PHYSICIAN JOINT NEGOTIATION RULES ADOPTION ORDER
May 17, 2000

TITLE I. ADMINISTRATION
Part III. Office of the Attorney General
Chapter 58. Physician Joint Negotiation
1 T.A.C. §§58.1-58.53

The Office of the Attorney General (OAG) adopts new Chapter 58, §§58.1-58.5, 58.11-58.15, 58.21-58.26, 58.31-58.33, 58.41, 58.42 and 58.51-58.53, relating to joint negotiations by physicians with health benefit plans. New §§58.4, 58.11, 58.12, 58.13, 58.25, 58.26, and 58.33 are adopted with changes to the proposed text as published in the November 19, 1999 Texas Register (24 TexReg 10263). New §§58.1-58.3, 58.5, 58.14, 58.15, 58.21-58.24, 58.31, 58.32, 58.41, 58.42, and 58.51-58.53 are adopted without changes to the proposed text and will not be republished. This chapter is adopted to implement SB 1468, 76th Leg., R.S., ch.1586 (1999) (codified at Insurance Code, Chapter 29), which allows competing physicians to jointly negotiate with health benefit plans when certain conditions are met.

The findings and purposes articulated in Insurance Code, Article 29.01 reflect the legislature's determination that it is appropriate and necessary as a matter of state policy to authorize joint negotiation to address imbalances in the market relationship between physicians and health benefit plans. Chapter 29 provides a procedure by which physicians may obtain permission from the OAG to jointly negotiate with health benefit plans when such negotiations will result in pro-competitive effects. Chapter 29 also authorizes the Texas Department of Insurance (TDI) to collect data relevant to this analysis and provide assistance to the OAG. Insurance Code, Article 29.11 authorizes the OAG and the TDI to adopt rules necessary for implementation of this chapter.

The OAG is charged with administering Chapter 29 by reviewing and approving or disapproving applications for joint negotiation and proposed contracts. In reviewing such filings, the OAG is required to determine whether applicants have demonstrated that the likely benefits resulting from a joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result. The statute also directs the OAG to consider physician distribution by specialty and its effect on competition, and to determine whether conditions support limiting the size of a negotiation group to less than (or permitting a negotiation group that exceeds) ten percent of the physicians in a geographic area. In addition, when fees are being negotiated, the OAG is required to determine whether the health benefit plan has substantial market power and whether the contract terms adversely affect the quality and availability of patient care.

Process for developing these rules

The Texas physician joint negotiation law is the first of its kind in the country. In developing the rules to implement it, therefore, the OAG ventured into uncharted territory. There was no model or precedent with which to begin the drafting process. There are no legislative studies underlying the findings in Insurance Code Article 29.01, and little legislative history indicating how the law should be implemented. The OAG staff, therefore, began by reviewing the following materials to aid in developing the rules: the text of Insurance Code, Chapter 29; the legislative history of S.B. 1468, including bill analyses and transcripts of legislative committee hearings and floor debates; federal case law creating and applying the state action doctrine; the Texas hospital cooperative agreements statute (the purpose of which was to create state action immunity) and rules adopted by the Texas Department of Health to implement it; law review articles analyzing various states' hospital cooperative legislation and the state action doctrine; the rules governing the federal antitrust enforcement agencies' business review and advisory opinion programs; antitrust and economic literature on monopsony antitrust analysis and health care antitrust analysis; antitrust cases, federal merger and health care enforcement guidelines and enforcement actions relating to health care antitrust analysis, including market definition and competitive effects of concerted action by competing health care providers; and information about physicians' medical billing and record-keeping practices (e.g., credentialing forms, tax forms, utilization review reports). The OAG also consulted staff from the Texas Department of Insurance who have expertise in managed care contracting regulation and quality of care measurement. Staff from the State Board of Medical Examiners advised the OAG regarding the availability of data regarding physician specialties and practice patterns.

The OAG provided extensive opportunities for interested persons to comment on implementation of Chapter 29 and the proposed rules. In late August 1999, OAG staff met with Texas Medical Association (TMA) representatives and exchanged preliminary ideas for implementing S.B. 1468. On September 8, 1999, the OAG held a stakeholders meeting. All parties who had testified at legislative hearings or otherwise expressed interest in the new legislation were invited, and approximately 40 attended. At that meeting, the OAG distributed a preliminary draft of the implementation rules and invited oral or written comments. On October 8, 1999, the OAG disapproved the first application for joint negotiation. The disapproval letter, which was distributed to all stakeholders, discussed the types of information that should be included in an application and the purpose of that information, which was a major topic of debate on the draft rules. On October 18, 1999, the OAG sent stakeholders draft rules that had been revised based on input received at the September 8 meeting. The OAG indicated its intention to publish this draft as proposed rules and solicited feedback in any form from all interested parties. Further revisions were made in late October in response to comments from the TMA, and the resulting draft was published in the November 19, 1999, issue of the *Texas Register*. The OAG encouraged interested persons to comment through December 19, 1999. The OAG held a public hearing on December 15, 1999, at which eleven people testified. At the request of Senator Harris, who sponsored S.B. 1468, the OAG extended the public comment period 30 days, to January 19, 1999. By the end of the 60-day official public comment period, the OAG had received comments from over 17 groups, 30 individual physicians, and over 100 podiatrists. In addition, the OAG had discussed the proposed rules in nearly a dozen separate meetings with

legislators and their staff, TMA, the health plans, and other physician groups during the five-month period in which the rules were being developed. At TMA's suggestion, OAG staff also visited several physicians' offices in January 2000 to learn more about business and medical record-keeping practices. The OAG analyzed all of the comments it had received and the information it had gathered, and made further revisions to the rules in response to the concerns that had been expressed. A majority of the changes were designed to ease the burden on physicians in assembling the information required for an application.

Chapter 58 Overview

Chapter 58 is intended to accomplish five objectives: 1) to establish sufficient regulatory control and oversight of the joint negotiations to create state action immunity; 2) to ensure the OAG receives adequate information to make the determinations required by the statute in a timely fashion; 3) to give potential applicants advance notice of the requirements and procedures for obtaining advance approval of joint negotiations and proposed contracts; 4) to establish a consistent, orderly and efficient process for the submission and processing of applications; and 5) to ensure that joint negotiations are conducted in compliance with the law. The OAG believes the rules, as adopted, strike an appropriate balance between achieving these five objectives and facilitating widespread use of Chapter 29 by easing the burden on applicants. This determination is based on the OAG's review and analysis of the text of Chapter 29 and its legislative history, relevant antitrust jurisprudence, public comments, and its expertise and experience investigating and prosecuting antitrust cases in health care services markets.

The legislative history indicates the legislature intended to immunize persons who act pursuant to this regulatory scheme from antitrust liability under what is known as the "state action" doctrine. Absent this legislation, joint negotiations by competing physicians would generally be illegal under the antitrust laws. State action immunity shields state-authorized, private conduct that would otherwise constitute a violation of federal antitrust laws where the state has clearly articulated a policy to displace competition with regulation and actively supervised the conduct. Active supervision requires that the state perform a substantive review of the merits of each proposed anticompetitive act or agreement to determine whether it furthers the state's policy goals. The U.S. Supreme Court has stated that active supervision means the state must implement the anticompetitive activity in its specific details, and play a "substantial role" in determining the specifics of the economic policy. *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S. 621, 633 (1992). In the case of a rate-setting agency, for example, the court said that immunity turned on whether the state "exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Ticor*, 504 U.S. at 634-35. The purpose of this scrutiny is to "make clear that the State is responsible for the price fixing it has sanctioned and undertaken to control." *Ticor,* 504 U.S. at 636. In addition, active supervision requires that the state continue to monitor the conduct after approving it to re-evaluate the effect of the conduct in light of changes in market conditions or other circumstances. *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105-6 (1980).

In order to immunize participants from the antitrust laws, therefore, the OAG must collect and analyze detailed information about the applicants, the proposed negotiations, and proposed contracts before approving them. The information required in the rules will enable the OAG to adequately supervise, and exercise control over, the joint negotiation process. This is extremely important since a fine line is all that will separate approved, immune, lawful joint negotiations from illegal conduct that constitutes a per se violation of the antitrust laws. Since conduct that falls outside the scope of OAG approval will not be immunized, the OAG also needs this information to enable it to specify parameters for conducting the negotiations and implementing the contracts. The OAG must supervise the conduct it authorizes to ensure that anticompetitive spillover effects, including retaliatory joint actions such as boycotts and strikes (which Chapter 29 expressly prohibits), will not occur. Because the course of negotiations is inherently unpredictable, the OAG needs sufficient information to understand the parties' relationship and the context in which negotiations will take place. For the same reason, the OAG needs to see the representative's detailed plan of operation for conducting the negotiations, information about the representative's background, and any history of antitrust violations. The OAG has determined, based on its review of relevant case law and prior antitrust enforcement experience, that the provisions of Chapter 58 establish a regulatory structure that will enable the OAG to exercise the requisite level of active supervision to immunize joint negotiations from the antitrust laws.

The OAG has determined that all of the information that Chapter 58 requires physicians to submit in an application for joint negotiation is relevant to, and will be used to make, the statutory determinations outlined previously. This determination is based on the text of Chapter 29, the legislative history, and previous antitrust enforcement experience. In addition, based on the text of Chapter 29 and the legislative history, the OAG believes that these requirements are necessary to implement Chapter 29 and that it is within the scope of our statutory authority to adopt these rules. The OAG further believes that the rules fulfill the purpose of the statute by providing sufficient flexibility to enable physicians to avail themselves of the benefits of Chapter 29 without placing unreasonable burdens on applicants. New §58.11, for example, instructs applicants to explain why information is missing from their application and provides that the OAG will decide case by case whether an application is complete without that information. It also includes a waiver form for physicians to sign so the OAG may seek contracts and fee schedules directly from the health plan and provides that applications will not be deemed incomplete when a health plan is preventing disclosure of that information. Application fees may also be refunded in this situation.

Another advantage of the approach taken in new Chapter 58 is that it establishes a consistent, orderly and efficient process for the submission and processing of applications and puts everyone on notice regarding what is required. Because this is a pioneering new law, this type of regulation has never been done before. By spelling out exactly which information is required, the rules will help the OAG compile information over time, enabling comparisons and facilitating consistent decision-making. Physicians are also better off knowing in advance what information is relevant to the OAG's analysis so that they understand how to satisfy their burden of proof (e.g., the statute requires the applicants to demonstrate that the benefits of the joint negotiation will outweigh the resulting harm to competition). Otherwise, groups may spend time and money applying, only to discover that they lack the information to support the findings for approval. The OAG would have to waste valuable resources following up on each application by requesting

additional information, or, driven by the statutory 30-day deadline, to disapprove applications due to insufficient information and issue detailed letters describing the deficiencies and remedial measures. That type of system would also impair physicians' ability to use this statute by significantly delaying the application approval. This could result in missed opportunities to jointly negotiate during the brief windows of opportunity that typically exist for contract renegotiation. These rules allow physicians to prepare their applications and time their filings based on employers' open enrollment periods, contract renewal and insurance regulation deadlines.

The OAG believes the rules accommodate both the OAG's need for adequate information to protect consumers by making the required determinations, and physicians' need for ease of compliance and protection from antitrust liability.

Section by Section Description

Subchapter A (General, §§58.1-58.5) houses the general provisions of Chapter 58, including the purpose, scope, and effect of the chapter, definitions of terms, required fees, and confidentiality of information submitted to the OAG. New §58.1 states the purpose of Chapter 58 as the establishment of procedures to enable competing physicians to jointly negotiate contracts with health benefit plans. New §58.2 describes the effect of the rules as not limiting any other authority of the OAG. New §58.3 provides the definitions of terms necessary for the implementation of the statute and understanding the rules.

As required by the Insurance Code, Article 29.13, new §58.4 sets fees for the filing of applications and proposed contracts in amounts reasonable and necessary to recover the OAG and the TDI's anticipated costs of administering Insurance Code, Chapter 29. The fees were computed based on the cost to both agencies in performing their respective review and data-gathering functions and the anticipated number of filings expected. Higher fees are required for fee-related negotiations because review of fee-related applications is more complex and requires more analysis than is necessary for non-fee-related negotiations. The text of this section was modified to reflect new provisions in §58.11(f) and §58.25 which set forth circumstances in which filing fees may be refunded.

New §58.5 provides that information that is submitted to the OAG and the TDI is a public record and subject to the Public Information Act. It also provides that the physicians' representative will be notified if an open records request is made for information which the representative has marked as confidential trade secret or commercial or financial information.

Subchapter B (Application Requirements, §§58.11-58.15) sets forth the information that must be included in an application for joint negotiation, and provides separate requirements for applications for fee-related and non-fee-related negotiations. New §58.11 sets out the general requirements for submitting an application to the OAG and provides the mailing addresses for these filings. The TDI mailing address was corrected. For greater clarity, text from proposed §58.12(a) was moved to §58.11 and combined with additional text to create new §58.11(c)-(f). New §§58.11(c) and (d) set forth instructions for organizing and labeling the application and dealing with unavailable and nondisclosable information. New §58.11(e) requires the

representative and the physicians to cooperate with OAG efforts to obtain unavailable or nondisclosable information. The proposed version only required cooperation from the physicians. At TMA's suggestion, the OAG decided to require the representative to cooperate as well. New §58.11(e) also requires physicians to sign a Contract Information Disclosure Authorization Form (Figure 1: 1 TAC §58.11(e)) authorizing the OAG to obtain copies of existing or past contracts directly from health benefit plans. This form was not part of the proposed rules, and was added in response to physicians' complaints that health benefit plans often refuse to provide copies of contracts and fee schedules, even when physicians specifically request them. The OAG plans to present the completed forms to the health benefit plans along with a request for the relevant contracts. The form is designed to prevent health benefit plans from asserting that they cannot produce the contract in order to protect physicians' confidentiality. New §58.11(f) contains new language stating that an application will not be deemed incomplete solely because of a health benefit plan's refusal to provide a copy of a relevant contract or fee schedule. That subsection also contains a new provision permitting applicants to withdraw their application and have their application fee refunded if a health benefit plan refuses to provide copies of these documents.

New §58.12 sets out the information to be submitted in all applications which the OAG considers necessary to ensure compliance with Chapter 29. This includes information about the physicians' representative, the participating physicians, the market for physician services, the proposed negotiations and the representative's plan of operation and procedures. The subsections have been re-numbered to reflect the fact that subsection (a) was moved up to §58.11. Accordingly, proposed §58.12(b) is adopted as new §58.12(a), etc. The OAG needs the information listed in this section to make the determinations required by Chapter 29, including analysis of the economic and patient care detriment or benefit that would result from approving the proposed negotiation. The information will also be used to establish sufficient state oversight and control over the joint negotiations to ensure that participants will enjoy state action antitrust immunity. The required information will show the physicians' representative's qualifications, background, and relationship to the participating physicians, the participating physicians' practice areas and affiliations, agreements with the health benefit plans with which joint negotiations are proposed, and past or pending antitrust investigations or proceedings. Also required is information about competing physicians, the medical procedures commonly performed by the participating physicians, the geographic area which they serve, and the subject matter of the proposed negotiation with an analysis of the expected economic and quality of care impact.

