

Health Care Contracting and the Minnesota Government Data Practices Act

Health Care Administration
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Executive Summary

In 2014 the Minnesota Legislature enacted changes to government contracting requirements within the Minnesota Government Data Practices Act (the Act). These changes clarified that the requirements of the Act apply to a private entity performing a government function regardless whether the executed contracts specify that the contractor is subject to the Act.¹

Part of the 2014 legislation also provided a temporary exemption from the contracting provision in the Act through June 30, 2015. This temporary exemption applies to health plans and other health service vendors contracting with a government entity. It also required the Department of Human Services (DHS) to study public policy issues and the economic impact on the health care market of applying changes to the Act to entities temporarily exempted in law. At issue are subcontractor data, including contracted fee schedules between health plans (under contract with the state of Minnesota) and the providers serving public health care program recipients.

DHS approached this report by first clarifying the current classification and treatment of health plan data to provide the appropriate framework for address the question of economic impact.

An analysis of the data classification by DHS concludes that much of the financial and individual level claims payment data provided to DHS by health plans is classified as not public under state law. This analysis is limited to the classification of data held by DHS. However, the report does include considerations for determining the classification of government data held by contractors (e.g. health plans and other entities under contract with the state).

To address the economic impact question, DHS took two approaches to receive information and analyses, including:

1. Contract with a health economist at the University of Minnesota to provide an independent analysis of potential market impacts.

The primary conclusion of the economic impact from faculty at the University of Minnesota is that classifying plan-provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets. Such disclosure may reduce the incentive for all providers to offer low prices and may facilitate collusion among providers. High levels of market concentration found in the health plan and provider markets in Minnesota would facilitate these outcomes.

2. Solicit public input and other evidence of potential market impacts through a Request for Information (RFI) and public stakeholder meeting.

Healthcare Contracting and the Minnesota Government Data Practices Act

The RFI generated 17 written comments from a range of stakeholders including health care provider groups, advocates, concerned citizens and health plans. While these responses addressed a broad range of topics, evidence and positions, two major themes emerged: (1) Additional access to health plan data related to public health care programs could improve taxpayer funded programs and (2) widespread knowledge of what health plans pay providers may encourage providers to seek higher rates and drive up the cost of care.

Through these processes, DHS found that there is a lack of community consensus regarding the economic impact of the public release of certain health plan data. There is also a lack of examples from health care markets and empirical evidence that definitively answers whether disclosure will lead to less competition and higher prices in the health care market. Therefore DHS is providing the above information to provide the framework and available evidence to assist and inform policymakers in determining whether further changes or clarifications to state law are needed.

I. Legislation

The 2014 Minnesota Legislature directed DHS to complete a study examining the effect of changes to the Act related to government contracts for health care services. The legislature required DHS, in consultation with interested stakeholders and other state agencies, to study the public policy issues and economic impact on the health care market of applying changes to the Minnesota Government Data Practices Act (the Act) to health plans, third party administrators, providers or other vendors contracting with a government entity for health-related services. The DHS Health Care Administration completed this study with support from its Legal Management Office and the Information Policy Analysis Division at the Department of Administration.

II. Introduction

DHS provides health care to more than 1.1 million Minnesotans through programs jointly funded by the State of Minnesota and the federal government, including Medical Assistance (Medicaid), and MinnesotaCare. Both programs provide health care coverage for low-income Minnesotans. Medical Assistance also covers long term services and supports for people with disabilities and older adults. These two programs are collectively referred to as Minnesota Health Care Programs (MHCP). In Fiscal Year 2014, total MHCP expenditures were over \$9.8 billion in both state and federal funds.

DHS contracts with eight managed care plans to deliver services to MHCP enrollees. The eight managed care plans include five Health Maintenance Organizations (HMOs) and three County-Based Purchasing plans (CBPs). In January, 2015, more than 850,000 MHCP enrollees (about 77 percent) received health care through a health plan. DHS pays each health plan a monthly capitation rate per enrollee and the plans pay providers for services provided to MHCP recipients.

Minnesota Government Data Privacy Act and the “Timberjay” Case

State law provides that when a private party or company contracts with a government entity to perform any of its functions, data related to the contract are subject to the Act. Under the Act, all data collected, created, received, maintained or disseminated by any government entity regardless of its physical form, storage, media or conditions of use are considered government data.² All government data are presumed public under the Act unless specifically classified under state or federal law.

