ESB 5773 - H COMM AMD
By Committee on Ways & Means

NOT CONSIDERED 04/22/2011

1 Strike everything after the enacting clause and insert the
2 following:

3 "**Sec. 1.** RCW 41.05.065 and 2009 c 537 s 7 are each amended to read
4 as follows:
5 (1) The board shall study all matters connected with the provision
6 of health care coverage, life insurance, liability insurance,
7 accidental death and dismemberment insurance, and disability income
8 insurance or any of, or a combination of, the enumerated types of
9 insurance for employees and their dependents on the best basis possible
10 with relation both to the welfare of the employees and to the state.
11 However, liability insurance shall not be made available to dependents.
12 (2) The board shall develop employee benefit plans that include
13 comprehensive health care benefits for employees. In developing these
14 plans, the board shall consider the following elements:
15 (a) Methods of maximizing cost containment while ensuring access to
16 quality health care;
17 (b) Development of provider arrangements that encourage cost
18 containment and ensure access to quality care, including but not
19 limited to prepaid delivery systems and prospective payment methods;
20 (c) Wellness incentives that focus on proven strategies, such as
21 smoking cessation, injury and accident prevention, reduction of alcohol
22 misuse, appropriate weight reduction, exercise, automobile and
23 motorcycle safety, blood cholesterol reduction, and nutrition
24 education;
25 (d) Utilization review procedures including, but not limited to a
26 cost-efficient method for prior authorization of services, hospital
27 inpatient length of stay review, requirements for use of outpatient
28 surgeries and second opinions for surgeries, review of invoices or
29 claims submitted by service providers, and performance audit of
30 providers;

1 (e) Effective coordination of benefits; and
2 (f) Minimum standards for insuring entities.
3 (3) To maintain the comprehensive nature of employee health care
4 benefits, benefits provided to employees shall be substantially
5 equivalent to the state employees' health benefits plan in effect on
6 January 1, 1993. Nothing in this subsection shall prohibit changes or
7 increases in employee point-of-service payments or employee premium
8 payments for benefits or the administration of a high deductible health
9 plan in conjunction with a health savings account. The board may
10 establish employee eligibility criteria which are not substantially
11 equivalent to employee eligibility criteria in effect on January 1,
12 1993.
13 (4) Except if bargained for under chapter 41.80 RCW, the board
14 shall design benefits and determine the terms and conditions of
15 employee and retired employee participation and coverage, including
16 establishment of eligibility criteria subject to the requirements of
17 this chapter. Employer groups obtaining benefits through contractual
18 agreement with the authority for employees defined in RCW 41.05.011(6)
19 (a) through (d) may contractually agree with the authority to benefits
20 eligibility criteria which differs from that determined by the board.
21 The eligibility criteria established by the board shall be no more
22 restrictive than the following:
23 (a) Except as provided in (b) through (e) of this subsection, an
24 employee is eligible for benefits from the date of employment if the
25 employing agency anticipates he or she will work an average of at least
26 eighty hours per month and for at least eight hours in each month for
27 more than six consecutive months. An employee determined ineligible
28 for benefits at the beginning of his or her employment shall become
29 eligible in the following circumstances:
30 (i) An employee who works an average of at least eighty hours per
31 month and for at least eight hours in each month and whose anticipated
32 duration of employment is revised from less than or equal to six
33 consecutive months to more than six consecutive months becomes eligible
34 when the revision is made.
35 (ii) An employee who works an average of at least eighty hours per
36 month over a period of six consecutive months and for at least eight
37 hours in each of those six consecutive months becomes eligible at the
38 first of the month following the six-month averaging period.

