MINNESOTA COUNCIL of HEALTH PLANS

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December 10, 2014

State Representative John Lesch, Chair
House Civil Law Committee
537 State Office Building
100 Rev. Dr. Martin Luther King Jr., Blvd.
St. Paul, MN 55155-1206

Dear Chairman Lesch:

I am writing about the upcoming hearing of the House Civil Law Committee on Monday, December 15, 2014. One of the agenda items is to discuss unresolved issues from the past legislative session including SF 1770 and the language regarding the health plan data practices exemption.

I apologize, but unfortunately, I will be out of town on December 15, 2014, and I regret I will be unable to attend the hearing.

I understand from contacting your Committee Administrator that the hearing agenda will include issues similar to the meeting on October 28, 2014, of the Legislative Commission on Data Practices where I testified on behalf of the health plans. You will recall at that meeting I testified that the health plans were continuing to analyze the potential impact of SF 1770. That is still the case.

The health plans are also looking forward to the report that the Department of Human Services is preparing on the economic impact this legislation may have on the health care market.

Because I will not be present for the hearing, I am attaching a written copy of the testimony I gave to the Data Practices Commission. Please let me know if you or the members of the committee have any questions. Again, I apologize that I will not be able to participate in the hearing.

Sincerely,

Kathryn Kmit
Director of Policy and Government Affairs

CC: Members of the House Civil Law Committee

Attachment

Comments to the House Civil Law Committee

By Kathryn Kmit, MN Council of Health Plans regarding SF 1770

December 15, 2014

Mr. Chairman and members of the Committee:

I regret that I am unable to attend the hearing on SF 1770, but I hope the following information is helpful in understanding this issue. As you may know, the Minnesota Council of Health Plans represents Minnesota's seven nonprofit health plans.

I want to provide you with some context of this issue. Specifically:

1) Some background on how the system works currently;
2) Concerns with this new law; and
3) Some ideas for improving price transparency.

It's important to keep in mind that the cost of health insurance reflects the cost of care. If health care prices increase due to this law, ultimately, it would impact the cost of health care for individuals, employers and for the State of Minnesota.

The real policy question facing you is this: Will making this information public be in the best interest of consumers or not?

Some background on how the system works currently

Health plans purchase medical care services on behalf of their customers – such as individuals, employers and the State of Minnesota. The health plans contract with a wide range of doctors, specialists, hospitals, labs, radiology facilities, pharmacies, etc., -- all of which are included in the health plans' networks.

When health plans develop their provider networks, they require providers to go through an extensive credentialing process to review and verify a provider's qualifications to assure the provider meets the highest safety and quality standards. To be included in a health plan's provider network, the provider must meet these quality standards and agree to accept the health plan's contracted rate as payment-in-full for services.

There are several ways in which health plans are different from other vendors that contract with the state.

- **First, Minnesota's health plans don't have a choice about whether or not to participate in state public programs:** That's because Minn. Stat. 62D.04, Subd. 5 requires health plans – as a condition of state licensure – to participate in state public health insurance programs. Unlike other industries that do business with the state, *health plans do not have a choice whether or not to bid on contracts with the state.* They must bid on these contracts.

- **Second, health plans bring a great deal of value to the State:** Minnesota's health plans compete to provide coverage of the highest quality of care for the lowest price possible. Since the early 1980s, the State of Minnesota has recognized the tremendous value that

health plans bring through their volume-purchasing of quality health care services and their business-driven cost-containment efforts. The State relies on the health plans to improve the quality of care, to increase access to health care services, and to hold down the cost of health care for enrollees on state public programs.

- **Third, this system is much more efficient for the State**: Contracting with the health plans results in better value for enrollees – value including higher quality, better access to care, and lower cost – than what the State could ever deliver on its own with individual providers.

- **Fourth, this system assures budget stability and predictability for the State**: When DHS purchases coverage from the health plans, it shifts the financial risk for covering the health care costs of the enrollees to the health plans. In exchange, the State pays the health plan a set dollar amount. This means that, if the final cost of the contract is more than what was originally negotiated, the health plan is at total financial risk to absorb those additional costs, not the State.

In economic terms, the buyer is DHS and the sellers are the health plans. As the buyer, DHS requires and already receives all of this pricing information from the sellers, the health plans: The contract terms between health plans and their providers are submitted to DHS, so, as the buyer, DHS already has this information. In fact, on a bi-weekly basis, the health plans send to DHS the amount the provider billed for the service and the amount that the health plan paid the provider, along with other information, for every single service that is reimbursed.

At every annual contract negotiation with the health plans, DHS uses all of this data on cost and reimbursement (as well as other information submitted by the health plans) to validate the rates and terms of the contract. Again, all of the contracts between DHS and the individual health plans are public information and are posted on the DHS Web site.

Concerns with this new law

From a consumer perspective, as a general rule, the more transparency the better. The more information consumers have when shopping for a TV or refrigerator, the better they are able to make a decision about which product is right for them. When consumers go shopping, they can see the retail price listed on the TV or the refrigerator. But what they cannot see is the wholesale price the store paid to the supplier of those TVs or refrigerators.