In 2013, the Minnesota Supreme Court issued an opinion about a dispute between the Timberjay newspaper group and Johnson Controls, Inc. Johnson Controls was awarded a contract for a public school construction project in St. Louis County and had hired subcontractors to help with various aspects of the project. The newspaper group sought access to the subcontractors’ data, arguing that the data related to the government project were public under the Act. The courts ultimately ruled against the Timberjay newspapers because the main contract between Johnson Controls and the school district did not include a required statement indicating that the general contractor was subject to the Act.³

In response to this case, the Legislature in 2014 enacted changes to the government contracting requirements to clarify that the requirements of the Act apply to a private entity performing a government function regardless whether the executed contracts specify that the contractor is subject to the Act. The Legislature provided an exemption from this contracting provision through June 30, 2015 for health plans and other health services vendors contracting with a

government entity, and required DHS to study public policy issues and the economic impact to the health care market of applying changes to the Act to entities temporarily exempted in law.

This report focuses on the legal classification of certain health plan financial and business data under contract with DHS and whether there is an economic impact on the broader health care market from the public release of these data. Specifically at issue are subcontractor data, including fee schedules agreed upon between health plans (under contract with the state of Minnesota) and the health care providers and other vendors providing services to public health care program recipients.

This introduction (Section II) includes a description of the overall approach to the study, including the process for soliciting public comment. Section III describes the process DHS uses to handle data requests including criteria for determining data classification. Section IV contains detail on the classification of health plan data held by DHS. The Appendices are divided into three sections: (1) the independent analysis of the potential economic impact of releasing health plan provider contract data conducted by Dr. Roger Feldman with the University of Minnesota and (2) all responses to the RFI issued by DHS and (3) a summary of statutes classifying health plan data when held by DHS and by state agencies performing a regulatory function.

Methodology

DHS began work on the study following the end of the 2014 legislative session. The final product includes input from legislators, other state agencies, academics, advocates and other stakeholders. Initial efforts involved internal research to assess the methodology and scope of the report, including an analysis of the resources available to DHS for completing the study.

To address the economic impact question, DHS:

- Sought the assistance of a health economist with experience studying health insurance markets. DHS contracted with the Division of Health Policy and Management at the University of Minnesota to analyze potential market effects of releasing health care pricing data. The study was carried out by Roger Feldman, PhD, Blue Cross Professor of Health Insurance.⁴

The full analysis conducted by Dr. Feldman is provided in Appendix I of this report.

- Solicited public comment through a Request for Information (RFI) and by hosting a public meeting in late 2014. The RFI generated 17 written comments from a range of stakeholders including health care provider groups, advocates, concerned citizens, and health plans. These comments represent a broad diversity of opinion and outline some of the challenges

encountered by the DHS in producing this report. Several themes emerged from the comments including:

- Additional public access to health plan financial data related to the public health care programs may improve oversight of taxpayer funded programs.
- Concern that widespread knowledge of what health plans pay providers may encourage providers to seek higher rates and drive up the cost of care.
- Price disclosure could also benefit health care recipients and improve the state's understanding of the relationship between payment rates and access to services.
- Concern about the ability of health plans to negotiate terms with subcontractors needed to deliver services to MHCP recipients which could reduce access.

All comments received are included in Appendix II.

DHS also held a public meeting at the Elmer L. Andersen Human Services Building in downtown St. Paul on December 29, 2014. DHS staff at the meeting informed participants that comments voiced at that time would be summarized in this report. DHS staff also encouraged attendees who wished their entire comments to be included to provide written responses to the RFI. Questions and concerns attendees raised at the meeting include:

- Concern over how DHS will distribute notices regarding the RFI and whether the timing of its release was sufficient to facilitate public response.
- Questions about whether DHS would consider the potential for health plan pricing data disclosure to reduce prices.
- Attendees requested the name of the contractor conducting the economic analysis portion of this study. DHS staff responded with the name of the contractor.
- A concern that the study will recommend broader protections than are necessary to protect any data that may be sensitive or currently classified as not public.
- Questions about whether the disclosure of pricing data would facilitate collusion between providers to receive higher reimbursement from health plans.

III. Considerations for Handling Data Requests

Classification of government data depends on a number of factors and there is not always an easy or clear answer to whether or not data should be public. The following section describes the DHS process for considering data requests.

Background

As a state agency, DHS has legal obligations under the Minnesota Government Data Practices Act to disclose public data that it has. The Department discloses public data when responding to data requests from the media and the public.

DHS's Process

DHS, upon receiving a public data request, first determines whether it has data that fit the request. If the DHS has such data, DHS must determine whether the data can be legally disclosed. If the data are protected from disclosure by statute or case law, DHS cannot disclose them. But if the data are not protected, DHS must disclose. In instances where the Department is not sure whether the data are protected, DHS may seek an advisory opinion from the Information Policy Analysis Division (IPAD), which is part of the Minnesota Department of Administration.

If DHS does not have data that fit a request, DHS is not obligated to collect data to respond. If DHS does not have data, a data requestor can seek that data directly from the contractor.

