At the top of the first page of the medical retainer agreement, the language shall prominently state in writing, in boldface type in 10 point font or greater and in the following form with all words capitalized:

NOTICE: THIS MEDICAL RETAINER AGREEMENT DOES NOT CONSTITUTE INSURANCE, IS NOT A MEDICAL PLAN THAT PROVIDES HEALTH INSURANCE COVERAGE FOR PURPOSES OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND COVERS ONLY LIMITED, ROUTINE HEALTH CARE SERVICES AS DESIGNATED IN THIS AGREEMENT.

This notice shall be followed by a short, parallel line which shall be initialed by the patient or the patient's legal representative to indicate the patient or patient's legal representative has read the notice statement.

History: L. 2015, ch. 46, § 1; July 1.

Louisiana
LA 37-1360.81

RS 37:1360.81

PART VII. DIRECT PRIMARY CARE PRACTICE

§1360.81. Definitions

For the purposes of this Part, the terms stated in this Section have the meanings assigned to them, respectively, unless the context otherwise requires:

(1) "Board" means the Louisiana State Board of Medical Examiners.

(2) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, the parent or legal guardian of the direct patient, or a family of direct patients whereby the direct practice charges a direct fee as consideration for being available to provide and providing primary care services to the individual direct patient. A direct agreement shall describe the specific health care services the direct practice will provide and be terminable at will upon written notice by the direct patient.

(3) "Direct fee" means a fee charged by a direct practice as consideration for being available to provide and providing primary care services as specified in a direct agreement.

(4) "Direct patient" means a person who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct practice.

(5) "Direct patient-provider primary care practice" and "direct practice" means a physician, group, or entity that meets the following criteria:

(a) Is any of the following:

(i) A physician who provides primary care services through a direct agreement.

(ii) A group of physicians who provide primary care services through a direct agreement.

(iii) An entity that sponsors, employs, or is otherwise affiliated with a group of physicians who provide primary care services only through a direct agreement, which entity is wholly owned by the group of physicians or is a nonprofit corporation exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and is not otherwise regulated under Title 22 of the Louisiana Revised Statutes of 1950. Such entity shall not be prohibited from sponsoring, employing, or being otherwise affiliated with other types of health care providers not engaged in a direct practice.

(iv) "Direct patient-provider primary care practice" or "direct practice" shall not include an organization or an entity that contracts with a primary care practice for the provision of research, technological, operational, and administrative support, but such an entity or an organization does not provide a direct medical care service.

(b) Enters into direct agreements with direct patients or parents or legal guardians of direct patients.

(c) Does not accept payment for health care services provided to direct patients from any entity subject to regulation under Title 22 of the Louisiana Revised Statues of 1950.

(d) Does not provide, in consideration for a direct fee, services, procedures, or supplies such as prescription drugs except as provided in R.S. 37:1360.84(B), hospitalization costs, major surgery, dialysis, high level radiology, including but not limited to X-ray computed tomography, positron emission tomography, magnetic resonance imaging, or invasive radiology, rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

(6) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the insurance commissioner that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization, or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(7) "Physician" means a natural person who is the holder of an allopathic (MD) degree or an osteopathic (DO) degree from a medical college in good standing with the board who holds a license, permit, certification, or registration issued by the board to engage in the practice of medicine in the state of Louisiana.

(8) "Primary care" means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.

Acts 2014, No. 867, §1.

Michigan
MI-500-129

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.129 Medical retainer agreement not subject to act.

Sec. 129. (1) A medical retainer agreement is not insurance and is not subject to this act. Entering into a medical retainer agreement is not the business of insurance and is not subject to this act.

(2) A health care provider or agent of a health care provider is not required to obtain a certificate of authority or license under this act to market, sell, or offer to sell a medical retainer agreement.

(3) To be considered a medical retainer agreement for the purposes of this section, the agreement must meet all of the following requirements:

(a) Be in writing.

(b) Be signed by the health care provider or agent of the health care provider and the individual patient or his or her legal representative.

(c) Allow either party to terminate the agreement on written notice to the other party.

(d) Describe and quantify the specific routine health care services that are included in the agreement.

(e) Specify the fee for the agreement.

(f) Specify the period of time under the agreement.

(g) Prominently state in writing that the agreement is not health insurance.

