Texas Administrative Code
TITLE 1: ADMINISTRATION
Part III: Office of the Attorney General
Chapter 58: Physician Joint Negotiation

Subchapter A: GENERAL

§58.1 Purpose and Scope

This chapter establishes procedures to implement Chapter 29 of the Insurance Code, under which competing physicians may jointly negotiate contracts with health benefit plans. These rules are adopted by the Office of the Attorney General pursuant to the authority granted in the Insurance Code, Articles 29.11 and 29.13.

§58.2 Effect of Rules

This chapter is not to be construed as limitations upon the exercise of the attorney general's constitutional or statutory authority.

§58.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Application – An initial filing submitted by a physicians' representative on behalf of a negotiation group seeking OAG approval to engage in communications with competitors and/or joint negotiations with a health benefit plan pursuant to the Insurance Code, Chapter 29 and this chapter.
(2) Fee-related negotiation – A joint negotiation involving one or more of the terms and conditions listed in the Insurance Code, Article 29.05.
(3) Health benefit plan – A plan described by the Insurance Code, Article 29.03.
(4) Integrated practice group – A group of non-competing physicians, including one or more participating physicians, who are clinically integrated and/or share substantial financial risk.
(5) Negotiation group – A group of participating physicians that is seeking, has sought, and/or has obtained OAG approval to engage in communications with competitors and/or engage in joint negotiations with a health benefit plan pursuant to the Insurance Code, Chapter 29 and this chapter.
(6) Non-fee-related negotiation – A joint negotiation involving none of the terms and conditions listed in the Insurance Code, Article 29.05.
(7) OAG – Office of the Attorney General.
(8) Participating physician – A member of a negotiation group.

(9) Person – An individual, association, corporation, or any other legal entity.
(10) Physicians' representative or representative – A third party, including a member of the physicians who will engage in joint negotiations, who is authorized by physicians to negotiate on their behalf with health benefit plans over contractual terms and conditions affecting those physicians.
(11) Product – A type of health benefit plan (e.g., a commercial HMO, a commercial PPO, or an indemnity plan).
(12) TDI – The Texas Department of Insurance.

§58.4 Fees

(a) Fee-related negotiations. Each application submitted to the OAG that proposes a fee-related negotiation must be accompanied by a $4000 fee. In addition, each contract (including contract renewals and modifications) submitted to the OAG which is the product of a fee-related negotiation must be accompanied by a $1000 fee.
(b) Non-fee-related negotiations. Each application submitted to the OAG that proposes only non-fee-related negotiations must be accompanied by a $2000 fee. In addition, each contract (including contract renewals and modifications) submitted to the OAG which is the product of only non-fee-related negotiations must be accompanied by a $500 fee.
(c) Physicians' representative. In addition to the fees listed above, for each application submitted to the OAG, the representative shall pay to the TDI a $500 fee to act as a representative.
(d) Payment of fees. The fees required by subsections (a) and (b) of this section shall be by cashier's check or money order, made payable to the Office of the Attorney General. The fee required by subsection (c) of this section shall be by cashier's check or money order, made payable to the Texas Department of Insurance. All fees are nonrefundable, except as provided in §58.11(f) and §58.25 of this chapter (relating to withdrawal of application).

§58.5 Public Disclosure and Use of Submitted Information

(a) Information submitted to the OAG pursuant to this chapter is subject to the Public Information Act, Government Code, Chapter 552. The OAG and the TDI consider information identifying the parties to the proposed negotiations and the proposed subjects to be discussed as public information and available to the public. The representative shall clearly mark the precise information in any document submitted to the OAG reasonably considered by law to be confidential under the Government Code, §552.101, or a trade secret or commercial or financial information excepted from disclosure under the Government Code, §552.110. If a request for information is made for information marked as provided in this section, the OAG will request an open records decision from the Open Records Division of

the OAG and make a good faith attempt to notify the representative who submitted the information as required by the Government Code, §552.305. At its discretion, the OAG may submit reasons why the information should or should not be withheld from public disclosure, as provided by the Government Code, §552.305.