Contractor's Process

Similar to DHS, a contractor that receives a public data request must determine whether it has data that fit the request. If a contractor does not have data, the contractor does not need to collect data to respond. But if a contractor has data that fit the request, the contractor must first determine whether the data are related to the contractor's performance of a government function pursuant to a contract with the DHS. *See* Minn. Stat. § 13.05, subd. 11(a).

If the data relates to the contractor's performance of a government function, the contractor follows similar steps as DHS to determine whether it can disclose the data: (1) disclose, if not protected; or (2) do not disclose, if protected. If a contractor is not sure whether to disclose, the contractor can: (1) seek an IPAD advisory opinion; or (2) file a declaratory-judgment action to ask a court with jurisdiction to decide the government-function question. In such an action, an entity or person requests a court to decide a legal question and then follows or appeals the court's decision.

Trade Secret Designations

Government data, including data that the DHS has are presumptively public unless the law classifies the data otherwise. One type of data classified as nonpublic data is trade secret information, which cannot be disclosed. DHS follows the statutory definition of trade secret information and applies the law to the data to determine whether the data can be disclosed.

Trade secret information is defined in Minnesota Statutes, section 13.37, subdivision 1(b), as

Government data, including a formula, pattern, compilation, program, device, method, technique or process:

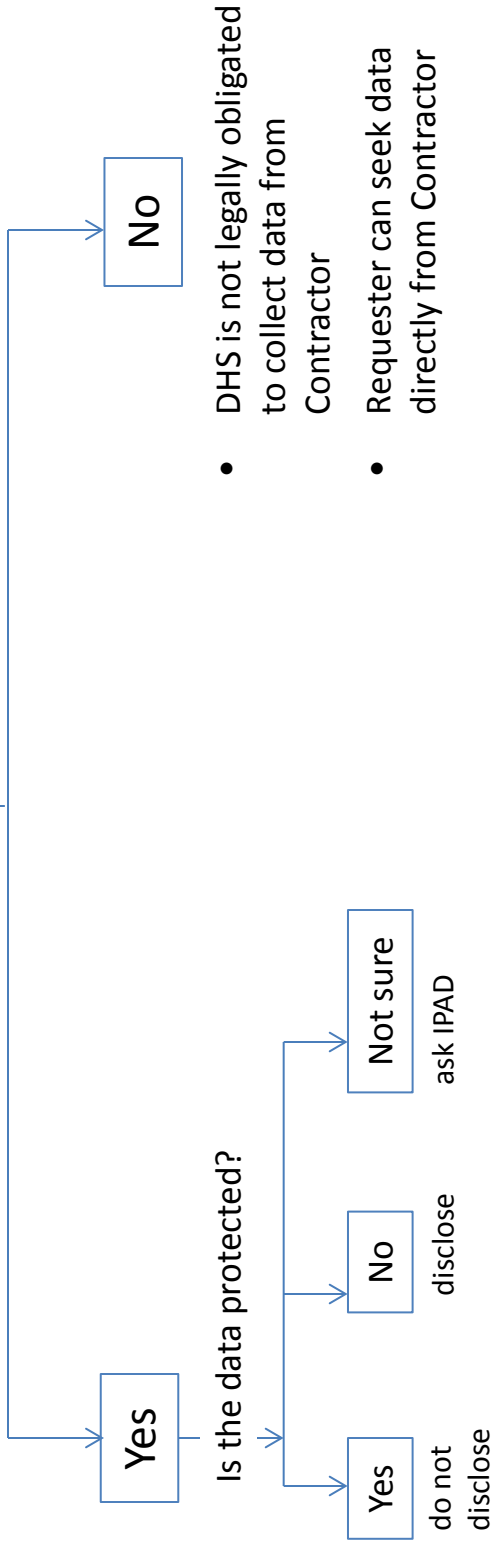
- (1) that was supplied by the affected individual or organization,
- (2) that is the subject of efforts by the individual or organization that are reasonable under the circumstances to maintain its secrecy, and
- (3) that derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.

Upon receiving a public data request that seeks data involving potential trade secret information, the DHS follows a multi-step process to analyze whether the data can be disclosed. First, the department must determine whether it has data that fits the request. Second, the department must determine whether the supplier of the data has sought to protect some part of it as trade secret information. Third, the Department must independently analyze whether the data may properly be characterized as trade secret information by evaluating Minnesota Statutes, section 13.37, subdivision 1(b), trade-secret case law, and previous advisory opinions from the Information Policy Analysis Division (“IPAD”), which is part of the Minnesota Department of Administration.

If the DHS concludes that the data is trade secret information, the data cannot be disclosed. But if the data is not trade secret information, and is not otherwise protected by law, the data must be disclosed. In instances where the department is not sure whether data is protected, the department may seek an advisory opinion from IPAD. Data requestors who disagree with the department’s conclusion regarding trade secret information, the requestor may also request an IPAD advisory opinion.