(h) Prohibit the health care provider and the patient from billing an insurer or other third party payer for the services provided under the agreement.

(i) Prominently state in writing that the individual patient must pay the provider for all services not specified in the agreement and not otherwise covered by insurance.

(4) As used in this section:

(a) "Health care provider" means an individual or other legal entity that is licensed, registered, or otherwise authorized to provide a health care service in this state under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. Health care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(b) "Medical retainer agreement" means a contract between a health care provider and an individual patient or his or her legal representative in which the health care provider agrees to provide routine health care services to the individual patient for an agreed-upon fee and period of time.

(c) "Routine health care service" means only the following:

(*i*) Screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury.

(*ii*) Medical supplies and prescription drugs that are dispensed in a health care provider's office or facility site.

(*iii*) Laboratory work including routine blood screening or routine pathology screening performed by a laboratory that meets either of the following requirements:

(A) Is associated with the health care provider that is a party to the medical retainer agreement.

(B) If not associated with the health care provider as described in sub-subparagraph (A), has entered into an agreement with the health care provider that is a party to the medical retainer agreement to provide the laboratory work without charging a fee to the patient for the laboratory work.

History: Add. 2014, Act 522, Eff. Mar. 31, 2015.

Oklahoma
OK Title 36
§ 46.04

Oklahoma Statutes Citationized

Title 36. Insurance

Chapter 1 - Insurance Code

Article Article 46 - Health Care for Oklahomans Act

Section 4604 - Health Care Empowerment Act

Cite as: 36 O.S. § 4604 (OSCN 2018)

A. This act shall be known and may be cited as the "Health Care Empowerment Act".

B. Nothing in state law shall be construed as prohibiting a patient or legal representative from seeking care outside of an insurance plan, or outside of the Medicaid or Medicare program, and paying for such care.

C. Nothing in state law shall be construed as prohibiting a physician, other medical professional or a medical facility from accepting payment for services or medical products outside of an insurance plan. Nothing in state law shall be construed as prohibiting a physician, other medical professional or a medical facility from accepting payment for services or medical products to a Medicaid or Medicare beneficiary, provided that such physician, medical professional or medical facility has opted out of Medicare. As used in this section, "medical products" include, but are not limited to, medical drugs and pharmaceuticals.

D. A patient or legal representative shall not forfeit insurance benefits, Medicaid benefits or Medicare benefits by purchasing medical services or medical products outside the system.

E. The offer and provision of medical services or medical products purchased and provided under this act shall not be deemed an offer of insurance nor regulated by the insurance laws of the state.

F. Providers must disclose the text of the Enrollee Hold Harmless Clause, or its equivalent, in insurance or managed care provider contracts to patients or legal representatives if authorization for services or claims is denied, together with a plain-English explanation of its meaning.

Historical Data

Laws 2015, SB 560, c. 159, § 1, emerg. eff. April 21, 2015

Citationizer© Summary of Documents Citing This Document

Cite	***Name Level***

None Found.

Citationizer: Table of Authority

Cite	***Name Level***

None Found.

Texas Occupations Code ch. 162, subch. F

OCCUPATIONS CODE

TITLE 3. HEALTH PROFESSIONS

SUBTITLE B. PHYSICIANS

CHAPTER 162. REGULATION OF PRACTICE OF MEDICINE

SUBCHAPTER A. REGULATION BY BOARD OF CERTAIN NONPROFIT HEALTH CORPORATIONS

Sec. 162.001. CERTIFICATION BY BOARD. (a) The board by rule shall certify a health organization that:

(1) applies for certification on a form approved by the board; and

(2) presents proof satisfactory to the board that the organization meets the requirements of Subsection (b) or (c).

(b) The board shall approve and certify a health organization that:

(1) is a nonprofit corporation under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) organized to:

(A) conduct scientific research and research projects in the public interest in the field of medical science, medical economics, public health, sociology, or a related area;

(B) support medical education in medical schools through grants and scholarships;

(C) improve and develop the capabilities of individuals and institutions studying, teaching, and practicing medicine;

(D) deliver health care to the public; or

(E) instruct the general public in medical science, public health, and hygiene and provide related instruction useful to individuals and beneficial to the community;

(2) is organized and incorporated solely by persons licensed by the board; and

(3) has as its directors and trustees persons who are:

(A) licensed by the board; and

(B) actively engaged in the practice of medicine.