(b) The OAG and the TDI reserve the right to retain information and documents submitted to it under this chapter and to use them for all governmental purposes.

Subchapter B: APPLICATION REQUIREMENTS

§58.11 Applications

(a) The representative shall submit a completed application containing the information required by this subchapter, along with the proper fee as required by §58.4 of this chapter (relating to fees). The representative shall submit one original and one copy of each completed application to each agency at the following mailing or street addresses:

Office of the Attorney General
Consumer Protection Division, Antitrust Section
ATTN: Physician Negotiation Application
P.O. Box 12548
Austin, TX 78711-2548

Texas Department of Insurance
ATTN: Filings Intake
Mail Code 106-1E
P.O. Box 149104
Austin, TX 78714-9104

William Clements Bldg.
300 W. 15th Street, Floor 9
Austin, TX 78701

William Hobby Bldg.
333 Guadalupe
Austin, TX 78701

(b) A single application may propose joint negotiations with more than one health benefit plan. However, a separate application is required for each negotiation group.

(c) Each application shall include the information listed in §58.12 of this chapter (relating to contents of application). The information must be grouped and labeled by subsection title. Applications shall include a table of contents and identifying subject tabs for each part of the application. Copies of relevant supporting documents should be included where appropriate. If the application contains data from third party sources, the source of the information shall also be specified.

(d) If any of the requested information is unavailable, the application shall include an explanation of the reasons why and the efforts that have been made to obtain the information and from what sources. If the participating physicians are contractually prohibited from disclosing requested information, the application shall identify the information or documents subject to such nondisclosure clauses,

the parties to the contracts that prohibit disclosure, and the contract terms which prohibit disclosure.

(e) The representative and the participating physicians must cooperate with the OAG in any efforts it undertakes to obtain otherwise unavailable or nondisclosable information. Each participating physician must complete and submit the following "Contract Information Disclosure Authorization Form":

Figure 1: 1 TAC §58.11(e)

(f) The OAG will decide on a case by case basis whether an application is complete without the missing information. 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. If a health benefit plan refuses to provide a copy of a relevant contract or fee schedule, applicants may elect to withdraw their application and receive a refund for their application fee.

§58.12 Contents of Application

(a) Information About the Physicians' Representative:

(1) the representative's name, title, employer, and business address;
(2) the representative's occupation, professional training, credentials and licenses, and experience in the health care field;
(3) any past or pending investigations or administrative or judicial proceedings in which it is alleged that the representative has engaged in any form of price fixing or other antitrust violation, or health care fraud or abuse, including any government or private investigations, lawsuits, settlements, judgments, fines or penalties relating to those allegations;
(4) contracts for services to be performed by the representative in connection with this chapter, including any compensation arrangements;
(5) the legal and business relationships between the representative and the participating physicians, including but not limited to any other contracting services provided by the representative for any participating physician;
(6) the representative's pecuniary interest, if any, in the contracts to be negotiated under this chapter;
(7) any other physician groups the representative has represented, is representing, or plans to represent under this chapter; and
(8) whether the representative has negotiated, is negotiating, or plans to negotiate with any payer on behalf of any other physicians in the same county as these participating physicians, and for each such negotiation, the names and specialties of all physicians, physician groups, and health benefit plans involved, and the nature and time frame of those negotiations.