The OAG has made many changes to §58.12 in response to physicians' comments about the difficulty of producing the required information. Proposed §58.12(c)(3) (adopted as new §58.12(b)(3) and (4)) was re-worded to clarify and reduce the amount of required information about independent practice associations that contract on behalf of the physicians. Proposed §58.12(c)(4) (adopted as new §58.12(b)(5)) was modified to clarify that "legal structure" means "type of legal organization." Proposed §58.12(c)(6) and (7) were deleted in response to comments from physician groups. Proposed §58.12(c)(8) (adopted as new §58.12(b)(7) was modified to reduce the amount of historical information required in response to physicians' comments about the availability of the requested information. Proposed §58.12(d)(1) was deleted in response to physicians' comments. Proposed §58.12(d)(2) (adopted as new §58.12(c)(1)) was re-worded to provide physicians more flexibility in determining which CPT codes comprise the

largest portion of their practice, as well as to narrow the types of CPT codes to be reported. In addition, small groups proposing non-fee negotiations are no longer subject to this requirement. Proposed §58.12(d)(3) (adopted as new §58.12(c)(2)) has been revised to reduce the burden on applicants; physicians no longer need to provide this information unless a significant portion of their patients come from outside the county in which they practice. In response to physicians' comments that market share information is generally unavailable, the requested market share estimate was removed from proposed §58.12(d)(4) (adopted as new §58.12(c)(3)). Proposed §58.12(d)(5) (adopted as new §58.12(c)(4)) no longer requires applicants to identify competing members in provider panels. Instead, as physician commenters suggested, applicants are asked to produce the most recent copy of the health benefit plan provider directory that they have on hand. Finally, proposed §58.12(e)(9) (adopted as new §58.12(d)(9)), was modified in response to physicians' comments to narrow the scope of the information sought. Rather than requiring identification of health care providers who "may have a pecuniary interest in the contracts to be negotiated," the revised rule seeks only the identities of those who "will be parties to and will share risk in the contracts to be negotiated." One example that may be reported under this section is a contract in which physicians share risk with a hospital. The hospital would have to be identified in the joint negotiation application.

New §58.13 describes additional information, including a Contract Information Form, that must be filed when fee-related negotiations are proposed. For this type of negotiation, the OAG must make the additional determinations that the health benefit plan has substantial market power and that the fee-related contract terms at issue adversely affect the quality of patient care. The information required in this section relates to those determinations. In order to determine whether a health benefit plan has substantial market power, the OAG needs information about how much of the physicians' business is controlled by that plan. The information reported in the Contract Information Form (Figure 2: 1 TAC §58.13(4)) aids in this analysis. Minor modifications were made to this form to correct typographical errors and to make it conform to revisions in §58.12. In response to comments, §58.13(2) was changed to provide flexibility on the number of health benefit plans reported. New §58.13(2) requires identification of the health benefit plans that comprise 80% of the physicians' business, rather than the ten largest health benefit plans. Since some physicians may not contract with as many as ten health benefit plans, and others may spread their business across dozens of plans, the new formulation permits reporting fewer plans or more plans, depending on the physician's circumstances. New §58.13(3) was re-worded to simplify and clarify what information is required by deleting the reference to "contracting history" and through other minor changes. New §58.14 sets out the notarized statements that must accompany applications, and remains unchanged. New §58.15, also unmodified, provides that the OAG may request additional information required to make its determinations.

Subchapter C (Review of Application, §§58.21-58.26) establishes rules governing the OAG's application review process. New §58.21 provides that an application will not be considered complete until all materials have been received by the OAG and all fees paid to the respective agencies. New §58.22 provides for pre-filing meetings with staff when novel or complex issues are presented by a proposed negotiation. New §58.23 requires full disclosure of all information by applicants and conditions OAG approvals on such disclosure. New §58.24 gives notice of and reserves the right of the OAG to conduct independent investigations. New §58.25 gives

applicants the right to withdraw their applications at any time. In response to physicians' comments, language was added providing for the refund of the filing fee in the event that an application is withdrawn within ten business days of filing as a result of a health benefit plan's refusal to negotiate. New §58.26 requires that all OAG approvals will be given by a written approval letter from the OAG. The reference to the Chief of the Antitrust Section was deleted for administrative convenience.

Subchapter D (Review of Proposed Contracts, §§58.31-58.33) establishes rules governing the OAG's contract review process. New §58.31 sets out the requirements for the filing of proposed contracts, reports and plans of action. New §58.32 establishes the contents of the filing of the contract, report, and plan of action. New §58.33 requires written approval prior to performance under any contract submitted. The reference to the Chief of the Antitrust Section was deleted for administrative convenience.

Subchapter E (Remedial Measures, §§58.41-58.42) governs situations where the OAG has disapproved an application or proposed contract and specified remedial measures to correct the deficiencies. New §58.41 provides the time frames for resubmission of a disapproved application or contract. New §58.42 states the time allowed for OAG review of a resubmission.

Subchapter F (Subsequent Negotiations and Contract Modifications, §§58.51-58.53) establishes requirements for resuming negotiations after an initial negotiation attempt has failed, or when jointly negotiating modifications to a previously-approved contract. New §58.51 sets out the procedure for resuming negotiations when the statutory time frames have expired. New §58.52 provides procedures for joint negotiation to modify a previously approved contract. New §58.53 states that any jointly negotiated contract renewals or modifications must be submitted to the OAG for approval.

Discussion of Comments

The OAG received written comments on the proposed rules after they were published from the following groups and individuals: Senator Chris Harris (Sen. Harris); Texas Medical Association (TMA); Harris County Medical Society (HCMS); Dallas County Medical Society (DCMS); Nueces County Medical Society (NCMS); Federation of Physicians and Dentists (FPD); Texas Independent Osteopathic Physicians Association (TIOPA); Texas Medical Group Management Association (TMGMA); Consumers Union, Advocacy, Inc., Center for Public Policy Priorities, Mental Health Association in Texas (Consumer Groups); Office of Public Insurance Counsel (OPIC); Texas Association of Business & Chambers of Commerce (TABCC); Texas Hospital Association (THA); Health Insurance Association of America (HIAA); American Association of Health Plans (AAHP); Texas Association of Health Plans (TAHP); Humana (Humana); Robert E. McMichael, M.D. (McMichael); Dean L. Peyton, D.O. of Arlington Family Practice, P.A. (Peyton); Scott P. Aarons, M.D. (Aarons); Mark B. Reimer, M.D. (Reimer); Robert L. True, M.D. (True); Roy W. Turner, M.D. of Harris Methodist H-E-B Mid-Cities OB-Gyn Association (Turner) ; Christopher Neill, M.D. (Neill); Ganana Tesfa, M.D. of Neurology Associates of Arlington (Tesfa) ; Steven A. Johnson, M.D. (Johnson); Mark Scroggins, M.D. (Scroggins); John Drobnica of Northwest Diagnostic Family Medical Center (Drobnica); Roberto

Nieto, M.D. of Neurology Associates of Arlington (Nieto); Ralph J. Marrero, M.D. of Northeast Texas Ear, Nose & Throat Center (Marrero); Justin V. Bartos, M.D. (Bartos); Pat Fox Fulgham, M.D. of Urology Specialists & Associates (Fulgham); Al Maillard, M.D. (Maillard); Bob Narvaez, M.D. (Narvaez); Annette G. Matthews, M.D. (Matthews); William S. Gilmer, M.D. (Gilmer); Bernard B. Bradley, M.D. of Lung Center Associates, P.A. (Bradley); Theodore J. Haywood, M.D. (Haywood), Lawrence G. Thorne, M.D. (Thorne), Venugopal K. Menon, M.D. (Menon), Gerald T. Machinski, M.D. (Machinski), Theresa C. Queng, M.D. (Queng), Lyna Kit Lee, M.D. (Lee), Robert D. Otte, CMPE of McGovern Allergy and Asthma Clinic, P.A. (McGovern Group); Michael Speer, M.D. of Baylor College of Medicine (Speer); Diana Fite, M.D. (Fite): Spencer Berthelsen, M.D. of Kelsey-Seybold Clinic (Berthelsen); A. Thomas Garcia, M.D. of Houston Heart Centre (Garcia): Priscilla Ray, M.D. (Ray); and the Texas Podiatric Medical Association (TPMA). Over one hundred individual podiatrists also submitted comments identical to TPMA's.

In addition, the following persons provided comments orally at the December 15 public hearing: John Gill, M.D., on behalf of the TMA and DCMS (Gill); Lynda Odenkirk, on behalf of the Federation of Physicians and Dentists (FPD); John Drobnica, on behalf of the Northwest Diagnostic Family Medical Center (Drobnica); Marcus Purvis, M.D., on behalf of the Texas Academy of Family Physicians (TAFP); Andrew Silverthorn, M.D. (Silverthorn); Randy Straach, on behalf of the Texas Medical Group Management Association (TMGMA); Mark Hanna and Kirk Koepsel, M.D., on behalf of the Texas Podiatric Medical Association (TPMA); Lisa McGiffert, on behalf of Consumers Union, Advocacy, Inc., Center for Public Policy Priorities, and Mental Health Association in Texas (Consumer Groups); Robert Leibenluft, on behalf of the American Association of Health Plans (AAHP); and Jerry Patterson, on behalf of the Texas Association of Health Plans (TAHP). To the extent that these comments differ from the submitted written comments, they are summarized herein.

The following groups supported adoption of the proposed rules: Consumer Groups, OPIC, and THA. OPIC said the proposed rules were fair to both physicians and health plans and would promote the new law's underlying purpose of providing better health care to consumers. Consumer Groups said the rules reflected the sentiment embedded in the language of Chapter 29 that limits joint negotiations to narrowly defined parameters. They said the collection of detailed information is the only tool available to protect the public, and that it is imperative for the OAG to ensure that joint negotiations are closely monitored and do not lead to anti-competitive behavior that could drive up health care costs and erode consumer choice. THA expressed general support for the proposed rules, but expressed concern about the disclosure of information relating to hospital contract rates. In addition, while not expressing outright support, HIAA and AAHP commended the OAG for its efforts in drafting the proposed rules. HIAA said the proposed rules were a good starting point for providing appropriate state supervision for joint negotiations by physicians. AAHP said the proposed rules, and the inclusive process the OAG has used to develop it, represent a good initial step toward protecting consumers.

The following parties opposed the adoption of the new chapter: Sen. Harris, TMA, HCMS, DCMS, NCMS, and several individual physicians. The following groups did not expressly oppose adoption, but were highly critical of the burdens imposed in the application requirements: FPD, TIOPA, and TMGMA.

A summary of the comments received and the OAG's responses follows. The discussion is organized by topic, beginning with general comments, then proceeding section by section through the rules in numerical order. Rule references are to the proposed citation (rather than the adopted citation) unless otherwise indicated.

General Comments

Pre-Approval Communications

Several parties expressed concern that certain pre-application activities might violate the antitrust laws. For example, physicians might violate the antitrust laws in the process of compiling the information necessary to file an application for joint negotiation by exchanging revenue and fee information, or by discussing the contract terms they want to negotiate. TMA asked for a rule clarifying that a negotiation group can come together to meet to provide information sufficient to comply with the application requirements. TMA said clarification is needed in both §58.3 (Definitions), as well as §58.12(e)(2), which seeks information about the proposed subject matter of the joint negotiations and previous attempts to resolve those issues through individual negotiations. In addition, TMA and Sen. Harris suggested a new rule be adopted authorizing "preparatory meetings" to clarify that physicians may meet with each other, and with their representative, without fear of reprisal, to discuss the terms of representation and items requiring discussion in fee-related negotiations. They argued that this activity is expressly authorized by Article 29.04 for non-fee-related negotiations, but that clarification is needed so that physicians may discuss items related to fee-related negotiations. Gill said it would be sufficient if physicians were allowed to talk to each other in general terms about which health plans they having trouble with, but without getting into what specific price or contract provisions they want. He added that the OAG should clearly define how far physicians can go in the process by specifying what they can and cannot say. Koepsel suggested a messenger model solution, where the physicians provide their information confidentially to the third-party representative, but added that physicians would need protection if they choose to have one of the physicians serve as the representative, since in that case he or she would be reviewing competitors' data.

On the other hand, AAHP said the rules should explicitly limit communications among physicians to only what is necessary to complete the application process, and if the application is approved, only what is needed to engage in negotiations within the scope of the approval. This would allow physicians to discuss, for example, which health plans they wish to jointly negotiate with, and which of the 20 categories of terms and conditions they wish to jointly negotiate. But they would not be allowed, prior to OAG approval, to discuss their negotiation strategy or the specific terms and conditions they wish to obtain, including fees. This would reduce the significant risk of unnecessary anticompetitive spillover effects, because these discussions could be used to cloak illegal collusive activities. The rules should similarly limit post-approval communications to that which is necessary to effectuate the negotiations. Similarly, TAHP requested a rule prohibiting physicians from discussing and disclosing information of a competitive nature, such as fees received from a health plan not a party to the negotiations.

The OAG disagrees that a rule addressing this concern is warranted at this time, and believes this issue is outside the scope of the proposed rules. While it is true that before obtaining OAG approval a negotiation group must be careful not to share current pricing information or reach agreement on what prices they want from a health benefit plan, federal antitrust enforcement guidelines explain when competing health care providers can and cannot share certain information. See United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, Statements 5 and 6, issued August 28, 1996, 4 Trade Reg. Rep. (CCH) ¶ 13, 153. The OAG also disagrees with AAHP and TAHP that a rule is needed to limit permissible communications, because the antitrust laws and federal enforcement guidelines already impose sufficient limits. Physicians' antitrust immunity will only extend to discussions of the specific terms and products the OAG has authorized. The OAG agrees with Koepsel's comment that this problem can be easily avoided through the use of a third party representative who is not a competing physician or a member of the negotiation group to assemble the required information. In addition, the OAG may provide additional informal guidance on this issue in the future.

Spillover Conduct

AAHP expressed concern about the potential for anticompetitive consequences that could flow from joint negotiations if physician collaboration is allowed to "spillover" into other areas or activities where joint negotiations have not been authorized or where they have been terminated. Citing the FTC and DOJ health care enforcement guidelines, AAHP argued there is a significant risk that this may happen. For example, physicians may exchange with each other competitively sensitive information about their current fees and agree to seek a certain level of compensation from a health plan for which joint negotiations have been authorized. This information exchange could then facilitate illegal collusion with respect to other health plans, or with the same health plan after negotiations have terminated and their authority has expired. Accordingly, AAHP said the rules should make it clear that the OAG will vigorously prosecute anticompetitive spillover conduct that is not protected under SB1468. AAHP also urged the OAG to make it clear that a group approved for non-fee-related negotiations may not negotiate fees under the guise that it is necessary to ensure adequate quality of services. In addition, AAHP sought a rule to make clear that SB1468 does not authorize express or implied threats of joint action, including boycotts or strikes, against health plans. Prohibited actions include jointly refusing to contract with a health plan or jointly deciding to contract only if they obtain certain contract terms in their negotiations. Such joint conduct would reduce or limit the availability of health care services to patients enrolled in the health plan, and would be inconsistent with Article 29.01 and Article 29.10.

Humana also suggested that the representative and the health benefit plan should be required to notify the OAG immediately of any violations that occur during the course of negotiations. Humana recommended that if the OAG finds that the negotiation group exceeded the scope of OAG approval (e.g., by discussing fee-related issues when only non-fee negotiations were approved), the OAG should require that negotiations immediately cease, and approval should automatically be rescinded and a new application required, including re-attestation. Further, depending on the severity of the violation, Humana recommends that the OAG should also

establish and enforce sanctions against any physicians as well as the representative involved in the violation.