(c) The board shall certify a health organization to contract with or employ physicians licensed by the board if the organization:

Sec. 162.204. BIENNIAL REPORT. A private medical school certified under Section 162.203 shall provide to the board a biennial report certifying that the school is in compliance with this subchapter.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.033(a), eff. Sept. 1, 2001.

Sec. 162.205. SUSPENSION OR REVOCATION OF CERTIFICATION. If the board determines at any time that a private medical school certified under Section 162.203 has failed to comply with this subchapter, the board may suspend or revoke the school's certification.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.033(a), eff. Sept. 1, 2001.

Sec. 162.206. LIMITATION ON SCHOOL'S AUTHORITY. A private medical school's authority to retain a physician's professional income does not apply to a physician providing care in a facility owned or operated by the school that is established outside the school's historical geographical service area as it existed June 19, 1999.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.033(a), eff. Sept. 1, 2001.

Sec. 162.207. APPLICATION OF SUBCHAPTER. This subchapter does not:

(1) affect the reporting requirements under Section 160.003; or

(2) apply to a private medical school certified under this subchapter if all or substantially all of the school's assets are sold.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.033(a), eff. Sept. 1, 2001.

SUBCHAPTER F. DIRECT PRIMARY CARE

Sec. 162.251. DEFINITIONS. In this subchapter:

(1) "Direct fee" means a fee charged by a physician to a patient or a patient's designee for primary medical care services provided by, or to be provided by, the physician to the patient. The term includes a fee in any form, including a:

(A) monthly retainer;

(B) membership fee;

(C) subscription fee;

(D) fee paid under a medical service agreement; or

(E) fee for a service, visit, or episode of care.

(2) "Direct primary care" means a primary medical care service provided by a physician to a patient in return for payment in accordance with a direct fee.

(3) "Medical service agreement" means a signed written agreement under which a physician agrees to provide direct primary care services for a patient in exchange for a direct fee for a period of time that is entered into by the physician and:

(A) the patient;

(B) the patient's legal representative, guardian, or employer on behalf of the patient; or

(C) the patient's legal representative's or guardian's employer on behalf of the patient.

(4) "Physician" includes a professional association or professional limited liability company owned entirely by an individual licensed under this subtitle.

(5) "Primary medical care service" means a routine or general health care service of the type provided at the time a patient seeks preventive care or first seeks health care services for a specific health concern, is a patient's main source for regular health care services, and includes:

(A) promoting and maintaining mental and physical health and wellness;

(B) preventing disease;

(C) screening, diagnosing, and treating acute or chronic conditions caused by disease, injury, or illness;

(D) providing patient counseling and education; and

(E) providing a broad spectrum of preventive and curative health care over a period of time.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Sec. 162.252. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to workers' compensation insurance coverage as defined by Section 401.011, Labor Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Sec. 162.253. DIRECT PRIMARY CARE NOT INSURANCE. (a) A physician providing direct primary care is not an insurer or health maintenance organization, and the physician is not subject to regulation by the Texas Department of Insurance for the direct primary care.

(b) A medical service agreement is not health or accident insurance or coverage under Title 8, Insurance Code, and is not subject to regulation by the Texas Department of Insurance.

(c) A physician is not required to obtain a certificate of authority under the Insurance Code to market, sell, or offer a medical service agreement or provide direct primary care.

(d) A physician providing direct primary care does not violate Section 1204.055, Insurance Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Sec. 162.254. BILLING INSURER OR HEALTH MAINTENANCE ORGANIZATION PROHIBITED. A physician may not bill an insurer or health maintenance organization for direct primary care that is paid under a medical service agreement.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Sec. 162.255. INTERFERENCE PROHIBITED. (a) The board or another state agency may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against:

(1) a physician solely because the physician provides direct primary care; or

(2) a person solely because the person pays a direct fee for direct primary care.

(b) A health insurer, health maintenance organization, or health care provider as that term is defined by Section 105.001 may not prohibit, interfere with, or initiate a legal proceeding against:

(1) a physician solely because the physician provides direct primary care; or

(2) a person solely because the person pays a direct fee for direct primary care.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Sec. 162.256. REQUIRED DISCLOSURE. A physician providing direct primary care shall provide written or electronic notice to the patient that a medical service agreement for direct primary care is not insurance, prior to entering into the agreement.

