Testimony by Kathryn Kmit before a Joint Hearing of the House Civil Law,
HHS Policy and HHS Finance Committees
April 25, 2014

Chairman Lesch and members of the joint committees: My name is Kathryn Kmit and I represent the Minnesota Council of Health Plans. Thank you for convening this meeting. I appreciate the opportunity to testify on this important issue.

My testimony will outline the current practice as it relates to this type of data for health plans, AND our primary concerns with the current language of HF 2167. I will also provide a relevant precedent that is already in law within Minnesota statutes. We believe this precedent should be the basis for creating an amendment that addresses our concerns. I will also discuss the consequences to both the state and health plans if this bill is not amended.

**Let me begin with our primary concerns:**
Without changes to HF 2167, health plans would be required to disclose proprietary information, such as confidential business information and subcontractor agreements with physicians, hospitals, and other vendors. HF 2167 changes the current practice of the Minnesota Department of Human Services (DHS) and potentially the practices of other state agencies.

The health plans have viewed their contracts with the state as meeting the terms of the Data Practices Act under Minn. Stat. 13.05, Subd. 11. This view was recently upheld by the Minnesota Supreme Court in a case last November.

In short, neither health plans contracting with the state nor the state itself has viewed the terms and conditions of subcontracts between health plans and providers, hospitals and other vendors as public information. This has been the understanding and practice for many years.

HF 2167 brings to light an important public policy issue: that is, should the subcontracts of private parties contracting with the state be public. In the past, several governmental entities have interpreted the statute as giving them discretion to determine whether and the extent to which subcontracts would be public. For example, in the recent Minnesota Supreme Court Case, Timberjay Newspapers versus Johnson Controls, the school district did not include the requirements of section 13.05, Subd. 11, in its contract with Johnson Controls. DHS has also narrowed the extent of the language in its contracts with health plans.

The language at issue is the notice provision in section 13.05, subd. 11, which if included in whole in a state government contract, would require a private person to be responsible for data as if it were a government entity. This means that the private person would be responsible for not only maintaining the privacy and security of the data (which is not at issue here), but also for releasing the data, including data in the private person's subcontracts, if a request by an outside party is made.

Mr. Anfinson, representing the Newspaper Association, believes that DHS has not properly applied section 13.05 to its contracts with health plans. He has argued that the Minnesota Court of Appeals and the State Information Policy Analysis Division (IPAD) have interpreted the statute as applying to virtually all government contracts, regardless of whether the mandated notice is actually included in a particular contract or not. However, the Minnesota Supreme Court (the supreme law of the state) has reversed the Court of Appeals determination and interpreted the law as giving discretion to state agencies to decide whether and the extent to which the notice provision should be included in government contracts.

This state agency discretion is reflected in contracts between DHS and health plans. In those contracts, DHS requires health plans to be bound by applicable state and federal laws governing the security and privacy of information, without also requiring that all data created, collected, or maintained by a health plan be subject to *all* of the

requirements of the data practices act - in other words, without requiring a health plan to comply with requests for the release of data as if it were a government entity. This is the crux of our concern with HF 2167.

A long-standing precedent to protect this information already exists. The legislature has previously recognized this exact concern. Chapter 62E is the Minnesota Comprehensive Health Association or MCHA statute which governs the state's high risk insurance pool. This statute includes a provision that protects this very type of data. Minnesota Statutes 62E.13, subd. 11, provides that if the writing carrier (meaning the health plan) uses its own provider agreements for MCHA's provider network, then the terms and conditions of those agreements are nonpublic data. This particular provision was enacted back in 1991.

Yesterday, we met with Mr. Anfinson and representatives from the Department of Administration's IPAD Division, in an attempt to come to an agreement on amendment language. We appear to have agreement conceptually and we have been trading language with Mr. Anfinson to memorialize our agreement. I believe we are very close to finalizing that language.

With this amendment, we are proposing language similar to the MCHA language, which would be included in the respective sections of law related to health plan contracts with the state. This includes sections in law pertaining to the state Medical Assistance program, the MNCare program, the State Employee Group Insurance Plan, the Public Employee Insurance Program, and contracts that the health plans have with school districts, both fully insured and self-insured.