Gathering and understanding price information for medical services is more difficult than most other products or services. Medical care is complex and many decisions about health care are made with urgency – meaning consumers don't always have time to shop adequately for the highest quality services at the best price, so they rely on the network of providers developed by their health plan.

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As you know, the data practices act makes all data public unless it is expressly protected as nonpublic. Data that are trade secret must be substantiated as trade secret by meeting certain elements defined in statute and case law. Relying on the state's trade secret provision to keep the terms of subcontracts nonpublic will likely require a lot of time and resources to clarify the status of every type of data.

This is a real concern since the proponents of this law have stated that reimbursement information included in provider contracts is NOT trade secret. Health plans disagree as they have always protected this information as trade secret.

Another problem is that health plans may be required to release proprietary or confidential business data that health plans should be allowed to keep as confidential. This is proprietary data that health plans use to compete against one another in the marketplace to drive value for the members we serve.

These are not new concerns. Back in 1991, the legislature recognized and acted to address this exact concern. This long-standing precedent to protect this very information exists in Chapter 62E – the Minnesota Comprehensive Health Association or MCHA statute, which governs the state's high risk insurance pool. Specifically, Minn. Stat. 62E.13, subd. 11, provides that *...if the [health plan] uses its own provider agreements for ...the provider network, then the terms and conditions of those agreements are nonpublic data.*

That is the same protection we would like to see for health plan subcontracts with providers and other vendors.

What do the experts have to say about this topic?
When analyzing these types of business-to-business marketplaces, some health care economists and the federal antitrust enforcement agencies have noted that public transparency of negotiated rates could actually inflate prices. This type of transparency, they argue, could discourage private negotiations. If providers can know how much other providers are getting paid, they will have no incentive to offer lower prices. That is why antitrust experts believe competing health plans negotiating privately with providers can help slow health care premium increases.

Concerns about the impact of price transparency on health care prices have led to some policy actions by antitrust authorities to limit transparency. For example, the Federal Trade Commission (FTC) has testified against legislation that would have required drug manufacturers to disclose rebates they give to Pharmaceutical Benefit Managers. The FTC argued that disclosure would facilitate collusion by drug manufacturers, raising the price that Pharmaceutical Benefit Managers pay for drugs, therefore leading to higher drug prices paid by insured consumers.

My point in raising these antitrust issues is not an argument against price transparency. Rather, it is a caution to consider the impact this could have on the marketplace and ultimately, on consumers.

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A few suggestions for improving price transparency

As patients assume greater financial responsibility for their health care coverage, they need meaningful information that will allow them to make informed health care decisions.

Price is not the only information needed to make these decisions, but it is an essential component that must be provided within the context of the individual's coverage. When medical services are covered by health insurance, the value of price information to consumers depends a great deal on the benefit structure. In addition, price transparency will only be useful if it is coupled with information on the quality of the care.

There are opportunities for the health plans to help consumers have greater power in the marketplace. One way to do this is to provide financial incentives for consumers to choose providers with lower per episode costs and higher measured quality. To the extent that consumers respond to the incentives that favor the high-performing providers, this expands the proportion of care that is delivered by high-performing providers. It also increases the health plans' negotiating clout with all providers to leverage lower prices. Health plans analyze complex data and use that analysis to offer products that highlight differences in both the cost and quality of care across providers. In fact, how to best provide this information to enrollees is an area of active competition between the health plans.

As you know, DHS is in the process of writing a report on this topic. The report is supposed to look at the public policy issues and the economic impact that disclosure of this type of pricing information could have on the health care marketplace. We anticipate the report will survey the literature by health economists who study and write about these issues for a living. The report findings should be used to inform the discussion and determine what the scope of this law ought to be.

In conclusion

The health care marketplace is extremely complex. Achieving a more transparent system involves multiple stakeholders and requires consensus among hospitals, physicians, and other care providers; the pharmaceutical and medical device industries; commercial and governmental payers; employers; patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution.

Any discussion of making additional price information available to consumers needs to take place in the context of whether or not consumers will be more successful in shopping for price and quality when they build upon the negotiating ability of health plans – compared to consumers who are just negotiating prices with providers on their own.

Health plans support engaging consumers to compare health care providers on the basis of both cost and quality. In most instances, the health plans are best positioned to provide the most accurate data on prices for their members.

- What we don't want to have happen is for our competitors to know the contract terms we have with our providers;
- We don't want our providers' competitors to know the contract terms we have with other providers; and
- We don't want our suppliers' competitors to know the contract terms we have with other suppliers.

As I stated at the outset, the cost of health insurance reflects the cost of care. Requiring this information to be public will likely reduce the health plans' ability to leverage price discounts from providers. If health plans lose the ability to negotiate lower prices for services, higher costs for consumers could be the result.

Again, the policy question facing you is this: will making this information public be in the best interest of consumers or not? We urge policymakers to exercise caution about price transparency between insurers and providers so that it does NOT adversely affect the marketplace by resulting in higher prices.

Thank you.