1 (b) A seasonal employee is eligible for benefits from the date of
2 employment if the employing agency anticipates that he or she will work
3 an average of at least eighty hours per month and for at least eight
4 hours in each month of the season. A seasonal employee determined
5 ineligible at the beginning of his or her employment who works an
6 average of at least half-time, as defined by the board, per month over
7 a period of six consecutive months and at least eight hours in each of
8 those six consecutive months becomes eligible at the first of the month
9 following the six-month averaging period. A benefits-eligible seasonal
10 employee who works a season of less than nine months shall not be
11 eligible for the employer contribution during the off season, but may
12 continue enrollment in benefits during the off season by self-paying
13 for the benefits. A benefits-eligible seasonal employee who works a
14 season of nine months or more is eligible for the employer contribution
15 through the off season following each season worked.
16 (c) Faculty are eligible as follows:
17 (i) Faculty who the employing agency anticipates will work
18 half-time or more for the entire instructional year or equivalent nine-
19 month period are eligible for benefits from the date of employment.
20 Eligibility shall continue until the beginning of the first full month
21 of the next instructional year, unless the employment relationship is
22 terminated, in which case eligibility shall cease the first month
23 following the notice of termination or the effective date of the
24 termination, whichever is later.
25 (ii) Faculty who the employing agency anticipates will not work for
26 the entire instructional year or equivalent nine-month period are
27 eligible for benefits at the beginning of the second consecutive
28 quarter or semester of employment in which he or she is anticipated to
29 work, or has actually worked, half-time or more. Such an employee
30 shall continue to receive uninterrupted employer contributions for
31 benefits if the employee works at least half-time in a quarter or
32 semester. Faculty who the employing agency anticipates will not work
33 for the entire instructional year or equivalent nine-month period, but
34 who actually work half-time or more throughout the entire instructional
35 year, are eligible for summer or off-quarter coverage. Faculty who
36 have met the criteria of this subsection (4)(c)(ii), who work at least
37 two quarters of the academic year with an average academic year
38 workload of half-time or more for three quarters of the academic year,

and who have worked an average of half-time or more in each of the two preceding academic years shall continue to receive uninterrupted employer contributions for benefits if he or she works at least half-time in a quarter or semester or works two quarters of the academic year with an average academic workload each academic year of half-time or more for three quarters. Eligibility under this section ceases immediately if this criteria is not met.

(iii) Faculty may establish or maintain eligibility for benefits by working for more than one institution of higher education. When faculty work for more than one institution of higher education, those institutions shall prorate the employer contribution costs, or if eligibility is reached through one institution, that institution will pay the full employer contribution. Faculty working for more than one institution must alert his or her employers to his or her potential eligibility in order to establish eligibility.

(iv) The employing agency must provide written notice to faculty who are potentially eligible for benefits under this subsection (4)(c) of their potential eligibility.

(v) To be eligible for maintenance of benefits through averaging under (c)(ii) of this subsection, faculty must provide written notification to his or her employing agency or agencies of his or her potential eligibility.

(d) A legislator is eligible for benefits on the date his or her term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible for benefits on the date his or her term begins or they take the oath of office, whichever occurs first.

(e) A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for benefits on the date he or she takes the oath of office.

(f) Except as provided in (c)(i) and (ii) of this subsection, eligibility ceases for any employee the first of the month following termination of the employment relationship.

(g) In determining eligibility under this section, the employing agency may disregard training hours, standby hours, or temporary changes in work hours as determined by the authority under this section.

(h) Insurance coverage for all eligible employees begins on the first day of the month following the date when eligibility for benefits is established. If the date eligibility is established is the first working day of a month, insurance coverage begins on that date.

(i) Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in (a) through (e) of this subsection shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

(j) Except for an employee eligible for benefits under (b) or (c)(ii) of this subsection, an employee who has established eligibility for benefits under this section shall remain eligible for benefits each month in which he or she is in pay status for eight or more hours, if (i) he or she remains in a benefits-eligible position and (ii) leave from the benefits-eligible position is approved by the employing agency. A benefits-eligible seasonal employee is eligible for the employer contribution in any month of his or her season in which he or she is in pay status eight or more hours during that month. Eligibility ends if these conditions are not met, the employment relationship is terminated, or the employee voluntarily transfers to a noneligible position.

(k) For the purposes of this subsection:

(i) "Academic year" means summer, fall, winter, and spring quarters or semesters;

(ii) "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees shall have the same meaning as "part-time" under RCW 28B.50.489;

(iii) "Benefits-eligible position" shall be defined by the board.

(5) The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient managed health care systems.

(6) For the open enrollment period beginning November 1, 2011, the board shall ((~~develop~~)) offer a health savings account option for employees that conforms to section 223, Part VII of subchapter B of chapter 1 of the internal revenue code of 1986. The board shall comply with all applicable federal standards related to the establishment of health savings accounts.

1 (7) Notwithstanding any other provision of this chapter, for the
2 open enrollment period beginning November 1, 2011, the board shall
3 ((develop)) offer a high deductible health plan ((to be offered)) in
4 conjunction with a health savings account developed under subsection
5 (6) of this section.