(b) Information About the Participating Physicians:

(1) each participating physician's name and business address;
(2) each participating physician's specialties, primary practice areas, clinic affiliations, and active hospital staff privileges;
(3) identify each integrated practice group (IPG) or independent practice association (IPA) to which each participating physician belongs, including the group's name, business address, type of legal organization, and approximate number of physician members;
(4) for each health benefit plan for which joint negotiations are proposed, state whether any participating physician is a provider for that health benefit plan through any IPG or IPA, and if so, indicate which IPG or IPA is a party to that contract;
(5) the type of legal organization, if any, of the negotiation group;
(6) the names of any persons, other than the representative, authorized to represent each participating physician or integrated practice group (separately from the negotiation group) in negotiations with any health benefit plan for which joint negotiations are proposed in the application;
(7) for each health benefit plan for which joint negotiations are proposed, state whether each participating physician or integrated practice group has had a contract with that health benefit plan within the last three years, and if so, produce a copy of the most recent contracts, and any correspondence from the past year concerning renewal, termination or modification of those contracts; and
(8) any past or pending investigations or administrative or judicial proceedings in which it is alleged that any participating physician or integrated practice group has engaged in any form of price fixing or other antitrust violation, or health care fraud or abuse, including any government or private investigations, lawsuits, judgments, fines or penalties relating to those allegations.

(c) Information About the Market for Physician Services:

(1) the number and the descriptor of the ten Current Procedural Terminology (CPT) codes, excluding office visit codes, which comprise the largest portion of the participating physicians' revenues or billed charges (if the participating physicians have different specialties, provide this information separately for each specialty); however, this information is not required for a non-fee-related negotiation by a joint negotiation group that accounts for less than 15% of the physicians who practice the same specialty as the participating physicians in the county in which the participating physicians practice, measured according to the most recent statistics compiled by the State Board of Medical Examiners;

(2) if the participating physicians draw a significant portion of their patients from outside the county in which they primarily practice, indicate which geographic area (e.g., by zip code, metropolitan statistical area (MSA), or county) those patients are drawn from, and provide relevant explanatory or supporting information which indicates that this area is part of the geographic area served by the negotiation group;

(3) the number of physicians, by specialty, who compete with the participating physicians in each geographic area identified in paragraph (2) of this subsection (if the participating physicians have different specialties, provide this information separately for each specialty); and

(4) for each product for which negotiations are proposed, produce the most recent provider directory in the participating physicians' possession.

(d) Information About the Proposed Negotiations:

(1) the products which the representative intends to negotiate on behalf of the negotiation group;

(2) the proposed subject matter to be discussed or negotiated with the identified health benefit plans, the impetus for such negotiations or discussions, and previous attempts made by participating physicians or their integrated practice groups to achieve these goals by negotiating with the health benefit plans independently;

(3) the specific contract terms and conditions to be negotiated and which of the twenty categories set forth in the Insurance Code, Articles 29.04 and 29.05 encompasses each term or condition;

(4) the proposed time line of the negotiations;

(5) the expected impact of the negotiations on the quality of patient care;

(6) the expected impact of the negotiations on competition;

(7) the expected impact of the negotiations on consumers;

(8) the benefits of a contract between the identified health benefit plan and physicians; and

(9) the identity of any health care providers, other than the representative and the participating physicians, who will be parties to and will share risk in the contracts to be negotiated.

(e) The Representative's Plan of Operation and Procedures to Ensure Compliance With the Insurance Code, Chapter 29 and These Rules:

(1) procedures governing the logistics of communications between the representative and the health benefit plans, between the representative and the participating physicians, and among the participating physicians, including procedures to limit these communications to approved products, terms and conditions;

(2) limitations on the representative's authority to bind the participating physicians, if any, and procedures governing the exercise of that authority;
(3) procedures to ensure that the health benefit plans remain free to contract with or offer different contract terms and conditions to individual competing physicians; and
(4) instructions the representative intends to give to participating physicians regarding these procedures and the corresponding risks associated with violating the antitrust laws.