DHS

Does DHS have the data being requested?



- DHS is not legally obligated to collect data from Contractor
- Requester can seek data directly from Contractor

Contractor

Does Contractor have the data being requested and
DHS does not maintain the data?

Yes

No

Is the data part of a contractor's
performance of a government function?

Yes

No

Not sure

Contractor does not disclose

Contractor does not disclose

Contractor can ask IPAD/seek Declaratory Judgment

Is the data protected?

Yes

No

Not sure

Contractor does not disclose

Contractor discloses

Contractor can ask IPAD

IV. Classification of Health Plan Data

Data Held by DHS

Health plans under contract with DHS provide financial reports and patient encounter data directly to DHS. Encounter data are the primary records of services provided MHCP recipients, including recipient and provider information, dates of service, procedure and diagnosis codes and the amount paid for services. Much of this data is derived from the health plans' adjudication of provider claims submitted to them for services provided to enrollees. Financial data include income and expense reports, utilization reports, administrative spending data, third-party liability information and payments to providers by category of service.

The application of the new contracting provision on July 1, 2015 does not change the classification of health plan data held or maintained by DHS. Minnesota Statutes, § 256B.69, subdivision 9 classifies much of the data provided to DHS by health plans as not public data. This includes certain detailed health plan financial information including administrative expense data and provider payment information.⁵ Health plan capitation rates, the methodology for rate development, and executed health plan contracts are available to the public.⁶

Data Held by Health Plans under Contract with DHS

Minnesota Statutes, section 13.05 subd. 11, clarifies that a private party contracting with a government entity to perform any of its functions is subject to the Act and must comply with data practices requirements as though it were a government entity.

The data most relevant to this report are contained in subcontractor agreements between health care providers and health plans contracting with DHS to serve MHCP recipients. DHS does not hold contract data or documents between health plans and health care providers or other vendors providing services to public health care program recipients. These contracts are negotiated between health plans and providers; DHS is not a party to these negotiations and has no business reason to hold the contract data.

Health plan provider contracts contain information that may include provider reimbursement rates or salaries, payment methodologies, rebate or discount information and other underlying business data. Pricing agreements between health care purchasers and providers are generally kept confidential as a condition of the contract.

Publicly Available Health Plan Data

DHS maintains managed care website containing information and reports relating to health plan procurements, financials, health outcome performance measures and other public information for state public programs. This information includes summary level health plan financial data including premium revenues, medical expenditures, administrative expenditures, medical loss ratio information and contributions to reserves. Also available are total payments from DHS to health plans, monthly enrollment reports, and capitation payments by health plan.⁷ The Minnesota Department of Health (MDH) maintains financial reports for all health plans doing business in the state. Information available on the MDH website includes annual revenue statements, expenses and net income for all Minnesota health plans (public and commercial plans), IRS filings and annual financial examination and administrative cost reports.⁸

Other Relevant Data

DHS also contracts and maintains agreements with several other entities to administer or otherwise support the operation of the MHCP. These entities include health actuaries, providers, consultants, auditors, medical and pharmaceutical review agents and other vendors providing professional and technical support. Professional and technical services contracts used by the State of Minnesota specify that both the contractor and the state must comply with the Act as it applies to all data provided by the state and all data created, collected, received, stored, maintained or disseminated by the contractor in the performance of a government function.⁹

V. Conclusion

In the completion of this report, DHS has attempted to bring clarity to issues raised by legislators and stakeholders regarding the current classification of health plan data. To help address that question, DHS has provided a list of all data maintained by DHS, its classification and how it would process public requests for this data to help inform the public policy discussion and draw a distinction between what DHS holds as a state agency versus what type of data is held by a health plan (and other related health services providers and vendors) under contract with the state. DHS attempts to describe a similar process for these entities but cannot ultimately speak to how a state contractor, such as a health plan, would treat a public request for information or how such information is classified under the Act.

As it relates to the primary focus of the report required by DHS relating to the economic impact of the potential public release of certain subcontractor, specifically contracts and pricing information between health plans and providers, there does not appear to be overwhelming evidence to suggest a definitive answer or conclusion. There is also a lack of clear examples of broad public release of price information in a health care market to provide any estimated impact. DHS is providing the Legislature with information and analyses contained in this report to assist policymakers in answering this question.

Endnotes

¹ *Government Contractors and the Data Practices Act*, Legislative Commission on Data Practices, Legislative Coordinating Commission of the Minnesota State Legislature. Accessed December 21st at: http://www.lcc.leg.mn/lcdp/meetings/10282014/Government_Contractors_and_the_Data_Practices_Act%2010-28.pdf

² Minnesota Statutes § 13.02, subd. 7

³ *Johnson Controls, Inc.*, 839 N.W. 2d at 532 (emphasis added), The court reasoned that “Johnson did not agree to be bound by the Act. Johnson has neither a contractual nor a statutory duty to disclose the subcontract.”