For the following reasons, it is clear that it is not necessary or in the best interests of the state to make health plan contracts with doctors and hospitals public.

**First, price transparency will drive up prices.**
The health plans are concerned that the disclosure of provider-specific pricing and contractual detail for the fees and pricing arrangements will result in higher health care prices for everyone. Today, each provider knows what his/her reimbursement rate is; the provider just doesn't know how much the provider down the street is being paid. If the rates are made public, there is no incentive for the providers to agree to a rate that is lower than the provider down the street. It will be a race to the top.

**Second, health plans are different; we are mandated do business with the State.**
As a reminder to the members of the committees, health plans are required – 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.*

Since the early 1980s, the State of Minnesota has recognized the value that health plans bring through their volume-purchasing of health care services and their business-driven cost-containment efforts. The State of Minnesota benefits from these cost savings, too. The State is able to depend on the sound business practices of the health plans to drive down the cost of health care for these state programs. Contracting with the health plans to provide these services ensures better coverage for enrollees than the State could ever negotiate on its own with individual providers.

**Third, unlike other contractors, health plans are at financial risk, not the State.**
Another important factor that differentiates health plans from most other contractors with the state is that health plans are at financial risk for their contracts with the state. This means if the final cost of the contract is higher than was originally negotiated, the health plan is at total financial risk to absorb those additional costs, not the State.

Making the health plans responsible for the full risk of these contracts provides budget stability and predictability for the State.

**Fourth, the health plan marketplace is already extremely competitive.**
As we've seen over the past year, competition works well in the private commercial health insurance market. In the last few years, DHS has moved to a competitive bidding model to drive down the cost of these health plan contracts even more. In fact, for fiscal year 2012, DHS reported they saved the state $175 million as a result of competitive bidding by the health plans for state public programs. Competitive bidding works because health plans compete fiercely against one another. They compete on price and added value. Therefore, it is necessary to maintain the confidentiality of subcontractor agreements to hold down price and ensure value through innovative proprietary business practices.

**Fifth, health plans already provide a lot of information publicly.**
The contracts that health plans have with the State of Minnesota are public information. They are posted on the state's website. In fact, a great deal of information about how health plans perform as vendors for the state is available on the DHS, and Minnesota Departments of Health and Commerce websites. These state agencies already have access to health plan financial and quality data to ensure that the needs of state public program enrollees are being met.

**Sixth, we must recognize the negative impact this bill could have on the state's overall health care marketplace.**
The majority of Minnesotans get their health insurance coverage through their employer or through a state public program like Medical Assistance or MNCare. The cost of coverage is negotiated with providers by the health plan. Health plans are able to leverage a lower rate because they can assure a certain patient volume for the provider. Health plans can also negotiate payment arrangements as a means to incent more efficient and quality-driven providers.

If enacted in its current form, HF 2167 will remove an important negotiating tool that health plans use to drive down the cost of coverage. If all of our negotiated rates are made public, we will lose much of our ability to negotiate lower prices. If the cost of coverage goes up, the cost will increase not only for the state budget for DHS and for SEGIP, but the cost of coverage will also increase for Minnesota individuals and employers who purchase coverage in the private commercial market.

**In summary**
The health plans care strongly about this issue for one simple reason. If health plans are forced to disclose the terms of their negotiated contracts, the market will respond accordingly and the cost of care will increase. As a result, the rates paid to providers will increase for the State of Minnesota when purchasing coverage for enrollees in Medical Assistance, MinnesotaCare and SEGIP, and may increase for individuals and employers who purchase coverage directly from the health plans.

We believe this amendment is needed for HF 2167 to do two things:

- To classify as nonpublic data under Chap. 13 the terms and conditions of the contracts between health plans and providers and other vendors; and
- To clarify that nothing in this section of law requires the release of trade secret information.

Thank you for the opportunity to testify. I would be happy to answer any questions.