6 (8) For the open enrollment period beginning November 1, 2011, the
7 board shall offer direct patient-provider primary care practices as
8 provided in chapter 48.150 RCW in conjunction with a health savings
9 account. The direct fee associated with the direct practice may be
10 paid by the employer outside the health savings account or paid
11 directly by the employee.

12 (9) Employees shall choose participation in one of the health care
13 benefit plans developed by the board and may be permitted to waive
14 coverage under terms and conditions established by the board.

15 (((9))) (10) The board shall review plans proposed by insuring
16 entities that desire to offer property insurance and/or accident and
17 casualty insurance to state employees through payroll deduction. The
18 board may approve any such plan for payroll deduction by insuring
19 entities holding a valid certificate of authority in the state of
20 Washington and which the board determines to be in the best interests
21 of employees and the state. The board shall adopt rules setting forth
22 criteria by which it shall evaluate the plans.

23 (((10))) (11) Before January 1, 1998, the public employees'
24 benefits board shall make available one or more fully insured long-term
25 care insurance plans that comply with the requirements of chapter 48.84
26 RCW. Such programs shall be made available to eligible employees,
27 retired employees, and retired school employees as well as eligible
28 dependents which, for the purpose of this section, includes the parents
29 of the employee or retiree and the parents of the spouse of the
30 employee or retiree. Employees of local governments, political
31 subdivisions, and tribal governments not otherwise enrolled in the
32 public employees' benefits board sponsored medical programs may enroll
33 under terms and conditions established by the administrator, if it does
34 not jeopardize the financial viability of the public employees'
35 benefits board's long- term care offering.

36 (a) Participation of eligible employees or retired employees and
37 retired school employees in any long-term care insurance plan made
38 available by the public employees' benefits board is voluntary and

1 shall not be subject to binding arbitration under chapter 41.56 RCW.
2 Participation is subject to reasonable underwriting guidelines and
3 eligibility rules established by the public employees' benefits board
4 and the health care authority.

5 (b) The employee, retired employee, and retired school employee are
6 solely responsible for the payment of the premium rates developed by
7 the health care authority. The health care authority is authorized to
8 charge a reasonable administrative fee in addition to the premium
9 charged by the long-term care insurer, which shall include the health
10 care authority's cost of administration, marketing, and consumer
11 education materials prepared by the health care authority and the
12 office of the insurance commissioner.

13 (c) To the extent administratively possible, the state shall
14 establish an automatic payroll or pension deduction system for the
15 payment of the long-term care insurance premiums.

16 (d) The public employees' benefits board and the health care
17 authority shall establish a technical advisory committee to provide
18 advice in the development of the benefit design and establishment of
19 underwriting guidelines and eligibility rules. The committee shall
20 also advise the board and authority on effective and cost-effective
21 ways to market and distribute the long-term care product. The
22 technical advisory committee shall be comprised, at a minimum, of
23 representatives of the office of the insurance commissioner, providers
24 of long-term care services, licensed insurance agents with expertise in
25 long-term care insurance, employees, retired employees, retired school
26 employees, and other interested parties determined to be appropriate by
27 the board.

28 (e) The health care authority shall offer employees, retired
29 employees, and retired school employees the option of purchasing long-
30 term care insurance through licensed agents or brokers appointed by the
31 long-term care insurer. The authority, in consultation with the public
32 employees' benefits board, shall establish marketing procedures and may
33 consider all premium components as a part of the contract negotiations
34 with the long-term care insurer.

35 (f) In developing the long-term care insurance benefit designs, the
36 public employees' benefits board shall include an alternative plan of
37 care benefit, including adult day services, as approved by the office
38 of the insurance commissioner.

(g) The health care authority, with the cooperation of the office of the insurance commissioner, shall develop a consumer education program for the eligible employees, retired employees, and retired school employees designed to provide education on the potential need for long-term care, methods of financing long-term care, and the availability of long-term care insurance products including the products offered by the board.

((~~(11)~~)) (12) The board may establish penalties to be imposed by the authority when the eligibility determinations of an employing agency fail to comply with the criteria under this chapter.