⁴ The University of Minnesota’s policy on Endowed Chairs and Professorships can be found at <http://www.policy.umn.edu/Policies/Education/Colleges/ENDOWEDCHAIRS.html#200>

⁵ Minnesota Statutes §13.461, subd. 24a and §256B.69 subd. 9a and 9c

⁶ Minnesota Rules, part 9500.1459

⁷ For more information, please consult the DHS managed care reporting website at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905

⁸ For additional information, please see the MDH HMO reporting website at <http://www.health.state.mn.us/divs/hpsc/mcs/reports.htm>

⁹ For clarification, please see the sample professional and technical services contract used by the Department of Administration at <http://www.mmd.admin.state.mn.us/pdf/samplecontract.pdf>

Appendix I: Economic Study

Summary of Findings

DHS contracted with the University of Minnesota to provide an independent analysis regarding the economic impact of making the health plan-provider contracts public under the Act. The primary finding of this analysis is that classifying plan-provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets.

This conclusion is at variance with conventional wisdom, which holds that more information is better because it helps consumers shop for lower prices. However, in health care markets, and, more specifically, the MHCP health plans overseen by DHS, recipients do not face market prices and have little reason to shop for low-priced providers. In fact, MHCP recipients might gravitate to higher-priced providers if they associate high prices with high quality.

Furthermore, a distinction must be made between price transparency for final consumers (e.g. patients) and price transparency at the health plan-provider level. When health plans learn that one provider is offering a low price, they may demand that other providers offer a similar price. This will reduce the incentive for all providers to offer low prices. Price disclosure also may facilitate collusion among providers. High levels of market concentration found in the health plan and provider markets in Minnesota would facilitate these adverse outcomes.

The effect of price disclosure on sellers' incentives could be similar to the effect of a health plan contract feature known as "most-favored nation" (MFN) clauses. Under a MFN clause with a particular buyer, a seller agrees that it will not give any other buyer a lower price. MFN clauses prevent new insurers from entering the market and using innovative methods to negotiate lower prices. Such results might also follow from disclosure of DHS plan-provider contracts.

Empirical evidence suggests that price disclosure in concentrated markets can lead to higher prices. The most notable example occurred in 1993, when the Danish Competition Authority required that ready-mix concrete prices be made public. It hoped that price disclosure would stimulate greater competition. Instead, average prices rose by 15-20 percent. Other studies have found similar price increases, although the evidence is not uniformly hostile to price disclosure.

The primary focus of price disclosure has been on the payment methodologies and rates that health plans have negotiated with providers. However, price disclosure may extend "down the line" to the subcontractors that health plans use to conduct much of their business. Health plans subcontract to pharmacy benefit managers (PBMs), dental carriers and behavioral health organizations that "rent" their provider networks to the plans. Disclosing the terms of these contracts also has the potential to reduce competition.

The United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) have evaluated the likely effects on competition of disclosing prices paid by buyers of an intermediate product. The DOJ has indicated that it would have serious concerns over the potential anti-competitive effects of hospital price disclosure by private parties. The FTC has analyzed a number of state legislative proposals involving mandatory transparency requirements for PBMs and their likely effect on competition. A series of staff comments have highlighted two types of concerns: (1) mandatory disclosure requirements may hinder the ability of health plans to negotiate an efficient level of disclosure with PBMs; and (2) if such disclosures publicly reveal previously proprietary and private information, disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers.

More limited forms of price disclosure that do not have these likely adverse consequences are possible. For example, health plans could be required to disclose their patients' out-of-pocket expenses at different providers. But health plans can do this without legal compulsion; and as noted earlier, even this limited form of price information will not help consumers shop for low prices if they do not face copayments that differ across providers.

These findings do not imply that consumers do not want information to help them make smarter health care purchases. Among the types of information that could be disclosed are the following: (1) Is my doctor or hospital in the network? (2) Does the doctor I want to see accept new patients? (3) Will I be charged a facility fee? and (4) What is the quality of the provider I want to see?

I. Methodology and Background

A. Methodology

Dr. Feldman met with DHS staff to clarify the scope of work for the study. Then he reviewed the literature on price disclosure using a “cascading search” approach. This begins by searching data bases of scholarly articles with key phrases such as “price disclosure *and* health care.” Articles produced by this search are reviewed, and then the references in those articles are reviewed. The search was limited to English-language articles but not to studies conducted in the United States or to price disclosure in health care. The goal was to take a broad perspective on price disclosure in different industries. In fact, one of the most important studies of price disclosure (described below) focused on disclosing the price of ready-mix concrete in Denmark.