The OAG generally disagrees with these suggestions. These issues are outside the scope of the proposed rules. The OAG agrees that joint negotiations must not exceed the scope of approval granted by the OAG, and that retaliatory joint actions such as boycotts and strikes are prohibited, but does not believe that a rule is needed to clarify the status of the law. Under the state action doctrine, unauthorized conduct will remain subject to the antitrust laws. Furthermore, these issues are addressed in Chapter 29. Insurance Code Article 29.09(a) states that "[a] representative who fails to obtain the attorney general's approval is deemed to act outside the authority granted under this article," and Article 29.10 requires the representative to "warn physicians of the potential for legal action against physicians who violate state or federal antitrust laws when acting outside the authority of this chapter." Article 29.10 also prohibits physicians from jointly coordinating any cessation, reduction, or limitation of health care services, complementing the Article 29.01 finding that joint negotiations are beneficial only in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians. The OAG will actively supervise the joint negotiation process as part of its overall regulatory oversight to ensure that participants' conduct conforms to the law and the scope of the approval that has been granted. New §58.12(e), for example, requires submission of a detailed plan of operation and procedures to ensure compliance, including instructions the representative must give to the physicians regarding antitrust restrictions. In addition, the OAG may issue informal guidance either in the form of a statement of enforcement intentions, or on a case by case basis. Because spillover conduct may arise in countless, unpredictable forms, the OAG believes this issue will best be handled case by case in the context of specific joint negotiation applications.

Application Requirements Too Burdensome in General

Many physicians complained that the application requirements were too burdensome. TMA argued it would be prohibitively expensive for a negotiation group to amass and submit the immense amount of information and documentation required by the proposed rules. TMA also said the proposed rules would defeat the purpose of the legislation because no physicians' group would be able to comply. HCMS, DCMS, NCMS, and TIOPA echoed TMA's concerns that the application process as proposed was too cumbersome and unworkable. NCMS said much of the required information is not normally maintained by a medical practice, is not readily available, and would cost thousands of dollars to prepare. DCMS also asserted that a significant portion of the information requirements were duplicative, but did not specify which requirements they considered redundant. In addition, over 20 individual physicians complained that the application requirements required too much paperwork and were unnecessarily onerous, cumbersome, complex, difficult, costly and unworkable. Some said complying with the proposed requirements would be impossible. A few explained why compliance would be difficult, citing inadequate staff, busy schedules, and unsophisticated or inconsistent record-keeping systems. Physicians reported that most small practitioners do not maintain computerized records. Others said health plans refuse to give them copies of their contracts and fee schedules.

HCMS said that most negotiations were expected to focus on patient care and administrative processes, not on fees, but that an inordinate amount of the information requested by the proposed rules does deal with fees and reimbursements. HCMS urged the OAG to revise the rules to simplify the requirements for non-fee-related negotiations. Specifically, HCMS said that additional information related to fees, and revenue by CPT coding, should only be required for fee negotiations.

TMGMA supported the collection of appropriate, comparable data for the accurate analysis of joint negotiation applications, and said they understood the theoretical value of each of the data items requested. TMGMA urged the OAG, however, to consider the practical availability and reliability of this information. TMGMA also said that few could afford, and even fewer would be willing, to pursue joint negotiations under the proposed requirements. They estimated that collecting the data necessary to complete an application would cost approximately $1500 for each member of a ten-physician group if they have the internal operating systems and staffing to complete the process internally. This estimate was based on actual costs of similar data collection/ application projects managed by TMGMA members. Most small practices would need to subcontract these services, which TMGMA estimated would increase the cost by 20-60%. Manual extraction from source documents could further increase the total clerical costs by 50-80%. When added to the organizational development expenses of $20,000, the total, first-year expenses for a newly formed ten-physician network group would exceed $40,000 to apply for an exemption. TMGMA said that most physicians would be unwilling to make that level of financial commitment to attempt the proposed process. Finally, TMGMA said the proposed rules discriminate against smaller integrated group practices and negotiation groups because these entities lack the financial resources to complete the application process.

Consumer Groups said they appreciated that the information physicians are required to submit under the proposed rules seems onerous. However, Consumer Groups said it is imperative for the state to ensure that these negotiation activities are closely monitored and do not lead to anti-competitive behavior that could drive up health care costs and erode consumer choice. They said collecting detailed information is the only tool available to protect the public.

The OAG agrees that the application requirements, as proposed, imposed a significant burden on physicians seeking permission to enter into joint negotiations. The OAG disagrees, however, that the requirements were so onerous that compliance would have been impossible or that the purpose of the statute would have been defeated. As described previously and discussed in greater detail in the following sections, the OAG has greatly reduced the application requirements, particularly for non-fee negotiations. The OAG has determined, based on its interpretation of Chapter 29, the state action doctrine, its research into physician record-keeping practices, and its antitrust enforcement experience, that all of the remaining application requirements are relevant, appropriate, and necessary to implement the statute and effectuate the legislature's intent.

The OAG disagrees with DCMS' comment that certain requirements are duplicative. The OAG does not believe any of the application requirements are duplicative. The OAG has no basis on which to agree or disagree with TMGMA's estimated compliance costs. The OAG does not believe that the costs of compliance have been demonstrated to be financially prohibitive or

unreasonably large in light of the benefits physicians stand to gain if joint negotiations are authorized. The OAG has also determined, based primarily on comments from physicians regarding the difficulty of complying, that the revisions to the proposed rules will significantly reduce the cost of compiling an application. Those revisions primarily reduce requirements that physicians identified as particularly burdensome, such as the requirement to submit copies of historical contracts.

The OAG believes the adopted requirements reflect the realities of physicians' practices and strike a reasonable balance between the OAG's need for information and the burden imposed on physicians who must supply that information. The OAG further believes that the adopted requirements, while still requiring some effort on the part of physicians, are not more burdensome than necessary to achieve the purposes of the statute: authorizing joint negotiations only when applicants have satisfied the statutory criteria for approval, and immunizing joint negotiations from the antitrust laws.

Health Plan Participation

Several commenters suggested the OAG adopt rules clarifying the role of the health benefit plans in the joint negotiation process. NCMS suggested a rule setting a time limit by which a health benefit plan must inform the negotiation group whether the health benefit plan will enter into negotiations. NCMS recommends that the health benefit plan be required to respond to the group within fifteen days of receiving a request for negotiation. AAHP suggested the OAG adopt a rule requiring that the negotiation group provide evidence in its application that each of the identified health benefit plans is willing to engage in joint negotiations with it. AAHP argued that this would reduce the danger of unnecessary spillover effects by preventing unnecessary communications between competing physicians regarding their joint negotiation strategy concerning the plan's reimbursement rates or other contract terms and conditions, and that it would also spare the OAG the cost of needlessly reviewing applications.

The OAG agrees that it would be beneficial for health plans to make their intentions known early in the process. The OAG does not, however, agree that a rule should be adopted mandating such a response.. Chapter 29 contemplates a voluntary negotiation process, and it would be contrary to the language of the statute to promulgate a rule that requires a response within a given period of time. Furthermore, the OAG disagrees that AAHP's suggested rule is warranted or advisable. Chapter 29 contemplates that physicians may seek and obtain approval, then approach the health plan and ask them to negotiate, regardless of whether the health plan is willing to commit to such negotiations in advance. The OAG believes AAHP's rule would give health plans a perverse incentive to decline negotiations in order to prevent physicians from proceeding with the OAG review and approval process. It may also be interpreted to encourage improper communication between the negotiating group and health benefit plans prior to OAG authorization.

TAHP expressed concern that the preamble to the proposed rules implied that negotiations are automatic, and suggested a rule indicating that health plans are not required to negotiate. The OAG does not believe that such a rule is necessary. TAHP's concern is based on the part of the

preamble that explains the assumptions underlying the application fees. That part of the preamble states that the OAG calculated the application fee by assuming that approximately 112 applications will be filed each year. It also refers to the number of negotiations that will occur, but does not imply that health benefit plans are required to negotiate. Nor does Chapter 29 impose or imply such a requirement. Therefore, the OAG does not believe that any clarification is necessary.

TAHP, AAHP, HIAA, and Humana requested a rule giving health plans and consumers an opportunity to participate in deliberations regarding negotiations which affect them. Noting that health plans are in a unique position to provide important information concerning which physicians compete with one another, how many are needed to form a viable network, and the geographic area covered by various physician groups, they argued that health plans should be allowed to make filings and provide the OAG with information about proposed joint negotiations and contracts. They indicated they would like to provide input regarding issues such as competition, impact on patient care and consumers, products and pricing, substantial market power, the acceptable size of the negotiation group that it will face, service and geographic market definition.

The OAG disagrees, and sees no need to adopt such a rule. Chapter 29 does not suggest that the application review and approval process should resemble a formal, contested proceeding. The OAG agrees, however, that health benefit plans have relevant information that may aid the OAG in its analysis. The OAG believes that health plans will have adequate opportunities to provide input informally, and that they have not demonstrated the need for a formalized process.

Automatic Approval

NCMS commented that the statutory mandamus remedy is not realistic because health benefit plans usually only allow physicians 60 days to decide whether to sign a contract, and that the OAG should adopt a rule that provides that permission to negotiate is automatically granted if the OAG fails to act within 30 days. Alternatively, NCMS suggested including a rule which specifically grants permission to physicians to begin their preparations for submission of an application to negotiate six months prior to the expiration date of the new contract.

The OAG disagrees because any form of "automatic approval" would violate Chapter 29 of the Insurance Code and would fail to establish state action immunity for the negotiation group's conduct. The federal courts will not recognize state action immunity unless the state has actively supervised the joint negotiations. The U.S. Supreme Court has held that "negative option" regulatory schemes that involve automatic approval such as that proposed by NCMS do not create state action immunity. Moreover, automatic approval in these circumstances would be an abdication of the OAG's statutory duty to base approvals on the required Chapter 29 determinations, such as whether the benefits outweigh the harm to competition. Lastly, nothing in the statute or the proposed rules suggests that physicians cannot begin preparing an application before the expiration of a contract. An application may be compiled and submitted at any time, before, during, or after the pendency of a contract between the parties involved.

Active Supervision

AAHP argued that there does not appear to be any ongoing OAG supervision of agreements and information exchanges among physicians. They submitted the following comment: "As we understand the process, negotiations could continue indefinitely after the OAG grants its initial approval. The approval process, therefore, does not take into account potential changes to the competitive landscape during the course of the negotiations. We do not believe that this initial approval amounts to active supervision of negotiations occurring over an extended period of time. If fee-related negotiations were to take place over the course of several years, it is possible that the state's rationale for permitting them would no longer be valid. The FTC called attention to this very flaw in a letter to the Hon. Rene O. Oliveira commenting on SB1468. One simple solution to this concern would be a rule limiting the duration of approved joint negotiations."

The OAG does not believe that a rule limiting the duration of approved joint negotiations is necessary. Based on its experience investigating antitrust cases involving negotiations between health care providers and health plans, the OAG thinks the likelihood of protracted negotiations lasting a year or more is remote. Moreover, the OAG will be monitoring market conditions and actively supervising all active joint negotiations. The representative is required to submit a projected time line for negotiations pursuant to new §58.12(d)(4). In addition, new §58.51 requires the representative to keep the OAG apprised of the status of joint negotiations and attempted joint negotiations. The OAG believes these controls will result in adequate supervision to satisfy the state action doctrine.

Approval Standards

AAHP argued that consumers and health benefit plans be given the opportunity to participate in the development of the substantive criteria to be employed by the OAG in implementing Chapter 29. Specifically, AAHP said the OAG should develop criteria, with public input, addressing the following issues: (1) when the 10% standard for negotiation group size will be modified (including what is meant by the health plan's defined service area), (2) how physician distribution by specialty will be taken into account, (3) how the benefits and disadvantages of a joint negotiation will be determined and weighed, (4) how the OAG will determine whether to approve or disapprove contracts, and (5) whether a health plan has substantial market power.

In addition, TAHP and AAHP urged the OAG to adopt criteria for approval or disapproval of proposed contracts. TAHP said that all parties lack guidance as to the standards imposed by the OAG and will be unable to know if they have likely met those standards. TAHP and AAHP also said that the lack of expressed criteria for approval or disapproval of proposed contracts, the grounds for disapproval may be objectionably vague and may not satisfy the active supervision requirement of the state action doctrine.

The OAG disagrees, believing that a formal statement of substantive approval criteria would be premature at this time. Because this is the first time this type of regulation has been attempted, inadequate information exists to form the basis for the adoption of this type of formal, substantive rules. The OAG will consider issuing appropriate enforcement guidelines in the future after

gaining some experience analyzing joint negotiation applications and proposed contracts. In the meantime, the OAG will apply the substantive approval standards set forth in Chapter 29, which provide adequate guidance for the active supervision of physician joint negotiations. The state action doctrine does not require enumeration of more specific criteria. If substantive rules are eventually proposed, of course the public would have ample opportunity to participate in development of those rules.

Substantial Market Power

Several groups recommended that the OAG adopt rules defining substantial market power or setting standards or methodology for determining when a health plan has substantial market power. Two commenters recommended adoption of the following definition: "A health benefit plan has substantial market power if it meets one or more of the following conditions: 1) the health benefit plan and/or its affiliates covers more than 5% of the covered lives in the state; covers more than 25,000 lives in the state; covers more than 10% of covered lives in any one MSA; covers more than 10% of covered lives in any one county; covers more than 10% of a participating physician's or negotiating group's covered patients, on an annual or historic basis; or accounts for more than 10% of a participating physician's or negotiating group's annual income; or 2) the health benefit plan fails to provide to a provider with whom the health benefit plan has a contract, a complete fee schedule...within 7 days of an initial request; or 3) the OAG determines the market power of the health benefit plan significantly exceeds the countervailing market power of a participating member acting individually."

AAHP said the OAG's inquiry should focus on whether the plan can depress prices that it pays for health care services to below competitive levels. This, they said, would require information for each physician in the market concerning what share of his or her revenues come from various sources, including Medicare, Medicaid, each commercial health plan, workers compensation, CHAMPUS/Tricare, self-pay and other sources. They commented that the need for information by product, as requested in proposed §58.13(2) and in the Contract Information Form, is unclear, and seems less relevant. They expressed concern that the OAG plans to make a determination that a health plan has substantial market power if it accounts for a relatively large share of the participating physicians' revenues by product. They said that this could lead to absurd results–for example, in many geographic areas, commercial HMOs may account for 20% of the average physician's revenue. In this situation, they argued, a health plan that had a 50% share of "commercial HMO products" would account for 10% or less of the average physician's income, and could hardly be able to exercise "substantial market power." They asked that the OAG consider whether an exclusive contract or other similar arrangement is the reason a health plan accounts for a large share of a particular physician's revenues.

HIAA suggested including market share thresholds below which a plan would not be presumed to have substantial market power. HIAA suggested using market share thresholds similar to those used by the US DOJ and FTC in the Statement of Antitrust Enforcement Policy in Health Care. They said this will help demonstrate active supervision.

The OAG disagrees. Based on the OAG's previous antitrust enforcement experience involving health care markets, particularly the investigation of the Aetna-Prudential HMO merger, the OAG believes that this determination will best be made on a case by case basis, following a monopsony antitrust mode of analysis. The nature of that analysis depends on the particular circumstances of the physicians involved, in addition to the health plan's overall market share, and is not particularly amenable to rigid definition. Moreover, the OAG lacks adequate market data and experience to declare any "safe harbors" at this time. The first definition proffered above bears little relationship to monopsony antitrust analysis, which the legislative history indicates was intended by the use of the term "substantial market power." The federal guidelines HIAA suggested as a model, moreover, would be of limited use, since they do not purport to establish safe harbor thresholds in this context (i.e., monopsony purchases of physician services).

Podiatrists

TPMA and over 100 individual podiatrists submitted similar or identical comments urging the adoption of a rule clarifying that podiatrists may participate in the joint negotiations permitted by Chapter 29, both independently of physicians (i.e., as a group comprised solely of podiatrists), as well as together with physicians (i.e., as a group comprised of both podiatrists and physicians).