§58.13 Fee-Related Negotiations

In addition to the information listed in §58.12 of this chapter (relating to contents of application), the following information is required for applications that propose fee-related negotiations:

(1) information demonstrating that each of the fee-related terms and conditions named in §58.12(d)(3) have already affected or threaten to adversely affect the quality and availability of patient care;
(2) the names of the health benefit plans, by product, which collectively account for 80% of each participating physician's or integrated practice group's business in the last year, measured by revenue, or if revenue data is unavailable, then measured by billed charges, or if billed charges data is unavailable, then measured by patient visits;
(3) for each of the health benefit plans named in response to subsection (2) of this section, provide the effective dates of each contract currently in effect, the termination dates of any contracts that have been terminated in the past three years, and the reason for each of those terminations;
(4) for each product named in §58.12(d)(1), complete and submit the following "Contract Information Form":

Figure 2: 1 TAC §58.13(4)

This form must be filled out and submitted for each participating physician or single-specialty integrated practice group; and

(5) any other information demonstrating that the health benefit plan has substantial market power in the purchase of physician services.

§58.14 Attestations

(a) Each application shall include a notarized statement by the representative attesting to:
(1) his or her authority to represent the participating physicians;
(2) the truthfulness, accuracy and completeness of the enclosed information;

(3) the fact that the proposed negotiations with the named health benefit plans regarding the specified terms and conditions are actually intended, and not merely possible; and
(4) that he or she will promptly notify the OAG, in writing, of any material change in the facts or circumstances he or she has provided or attested to.

(b) Each application shall include a notarized statement from each participating physician attesting to:
(1) the truthfulness, accuracy and completeness of the information he or she provided in the application,
(2) the fact that he or she has read and agrees with the information provided in the portion of the application titled "Information About the Proposed Negotiations;"
(3) the fact that the representative named in the application is authorized to represent him or her in joint negotiations with the health benefit plans named in the application; and
(4) that he or she will promptly notify the representative, in writing, of any material change in the information he or she has provided or the facts or circumstances he or she has attested to.

§58.15 Requests for Additional Information

The OAG may request additional information which the OAG deems necessary to fulfill its duties under the Insurance Code, Chapter 29 and this chapter.

Subchapter C: REVIEW OF APPLICATION

§58.21 Complete Filing

An application shall not be considered filed until a completed application and application fee is received by the OAG and the representative's fee has been paid to the TDI. The OAG and TDI may return an incomplete or unorganized application to the representative.

§58.22 Meetings With Staff

If the application presents novel or complex issues, the representative should consider requesting a meeting with OAG Antitrust Section staff to discuss the issues in advance of submitting an application to help focus the analysis and fact-gathering efforts.

§58.23 Full Disclosure

The representative and the participating physicians are under an affirmative obligation to make full and true disclosure with respect to the information required by this chapter. The conclusions in

the approval letter are expressly conditioned on the truthfulness and accuracy of the factual representations made by the representative and the participating physicians.

§58.24 Attorney General's Investigation

The OAG will conduct an independent investigation regarding whether the proposed negotiations meet the requirements of the Insurance Code, Chapter 29 when the OAG believes such an investigation is appropriate.

§58.25 Withdrawal of Application

The representative may withdraw an application at any time by submitting a written notice of withdrawal to the OAG. If a health benefit plan indicates it is unwilling to participate in joint negotiations, and an application is withdrawn as a result within ten business days from the date it was filed with the OAG, the application fee will be refunded, less an amount sufficient to compensate the state for costs incurred reviewing that application.

§58.26 Written Authorization Required

(a) The OAG shall indicate OAG approval or disapproval of an application by a written approval or disapproval letter within 30 days of receipt of a complete filing. No oral approval or other oral statement purporting to bind the state shall be valid or may be relied upon by the representative, a participating physician or any other person.

(b) The representative must initiate the approved negotiations, if at all, within 60 days of receiving the approval letter from the OAG

Subchapter D: REVIEW OF PROPOSED CONTRACTS

§58.31 Filing Requirements for Proposed Contracts

(a) Not later than 14 days after the parties identified in the initial filing have reached an agreement, and at least 30 days before the effective date of the agreement, the representative shall submit, for the OAG's approval, the proposed contract and any attachments or addenda, a report, and a plan of action, along with the proper fee as required by §58.4 of this chapter (relating to fees). A copy of the filing required by this subsection shall be submitted to the TDI at the address listed in §58.11 of this chapter (relating to applications).