Dr. Feldman also reviewed the position of the two main antitrust agencies – the United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) – on price disclosure. He identified and summarized a DOJ business review letter and several FTC staff comments on price disclosure.

B. Managed Care Organizations Serving Minnesota Health Care Programs

DHS contracts with five health maintenance organizations (HMOs) and three county-based purchasing organizations to administer the MHCP programs. The HMOs are Blue Plus, HealthPartners, Medica, Metropolitan Health Plan, and UCare. The county-based purchasing (CBPs) organizations are Itasca Medical Care, South Country Health Alliance, and PrimeWest Health. Plans' service areas are shown in Figure 1 and enrollments in Figures 2 and 3.

Two HMOs, Medica and UCare, have statewide service areas, and Blue Plus is statewide except for partial service in Lake County.¹ The other HMOs and county-based purchasing organizations have regional service areas, often in non-contiguous counties.

UCare enrolls the largest share of families (under age 65) and children, followed by Medica, HealthPartners, and Blue Plus. UCare also is the largest plan for the elderly and people with disabilities, but it is followed closely by Medica with Blue Plus holding a smaller share of the senior and special needs enrollment.

MHCP enrollment is spread throughout the state. The Minneapolis-St. Paul (MSP) metropolitan area² has 59 percent of statewide enrollment for families and children, with Hennepin and Ramsey Counties accounting for 184,124 and 104,451 of those enrollees. A similar pattern is observed for the elderly and people with disabilities, with 55 percent of state-wide enrollment in the MSP metropolitan area. However, because the MSP metropolitan area has 61 percent of the total Minnesota population, MHCP enrollees are not disproportionately concentrated in the MSP metropolitan area.³

C. The Health Insurance Market in Minnesota

The health insurance market in Minnesota is highly concentrated. According to data analyzed by the American Medical Association, Blue Cross and Blue Shield of Minnesota and Medica have a combined market share of at least 60 percent in all of the state's four metropolitan areas, as well as a state-wide market share of 72 percent.⁴ This includes all product types (PPO, HMO, and Point-of-Service) and both self-insured and fully-insured enrollment.

The Herfindahl-Hirschman Index (HHI) is a widely-used measure of market concentration. The HHI is calculated by summing the squared shares of all market participants and then multiplying by 10,000; it ranges from zero (many small firms) to 10,000 (a monopolist). The Horizontal Merger Guidelines issued by the U.S. Department of Justice and the Federal Trade Commission generally consider markets with HHIs above 2,500 to be highly concentrated.⁵ Mergers resulting in highly concentrated markets that involve an increase of 100-200 points in the HHI raise potential competitive concerns that often warrant scrutiny from the antitrust agencies.⁶

According to this standard, the health insurance market in Minnesota is highly concentrated, with an overall HHI of 2,960. HHIs in individual metropolitan areas are higher, which is generally the case when the geographic area is smaller than the whole state.

D. Health Care Markets in Minnesota

Health care markets in Minnesota are highly concentrated for the most part. In 2011, 51 of the state's 87 counties had only one hospital.⁷ The Twin Cities had more hospitals (11 in Hennepin County and 7 in Ramsey County), but hospital ownership is concentrated in several large systems than can negotiate as single entities with insurance companies. Allina Health and Fairview Health Services had 1,857 and 1,414 of the 11,721 hospital beds available in Minnesota in 2012.⁸ The Mayo Clinic was the third-largest hospital system with 1,748 beds.

Information on concentration in the physicians' market is lacking, but if data from Medica are representative, the three largest integrated delivery systems control 43 percent of the physicians' services in the state.⁹

II. Economic Analysis of Price Disclosure

Economists agree that perfect information is a requirement for market competition.^{10,11} Perfect information enables buyers and sellers to take advantage of every market opportunity. Buyers can discover and shop at sellers with lower prices; sellers can avoid selling their goods at prices below those generally available in the market. The interplay of informed buyers and sellers in a perfectly competitive market ensures that prices are no higher than an informed buyer would pay, but no lower than an informed seller would need to stay in business. Therefore, providing more information often is recommended to promote competition and reduce prices in markets where information is imperfect.¹²

However, it is not clear that providing more information will reduce prices in markets where another requirement for market competition is not met. The other requirement is that buyers and sellers are too small to influence prices by their individual actions and they do not collude to set prices. Will disclosure of information reduce prices when buyers or sellers – either individually or collectively – have the power to set prices?

In 2008 Congress commissioned the Congressional Research Service (CRS) to prepare a report on price transparency in the health care sector. The CRS examined many empirical studies that had been conducted in other markets and concluded that most of the evidence suggests that price transparency leads to lower and more uniform prices.¹³ Much of that evidence pertained to the effects of imposing or lifting restrictions on advertising of prices. In industries as diverse as vision exams and eyeglasses, prescription drugs, and gasoline, the ability of sellers to advertise prices resulted in lower prices.