Added by Acts 2015, 84th Leg., R.S., Ch. 165 (H.B. 1945), Sec. 1, eff. May 28, 2015.

Utah
UT 31A-4-
106.5

31A-4-106.5 Medical retainer agreements.

(1) For purposes of this section:

(a) "Medical retainer agreement" means a written contract:

(i) between:

(A) except as provided in Subsection (1)(b)(iii)(B), a natural person or a professional corporation, alone or with others professionally associated with the natural person or professional corporation; and

(B) an individual patient or a patient's representative; and

(ii) in which:

(A) the person described in Subsection (1)(a)(i)(A) agrees to provide routine health care services to the individual patient for an agreed upon fee and period of time; and

(B) either party to the contract may terminate the agreement upon written notice to the other party.

(b) "Routine health care services" include:

(i) screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury;

(ii) supplies and prescription drugs that are dispensed in a health care provider's office; and

(iii) laboratory work, such as routine blood screening or routine pathology screening performed by a laboratory that:

(A) is associated with the health care provider entering into the medical retainer agreement; or

(B) if not associated with the health care provider, has entered into an agreement with the health care provider to provide the laboratory work without charging a fee to the patient for the laboratory work.

(2) A medical retainer agreement exempt from the provisions of Subsection 31A-4-106(2) shall:

(a) describe the specific routine health care services that are included in the contract;

(b) prominently state in writing that the retainer agreement is not health insurance; and

(c) prohibit the health care provider, but not the patient, from billing an insurer for the services provided under the medical retainer agreement.

Enacted by Chapter 50, 2012 General Session

Washington
48-150 RCW

Chapter 48.150 RCW

DIRECT PATIENT-PROVIDER PRIMARY HEALTH CARE

Sections

48.150.005
Public policy.

It is the public policy of Washington to promote access to medical care for all citizens and to encourage innovative arrangements between patients and providers that will help provide all citizens with a medical home.

Washington needs a multipronged approach to provide adequate health care to many citizens who lack adequate access to it. Direct patient-provider practices, in which patients enter into a direct relationship with medical practitioners and pay a fixed amount directly to the health care provider for primary care services, represent an innovative, affordable option which could improve access to medical care, reduce the number of people who now lack such access, and cut down on emergency room use for primary care purposes, thereby freeing up emergency room facilities to treat true emergencies.

[2007 c 267 § 1.]

48.150.010
Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, or the parent or legal guardian of the direct patient or a family of direct patients, whereby the direct practice charges a direct fee as consideration for being available to provide and providing primary care services to the individual direct patient. A direct agreement must (a) describe the

specific health care services the direct practice will provide; and (b) be terminable at will upon written notice by the direct patient.

(2) "Direct fee" means a fee charged by a direct practice as consideration for being available to provide and providing primary care services as specified in a direct agreement.

(3) "Direct patient" means a person who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct practice.

(4) "Direct patient-provider primary care practice" and "direct practice" means a provider, group, or entity that meets the following criteria in (a), (b), (c), and (d) of this subsection:

(a)(i) A health care provider who furnishes primary care services through a direct agreement;

(ii) A group of health care providers who furnish primary care services through a direct agreement; or

(iii) An entity that sponsors, employs, or is otherwise affiliated with a group of health care providers who furnish only primary care services through a direct agreement, which entity is wholly owned by the group of health care providers or is a nonprofit corporation exempt from taxation under section 501(c)(3) of the internal revenue code, and is not otherwise regulated as a health care service contractor, health maintenance organization, or disability insurer under Title **48** RCW. Such entity is not prohibited from sponsoring, employing, or being otherwise affiliated with other types of health care providers not engaged in a direct practice;

(b) Enters into direct agreements with direct patients or parents or legal guardians of direct patients;

(c) Does not accept payment for health care services provided to direct patients from any entity subject to regulation under Title **48** RCW or plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW; and

(d) Does not provide, in consideration for the direct fee, services, procedures, or supplies such as prescription drugs except as provided in RCW **48.150.040**(2)(b)(i)(B), hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI, PET scans or invasive radiology), rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

(5) "Health care provider" or "provider" means a person regulated under Title **18** RCW or chapter **70.127** RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law.