The OAG agrees, and will publish a new proposed rule to address this issue.

Comments on Specific Sections

Effect of Rules – §58.2

TMA and Sen. Harris said this section should be deleted because it is without legal effect. They argued that the OAG may not, by rule, limit its constitutional authority. They also said the OAG will be bound to follow any rules it adopts and therefore the rules can be construed as the OAG's interpretation of its own authority.

The OAG disagrees, and believes the rule provides helpful clarification that Chapter 58 does not limit the attorney general's constitutional or statutory authority.

Definitions – §58.3

TMA and Sen. Harris recommended deleting the definitions of health benefit plan, person, and physicians' representative, because those terms are defined in Chapter 29 and to avoid unnecessary wording and the potential development of inconsistent interpretations of the same terms. McMichael said the definition of "person" should include "professional association, partnership, and limited liability company."

The OAG disagrees. The Chapter 58 definitions of these terms are identical to the Chapter 29 definitions. Including these definitions improves clarity and raises no danger of inconsistent interpretation. McMichael's suggestion would deviate from the statutory definition, and the OAG

disagrees with it for that reason. In addition, the statutory/adopted definition already encompasses those business forms, so the suggested change is unnecessary.

TMA and Sen. Harris suggested using the term "report" rather than "application." They argued that Insurance Code Article 29.08 requires a "report," and that no other "application" process is required or authorized by the statute. As a matter of consistency, they said, these rules should use the same terms as Insurance Code Article 29.08.

The OAG disagrees. The statute refers to several different types of filings that must be made with the OAG. Article 29.08(1) requires the representative to submit a "report" for the attorney general's approval. Article 29.08(2) further requires the representative to furnish a copy of the "proposed contract" and "plan of action" for the attorney general's approval. Article 29.08(3) requires the representative to provide "notification" to the attorney general to report the end of negotiations. Article 29.09(a) requires the OAG to approve or disapprove "an initial filing, supplemental filing, or proposed contract" within 30 days of each filing. Article 29.09(b) requires the OAG to approve "a request to enter into joint negotiations" or a "proposed contract" if he determines that "the applicants" have demonstrated certain facts. Article 29.09(c) again mentions OAG approval of an "initial filing." Finally, Article 29.09(d) refers to OAG approval or rejection of "an initial filing, supplemental filing, or proposed contract." The rules consistently uses the term "application" to avoid the confusion inherent in the various inconsistent statutory terms.

TMA and Sen. Harris said the word "participating" should be deleted from the definition of "Negotiation group" to avoid the use of circular definitions (see the definition of "Participating Physician"). Similarly, Humana proposed use of the term "Negotiating physician" rather than "Participating physician" to avoid confusion with the common industry term for a physician who is contracted to provide health care services to members of a health benefit plan. The OAG disagrees because it believes the suggested changes would make the meaning of negotiation group less clear. Chapter 58 defines the term "participating physician" and uses it consistently throughout, and no one has provided examples of particular rules where use of the term, in context, is likely to be confused with similar industry terms.

Humana suggested defining "Negotiation group" to restrict members of an IPA, integrated practice group, or other non-competing joint practice from participating in joint negotiations because the clearly stated intent of SB1468 is to address concerns of "competing physicians." Humana also said the rules should make clear that a negotiating group must be a distinct, static group of negotiating physicians that must remain constant throughout negotiations.

The OAG disagrees with both comments. First, the OAG believes restricting membership to competing physicians would be unnecessary and contrary to the intent of the statute. The statute refers to competing physicians because non-competing physicians do not need antitrust immunity in order to negotiate with health plans. Humana is correct that the purpose of the statute is to enable competing physicians to jointly negotiate contracts with health plans. Neither the text of Chapter 29 nor the legislative history suggest, however, that no two members of a negotiation group may also be members of the same integrated practice group. To the contrary, the

legislative history clearly indicates that the legislature intended to enable competing practice groups (as well as competing solo physicians) to form joint negotiation groups.

With respect to the second comment, the OAG disagrees that such a rule is necessary because the adopted rules adequately address Humana's concern about changes in the membership of a negotiation group. New §58.12(a)(1) requires the application to name the members of the negotiation group. If the OAG approves the application, only those physicians listed in the application will have state action immunity. Physicians are, however, free to withdraw from joint negotiations and drop out of the negotiation group at any time. New §58.14 requires the representative and the physicians to notify the OAG of any material changes, such as membership changes, in the information provided in the application.

TMA and Sen. Harris also suggested elimination of the term "Product." For the sake of consistency, they said, only one term, "health benefit plan," should be used.

The OAG disagrees. The rules intentionally use these two terms to distinguish a single product (such as an HMO) from a health benefit plan (which may include several products) in order to obtain more useful and precise information from applicants. These are terms commonly used in the health insurance industry, and are also used in Chapter 29. For example, Article 29.10 refers to an all products clause as a requirement that physicians "must participate in all the products within the same health benefit plan." See the discussion of comments on §58.13 for further explanation.

Fees -- §58.4

TMA requested clarification that §58.4(a) and (b) do not require a new fee when a contract is automatically renewed under an "evergreen" clause or when a contract is modified without additional negotiation (e.g., a new statute requires a modification). TMA also sought clarification that §58.11(b) requires only one fee per application, even if multiple negotiations are proposed in one application. FPD asked for clarification that two fees are not required if an application proposes both fee-related and non-fee-related negotiations.

The OAG agrees that these are correct interpretations of those provisions, but does not believe any clarifying changes are necessary. The rules do not require an additional fee for automatic contract renewals or modifications that do not involve additional joint negotiations. §58.4(a) and (b) are not intended to imply that a new fee is required when a contract is renewed or modified in the absence of any additional joint negotiations. The OAG does not believe clarification is necessary because §58.4(a) and (b) only require fees for those contract renewals and modifications *"which are the product of a fee-related [or non-fee-related] negotiation."* Similarly, only one fee is required per application, even if the application proposes joint negotiations with more than one health plan. §58.11(b), which does not mention fees, specifies that a single application may propose joint negotiations with more than one health benefit plan. The fee rule, §58.4, specifies the fee that must accompany *"each application"* submitted to the OAG. Therefore, it is clear that a single fee is required for a single application, even when a single application proposes joint negotiations with multiple health benefit plans. The same is true

for a single application that proposes both fee-related and non-fee-related negotiations. §58.4 requires a $4,000 fee for a fee-related application. This is the required fee for any application that includes fee-related issues. The fee is the same even if that application also include non-fee-related issues. A $2,000 fee is required for applications that include only non-fee-related matters.

In another set of comments, TMA and Sen. Harris said that §§58.4(a) and (b) should be deleted. They argued that Insurance Code Article 29.13 may limit the OAG's authority to charge these fees. They suggested retaining only the representative's fee, and setting the amount to cover the cost of administering the program. They also recommended refunding any unearned portion of a fee if an application is withdrawn before the OAG or TDI have completed a review, and permitting payment by personal checks instead of requiring cashier's checks or money orders.

TMA also said the proposed fees are to high and should be cut in half because the OAG's review of reports proposing non-fee negotiations is limited to the cost/benefit balancing test set forth in Article 29.09(b). TMA also commented that since non-fee negotiations are presumptively pro-competitive and beneficial to the quality of patient care, according to Article 29.01, the OAG's review of non-fee negotiations should be direct and simple. TMA said that the proposed fee is not justified and should be reduced by at least half. TMA argued that while OAG review of fee negotiations is somewhat more complex, the proposed fee is still disproportionate to the costs involved, and the costs and benefits of each fee-based negotiation should be evident from the material submitted by a physicians' representative. TMA suggested that little, or no, investigation by the OAG should be required to develop or analyze this information, and that much of the information required in the proposed rules is actually irrelevant to the review the OAG must conduct to authorize fee negotiations. According to the TMA, physicians should not be required to fund such a review, therefore this fee should be reduced by half as well. TMA argued that the proposed fees for contracts are too high and should be reduced by half as well, since little, if any, review of proposed contracts is required. TMA commented that the OAG must simply determine whether the contract is beyond the limits considered in approving the initial report. Any further review would be redundant and unnecessary.

Other physicians agreed that the fees were excessive. McMichael said the fees may be prohibitive for small groups wishing to engage in multiple negotiations, and suggested the OAG set a maximum per-physician fee. TMGMA agreed that the contract fee was too high. They argued that the contract review fee assumes each contract is unique and requires complete review, when, in fact, all contracts are based on the same TDI template, so review should cost less than $1,000.

FPD questioned why the fees were based on an assumption that there will be 112 filings each year, arguing that the fact that there are 73 health benefit plans in Texas is not a relevant basis for that assumption. FPD argued that because some of the plans are subsidiaries or affiliates of one another, and physicians are forced to participate in all or none, this number should be reduced. FPD also questioned whether copying costs to be borne by physicians while compiling their applications were included in the calculation fo the state's costs.

On the other hand, TAHP and Humana expressed concern that the fees were set too low to cover the state's costs. They said the revenues generated may be inadequate to fund the state's review and result in a lack of active supervision of joint negotiations.

The OAG disagrees that the fees are either inadequate or excessive. Chapter 29 requires the state to set fees that will generate revenues adequate to cover the state's implementation costs. The preamble to the proposed rule, incorporated by reference here, set forth in detail the anticipated costs to the state, and the assumptions underlying those estimates. Applicants' copying costs were not included in the estimate of the state's costs. Those calculations were based on the combined judgment and experience of the OAG and TDI. Moreover, the OAG disagrees with FPD's assertion that the assumptions underlying its estimated number of annual filings are unsound. No one has suggested a better basis for estimating the number of annual filings. Based on all the information presented in these comments, the proposed fee structure represents the best estimate of the state's costs and the number of anticipated filings. The OAG also believes that the fee structure is fair, and disagrees with McMichael's suggestion that fees be capped on a per-physician basis. The cost to the state to evaluate an application will not vary greatly depending on the number of physicians in the negotiation group. The OAG, therefore, believes that a per-physician cap would be an inappropriate way to structure the fees because it would make it more difficult for the state to ensure that it recoups its costs.

The OAG has modified the proposed rules to allow for refunds of application fees in two instances. First, under new §58.11(f), applicants may receive a refund of their application fee if they withdraw their application when a health plan refuses to provide a copy of a relevant contract or fee schedule. Second, under new §58.25, applicants may receive a partial refund of their application fee if an application is withdrawn within ten business days of filing as a result of a health plan's refusal to participate in joint negotiations.

As described previously, Chapter 29 and the state action doctrine require the OAG to make numerous complex determinations before approving a proposed application or contract. The OAG must perform an intensive analysis of the information submitted in applications and proposed contract filings. The OAG disagrees with TMA's assertion that evaluating proposed non-fee negotiations will be "direct and simple" or that little or no investigation by the OAG will be required to develop and analyze the information submitted by the physicians' representative. The OAG also disagrees that little, if any, review of proposed contracts is required. Before approving a proposed contract, the OAG must determine that the benefits of the proposed contract outweigh the harm to competition resulting from it. The terms of proposed contracts will be the unique product of the joint negotiation process. The benefits and competitive implications of proposed contracts will not, therefore, be evident on the face of the original application, will vary greatly depending on the market circumstances, and will require substantial analysis by the OAG. The OAG believes the amounts of the fees are justified and that the total cost to both agencies to administer this program can be covered by the filing fees set out in §58.4. Those fees are based upon a dollar for dollar recovery of the costs incurred, as mandated by Insurance Code, Article 29.13. Finally, the OAG believes it is within the statutory authority granted in Article 29.11 and Article 29.13 to adopt these fees.

TMGMA also questioned whether the $500 representative's fee should be repeated with each application. They argued that there are MSOs and consulting firms that may serve as representative for more than one application, and that once a representative is registered, there are minimal costs for confirming that registration.

The OAG disagrees that multiple applications do not warrant multiple representative's fees. Each additional joint negotiation a single representative wishes to perform raises new issues that the OAG must evaluate. Concerns that are likely to arise include potential conflicts of interest and the increased the danger of "spill over" effects when one representative engages in joint negotiations with a single health benefit plan on behalf of multiple clients. For example, issues include whether information gathered for one joint negotiation might be used to influence another joint negotiation, and how aggregation of the various groups' market power can be avoided.

Public Information -- §58.5

Numerous parties expressed concern about public disclosure of confidential information submitted to the OAG under Chapter 58. Sen. Harris, TMA, HCMS, TMGMA, and individual physicians asked for rules designating that information filed with the OAG is confidential and assuring that it will be protected from disclosure. Specifically, TMA suggested that §58.5 be modified to state that any information submitted by a representative (other than information identifying the parties to the proposed negotiations and the proposed subjects to be discussed) shall be considered as confidential, and will be protected by the OAG and TDI to the extent permitted by the Public Information Act. Furthermore, they suggested revising the rule to make it optional for the representative to mark confidential information, and requiring the OAG to request an open records decision and notify the representative if a request is made for <u>any</u> information (other than the parties' identity and the subjects to be discussed), whether marked or not.

FPD recommended a rule holding the representative and the physicians harmless against breach of confidentiality claims made by health plans for disclosing information as part of the application process.

AAHP requested a rule requiring that health plans be notified prior to disclosure of any documents that may contain its confidential information so that the plan will have an opportunity to seek to prevent the disclosure of such information. Similarly, THA recommended revising the rule to <u>require</u> the OAG to notify both the representative and all third parties who are identified in the information requested. In addition, to facilitate notice, THA suggested that §58.12 be revised to require identification of the appropriate third party contact for any third party information being submitted. TAHP sought a rule protecting information which contains a patient's identifier or other information relating to a patient's care and treatment from disclosure.

Consumer Groups said they support §58.5(a), stating that the rules provide a reasonable process for determining whether certain information should be excepted from disclosure. They argued that accountability will fall short if interested members of the public cannot see how the process of approving joint negotiations is working.

The OAG agrees that confidential information should be protected from disclosure to the extent allowed under the Public Information Act. The OAG disagrees, however, that this rule can be modified in a way that would better achieve the commenters' objectives. The Public Information Act, Tex. Gov't. Code Chapter 552, governs whether information may or must be disclosed when requested. The Public Information Act applies to all information that is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body, including information submitted to the state in connection with physician joint negotiations. Under the Public Information Act, information must be disclosed upon request unless a statutory exception applies. For example, trade secrets are excepted from disclosure under the Public Information Act. In addition, commercial and financial information is excepted from disclosure when specific factual evidence demonstrates that disclosure would cause substantial competitive harm to the person who provided it.

The Texas Supreme Court has held that exceptions cannot be created or expanded by agency rules. Therefore, new §58.5(a) merely facilitates applicants' use of existing procedures under the Public Information Act to protect their confidential and proprietary information. Nor can the OAG adopt a rule that would have the legal effect of protecting the representative or physicians from claims for breaching the confidentiality of a private contract between the physicians and the health benefit plan. §58.12(a) instructs applicants to identify responsive information which is subject to nondisclosure clauses so that the OAG may seek that information from the health benefit plan. A waiver form has been added to facilitate the OAG's efforts to obtain copies of contracts and fee schedules from health plans.