In all of these examples, the price information was used by final consumers (e.g. patients or motorists) to shop for lower prices. The sellers and final customers were very numerous and did not have the power to set prices, either individually or collectively. The effects of price information in the hands of final consumers may not apply to large purchasers such as health plans.

A. The Ready-Mix Concrete Case

However, the CRS noted that increased price transparency could have the opposite effect. They discussed one example at length. In 1993 the Danish Competition Authority required that ready-mix concrete prices be made public, which it hoped would stimulate greater competition. Instead, average prices rose by 15-20 percent. Because this example was associated with such a large price increase, it is useful to refer to the source documents for a more detailed description:^{14,15}

In October 1993 the Danish antitrust authority, the Competition Council (CC in the following), decided to gather and regularly publish statistics on transactions prices of individual firms for two grades of ready-mixed concrete in three regions of Denmark. The intervention by the CC was based on The Competition Act of 1990. According to Article 1, “The purpose of this Act is to promote competition and, thus, strengthen the efficiency of production and distribution of goods and services, etc., through the largest possible transparency of competitive conditions and through measures against restraints on the freedom of trade and other harmful aspects of anti-competitive practices” (our translation and emphasis). In the interpretation of the Act by the CC, any suspected abuse of dominant position, e.g. through oligopoly collusion, coordination or price discrimination, should be countered by measures to increase market transparency. Thus, the general premise of Danish antitrust policy seems to have been that easing the flow of firm-specific price information always improves the possibilities for potential customers to shop around for bargain-prices and thereby put pressure on oligopolists to lower their prices.

However, following initial publication, average prices of the reported grades of concrete increased by 15-20 percent within less than a year as compared to annual inflation rates of a mere 1-2 percent. Furthermore, the data reveal that, at least locally, the prices converged significantly across firms serving the same market. We investigate whether these phenomena may be due to a business upturn and/or capacity constraints in the concrete industry, but argue that these seem to have little explanatory power.

What differentiates this example from those where price disclosure was associated with lower prices? The CRS offered two explanations for the increase in prices in the concrete case: first, price disclosure may have facilitated collusion among the sellers; second, price disclosure may

have altered the sellers' incentives, inducing them to become tougher bargainers.¹⁶ These outcomes were possible because market concentration in the Danish ready-mix concrete industry was exceptionally high. In 1987 four firms controlled 57 percent of the industry output, with the top firm having a 37 percent market share. Two years later, the top firm bought the number three firm, increasing its market share to 43 percent.¹⁷ These were national market shares; the authors noted that high transportation costs likely created distinct geographic markets within which concentration would have been higher.¹⁸

The formal name for an industry with few sellers is an "oligopoly." In an oligopolistic industry, price disclosure enables a small number of sellers to discern the prices being charged by other sellers. This type of price disclosure may facilitate collusion and/or change the sellers' incentives. The authors suggested that "...publication of the firm-specific prices reduced the extent of oligopoly competition and, hence, led to increased prices."¹⁹

Concerning the argument that price disclosure may facilitate oligopoly collusion, *explicit collusion* occurs when firms have an expressed agreement to set prices. There is no evidence of explicit collusion among the Danish cement firms. However, *tacit collusion* can occur when parallel actions among competing firms achieve higher prices and profits, as if they were guided by an explicit agreement. For either form of collusion to be feasible, firms need to be able to observe deviations from the collusive prices, such as secret discounts. The economists who analyzed the Danish cement case reasoned that price disclosure made it easier to detect cheating on the collusive prices.²⁰

In general, the longer it takes before a deviation is discovered or the less likely it is that it will be discovered, the more difficult will it be to sustain perfect collusion. Hence, increased transparency, in the sense of faster or more reliable information about deviations, may allow prices to increase from static Nash equilibrium prices to monopoly prices.

Two features of an industry that facilitate tacit collusion are (1) a plausible amount of mutual understanding among firms and (2) a transparent mechanism for coordinating on the collusive outcome.²¹ Both features were present in the Danish concrete case. The industry in the Aarhus (Denmark's second-largest city) region, which was studied most extensively, was described as a "tight oligopoly of four firms."²² A plausible amount of mutual understanding was present. The coordination mechanism was monthly publication of the list, average, and low prices. In the second three months of the price transparency program, the low prices of all four firms in the Aarhus area shot up by 20-25 percent.