(6) "Health carrier" or "carrier" has the same meaning as in RCW **48.43.005**.

(7) "Network" means the group of participating providers and facilities providing health care services to a particular health carrier's health plan or to plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW.

(8) "Primary care" means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.

[**2013 c 126 § 1.** Prior: **2009 c 552 § 1; 2007 c 267 § 3.**]

NOTES:

***Reviser's note:** Chapter **70.47A** RCW was repealed in its entirety by **2017 3rd sp.s. c 25 § 9.**

48.150.020
Prohibition on discrimination.

Except as provided in RCW **48.150.050**, no direct practice shall decline to accept any person solely on account of race, religion, national origin, the presence of any sensory, mental, or physical disability, education, economic status, or sexual orientation.

[2007 c 267 § 4.]

48.150.030
Direct fee—Monthly basis—Designated contact person.

(1) A direct practice must charge a direct fee on a monthly basis. The fee must represent the total amount due for all primary care services specified in the direct agreement and may be paid by the direct patient or on his or her behalf by others.

(2) A direct practice must:

(a) Maintain appropriate accounts and provide data regarding payments made and services received to direct patients upon request; and

(b) Either:

(i) Bill patients at the end of each monthly period; or

(ii) If the patient pays the monthly fee in advance, promptly refund to the direct patient all unearned direct fees following receipt of written notice of termination of the direct agreement from the direct patient. The amount of the direct fee considered earned shall be a proration of the monthly fee as of the date the notice of termination is received.

(3) If the patient chooses to pay more than one monthly direct fee in advance, the funds must be held in a trust account and paid to the direct practice as earned at the end of each month. Any unearned direct fees held in trust following receipt of termination of the direct agreement shall be promptly refunded to the direct patient. The amount of the direct fee earned shall be a proration of the monthly fee for the then current month as of the date the notice of termination is received.

(4) The direct fee schedule applying to an existing direct patient may not be increased over the annual negotiated amount more frequently than annually. A direct practice shall provide advance notice to existing patients of any change within the fee schedule applying to those existing direct patients. A direct practice shall provide at least sixty days' advance notice of any change in the fee.

(5) A direct practice must designate a contact person to receive and address any patient complaints.

(6) Direct fees for comparable services within a direct practice shall not vary from patient to patient based on health status or sex.

[2007 c 267 § 5.]

48.150.040
Prohibited and authorized practices.

(1) Direct practices may not:

(a) Enter into a participating provider contract as defined in RCW **48.44.010** or **48.46.020** with any carrier or with any carrier's contractor or subcontractor, or plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW, to provide health care services through a direct agreement except as set forth in subsection (2) of this section;

(b) Submit a claim for payment to any carrier or any carrier's contractor or subcontractor, or plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW, for health care services provided to direct patients as covered by their agreement;

(c) With respect to services provided through a direct agreement, be identified by a carrier or any carrier's contractor or subcontractor, or plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW, as a participant in the carrier's or any carrier's contractor or subcontractor network for purposes of determining network adequacy or being available for selection by an enrollee under a carrier's benefit plan; or

(d) Pay for health care services covered by a direct agreement rendered to direct patients by providers other than the providers in the direct practice or their employees, except as described in subsection (2)(b) of this section.

(2) Direct practices and providers may:

(a) Enter into a participating provider contract as defined by RCW **48.44.010** and **48.46.020** or plans administered under chapter **41.05**, 70.47, or * **70.47A** RCW for purposes other than payment of claims for services provided to direct patients through a direct agreement. Such providers shall be subject to all other provisions of the participating provider contract applicable to participating providers including but not limited to the right to:

(i) Make referrals to other participating providers;

(ii) Admit the carrier's members to participating hospitals and other health care facilities;

(iii) Prescribe prescription drugs; and

(iv) Implement other customary provisions of the contract not dealing with reimbursement of services;

(b)(i) Pay for charges associated with:

(A) The provision of routine lab and imaging services; and

(B) The dispensing, at no additional cost to the direct patient, of an initial supply, not to exceed thirty days, of generic prescription drugs prescribed by the direct provider.