With respect to the hospitals' and health plans' request to be notified when someone requests their proprietary information, the OAG believes the provisions of the Public Information Act are adequate to protect their interests. §58.5 was drafted to conform to the Public Information Act, Gov't Code §552.305, which requires agencies to make a good faith attempt to notify third parties whose proprietary information is requested if that information may be subject to exception under Gov't Code §§552.101, 552, 110, 52.113, or 552.131. The proposed modification, therefore, would have little, if any, practical effect. The rule as written will ensure that everyone receives notice, except in the unusual circumstance that a party has moved and cannot be located with reasonable efforts. The same is true with respect to suggestions that the rule should require the OAG (rather than merely obligate the OAG to make a good faith effort) to notify third parties before disclosing their confidential information. Because the statute imposes a good faith effort requirement, the OAG believes a rule purporting to impose a greater requirement, might result in confusion. The legislature presumably has determined, and the OAG agrees, that the requirement that the OAG make a good faith attempt to notify sufficiently protects third parties' interests without overburdening state agencies.

Multiple Joint Negotiations

Humana strongly objected to §58.11(b) permitting a single application to include joint negotiations with multiple health benefit plans, because the OAG must make separate determinations regarding each health benefit plan (e.g., whether an imbalance exists or quality of care is being affected). Humana argued that allowing multiple health benefit plans to be cited in a

single application will create significant confusion and difficulty, and suggested that the OAG should approve only singular applications to negotiate with an identified health benefit plan.

The OAG disagrees. §58.11(b) allows physicians to use one application to propose joint negotiations with multiple health benefit plans simply as a matter of convenience. It does not in any way alter the applicants' statutory burdens to make the required showings with respect to each individual health benefit plan they name. Nor will it affect the OAG's analysis of the patient care and competitive implications of the proposed joint negotiations. The OAG will only approve joint negotiations for which all the required determinations have been made. If an application satisfies the statutory tests with respect to one health benefit plan, but not with respect to another, the OAG will approve one of the proposed joint negotiations, and disapprove the other. The OAG will clearly state in the approval letter the exact terms of the approved joint negotiations to avoid confusion.

Unavailable Information -- §58.12(a)

HCMS and McMichael expressed concern about the requirement in §58.12(a) to cooperate with the OAG in its efforts to obtain unavailable information and information subject to nondisclosure clauses. McMichael said the requirement is unreasonable and will likely result in the health plan suing or terminating the physician. HCMS said it appears to require physicians to violate the terms of their contracts, and suggested modifying the rule to allow disclosure for the purpose of joint negotiation.

The OAG disagrees that this requirement is unreasonable, and does not believe it requires physicians to violate the terms of their contracts. Physicians who attended the September 8, 1999, stakeholders meeting indicated that nondisclosure clauses in many health benefit plan contracts prohibit physicians from disclosing the contract terms and other information required by the rules. Because the OAG needs this information to fulfill its implementation obligations, §58.12 requires physicians to cooperate with the OAG in any efforts it undertakes to obtain the information from third party sources, obviating the need for physicians to make disclosures that would violate their contracts. For example, physicians may be asked to help identify specific documents which contain relevant information. The OAG cannot, by rule, intervene in the health plan-physician contractual relationship to protect physicians from breach of contract lawsuits or terminations. The OAG has added a Contract Information Disclosure Authorization Form (new §58.11(e)) to help clarify the purpose of this rule and to facilitate OAG efforts to obtain contract information directly from the health plans.

The TMA also suggested that the physicians' representative be included in the effort to "obtain otherwise unavailable or nondisclosable information" because the representative's ongoing participation is important to maintain education and compliance with the law.

The OAG agreed and has made the requested change. See new §58.11(e).

Statutory Authority -- §§58.12-58.15

Two commenters argued that all of §§58.12-58.15 should be deleted because the OAG lacks authority to require or request that physicians submit any information other than what is listed in Insurance Code Article 29.08(1). According to them, the OAG is not free to add to, subtract from, or change the procedures prescribed in Insurance Code Article 29.09(b) and Article 29.08(1).

The OAG disagrees. Chapter 29 does not purport to set forth a comprehensive set of procedures for obtaining OAG approval to enter into joint negotiations. While it does require the representative to submit certain information to the OAG, it does not purport to set forth an exhaustive list. For example, Article 29.09(b) requires the OAG to "consider physician distribution by specialty and its effect on competition," but nowhere does Chapter 29 require applicants to report their specialty to the OAG. The OAG is authorized to promulgate rules necessary to implement Chapter 29. That authority includes the power to require the submission of more information than is listed in Article 29.08(1). As explained previously, the OAG has determined that the best way to fulfill the legislature's intent is to give potential applicants advance notice, in the rules, of the information the OAG believes is necessary to satisfy its statutory obligations and confer state action immunity. The OAG's experience with the first application submitted pursuant to this statute indicates a need for a more explicit description of the types of information required, and that physicians need guidance regarding what should be submitted in order to satisfy their burden of proof. If the rules did not set forth a list of required information, the OAG believes many applications would be denied for lack of information, delaying the joint negotiation process and frustrating the intent of the statute.

Information About the Physicians' Representative – §58.12(b)

McMichael argued that §58.12(b)(2), (3), (4), (5), (7) and (8) were neither authorized by, nor necessary to accomplish the purposes of, Chapter 29. He recommended that §58.12(b)(2), (4), (5), (7), and (8) be deleted. Humana, on the other hand, said it supported the need for all specified requirements in §58.12(b) and encouraged the OAG to retain all provisions.

With respect to §58.12(b)(3), which inquires into the representative's antitrust compliance history, McMichael said that past matters that did not result in the imposition of a penalty or payment of a judgment should not be required to be disclosed, and suggested that §58.12(b)(3) should be amended accordingly. TAHP, in contrast, said that it was extremely important for the OAG to collect this information, and urged the OAG to adopt the rules as proposed.

Finally, TMA complained that §58.12(b)(7) and (8) require the representative to speculate about unascertainable future events. They said requiring such information at the risk of censure or worse from a regulatory agency creates a potential barrier for representatives. AAHP, on the other hand, said that this requirement was needed. They argued that if a representative is seeking to negotiate on behalf of other physicians or groups, such other negotiations should be taken into account in determining how many physicians she can represent. This requirement is therefore

needed, they said, because of the risk that the negotiator would coordinate the conduct of those in the negotiating group she seeks to represent with those she is already representing.

The OAG disagrees with McMichael and TMA, and agrees with Humana, TAHP and AAHP. The OAG believes all of these requirements are authorized by the statute. See the previous discussion of the OAG's regulatory oversight responsibilities under Chapter 29. Specifically, the OAG needs the information required by these sections (including the representative's compensation, other contracting activities, and interest in the contracts to be negotiated) in order to understand the relationship between the representative and the physicians, and between the representative and the health benefit plan. Such relationships may affect the parties' relative negotiating power, and influence the conduct and outcome of the negotiations. The OAG also must be aware of potential conflicts of interest or improper incentives which may bear on the conduct of the negotiations.

Chapter 29 charges the representative with conducting the joint negotiations, which must strictly adhere to the statute, the rules, and the terms of the OAG approval in order to avoid violating the antitrust laws. For example, the statute limits the subject matter of the negotiations and the parties to the negotiation, and prohibits certain negotiation tactics, including boycotts or strikes. The representative bears the responsibility for ensuring that communications are limited to that which the state has authorized. The statute also requires the representative to warn the physicians of the antitrust risks involved, a difficult task in light of the ease with which immunized conduct may cross the line and become a per se antitrust violation. Accordingly, the OAG believes that information about the representative's past conduct that may have violated the antitrust laws is relevant. Even allegations of conduct that did not ultimately lead to imposition of a penalty or payment of a judgment are relevant, because they will help the OAG identify the types of conduct that raise potential antitrust problems, and take steps to ensure that joint negotiations are conducted in a manner consistent with the antitrust laws. In addition, in order for the Attorney General to determine that a joint negotiation will further the state's regulatory policies, it is necessary to find out whether the physician's representative has a history of violating the antitrust laws. This information is relevant to the representative's ability to carry out the duties described above, and may affect the OAG's assessment of the likely benefits and competitive implications likely to flow from a proposed negotiation. Information about past antitrust conduct is relevant to the credibility of the representative's assurances that the negotiation will be conducted in accordance with the law, and may help the OAG develop appropriate safeguards in the representative's plan of operation and procedures to ensure compliance.

The OAG also disagrees with TMA's comment that the information requested in §58.12(b)(7) and (8) calls for speculation. Those sections seek information about the representative's existing plans (not speculative future plans) to represent other physicians in negotiations with health benefit plans. This information is relevant to the OAG's assessment of the competitive implications of the joint negotiations. For example, the OAG must ensure that a representative who negotiates with a single health benefit plan on behalf of multiple, separate joint negotiation groups (or one joint negotiation group plus one or more independent physicians) follows strict safeguards to avoid running afoul of the antitrust laws. The risk of violating the antitrust laws by

implicitly combining these groups' negotiation leverage (exceeding the scope of OAG approval) is high, and that is a factor the OAG must consider in evaluating applications. Lastly, neither SB1468 nor these rules provide for "censure" for failure to provide this information, as TMA suggested, so this requirement does not raise any barriers for representatives.

Information About the Participating Physicians -- §58.12(c)

Statutory Authority

McMichael argued that §58.12(c)(2), (3), (5), (6), (7), and (8) are not authorized by Chapter 29. He said all of them should be deleted, except (2), which should be amended to require that only the physicians' specialties be reported (delete the requirement for reporting their practice areas, clinic affiliations, and active hospital staff privileges).

The OAG believes these sections are authorized by Chapter 29. See the previous discussion regarding the OAG's statutory authority to adopt rules necessary to implement the statute. Insurance Code Article 29.08 requires the representative to submit information identifying the relationship of the physicians requesting joint representation to the total population of physicians in a geographic service area. Information required in §§58.12(c) will help the OAG assess that relationship by revealing basic information about the participating physicians' practices, such as the types of medicine they practice, the location of their practices, the institutions they practice in, and with whom they practice and contract. The OAG will also use this information to analyze the competitive effects of a proposed joint negotiation or contract, as the statute requires.

IPA Contracts -- §58.12(c)(3)

TMA, HCMS, TIOPA, McMichael, and Gilmer said physicians do not have knowledge of or access to information or records regarding contracts their IPAs negotiate on their behalf. Therefore, they argued, physicians are unable to provide the requested information. HCMS and McMichael also said the requested information is not relevant, particularly when only non-fee-related negotiations are involved. HCMS said physicians often have individual contracts that override the IPA contract. Others said the responsive information would be voluminous, since physicians belong to multiple IPAs that contract with hundreds of health plans. McMichael suggested deleting this section or changing it to require only the name and business address of the integrated practice group and IPAs.

AAHP thought this section should be modified to require even more information. They suggested requiring the names of all health benefit plans with which the IPA has <u>engaged in contract negotiations</u> (instead of with which that group has <u>negotiated a contract</u>). The current language would not cover situations in which a physician has negotiated with a health plan, but has failed to agree on a contract. AAHP also recommended seeking information for the last 3 years instead of the last 2 years, to be consistent with the other application requirements and to reflect the fact that many health plan contracts are multi year agreements and are not negotiated annually. Limiting the request to two years risks missing relevant information about recent contract negotiations.

The OAG agrees with the physician groups that the proposed requirements were more inclusive than necessary. Accordingly, this section has been modified to reduce the burden on applicants. The OAG disagrees, however, that information about IPA contracts is not relevant to the OAG's analysis. Therefore, some information about IPA contracts is still required. New §58.12(b)(3) and (4) requires less information about IPA members and contracts. Now applicants only need to report whether they have a current contract with each targeted health benefit plan through an IPA or integrated practice group, and identify the groups. The OAG believes physicians should have this basic information about the IPAs and practice groups to which they belong. The required information is relevant to the OAG's analysis of the physicians' relative negotiating power. In addition, this information will help the OAG determine the competitive impact of a proposed joint negotiation, since membership in an IPA or integrated practice group affects the nature of the physicians' relationship to the health benefit plan. Even in those situations where overlapping individual and IPA contracts are in place, that fact is relevant to the OAG's analysis. In order to ascertain the benefits and competitive implications of the proposed joint negotiation or contract, the OAG must first know the nature of any existing contractual relationships between the parties. This is true even when only non-fee-related terms are being jointly negotiated. Finally, the OAG disagrees with AAHP. The information requested in new §58.12(b)(3) and (4) is sufficient for the OAG's analysis, without imposing unnecessary burdens on applicants. This information will be supplemented in other sections of the application where information regarding ongoing or unsuccessful negotiations must be provided. The OAG believes 3 years of historical information is unnecessary. The adopted rule requires information about all existing contracts with targeted health plans, so information about multi-year agreements will be captured.

Other Representatives -- §58.12(c)(5)

McMichael said the information requested in §58.12(c)(5) is duplicative or not readily obtainable by a physician. The only persons who can represent the physician are the physician himself, the physician's group practice, or an IPA in which the physician is a member. TMGMA said this information is not available within the business records of a physicians' practice because most small offices have historically allowed an affiliated PHO, MSO or IPA to provide all their managed care contract negotiations. TMGMA urged that the unavailability of this data should not be cause for denial of an application, and recommended that the rules give guidance to physician groups that are unable to provide a given data item.

The OAG disagrees that this information is unavailable. §58.12(c)(5) asks whether a participating physician has authorized anyone other than the representative to negotiate with the health benefit plan for which joint negotiations are proposed. Physicians should know whom they have authorized to negotiate for them, even if it is a PHO, MSO or IPA. The OAG needs this information to effectively monitor the conduct of joint negotiations, including simultaneous side negotiations that could take place between the health plan and any authorized agent of a participating physician. It will also help the OAG evaluate the adequacy of procedural safeguards (such as the representative's plan of operation) to avoid antitrust violations that could arise from the involvement of unauthorized representatives in joint negotiations.

Previous Applications – §58.12(c)(6)

McMichael said that physicians will not likely have the information requested in §58.12(c)(6), and the OAG will have it in its files.

§58.12(c)(6) requested the name of the representative and the date of any previous applications for joint negotiations filed on behalf of any of these participating physicians. Physicians should be aware of any previous applications they may have filed. Because the OAG will have access to this information in its own files, however, this requirement has been eliminated in order to reduce the burden on applicants.

Joint Business Activities – §58.12(c)(7)

McMichael asserted that §58.12(c)(7) is vague and ambiguous.

The OAG disagrees that this requirement was vague and ambiguous. §58.12(c)(7) requested information about physicians' joint business ventures between competing physicians in the joint negotiation group. This information was requested because evidence of procompetitive integration (e.g., shared equipment or facilities) among the members of the joint negotiation group would tend to decrease the negative competitive consequences of a proposed joint negotiation, making approval more likely. The OAG has eliminated this requirement, however, in order to reduce the burden on applicants.

Contract History With Targeted Health Benefit Plans -- §58.12(c)(8)

This rule seeks information about the contracting history between the participating physicians and the health plans with which they desire joint negotiations. Numerous physician groups and individual physicians complained that the contracts and correspondence this section requires would be voluminous, and that physicians do not normally keep copies of these documents in their files. They also argued that the information is not relevant to the OAG's analysis. TMA said that rapid market changes render historical contract information irrelevant.

HCMS and McGovern Group suggested the rule be revised to allow physicians to indicate which contracts are currently in force or which may have been in effect for the previous three years. They reasoned that the OAG could then obtain copies of the contracts from the Texas Department of Insurance, since managed care entities are required to file copies of their contracts with TDI. TMA requested clarification that this requirement applies to an individual physician or an integrated practice group, but not both (unless the individual physician is outside of the integrated practice group). Finally, TMGMA added that the rules should give guidance to physicians that are unable to provide a given data item.

