WAC 246-25-040 Collective negotiations—Policy statement—Permitted negotiations—Petitions. (1) The board finds that collective negotiation by competing health care providers of certain nonfee terms and conditions of contracts with health carriers may result in procompetitive effects in the absence of any express or implied threat of retaliatory collective action by health care providers. However, the board finds few or no procompetitive effects in permitting competing health care providers to collectively negotiate contract terms and conditions that include fees or prices for provider services. The potential anticompetitive harms arising from collective exchanges of fee or price information by competing providers and collective negotiation by competing providers of the fees to be paid providers by health carriers far outweigh any potential gains in simplifying provider and health carrier negotiations, any reduction in transaction costs, and any potential gains in cost-effective health care delivery systems. To the contrary, the board finds that collective negotiation of fees or other prices for services by competing health care providers creates the potential to thwart the cost containment goals of health care reform by enabling health care providers to resist health carrier and purchaser pressure to reduce or limit the increase in prices for health care services. Except as herein provided, nothing contained in this section shall authorize any person or entity to engage in activities that would constitute violations of state or federal antitrust laws.

(2) Competing health care providers within the service area of a health carrier may meet and communicate for the purposes of collectively negotiating the following terms and conditions of contracts with health carriers:

(a) Respective provider and health carrier liability for the treatment or lack of treatment of health carrier enrollees;

(b) Administrative procedures including methods and timing of provider payment for services;

(c) Dispute resolution procedures relating to disputes between health carriers and providers including disputes between providers and health carriers that originate from enrollees;

(d) Patient referral procedures;

(e) Formulation and application of reimbursement methodology, e.g., risk pools, capitation, and capitation between providers and hospitals, except as provided in section 3;

(f) Quality assurance programs;

(g) Health service utilization review procedures; and

(h) Carrier provider selection and termination criteria, or whether to engage in selective contracting.

Nothing herein shall be construed to allow a boycott.

(3) Competing health care providers shall not meet and communicate for the purposes of collectively negotiating the following terms and conditions of contracts with health carriers:

(a) The fees or prices for services, including those arrived at by applying any reimbursement methodology procedures;

(b) The conversion factor in a resource based relative value scale reimbursement methodology or similar methodologies;

(c) The amount of any discount on the price of services to be rendered by providers;

(d) The dollar amount of capitation or fixed payment for health services rendered by providers to health carrier enrollees; or

(e) The inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question; however, such restriction does not limit provider rights to collectively petition government for a change in such regulation.

(4) Competing health care providers' exercise of collective negotiation rights granted by this section shall conform to the following criteria:

(a) Providers shall communicate or negotiate with health carriers through a third party who is authorized by the providers;

(b) Each competing provider involved in the communication and negotiation with health carriers shall make an independent decision to accept or reject a specific offer from a health carrier;

(c) Health carriers communicating or negotiating with the providers' representative shall remain free to contract with or offer different contract terms and conditions to individual competing providers;

(d) The providers' representative shall not recommend to providers that providers accept or reject the health carrier offer; the representative may only deliver the offer to providers and communicate to providers an evaluation of the positive or negative aspects of the offer;

(e) The providers' representative shall not represent more than 30% of the market of practicing providers for the provision of services of a particular provider type or specialty in the service area or proposed service area of a health carrier with less than 5% of the market, as measured by 1) the number of covered lives as reported by the Insurance Commissioner, or 2) the actual number of consumers of prepaid comprehensive health services; and

(f) The providers' representative shall comply with the provisions of subsection (5) of this section.

(5) Any person or organization proposing to act or acting as a representative of providers for the purpose of exercising the authority granted under this section shall comply with the following requirements:

(a) Before engaging in any collective negotiation with health carriers on behalf of competing health care providers, the representative shall file with the board information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this section;

(b) Before engaging in any collective negotiations with health carriers on behalf of providers, the representative shall furnish for the board's approval, a brief report identifying the proposed subject matter of the negotiations or discussions with health carriers and the efficiencies expected to be achieved thereby.

Approval shall be withheld by the board if the proposed negotiations would exceed the authority granted under this section. The representative shall supplement the report to the board as new information becomes available that indicates that the subject matter of the negotiations with the health carrier has or will change;

(c) Within fourteen days of a health carrier decision declining negotiation, terminating negotiation, or failing to respond to a request for negotiation the representative shall report to the board the end of negotiations;

(d) Before reporting the results of negotiations with a health carrier and before giving providers an evaluation of any offer made by a health carrier, the representative shall furnish for the board's ap-

proval prior to dissemination to providers, a copy of all communications to be made to providers related to negotiations, discussions, and health carrier offers.

(6) With the advice of the attorney general, the board shall either approve or disapprove the activity as identified in the report within thirty days of filing. If disapproved, the board shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies could be corrected. A representative who fails to obtain the board's approval is deemed to act outside the authority granted under this section.

(7) Nothing contained in this section is intended to authorize competing providers to act in concert in response to a report issued by the providers' representative related to the representative's discussions or negotiations with health carriers. The representative of the providers shall advise providers of the provisions of this section and shall warn providers of the potential for legal action against providers who violate state or federal antitrust laws by exceeding the authority granted under this section.

[Statutory Authority: RCW 43.72.310. WSR 99-04-049, recodified as § 246-25-040, filed 1/28/99, effective 1/28/99; WSR 96-11-133, § 245-02-040, filed 5/22/96, effective 6/22/96; WSR 95-04-115, § 245-02-040, filed 2/1/95, effective 10/1/95.]