(b) A proposed contract shall not be considered filed until the documents listed in subsection (a) of this section are received by the OAG. Incomplete submissions shall be returned to the representative.

§58.32 Contents of Filing for Proposed Contracts

(a) The report required by this subchapter shall identify the likely benefits of the proposed contract and the effect the proposed contract may have on competition. It shall also include factual information and documentation supporting the identified benefits and competitive effects.

(b) The report shall be accompanied by a notarized statement from the representative attesting to the fact that, since the filing of the initial application, he or she has not engaged in any negotiations or communications with this health benefit plan regarding any terms or conditions other than those specified in the application and approved by the OAG.

(c) The plan of action required by this subchapter shall specify the proposed effective date of the contract, which must be at least 30 days after the contract is submitted to the OAG for approval, the term of the contract, and procedures governing the reporting and resolving of disputes.

§58.33 Written Authorization Required

(a) The OAG shall indicate OAG approval or disapproval of a proposed contract by a written approval or disapproval letter within 30 days of receipt of a complete filing. No oral approval or other oral statement purporting to bind the state shall be valid or may be relied upon by the representative, a participating physician or any other person.

(b) The parties to the contract may not begin performance of the contract before receiving such approval.

Subchapter E: REMEDIAL MEASURES

§58.41 Time for Re-Submission

Within 90 days of receiving a letter from the OAG disapproving an application or proposed contract, the representative may re-submit the original application or contract for approval along with a report documenting the remedial measures that have been taken and demonstrating how the modifications will address the OAG's concerns.

§58.42 Review of Remedial Actions

The OAG will review the revised submission and either approve or disapprove it within 30 days of receipt by the OAG.

Subchapter F: SUBSEQUENT NEGOTIATIONS AND CONTRACT MODIFICATIONS

§58.51 Resuming Joint Negotiations After a Failed Negotiation

(a) As required by the Insurance Code, Article 29.08(3), the representative shall report to the OAG a failed negotiation attempt.

(b) Once the representative has reported a failed negotiation attempt to the OAG, the representative and participating physicians shall no longer be authorized to engage in any joint negotiations or communications among competitors which, absent state approval, would constitute a violation of the antitrust laws.

(c) The negotiation group, through its representative, may resume negotiations within 60 days of reporting a failed negotiation if it provides the OAG with 7 days prior notice of its intent to do so. Subsequent negotiations must not deviate from the terms of the negotiation group's previous filings and must be conducted in compliance with the Insurance Code, Chapter 29, this chapter, and any requirements prescribed in the OAG approval letter.

(d) In order to resume negotiations later than 60 days (but fewer than 180 days) after reporting a failed negotiation, the negotiation group must renew its original application by filing a report reflecting any changes in competitive conditions since the initial filing. No fee is required with this filing. The OAG will review and either approve or disapprove the revised application pursuant to subchapter C of this chapter. Negotiations may not resume without the express written authorization of the OAG.

(e) In order to resume negotiations later than 180 days after reporting a failed negotiation, the negotiation group must file a new application and fee pursuant to subchapter B of this chapter and obtain OAG approval pursuant to subchapter C of this chapter.

§58.52 Joint Negotiations to Modify an Approved Contract

During the original term of a contract approved pursuant to subchapter D of this chapter, the negotiation group may engage in joint negotiations or communications for the purpose of modifying the contract terms. The representative must provide the OAG written notice of the group's intention no later than 14 days before commencing such joint negotiations. The report must include a notarized statement by the representative certifying that the negotiations will not deviate from the negotiation group's previous filings and will be conducted in compliance with the Insurance Code, Chapter 29, this chapter, and any requirements prescribed in the OAG approval letter.

§58.53 Review of Contracts Negotiated Under This Subchapter

Any contract or agreement negotiated pursuant to this subchapter must be submitted for OAG approval pursuant to the procedures outlined in subchapter D of this chapter.