The OAG agrees with HCMS and McGovern, and has modified the rule consistent with their suggestion in order to reduce the burden on applicants. Physicians are still required, however, to produce a copy of the most recent contract they have. This is due to the fact that only certain types of health benefit plans are required to place their contracts on file at TDI. While standard

HMO contracts may be available at TDI, ERISA plan contracts, PPO contracts, and indemnity contracts are not. Non-standard contracts may not be on file either. The correspondence requirement also remains in place, since this information is unavailable from any other source. Other new provisions such as the Contract Information Disclosure Authorization Form, discussed elsewhere, should help further reduce this burden by facilitating OAG efforts to procure copies of contracts directly from the health plans. New §58.11 gives guidance to applicants regarding information they are unable to produce.

The OAG disagrees, however, that contracts, and historical contract information, is not relevant to its analysis. The OAG believes this information is highly relevant to its determination whether benefits of the proposed joint negotiations outweigh the harm to competition likely to flow from it. The OAG needs to understand the history of contract relations between the parties in order to evaluate the projected benefits of a joint negotiation to alter that relationship. It is also important for the OAG to know the current status of the parties' contract. The correspondence will reveal whether a renewal or termination is pending, or whether a modification has been recently proposed. The existence of rapid market changes does not diminish the relevance of this information. In fact, the pace of change in the market is a relevant factor in and of itself that the OAG will consider in evaluating the parties' relative negotiating strength and determining whether a health plan has substantial market power.

The OAG also agrees that TMA's requested clarification was warranted. The rule has been re-worded for clarity. The requirement applies both to each individual physician and their integrated practice group. The OAG believes that all contracts between participating physicians and the health benefit plan for which joint negotiations are proposed are relevant. The proposed joint negotiations would affect all such contracts. Therefore, the OAG must review them to evaluate the impact of the joint negotiation. Accordingly, if an individual physician within an integrated practice group has a separate (individual) contract with the health benefit plan, that contract should be produced, in addition to the group contract. Of course, if no individual contract exists, then the integrated practice group can produce only the group contract on behalf of the entire group.

History of Antitrust and Fraud Violations – §58.12(c)(9)

DCMS said the rule should only require information about final determinations rather than about allegations. In addition, they commented that "fraud and abuse" is a broad term and can be all-encompassing. The State Board of Medical Examiners commonly investigates and dismisses allegations without the knowledge of the physician in question. DCMS further said "we understand the relevance of final determinations, we question the reasoning of assembling information about every allegation, known or unknown, and speculation about its relevance."

The OAG disagrees. This information is relevant for the same reasons discussed in response to comments regarding §58.12(b)(3). Physician conduct during the joint negotiation process may violate the antitrust laws, so the OAG needs information about past allegations of misconduct in order to impose appropriate procedural safeguards and ensure that anticompetitive spillover effects will not occur. Moreover, this rule does not require physicians to report all allegations.

Rather, the rule requires that investigations or administrative or judicial proceedings be reported. The rule does not purport to place physicians under a duty to report investigations or proceedings of which the physician has no knowledge.

Humana recommended that a copy of any applicable records on file with the State Board of Medical Examiners be provided, in full, and attached to the application at the expense of the applicant. Humana also said a minimum of three years worth of information relating to the personal income and assets as well as business costs, profits and overhead of each member of a negotiation group should be required as well. This information is critical to establish if an anticompetitive environment truly exists in a geographic service area. Physician income trends are important to quantify competition in a market.

The OAG disagrees. If needed, the OAG can obtain copies of State Board of Medical Examiners records from that agency. The OAG does not believe that the other suggested information is necessary to perform the analyses required by Chapter 29, and also believes it would be too burdensome for physicians to provide.

Information About the Market for Physician Services – §58.12(d)

McMichael argued that §58.12(d) goes outside the information authorized by the statute and directly conflicts with the requirements of the statute. It goes against the legislative intent, which was to allow small medical practices, comprising up to 10 percent of an insurance plan's service area, irrespective of their specialties, to negotiate jointly with that plan.

The OAG disagrees. See the previous discussion of the OAG's rulemaking authority. In addition, the text of the statute does not indicate that the legislature intended to permit joint negotiations by small medical practices "irrespective of their specialties." To the contrary, Article 29.09(b) requires the OAG to "consider physician distribution by specialty and its effect on competition." Moreover, the statute does not provide separate standards or procedures for participation by small medical practices.

TMGMA said many of the requested data items in this section are non-objective and inappropriate for use in a technical analysis of an application. Much of the market analysis information requested in §58.12(d) cannot be defined due to the inability to identify a fixed set of competitors. The medical services of a given physician are not an exclusive subset for that specialty. Family practitioners, internal medicine specialists, and cardiologists, for example, may provide and interpret electrocardiograms. Defining market share for a given physician would require several biased assumptions that would undermine the integrity of the reported data. The rules should use an independent source of data to establish fixed market share information.

In general, the OAG disagrees that the requested information is an inappropriate basis for analyzing and defining relevant markets. The purpose of this section is to help the OAG define the relevant markets, and, in particular, to sort out the issue TMGMA described: where services provided by physicians practicing different specialties overlap. The proposed rules were designed to give physicians an opportunity to assert that the market for their services includes physicians

who practice specialties different than their own. The OAG intends to consider data from official sources, such as the State Board of Medical Examiners, and health plans, as well, but that does not diminish the usefulness of whatever additional information the physicians might want to submit. Official sources of information may provide an incomplete picture. The State Board of Medical Examiners, for example, does not collect data that would reveal the extent to which physicians practicing different specialties routinely perform the same procedures. Moreover, the OAG is capable of evaluating the validity and relevance of the information submitted. Information from market participants is not inherently subjective or inappropriate for use in defining a market as TMGMA suggests. For further explanation, see the discussion of individual §58.12(d) provisions below.

Humana stressed the importance of obtaining accurate and verifiable information relating to a specific market for physician services and a geographic service area. Humana said the OAG should establish some verification procedure or independent analysis of all information submitted by an applicant prior to and as a condition of approval. Furthermore, Humana said the OAG should use the information on record at the TDI and OPIC, as well as resources available from health benefit plans, to obtain a global perspective on the health care marketplace in Texas. According to Humana, the statute clearly places the burden of proof on the physicians to show that an imbalance exists and joint negotiations are necessary, so health benefit plans should not be required to provide any information, and it should be left to their sole discretion to provide information to an applicant or negotiation group at a cost determined to be reasonable by the health benefit plan.

Humana suggested adding the following specific requirements to §58.12(d) in order to provide a true picture of physician market power as needed to satisfy Article 29.09(b): 1) The percentage of physicians in identified specialties in the negotiation group relative to the total number of substantially similar specialists in that geographic service area; 2) the percentage relative to the total number of substantially similar specialists who contract with the health benefit plan in the geographic service area; 3) the percentage of physicians in identified specialties in the negotiation group with admitting privileges to each hospital in the geographic service area; and 4) that percentage relative to the total number of substantially similar specialists contracted with the health benefit plan with admitting privileges to each hospital in the geographic service area.

The OAG disagrees that additional rules are needed to address these concerns or to implement these practices. The OAG will verify information when necessary, and will utilize official sources of information whenever possible to aid its analysis of proposed joint negotiations. The rules do not require health benefit plans to provide any information. Moreover, the OAG has determined that the rules require sufficient information from applicants to enable the OAG to define appropriate markets and analyze the parties' market power. The OAG will be able to obtain any additional information it may need to fulfill its statutory duties and does not believe that Humana's suggested additional application requirements are necessary.

Competing Specialties -- §58.12(d)(1)

McMichael said §58.12(d)(1) conflicts with Insurance Code Article 29.09(b), which does not require analysis by specialty. He said that opponents of SB 1468 complained to the legislature that this language was based on the total number of physicians and not the number of physicians by specialty, and recommended that this paragraph should be deleted. The TMGMA comment discussed previously also questioned the usefulness of this requirement.

The OAG disagrees that §58.12(d)(1) conflicts with Chapter 29, and that the requested information would not be helpful to the OAG's analysis of the relevant service markets. The OAG also disagrees that Article 29.09(b) does not require analysis by specialty. In fact, it requires the OAG to "consider physician distribution by specialty and its effect on competition" and provides that negotiation groups may be limited to less than 10% (or permitted in excess of 10 percent) of the physicians in an area when conditions support it.

In order to reduce the overall burden on applicants, however, the OAG has eliminated §58.12(d)(1). Applicants should nevertheless note that this rule was proposed for their benefit, giving physicians an opportunity to argue that the market should be broadly defined because they face competition from specialties different than their own. Many physician services are not substitutes for one another, so information about which specialties compete aids in the evaluation of the competitive impact of a proposed joint negotiation or contract. For example, a health plan cannot replace cardiovascular surgeons with obstetricians in its provider panels. Internists, on the other hand, may be substitutes for family practitioners. Without information from applicants, the OAG may be forced to rely more heavily on data from health plans and public sources to determine which specialties compete with one another. Applicants are, of course, still welcome to provide this information on a voluntary basis.

Top Ten CPT Codes -- §58.12(d)(2)

HCMS, TMGMA, and FPD said that some physicians, particularly those in small practices, lack record-keeping systems that have the technical sophistication required to compile this information without significant investment of time and money. TMA and others said some physicians do not know what their revenues are under certain contracts because many health plans do not reveal their fee schedule to the physician. In addition, McMichael argued that this section requests information that is not authorized by the statute.

TMA urged the OAG to provide some leeway for inability to comply with this requirement. HCMS suggested that this requirement should not apply to non-fee-related negotiations. HCMS also sought clarification regarding whether the calculation should be for each individual physician or aggregated for the entire negotiation group.

TAHP said it is very important that the OAG collect this information. TAHP and AAHP recommended that this section be modified to obtain more information about each code, or information about a larger number of codes, because for many physicians, several of the top ten

CPT codes will be "Evaluation and Management" codes or "Office Visit" codes which are not helpful in distinguishing the nature of the services provided.

In general, the OAG agrees with both sets of comments. Accordingly, this rule has been revised to make compliance easier and to place more emphasis on procedure codes. The revised rule provides physicians greater flexibility to determine how to compile this information, and exempts certain small groups from this requirement altogether. In addition, office visit codes are excluded. The OAG disagrees that this requirement is not authorized by the statute (see the previous discussion regarding the scope of OAG rulemaking authority). This information is important to the OAG's analysis in that it reveals which procedures the participating physicians perform most often, which will help the OAG define the relevant service market and analyze physician distribution by specialty and its effect on competition, as well as ascertain the likely competitive effects of proposed joint negotiations.

Geographic Area – §58.12(d)(3)

DCMS said the usefulness of the information required by §58.12(d)(3) is unclear, as is the cost of producing it. Gilmer said he did not have a way of sorting this information easily, and asked whether the response should be based on where the patient lives, works, or where their PCP is officed. DCMS and Gilmer suggested that in a major metropolitan area, the rule should assume that the vast majority of the patients reside in the MSA.

McMichael argued that §58.12(d)(3) is not authorized by the statute and conflicts with the statute. Insurance Code, Article 29.06 authorizes the TDI to collect certain information from every health care entity in the state. Physicians are not health care entities. Therefore, McMichael said, this paragraph should be deleted.

AAHP said §58.12(d)(3) should be modified to require physicians to indicate how many patients he or she serves for each zip code which would address the fact that the relevant geographic market for physician services often may be less than an MSA or county, and "significant" is not defined in the proposed rule. This information, AAHP commented, should be readily available, and more useful than the information sought in the proposed rule. In the event that actual patient numbers by zip code are not available, AAHP proposed that the physician should indicate from which zip codes he or she provides services to a "significant" number of patients, where "significant" is defined to include at least 10% or more of his or her patients.

AAHP also argued that in determining the permissible size of the negotiation group, the OAG should consider the share of the physicians in the properly defined relevant geographic market for each physician specialty. They said that Insurance Code Article 29.09(b) establishes the 10% physician share percentage as it relates to physicians in a health plan's "defined geographic service area," and the proposed regulations do not further define this term. Further, health plan service areas, which are approved by the TDI, vary considerably, ranging from one county to the entire state. Therefore, they argue, it would make little sense to consider all the counties in which a health plan is approved as the relevant geographic service market, since 10% of the physicians in a health plan's service area may comprise 100% of the physicians in a city. They suggest that the

OAG may find a single county service area is a useful starting point for this analysis, but ultimately the OAG should focus on the relevant geographic market for each physician specialty, as such markets would be defined for antitrust purposes.

The OAG generally agrees with DCMS and Gilmer, and has revised the rule in order to reduce the burden on applicants. The OAG determined that it can gather information from other sources, such as the health plans, to aid in defining the appropriate geographic market. This analysis is necessary to ascertain the proper size of the negotiation group, as well as the competitive effects of the joint negotiations. The adopted rule requires no response from physicians who draw most of their patients from within the same county in which they practice. Physicians who draw a significant portion of their patients from outside their county must indicate where those patients come from. Applicants should designate whether their response is based on the patient's residence or work place.

The OAG disagrees with AAHP. The comments regarding the substantive standards that should govern the analysis of negotiation group size are outside the scope of these rules. This rule is designed simply to elicit information, not to suggest that the OAG has adopted the county as the presumptive geographic market. Furthermore, the OAG believes requiring physicians to perform a zip code level analysis of their patient flow data would be unnecessarily burdensome. The information required by the revised rule, combined with information available from other sources, will suffice for the OAG's geographic market analysis.

The OAG also disagrees with McMichael. This rule is unrelated to the TDI authority set forth in Article 29.06(b). See the previous discussion regarding the OAG's rulemaking authority.

Market Share Estimate -- §58.12(d)(4)

TMA and other physician groups said that physicians lack the information necessary to estimate the negotiation group's market share, and recommended deleting this requirement. In addition, HCMS said that information as to the numbers of physicians by specialty within a given area (county, MSA, etc.) is not difficult to come by, but that determining whether or not all are competitors is speculative at best. Consumer Groups further suggested that the rule designate an official source of information upon which responses should be based so the information will be standardized.

The OAG agrees with the first comment, and has therefore eliminated the portion of the rule that requested a market share estimate. The OAG disagrees, however, that determining which physicians compete with the participating physicians requires speculation. For example, a conservative approach would be simply to assume that all physicians who practice the same specialty as the participating physicians in the county or MSA are competitors. The OAG agrees with Consumer Groups that it is important to consider the source of the information, and that standardization would facilitate accurate comparisons. The OAG does not believe applicants should be limited to one "official" source, however, for two reasons. First, the OAG will obtain and review information from the Board of Medical Examiners on its own. Second, the OAG's review will benefit from analyzing information from other sources as well. Physicians may have

other sources of more detailed or more accurate information. And §58.12(a) requires applicants to specify the source of any third party information used in an application, so the OAG will be able to evaluate the reliability of that information.

Provider Panel Competitors – §58.12(d)(5)

TMA said physicians do not currently keep, nor have the ability to know or ascertain this type of information. McMichael argued that this requirement is not authorized by the statute and should be deleted. He also said that physician panels are constantly changing, and that only the insurance plan accurately knows who is on their panels. In addition, he said some plans do not publish provider directories, and others are out of date and inaccurate. Gilmer and FPD suggested the OAG get this information directly from the health plans.

The OAG agrees that this section required information which physicians may not have ready access to. Therefore, the requirement was eliminated. The adopted rule simply requires applicants to submit a copy of the most recent provider directory they have, if any.

Information About the Proposed Negotiations – §58.12(e)

McMichael argued that §58.12(e)(4), (6), (7), and (9) are not authorized by the statute and should be deleted. He added that the information requested is highly speculative.

The OAG disagrees. The information requested by these rules is relevant to the determinations the OAG must make regarding the benefits and detriments (including the impact on competition) of the proposed negotiations. The rules do not call for speculation. Applicants should have some idea of when they want to initiate negotiations and how long those negotiations might last. In addition, applicants bear the burden of demonstrating that the benefits of their proposal outweigh the resulting harm to competition. Satisfying that burden requires that they articulate the expected impact of the negotiations on the quality of patient care and on consumers.