(ii) In aggregate payments made under (b)(i)(A) and (B) of this subsection per year per direct patient are not to exceed fifteen percent of the total annual direct fee charged that direct patient. Exceptions to this limitation may occur with respect to routine lab and imaging services in the event of short-term equipment failure if such failure prevents the provision of care that should not be delayed; and

(c) Charge an additional fee to direct patients for supplies, medications, and specific vaccines provided to direct patients that are specifically excluded under the agreement, provided the direct practice notifies the direct patient of the additional charge, prior to their administration or delivery.

[2013 c 126 § 2; 2009 c 552 § 2; 2007 c 267 § 6.]

NOTES:

***Reviser's note:** Chapter **70.47A** RCW was repealed in its entirety by **2017 3rd sp.s. c 25 § 9.**

48.150.050
Acceptance or discontinuation of patients—Third-party payments.

(1) Direct practices may not decline to accept new direct patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice. So long as the direct practice provides the patient notice and opportunity to obtain care from another physician, the direct practice may discontinue care for direct patients if: (a) The patient fails to pay the direct fee under the terms required by the direct agreement; (b) the patient has performed an act that

constitutes fraud; (c) the patient repeatedly fails to comply with the recommended treatment plan; (d) the patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice; or (e) the direct practice discontinues operation as a direct practice.

(2) Subject to the restrictions established in this chapter, direct practices may accept payment of direct fees directly or indirectly from third parties. A direct practice may accept a direct fee paid by an employer on behalf of an employee who is a direct patient. However, a direct practice shall not enter into a contract with an employer relating to direct practice agreements between the direct practice and employees of that employer, other than to establish the timing and method of the payment of the direct fee by the employer.

[2009 c 552 § 3; 2007 c 267 § 7.]

48.150.060
Direct practices are not insurers.

Direct practices, as defined in RCW **48.150.010**, who comply with this chapter are not insurers under RCW **48.01.050**, health carriers under chapter **48.43** RCW, health care service contractors under chapter **48.44** RCW, or health maintenance organizations under chapter **48.46** RCW.

[2007 c 267 § 8.]

48.150.070
Conduct of business—Prohibitions.

A person shall not make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a direct practice, or relative to the business of a direct practice.

[2007 c 267 § 9.]

48.150.080
Misrepresenting the terms of a direct agreement.

A person shall not make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of any direct agreement, or the benefits or advantages promised thereby, or use the name or title of any direct agreement misrepresenting the nature thereof.

[2007 c 267 § 10.]

48.150.090
Chapter violations.

Violations of this chapter constitute unprofessional conduct enforceable under RCW **18.130.180**.

[2007 c 267 § 11.]

48.150.100
Annual statements—Commissioner's report.

(1) Direct practices must submit annual statements, beginning on October 1, 2007, to the office of [the] insurance commissioner specifying the number of providers in each practice, total number of patients being served, the average direct fee being charged, providers' names, and the business address for each direct practice. The form and content for the annual statement must be developed in a manner prescribed by the commissioner.

(2) A health care provider may not act as, or hold himself or herself out to be, a direct practice in this state, nor may a direct agreement be entered into with a direct patient in this state, unless the provider submits the annual statement in subsection (1) of this section to the commissioner.

(3) The commissioner shall report annually to the legislature on direct practices including, but not limited to, participation trends, complaints received, voluntary data reported by the direct practices, and any necessary modifications to this chapter. The initial report shall be due December 1, 2009.

[2007 c 267 § 12.]

48.150.110
Direct agreement requirements—Disclaimer.

(1) A direct agreement must include the following disclaimer: "This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described." The direct agreement may not be sold to a group and may not be entered with a group of subscribers. It must be an agreement between a direct practice and an individual direct patient. Nothing prohibits the presentation of marketing materials to groups of potential subscribers or their representatives.

(2) A comprehensive disclosure statement shall be distributed to all direct patients with their participation forms. Such disclosure must inform the direct patients of their financial rights and responsibilities to the direct practice as provided for in this chapter, encourage that direct patients obtain and maintain insurance for services not provided by the direct practice, and state that the direct practice will not bill a carrier for services covered under the direct agreement. The disclosure statement shall include contact information for the office of the insurance commissioner.

[2007 c 267 § 13.]