Figure 1: 1 TAC §58.11(e)

Contract Information Disclosure Authorization Form

In connection with my application for joint negotiation, I authorize the Office of the Attorney General ("OAG") to obtain information from third parties regarding the status and terms of any existing or past contracts or agreements involving the provision of physician services by me for members of the following health benefit plans: [list all health benefit plans named in §58.12(d)(1), and in §58.13(2) if application proposes fee-related negotiations]

_____ _____

_____ _____

_____ _____

_____ _____

I authorize any person who possesses information about these contracts or agreements to release it to the OAG, and waive any rights I may have to withhold this information from the OAG, including any rights created by nondisclosure clauses that may appear in these contracts or agreements.

_____ _____

Signature Date

Figure 2: 1 TAC §58.13(4)

Contract Information Form
For Fee-Related Negotiations

Instructions: A separate form must be completed and submitted for each participating physician. Participating physicians who practice the same specialty together in an integrated practice group, however, may submit their information in aggregated form on a single form.

1. This form provides information for (check one):

9 one physician

9 an entire single-specialty integrated practice group

(name of group _____)

9 a single-specialty subset of a multi-specialty integrated practice group

(name of group _____)

2. List Name(s) of Physician(s) reporting on this form:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. CURRENT REIMBURSEMENT RATES. For the ten CPT codes which you identified in §58.12 (c)(1) of your application, provide the contract reimbursement rates currently paid by the products which you identified in §58.13(2) of your application. If reimbursement is not based on a CPT code scheme, provide equivalent information about reimbursement rates in a manner that facilitates comparison of different payers' rates (e.g., on a per member per month basis for capitated contracts), or contact the Office of the Attorney General for additional guidance.

PRODUCTS REPORTED IN *§ 58.13(2)*	**CPT CODES** REPORTED IN *§ 58.12(c)(1)*									
1.	$	$	$	$	$	$	$	$	$	$
2.	$	$	$	$	$	$	$	$	$	$
3.	$	$	$	$	$	$	$	$	$	$
4.	$	$	$	$	$	$	$	$	$	$
5.	$	$	$	$	$	$	$	$	$	$
6.	$	$	$	$	$	$	$	$	$	$
7.	$	$	$	$	$	$	$	$	$	$
8.	$	$	$	$	$	$	$	$	$	$
9.	$	$	$	$	$	$	$	$	$	$
10.	$	$	$	$	$	$	$	$	$	$

4. REVENUE OR PATIENT VISITS INFORMATION. Provide the percentage of your services purchased by each product for which you are proposing fee-related negotiations by completing the Revenue Table, below, with information for the last year for which data is available. If revenue information is unavailable, explain why, and complete the Patient Visits Table, below, in lieu of the Revenue Table. **Provide a separate table for each product with which you are proposing fee-related negotiations.** To the extent that the data provided does not accurately reflect current trends in your practice or differs significantly from your historical practice trends, describe those differences.

PRODUCT: _____

REVENUE TABLE

		Year _____
A	Total Revenue from the practice of medicine (all sources – commercial and government payers)	$
B	Revenue from the practice of medicine from all commercial payers	$
C	Revenue from the Product	$
D	• Percent of Total Revenue (Row C ÷ Row A)	%
E	• Percent of Commercial Revenue (Row C ÷ Row B)	%

PATIENT VISITS TABLE

		Year _____
A	Total number of patient visits (regardless of source of payment)	
B	Number of patient visits covered by commercial health insurance	
C	Number of patient visits covered by the Product	
D	• Percent of Total Patient Visits(Row C ÷ Row A)	%
E	• Percent of Commercial Patient Visits (Row C ÷ Row B)	%

OFFICE OF THE ATTORNEY GENERAL " STATE OF TEXAS
JOHN CORNYN

Sample Letter to Health Plan

Date

Dear Health Plan:

I am writing to notify you that an application has been made to the Office of the Attorney General ("OAG") on behalf of [list physicians or physician groups] to negotiate on fee related and/or non-fee related matters including the following commercial health benefit plans offered in [city or county] pursuant to Chapter 29 of the Texas Insurance Code. _____ is the physicians' representative.