Products to be Negotiated – §58.12(e)(1)

TAHP complained that the meaning of "products" is unclear. They also comment: "We are concerned that the determination of a significant market will be based on the products which the representative intends to negotiate. Are negotiations limited to one specific product? Health plans should be permitted to participate in making the determination of what constitutes a significant market." In addition, AAHP said §58.12(e) should be modified to clarify that the negotiation group must identify the specific health plans with which it intends to negotiate.

The OAG disagrees that the meaning of the term "products" is unclear. See the previous discussion of §58.3 (Definitions). AAHP's suggested modification is unnecessary because §58.12(e)(1) does require applicants to identify the specific health plans with which it intends to negotiate. TAHP's comment is beyond the scope of the proposed rules. The rules do not set forth substantive standards for determining what constitutes a significant market. The OAG does

not believe a rule is needed to address whether negotiations are limited to one specific product. The OAG will delineate the scope of approved negotiations in the approval letter.

Subject of Negotiations -- §58.12(e)(2)

TMA said that §58.12(e)(2) should be clarified to assure the information is to be provided by either participating physicians or an IPA but not both.

The OAG disagrees. §58.12(e)(2) seeks information about the proposed subject of the joint negotiations and previous attempts to address those issues independently (rather than through this joint negotiation group). The OAG believes that information about all previous attempts, whether made by individual physicians or their integrated practice groups, is relevant, and therefore does not agree that this requirement should apply only to one or the other.

McMichael argued that §58.12(e)(2) is not authorized by the statute. He said this information is not necessary to carry out the intent of the statute, and that physicians are not required to prove they have unsuccessfully attempted to change the terms of the contracts offered by the health plans.

The OAG disagrees. §58.12(e)(2) asks for the proposed subject matter to be negotiated. Insurance Code Article 29.08(1)(E) requires this information. The rule also asks for the impetus for the joint negotiations and information about previous individual attempts to address these issues with the health plans. This information will help the OAG understand the context in which the joint negotiations would take place, evaluate the parties' relative negotiating power, and assess the likely benefits and detriments. The rule does not imply that physicians must prove they have unsuccessfully attempted to change the terms of the contracts offered by the health plans.

Contract Terms to be Negotiated – §58.12(e)(3)

McMichael said §58.12(e)(3) requires the representative to specify the contractual terms to be negotiated, and therefore conflicts with Insurance Code Article 29.08(1)(E), which requires that the proposed subject matter of the negotiations be disclosed. He also argued that this requirement is impossible to meet and contravenes the will of the legislature, and should be deleted.

The OAG disagrees. The statute only authorizes joint negotiations regarding the terms and conditions listed in Insurance Code Article 29.04 (non-fee-related terms) and Article 29.05 (fee-related terms). The statute prescribes different standards for approval of fee-related and non-fee-related negotiations. Therefore, the rule requires applicants to specify which contract terms and conditions they wish to negotiate and which of the statutory categories encompass those terms

Impact on Quality, Competition, and Consumers – §58.12(e)(5), (6), & (7)

TAHP suggested that the OAG should provide clear guidance as to the criteria the OAG will apply when assessing the impact of negotiations on quality, competition, and consumers. TAHP argued that the lack of substantive criteria may lead to confusion among the applicants, and may

make it difficult for the OAG to justify the qualitative judgments necessary for the discharge of its statutory responsibility.

The OAG disagrees and believes this comment is beyond the scope of the proposed rules. The rules seek information from the applicants as a starting point for the OAG's analysis. The OAG will apply the statutory criteria for approving applications. The OAG will fully evaluate the evidence to determine whether the applicants have demonstrated that the likely benefits resulting from the joint negotiation outweigh the disadvantages attributable to a reduction in competition that may result.

AAHP expressed concern that the draft regulations do not give adequate attention to the statutory requirement for fee-related negotiations regarding the expected impact on the availability of care. This requirement, they say, is omitted in the preamble, as well as in §58.12(e). They are particularly concerned about this issue because fee-related joint negotiations are likely to increase health care costs, and inevitably force employers to reduce health care benefits and thereby adversely affect the availability of health care services. The OAG must, they say, separately determine whether this requirement has been met when authorizing fee-related negotiations.

The OAG disagrees that the rules neglect the issue of the impact of joint negotiations on the availability of care. Availability of care is not included in §58.12(e) because this is not a required showing for non-fee-related negotiations. It is required in §58.13(1), which sets forth additional requirements for fee-related negotiations. The Preamble is a broad brush description of the rules; the sections cited by AAHP do not purport to articulate the complete and definitive standard for application or contract approval. The OAG believes the assessment of the impact on availability of care is extremely important. The OAG will carefully make that determination, as well as all the required statutory determinations, when ruling on proposed negotiations and contracts.

Humana said §58.12(e)(7) should specify that the focus of the analysis should be on the cost, access or availability of health care services to the members of the health benefit plan, since (e)(5) and (6) already deal with "quality of patient care" and "competition." In addition, Humana argued that §58.12(e)(8) should be amended to focus on the benefits for consumers, consistent with the intent of Article 29.08(1)(H). Finally Humana recommended that the information required in §58.12(e)(5) be quantitative and verifiable by the OAG prior to and as a condition of its approval.

The OAG disagrees that these modifications are warranted. As written, §58.12(e)(7) seeks information about all aspects of consumer impact, including but not necessarily limited to cost, access or availability issues. §58.12(e)(8), which is identical to Article 29.08(1)(H), solicits information about all types of "benefits," including benefits for consumers. Lastly, the OAG does not believe that §58.12(e)(5) should specify that quantitative data be provided. The OAG will evaluate the validity and persuasiveness of whatever information applicants submit to determine whether they have adequately demonstrated the purported benefits of the proposed negotiations.

Other Providers' Pecuniary Interests in the Contracts – §58.12(e)(9)

TMA and HCMS said this is an impossible requirement that calls for speculation or guessing and is outside the knowledge of the physician group.

The OAG agrees that this requirement was overbroad. Accordingly, the rule was revised to narrow the scope of the information requested. The revised rule only requires identification of other health care providers who will be a party to, and share risk in, the contract to be jointly negotiated. For example, applicants would have to disclose the identity of the hospital in the case of a physician-hospital risk sharing contract.

Plan of Operation -- §58.12(f)

McMichael argued that §58.12(f)(3) conflicts with Insurance Code Article 29.08 and should be deleted.

The OAG disagrees. McMichael has not demonstrated how this rule conflicts with Article 29.08. §58.12(f)3) requires the representative to describe procedures governing the logistics of the negotiations. This is part of the plan of action required by Insurance Code Article 29.08(F). These procedures are important to ensure that the negotiations are conducted in compliance with the statute, the rules, and the OAG approval letter. Negotiation conduct which deviates from these requirements may not be immune from the antitrust laws.

AAHP said §58.12(f)(4) should be modified to require the representative to advise physicians about the antitrust risks associated with anticompetitive spillover and joint refusals to deal, or that the OAG itself provide instructions to the representatives on these issues that could be distributed to the physicians.

The OAG agrees that such instructions are advisable, but does not believe that the rule should list detailed requirements such as this. The OAG will handle the issue of appropriate antitrust warnings on a case by case basis when approving applications.

TAHP suggested that §58.12(f)(4) be modified to require the representative to advise physicians that all information obtained or discussed in negotiations must remain confidential and cannot be used outside of the approved negotiations or communicated in any form or fashion to any physician or provider who is not a member of the negotiating group.

The OAG disagrees. As explained previously, the nature of the instructions the representative should give to the negotiation group will best be handled on a case by case basis.

Fee-Related Negotiations – §58.13

Impact on Quality of Care – §58.13(1)

TMGMA, FPD, TAHP, and TABCC suggested that the OAG adopt substantive guidelines indicating how an applicant may demonstrate the effect of fees on quality and availability of patient care, and clarifying the criteria the OAG will use to evaluate that impact. TABCC suggested that THCIC could collect data on physician encounters in relation to patient care and outcomes, arguing that empirical measures of past outcomes and quality are required in order for a negotiating group to demonstrate that present and future quality would be adversely affected. TABCC also suggested that the negotiating group should be required to submit quality data for analysis to THCIC to demonstrate a clear effect on patient quality of care in order to meet the requirements of this section. Similarly, Humana said the information submitted in response to this section should be quantitative and verifiable by the OAG. OPIC suggested that the OAG consider historical data and assess the situation prospectively when determining whether contract provisions undermine quality of care. OPIC added that the proposed rules allow the OAG the flexibility to consider all aspects of each case in order to make a reasonable determination.

The OAG disagrees that this type of substantive rule is warranted at this time. The statutory basis for this rule is Insurance Code, Article 29.06(a), which permits joint negotiations on fee-related matters only where "those terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care." The relationship between what physicians are paid and quality and availability of patient care must be articulated by the physicians based on the facts of their particular situation. The OAG lacks information to form any basis for clarifying the statutory standard at this time. The OAG will, however, explore the availability of data regarding patient care quality from a variety of sources, including THCIC, medical societies, and other governmental and commercial sources. This will best be accomplished informally. The OAG does not see a need to adopt a rule addressing the use of THCIC data at this time. Moreover, Chapter 29 does not expressly require that an adverse affect on patient care be quantified. The OAG believes that, at this time, these determinations will best be made on a case by case basis. Therefore, the rule does not establish specific requirements for satisfying this burden. The OAG will evaluate the merits of the qualitative and quantitative claims made in each application to determine whether the terms and conditions at issue have had an adverse effect on the quality and availability of patient care.

TAHP said the rules are unclear as to whether the applicant should claim that current fees adversely affect patient care or that fees proposed might adversely affect patient care and how.

The OAG disagrees. Insurance Code Article 29.06(a) authorizes joint negotiations on fee-related issues where those terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care. The OAG believes the statutory provision is clear: it requires evidence of either past or future adverse affects on the quality and availability of patient care. The rules need not re-state this standard.

Book of Business Information – §58.13(2) and (3)

TMA said the information requested in §58.13(3) is unavailable, not relevant, and impossible to supply. They suggested the OAG should look to current information as the marketplace changes rapidly and dramatically. In addition, they say the contracts almost universally prohibit disclosing the contract terms. They commented that OAG must assure the information requested for fee negotiations will remain confidential. TMGMA said the information requested in §58.13(2) and (3) is not available within the business records of a physicians' practice, adding that most smaller groups do not have sophisticated information systems that can produce the necessary reports on demand. FPD questioned the relevance of the requested information. TIOPA said this is a voluminous, resource-intensive request, and suggested narrowing the information down to specialty level would appear to provide the information needed. TAHP said that information about five health plans should be sufficient since many physicians may not have as many as ten with which they contract.

The OAG generally disagrees with these comments. §58.13(2) seeks identification of the health plans with which the participating physicians do the most business. §58.13(3) seeks information about effective dates and termination dates for the physicians' ten largest health benefit plan contracts. While it may not be easy for physicians to gather this information, the OAG believes physicians should have this information. Moreover, this information is important and relevant to the determination of whether the health benefit plan with which the physicians want to negotiate has substantial market power. The fact that the market changes rapidly and dramatically is relevant to the issue of whether a health benefit plan is so dominant that physicians are effectively "locked in" to their contracts. The termination history reveals the nature and degree of flexibility the physicians have to shift their business from one health plan to another. The information will help the OAG determine whether the health benefit plan named in the application has substantial market power. The rule seeks information separately for each individual physician or integrated practice group because these are independent economic entities that compete with one another. A health benefit plan could have substantial market power with respect to some physicians, but not others. If the information were aggregated by specialty, it would not reveal whether a health benefit plan has substantial market power over a particular group or individual physician. These rules were revised slightly to address some of the concerns that were raised. §58.13(2) was revised to provide more flexibility by allowing the identification of fewer or more than ten health plans, based on the structure of the physicians' book of business. §58.13(3) was revised to simplify the requirement, ease the historical reporting burden, and improve clarity.

Contract Information Form – §58.13(4)

Several physicians said supplying this information would be difficult because health plans refuse to give physicians copies of the fee schedule and coding guidelines. Physicians do not generally know how much the health plan is going to pay them for a procedure until they see what the health plan actually sends them, making it difficult to track revenues by payer as required in the Contract Information Form.

The OAG disagrees that revisions are warranted. The Contract Information Form allows physicians to perform these calculations based on billed charges or patient visits if revenue information is unavailable. If physicians do not have a fee schedule, they could check recent claims payments records to determine the amount they are being paid for particular CPT codes. In addition, the OAG will try to obtain copies of fee schedules directly from health plans. See the discussion of the Contract Information Disclosure Authorization Form.

FPD suggested this information could come directly from the health plans.

The OAG disagrees. A health plan is not in a position to know what percentage of a physicians' services they purchase, since they only have information about their own purchases, and lack information about purchases by other health plans and government purchasers. Only the physician can provide this information. The OAG believes that most physicians can compile this information. For example, the amount of revenues derived from each payer is available on certain IRS forms. The OAG's experience investigating health plan mergers supports this assumption. The fact that almost half of the physicians in Dallas County were able to estimate the percentage of their patients covered by Aetna/Nylcare and Prudential in response to a 1999 survey by the Texas Medical Association indicates that physicians can provide this information.

TMA suggested this section be clarified to assure that the information required is from either the participating physicians or the single specialty integrated practice group but not both.

The OAG disagrees. §58.13(4) states that a Contract Information Form must be filled out and submitted *"for each participating physician or single-specialty integrated practice group."* Further, the instructions on the Contract Information Form state that participating physicians who practice the same specialty together in an integrated practice group may submit their information in aggregated form on a single form. The OAG believes that this language clearly conveys that the information is required from either each participating physician or single-specialty integrated practice group, but not both.

Attestations – §58.14(a)

McMichael said that §58.14(a) is not justified by the statute and makes the application more complex and costly to prepare. He suggested that the representative's signature alone should be required. He also said that §58.14(b) goes outside what is authorized by the statute and will significantly increase the cost and difficulty of completing the application. He recommended that it be deleted or that the notarization requirement should be eliminated. Similarly, TIOPA said obtaining notarized statements wastes time and resources, and recommended using power of attorney vouchers instead.

The OAG disagrees. §58.14 seeks assurances from the representative and the participating physicians that the information being submitted is valid, so that the OAG can rely on it when evaluating the application. The OAG also believes this requirement will encourage applicants to carefully check the information before submitting it, resulting in more accurate applications. This rule also ensures that participating physicians will have notice of the information being submitted

on their behalf, including the plan of operation governing the conduct of the negotiations. Requiring notarized signatures is a simple and inexpensive way of accomplishing these objectives.

AAHP suggested adding a new section requiring that each physician attest that he or she has received and read instructions about the antitrust laws in order to reduce the possibility of anticompetitive conduct by physicians who might be unaware of the limits of protected behavior. Humana requested a provision requiring that all members of a negotiating group be present at the time the application is submitted and sworn in by an officer of the OAG. Humana also advocated requiring a sworn statement in writing clearly acknowledging that all information obtained or discussed through communications authorized for joint negotiations must remain confidential and cannot be used outside of the approved negotiations or communicated to any person who is not a member of the negotiating group. Humana said this protection is needed to prevent spillover effects.

The OAG disagrees. The OAG believes the existing attestations requirements are sufficient to protect the integrity of the application process. In addition, the representative's antitrust warning required by Chapter 14 and approved by the OAG under §58.12(4) provides adequate notice to physicians regarding the antitrust limits on their conduct.