Sec. 2. RCW 41.05.021 and 2009 c 537 s 4 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The administrator may delegate any power or duty vested in him or her by this chapter, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services; and administer grants that further the mission and goals of the authority. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

1 (b) To analyze state-purchased health care programs and to explore
2 options for cost containment and delivery alternatives for those
3 programs that are consistent with the purposes of those programs,
4 including, but not limited to:
5 (i) Creation of economic incentives for the persons for whom the
6 state purchases health care to appropriately utilize and purchase
7 health care services, including the development of flexible benefit
8 plans to offset increases in individual financial responsibility;
9 (ii) Utilization of provider arrangements that encourage cost
10 containment, including but not limited to prepaid delivery systems,
11 utilization review, and prospective payment methods, and that ensure
12 access to quality care, including assuring reasonable access to local
13 providers, especially for employees residing in rural areas;
14 (iii) Coordination of state agency efforts to purchase drugs
15 effectively as provided in RCW 70.14.050;
16 (iv) Development of recommendations and methods for purchasing
17 medical equipment and supporting services on a volume discount basis;
18 (v) Development of data systems to obtain utilization data from
19 state-purchased health care programs in order to identify cost centers,
20 utilization patterns, provider and hospital practice patterns, and
21 procedure costs, utilizing the information obtained pursuant to RCW
22 41.05.031; and
23 (vi) In collaboration with other state agencies that administer
24 state purchased health care programs, private health care purchasers,
25 health care facilities, providers, and carriers:
26 (A) Use evidence-based medicine principles to develop common
27 performance measures and implement financial incentives in contracts
28 with insuring entities, health care facilities, and providers that:
29 (I) Reward improvements in health outcomes for individuals with
30 chronic diseases, increased utilization of appropriate preventive
31 health services, and reductions in medical errors; and
32 (II) Increase, through appropriate incentives to insuring entities,
33 health care facilities, and providers, the adoption and use of
34 information technology that contributes to improved health outcomes,
35 better coordination of care, and decreased medical errors;
36 (B) Through state health purchasing, reimbursement, or pilot
37 strategies, promote and increase the adoption of health information

technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

(IV) Increase access to health information for consumers and their providers; and

(V) Improve health outcomes;

(C) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005;

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered under this chapter. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program approved by the authority;

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income

1 security act of 1974, as amended, the authority shall limit the
2 participation of employees of a county, municipal, school district,
3 educational service district, or other political subdivision, or a
4 tribal government, including providing for the participation of those
5 employees whose services are substantially all in the performance of
6 essential governmental functions, but not in the performance of
7 commercial activities;

8 (h) To establish billing procedures and collect funds from school
9 districts in a way that minimizes the administrative burden on
10 districts;

11 (i) To publish and distribute to nonparticipating school districts
12 and educational service districts by October 1st of each year a
13 description of health care benefit plans available through the
14 authority and the estimated cost if school districts and educational
15 service district employees were enrolled;

16 (j) To apply for, receive, and accept grants, gifts, and other
17 payments, including property and service, from any governmental or
18 other public or private entity or person, and make arrangements as to
19 the use of these receipts to implement initiatives and strategies
20 developed under this section;

21 (k) To issue, distribute, and administer grants that further the
22 mission and goals of the authority;

23 (l) To adopt rules consistent with this chapter as described in RCW
24 41.05.160 including, but not limited to:

25 (i) Setting forth the criteria established by the board under RCW
26 41.05.065 for determining whether an employee is eligible for benefits;

27 (ii) Establishing an appeal process in accordance with chapter
28 34.05 RCW by which an employee may appeal an eligibility determination;

29 (iii) Establishing a process to assure that the eligibility
30 determinations of an employing agency comply with the criteria under
31 this chapter, including the imposition of penalties as may be
32 authorized by the board.

33 (2) On and after January 1, 1996, the public employees' benefits
34 board may implement strategies to promote managed competition among
35 employee health benefit plans. Strategies may include but are not
36 limited to:

37 (a) Standardizing the benefit package;

38 (b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

(3) Should the authority offer a direct practice option to provide any portion of benefits, notwithstanding RCW 48.150.050(1), direct practices must not refuse to accept a patient or refuse to continue care to a patient because the patient is deemed by the practice to be beyond its capability to provide an appropriate level and type of health care services. Exceptions may be granted by the authority. The authority shall only grant an exception after making a determination that the patient's care needs are beyond the standard of care capability of a typical primary care practice.

Sec. 3. RCW 48.150.010 and 2009 c 552 s 1 are each reenacted and amended to read as follows:

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, 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.

Sec. 4. RCW 48.150.040 and 2009 c 552 s 2 are each amended to read as follows:

(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)(i) 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; or

(ii) Submit a claim for payment, other than the direct fee and any other ancillary costs, to any plan administered under chapter 41.05 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) Pay for charges associated with the provision of routine lab and imaging services. In aggregate such payments 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 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."

Correct the title.

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