The OAG is about to begin the review process for the referenced joint negotiation application. The joint negotiation group and the OAG will be required to expend considerable time and resources in collecting the information necessary to obtain approval. In view of the fact that the statute does not compel health benefit plans to participate in joint negotiations if approved, I would like to know by [date] whether you would be willing to participate in joint negotiations with this group of physicians.

If you do not respond to me in writing by [date] or if you respond that you are not willing to participate, the applicants will be offered the election of going forward with the OAG review process or withdrawing their application and receiving a refund of application fees paid to the State.

If you indicate that you would be willing to participate in such joint negotiations, please furnish a full and complete copy of all current contracts and fee schedules applicable to these physicians to this office, as the participating physicians have authorized in the enclosed Contract Information Disclosure Authorization Forms.

Also, please be advised that if review of this application moves forward, the OAG will likely request information from you and solicit your views concerning the proposed joint negotiations.

Sincerely,

John Cornyn
Attorney General of Texas

OFFICE OF THE ATTORNEY GENERAL " STATE OF TEXAS
JOHN CORNYN

May 17, 2000

Dear Physician:

The purpose of this letter to potential applicants under the physician joint negotiation statute is to outline the Office of the Attorney General's current antitrust enforcement intentions with regard to certain pre-application communications that are made in furtherance of and with the present intention of applying for antitrust immunity. This letter does not constitute legal advice. I cannot speak to the prosecutorial intentions of federal antitrust enforcement authorities or the right of private plaintiffs to bring a lawsuit.

Absent extraordinary circumstances, the Office of the Attorney General will not seek to prosecute competing physicians who communicate with each other about whether or not they should form a negotiation group and apply for approval under the physician joint negotiation statute (Insurance Code Chapter 29) and applicable rules. Physicians should refrain, however, from discussing, or sharing information about, specific fee-related terms and conditions until their application is approved, as discussed more fully below. Discussions about fee-related issues at this stage of the process should under no circumstances move beyond expressions of general dissatisfaction and evaluations of whether the issues warrant the formation of a negotiation group.[1]

Once an intention has been formed to apply for antitrust immunity under the statute and applicable rules, the physicians' representative should manage the assembly of information from competing physicians. Until the application is approved, the third party representative should carefully manage the collection of fee and non-fee related information so as not to share data improperly among competing physicians.

Fee-related information should not, except as outlined below, be shared by the third party representative with competing physicians. For this reason, from our experience, potential applicants are advised that antitrust problems may arise from utilizing a competing physician as the physicians' representative in a fee-related joint negotiation.

In assembling fee-related information, physicians need to be aware of the potential antitrust consequences of exchanging such information among competitors. Current fee-related information may be given to the third party representative but any information that is to be shared with or available to competing physicians should be more than three

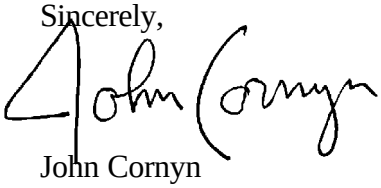
[1]This does not, however, contemplate the formation of any agreement by physicians to boycott or engage in other collective conduct that would, absent approval, violate the antitrust laws.

months old and sufficiently aggregated that it would not allow recipients to identify the prices charged by any individual competing physician.[2]

Third party negotiators should not collect, and physicians should decline to provide, information or views on what fees or rates are desired by the joint negotiation group until after the initial application has been approved. Moreover, once initiated, if negotiations fail or cease, participating physicians would be well-advised to discontinue communications with each other because failure to do so may subject the participants to antitrust scrutiny.

I hope you will find this guidance helpful should you decide to form a negotiation group and apply for approval to enter into joint negotiations. Questions may be directed to Assistant Attorney General Mark Tobey, at mark.tobey@oag.state.tx.us or (512) 463-1262.

Sincerely,



John Cornyn
Attorney General of Texas

[2] For further guidance, 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.