Requests for Additional Information -- §58.15

TMA said this rule should be clarified to indicate that the additional information will be requested of the representative and the physician, so both will be better able to communicate and comply.

The OAG disagrees. §58.15 states that the OAG may request additional information which it deems necessary to fulfill it duties. The OAG does not believe it is necessary to state that the information request will be directed to the representative and the physician, since the purpose of the rule is merely to put applicants on notice that additional information may be requested.

SUBCHAPTER C: REVIEW OF APPLICATION

Complete Filing -- §58.21

TMA suggested that §58.21 require the OAG to state the reasons why the report was returned or disapproved.

The OAG disagrees that such a clarification is necessary for such a minor administrative matter. The OAG will, in practice, communicate with applicants about what information is needed to complete their application. §58.11 addresses this issue by instructing applicants regarding how to handle unobtainable information and explaining how the OAG will decide whether an application is complete when certain information is missing.

Full Disclosure – §58.23

Sen. Harris and TMA argued that §58.23 exceeds the OAG's authority to place additional burdens on persons seeking authority to enter into joint negotiations. They contended that the OAG is without authority to require physicians to submit any information in order to participate in joint negotiations, or to request information from representatives that is not listed in Article 29.08(1).

The OAG disagrees for the reasons discussed previously with respect to the OAG's authority to require the submission of information other than what is listed in Article 29.08(1). Moreover, §58.23 does not add any new requirements. It merely serves to put applicants on notice and ensure the integrity of information submitted to the OAG.

Attorney General's Investigation – §58.24

Sen. Harris and TMA asserted that any antitrust violations committed in the course of joint negotiations are likely to be inadvertent (due to misunderstanding or miscommunication). Therefore, they recommended that §58.24 should be modified to require the OAG to notify a representative if the negotiation has exceeded the scope of approval.

This comment appears to be based on a misunderstanding of the purpose of this rule. The OAG investigation referenced in §58.24 is not an investigation into potential antitrust violations associated with joint negotiations. Rather, as the rule itself states, it refers to investigations into the merits of an application for joint negotiation (e.g., when the OAG contacts a third party to gather information to aid its analysis of the likely competitive effects of the joint negotiation). Nonetheless, the OAG disagrees with this suggested revision. The OAG will, in practice, attempt to notify joint negotiation participants if it has reason to believe their conduct is straying from the bounds of the law. A rule requiring the OAG to do so, however, is unnecessary.

Humana suggested that §58.24 should establish a policy requiring that all information submitted with an application be verified either by department staff or by an independent review representative. They said this verification should include review of financial records, ethics record, as well as independent status.

The OAG disagrees. As explained previously, the OAG review will include appropriate analysis of all information submitted, including verification of the accuracy of data when deemed necessary. The OAG does not believe that formalizing this procedure in the rules is appropriate or necessary.

Written Authorization -- §58.26

Sen. Harris and TMA said that the last clause of §58.26(a) ("a participating physician or any other person") should be deleted because Chapter 29 does not authorize the OAG to regulate the activity of any person other than a physicians' representative. No other person need rely on OAG approval, they said. They commented that §58.26(b) should also be deleted, and replaced with a

requirement that the OAG supply the reasons for the disapproval and the remedial measures as required in Article 29.09(a). They said that proposed subsection (b) is beyond the scope of the OAG's authority and is actually counter to the express language of Article 29.09(c). As a safeguard, they said, the OAG retains authority to approve, or disapprove, any contract reached through negotiations if the conditions change under which the OAG approved the negotiations.

The OAG disagrees. The purpose of this rule is to avoid confusion by specifying a single specific source of OAG approval. This serves two purposes. First, the written approval letter serves to put participants on notice as to exact parameters of the OAG's authorization, which will help prevent unauthorized spillover conduct. Second, it clarifies the source and boundaries of physicians' immunity for state action doctrine purposes. It does not attempt to "regulate the activity" of any person. No rule is needed to re-state the requirements of Article 29.09(a). §58.26(b) states that the representative must initiate approved negotiations within 60 days. Its purpose is to enable the OAG to exercise active supervision over joint negotiations as required by the state action doctrine. Without this provision, an approved joint negotiation could be initiated for the first time months or years later, after market conditions have changed, a regulatory feature that has undermined state action immunity in other contexts. The OAG has determined that this provision furthers the legislature's intent to immunize joint negotiations from the antitrust laws and therefore falls within the scope of the OAG's authority.

SUBCHAPTER D: REVIEW OF PROPOSED CONTRACTS

Contract Approval Process -- §§58.31-58.33

Sen. Harris and TMA argued that §§58.31-58.33 should be changed to eliminate the 14-day deadline in §58.31(a) and the report required in §58.32 because they exceed OAG authority. They commented that the requirements are set forth in Article 29.08(2), and that the only requirement that may be inferred from Article 29.08(2) is that the representative must obtain OAG approval before the contract becomes effective. In addition, they said, the OAG should delete the second sentence of §58.31(b), because Article 29.09 does not permit the OAG simply to return incomplete submissions. Instead, they said, the OAG should simply notify the representative of missing documents. They argued that the only information on which the OAG may base its approval of a contract is the initial report submitted under Article 29.08(1). Finally, they suggested that the OAG delete the last clause of §58.33(a) because the OAG is not authorized to regulate the activity of any person other than the representative. Physicians, they said, are free to conduct their own negotiations with health benefit plan without OAG approval.

The OAG disagrees, and has determined that all these provisions are within its statutory authority. For reasons discussed previously with respect to application requirements, the OAG does not believe that Insurance Code Article 29.08(2) sets forth exhaustive requirements for the filing and review of proposed contracts. To the extent the rules impose additional requirements in connection with the filing, review and approval of proposed contracts, those requirements are necessary for the OAG to fulfill its statutory obligations (to make the required statutory determination regarding the benefits and competitive effects of the proposed contract, and to exercise active supervision of the contract in order to immunize physicians from the antitrust

laws). Finally, the last clause of §58.33(a) does not purport to regulate anyone's activities. Rather, as explained previously, it serves to define the boundaries of the OAG's approval for state action purposes.

Filing Contracts with TDI – §58.31(a)

TMA said the reference to TDI in §58.31(a) should be stricken because the statute does not support such a filing and the requirement unnecessarily increases paperwork.

The OAG does not agree that the statute does not support a requirement that copies of proposed contracts be filed with TDI. Insurance Code, Article 29.06 grants TDI the authority to collect and investigate information necessary to determine the annual impact, if any, of the joint negotiation law on average physician fees in Texas. A logical starting point for this analysis is the contracts that result from joint negotiations. By requiring applicants to file a copy of proposed contracts with TDI, the rule minimizes the state's administrative burden and facilitates TDI's statutory data collection function. In addition, the OAG may draw on TDI's expertise in this area by seeking input regarding the likely effect of proposed contracts on patient care. Since this consultation must take place within the 30-day statutory response deadline, the efficient dissemination of contract filings facilitated by this rule is important to the OAG review process.

Identifying Contract's Benefits and Detriments – §58.32(a)

TMA and FPD sought revisions clarifying what constitutes "factual information and documentation supporting the identified benefits and competitive effects," and providing examples of the types of factual information requested. FPD also said this rule is redundant with the application requirements in §58.12(e).

The OAG does not believe revision is necessary. Insurance Code, Article 29.09(b) requires the OAG to approve a proposed contract if the applicants have demonstrated that the likely benefits resulting from it outweigh the disadvantages attributable to a reduction in competition that may result. §58.32(a) requires applicants to identify the benefits and competitive effects of the proposed contract, and to submit factual information and documentation supporting those assertions. The statute, not the rule, imposes this burden of proof on applicants. The OAG does not have enough experience processing applications to provide meaningful examples of types of supporting facts that might be persuasive. Moreover, the benefits and competitive detriments will be different in each case, and must be derived from the facts at hand, not from a list of hypothetical examples provided by the OAG.

Nor does the OAG believe this requirement is redundant with the application requirements. . When an application is submitted, the terms of the resulting contract are not yet known, so the benefits and competitive effects cannot be fully ascertained at that time. Therefore, after successful negotiations, when a contract is being submitted for OAG approval, §58.32(a) requires applicants to identify the likely benefits of the proposed contract, the effect of the contract on competition, and to back up those assertions with facts. In approving a contract, the OAG must

weigh the benefits and competitive effects of its particular terms, and make a second, separate determination. Therefore, this requirement is necessary and is not duplicative.

SUBCHAPTER E: REMEDIAL MEASURES

Remedial Actions – §58.42

TMA said §58.42 implies that only one remedial attempt is permitted. They suggested that good faith efforts to comply should not be cut off at one attempt.

The OAG believes that the rules need only provide for one attempt to correct the deficiencies identified in its disapproval letter. Insurance Code Article 29.09 requires the OAG, when disapproving applications or proposed contracts, to furnish a written explanation of deficiencies and a statement of specific remedial measures as to how such deficiencies could be corrected. The statute is silent with respect to what happens next. The rules, therefore, provide 90 days for applicants to take remedial action and re-submit the application or contract. This provides plenty of time for applicants to seek clarifications from the OAG, if necessary, regarding what corrective measures are required. The OAG believes all parties will be better served by the certainty this deadline brings to the process. If disapproved a second time, applicants are free to start over with a new application.

FPD sought clarification regarding what happens if a disapproved application or proposed contract is not re-submitted within 90 days of disapproval?

The OAG does not believe this rule needs to be clarified. The rule provides 90 days for re-submission of a disapproved application or proposed contract. If it is not re-submitted within 90 days, it is simply disapproved, and may no longer be re-submitted for approval. In other words, after 90 days, the disapproval is final.

SUBCHAPTER F: SUBSEQUENT NEGOTIATIONS & CONTRACT MODIFICATIONS

Subsequent Negotiations – §58.51-58.53

Two commenters made the following suggestions: Delete §58.51(b) because it misstates the law: Specifically, because Article 29.08(3) authorizes a negotiation group to renew failed negotiations within 60 days without seeking prior approval of the OAG and without paying any fee. They suggested that the OAG should define what constitutes a "failed negotiation attempt," and that the OAG should delete from §58.51(c) the 7-day notice requirement and the requirement that negotiations conform to the OAG approval letter, because the OAG cannot add additional burdens or requirements to the process set forth in Article 29.08(3). They said the OAG should delete §58.51(e) because it merely restates the law. One of them also recommended deleting §58.52 because the OAG cannot add additional burdens or requirements to the process set forth in Article 29.09(c). Finally, both recommended modifying §58.53 to read "Any <u>modified</u> contract or agreement..." to clarify that the OAG retains responsibility to approve every contract, whether new or modified, before the contract takes effect.

The OAG disagrees. For reasons explained previously, these provisions are within the scope of the OAG's authority and are consistent with Chapter 29. These commenters' interpretation of Article 29.09(c) defeats the purpose of the statute, because §58.51(b) is needed for state action purposes. It facilitates active supervision by limiting the duration of OAG approvals. Similarly, §58.51(c) is necessary to enable adequate oversight of joint negotiations to ensure antitrust immunity. The same is true of §58.52. The OAG does not believe it is necessary to define "failed negotiation attempt." It is described in Article 29.08(3). Finally, the OAG disagrees that the word "modified" should be added to §58.53, because the phrase "negotiated pursuant to this subchapter" conveys the same meaning.

NCMS said the rules should authorize a group that did not negotiate prior to signing a contract with a health benefit plan to attempt to negotiate with the health benefit plan at any time in the course of the contract. This is necessary, they said, because there can be changes in medical care or cost that make the contract with the health benefit plan onerous or overbearing. The right to negotiate "mid-term" would help remedy such situations.

The OAG does not believe such a change is warranted. Proposed §58.51 and §58.52 address this concern. After a group has obtained approval to enter into joint negotiations, any contract entered into between that group and the health benefit plan must be approved by the OAG. "Mid-term" joint negotiations to modify an approved contract are permitted pursuant to §58.52, after the representative gives notice to the OAG. If an approved group asks the health benefit plan to negotiate, but negotiations terminate, or never commence, the representative must inform the OAG pursuant to Article 29.08(3). Proposed §58.51 provides procedures for resuming negotiations in this situation.

AAHP suggested that §58.51(b) should be modified to provide that joint negotiations or communications concerning a health plan are no longer authorized as soon as negotiations are terminated. As currently drafted, that rule prohibits such conduct only after the representative has reported the failed negotiation to the OAG. This would allow anticompetitive conduct and communications during the time in between, which is a particularly sensitive period, during which physicians could coordinate a course of action that could stymie efforts by the health plan to contract individually with physicians.

The OAG disagrees, and believes that §58.51(b) adequately addresses this concern. This type of anticompetitive conduct would not be immune from the antitrust laws even during periods when joint negotiations are authorized. The only anticompetitive conduct that could legally take place during the window of time hypothesized by AAHP are "joint negotiations" (conducted exclusively by the physicians' representative, within the scope of and conforming to all the terms of the original OAG approval). The OAG believes the danger posed by this scenario is insignificant, and is more than outweighed by the difficulty of enforcing a requirement for "immediate" notification when joint negotiations terminate.

Resuming Joint Negotiations After a Failed Negotiation

TMA argued that if everything has remained unchanged, a previously-approved group should be permitted to pay a lesser fee to resume negotiations, especially for non-fee-related negotiations.

The OAG disagrees. §58.51 addresses three different scenarios for resuming joint negotiations after a failed negotiation attempt. §58.51(c) governs negotiations resumed within 60 days of a failed negotiation. No fee is required. §58.51(d) governs negotiations resumed later than 60 days, but fewer than 180 days after a failed negotiation. Again, no fee is required. §58.51(e) requires a new application and fee for resuming negotiations later than 180 days after a failed negotiation. The OAG assumes that conditions are likely to have changed if over six months have passed since negotiations failed. This assumption is based on TMA's comment about how the marketplace changes so rapidly and dramatically. In addition, the OAG's experiences in prior antitrust investigations indicates that health plan enrollment can fluctuate significantly, and health plan ownership and provider panel composition can change significantly in a six-month period. Therefore, if more than six months has passed, the application information needs to be updated, and the OAG will incur additional review expenses, requiring another fee to cover its costs.

All comments, including any not specifically discussed herein, were fully considered by the OAG. In adopting these sections, the OAG makes other minor modifications for the purpose of clarifying its intent.

The OAG has determined that the anticipated public benefit from adopting these rules is the administration of this program by the Office of the Attorney General and the Texas Department of Insurance, without increased costs to the state. The fees generated will enable the two agencies to recoup their costs for administering the program from those who intend to seek benefits under the program, not from other state revenue sources. The public, physicians who wish to negotiate, and other interested parties will also be on notice as to the requirements for such negotiations and the physicians' representatives will be able to provide the OAG and TDI with the information necessary to make a proper determination. These proposed rules will allow joint negotiation to take place when the likely benefits outweigh the disadvantages attributable to a reduction in competition that may result, putting into effect the public policy established by the legislature. Further, the OAG believes that the regulatory structure established under these proposed rules will provide state action immunity from state and federal antitrust laws.

Chapter 58 is adopted under the Insurance Code, Articles 29.11 and 29.13, which authorizes the OAG to adopt rules reasonable and necessary to implement Chapter 29 and requires the OAG to adopt rules establishing fees that cover costs incurred by the OAG and TDI in administering Chapter 29.

The new sections of the proposed rules affect Texas Insurance Code, Chapter 29.

[RULE TEXT HERE]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Filed with the Office of the Secretary of State on May 17, 2000.

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Rick Gilpin
Certifying Official
Office of the Attorney General

Effective date: June 6, 2000

Proposal publication date: November 19, 1999

For further information, call:(512) 463-2185.

Prepared by Mark Tobey, May 17, 2000.