Concerning the change in sellers' incentives, in subsequent work motivated by the Danish concrete case, Hviid and Møllgaard developed a model of price transparency in a monopolistic

industry.²³ In their model, two buyers negotiate with the single seller of an intermediate product (cement is an intermediate product in the construction of buildings, roads, etc.). One of the buyers has relatively better information about price than the other buyer. When the less-informed buyer sees the better-informed buyer paying a lower price, it demands a lower price. But the seller realizes that the low price charged to the informed buyer has a “spillover effect” and it responds by tougher bargaining with the informed buyer. The result is that transparency raises the price for the informed buyer and lowers it for the uninformed buyer. The *average* price could rise or fall.

Hviid and Møllgaard’s model is purely theoretical, but the authors of the CRS report noted the similarity between that model and negotiations between hospitals and insurers:²⁴

Hospitals engage in negotiations with private insurers, which make about one-third of hospital payments. Some insurers are in a stronger bargaining position than others due to better data analysis, larger size, or managerial talent. The Hviid and Møllgaard model and the Danish experience with price transparency in the concrete market suggest that it is not inevitable that greater price transparency in hospital markets would lead to lower average prices.

B. “Most-Favored Nations” Clauses

Two American economists, David Cutler and Leemore Dafny, noted the similarity between the change in sellers’ incentives under price disclosure and a feature of health plan contracts known as “most-favored nation” (MFN) clauses.²⁵ Under a MFN clause with a particular buyer, a seller agrees that it will not give any other buyer a lower price. For example, suppose that hospital X has 2,000 admissions from Insurer A and 1,000 admissions from insurer B. Insurer A has a MFN clause in its contract with Hospital X specifying that Hospital X cannot sell admissions to any other insurer at a lower price. If Hospital X were to cut the price for Insurer B’s 1,000 admissions, it must cut the price for Insurer A’s 2,000 admissions. The volume of admissions affected by the price cut to Insurer B would be magnified by 200 percent.

Insurer A in is similar to the less-informed buyer in Hviid and Møllgaard’s model – when it sees the better-informed buyer (Insurer B) paying a lower price, it demands a lower price as well. Cutler and Dafny think that such contracts have “a particularly pernicious effect” because they prevent new insurers from entering the market and using innovative methods to negotiate lower prices.²⁶

In both cases (ready-mix concrete and hospital-insurer bargaining), the buyer must have some unexploited market power to demand a lower price. This is more likely when it buys a substantial share of the good in question. Otherwise, the concrete seller would not yield to a less-informed buyer that demands a lower price, and the hospital would refuse to contract with a less-informed insurer that demands a MFN contract.

C. Price Disclosure “Down the Line”

The primary focus of price disclosure has been on the payment methodologies and rates that health plans have negotiated with providers. However, price disclosure may extend “down the line” to the subcontractors that health plans use to conduct much of their business. MCOs contracting with DHS subcontract with pharmacy benefit managers (PBMs), dental carriers, and behavioral health organizations that “rent” their provider networks to the plans. To what extent can economic analysis determine the likely impact of disclosing these prices?

The subcontractor that has received the most attention in the literature is the PBM. PBMs provide prescription drug management services to employers, health plans, union groups, and other health plan sponsors. A full-service PBM maintains eligibility information, adjudicates claims, provides clinical services including selecting and managing a formulary, contracts with and manages a pharmacy network, and runs a mail-order pharmacy.

Pharmacies compete to be in the PBM’s network by offering discounted prices, and drug manufacturers compete to be in the PBM’s formulary by offering rebates on their drugs. These sources of revenue, in addition to fees for administrative services and the mail order pharmacy, comprise the PBM’s revenue. There are about 60 PBMs in the United States, with the four largest being Express Scripts (which acquired Medco Health Solutions in 2012), CVS Caremark, Prime Therapeutics (owned and operated by a collection of Blue Cross and Blue Shield Plans), and UnitedHealth Group.

By reducing the price of prescription drugs and the cost of drug coverage, PBMs are estimated to save from 30 to 35 percent of total prescription drug spending.²⁷ Despite evidence of significant cost savings, PBMs have come under scrutiny for not releasing data on their pharmacy discounts and manufacturer rebates to health plans and the public. Several states have enacted mandatory disclosure laws (e.g. Maryland, Mississippi, North and South Dakota, and Vermont).

In a scathing review of these laws, Professor Joanna Shepherd from the Emory University School of Law maintains that “...there is no theoretical or empirical reason to believe they are essential to ensure that health plan sponsors pay a competitive price for PBM services.”²⁸ Her argument is that PBM disclosure laws are based on the false premise that health plan sponsors need to know the PBM’s costs. This would be unlike almost every other product that consumers buy. For example, consumers don’t know the costs of the company that made their iPhone. Why do consumers need to know the costs of Apple or Samsung, when they can compare iPhones on the basis of price and features they want? The argument applies even more strongly to PBMs, where the purchasers are large, well-informed health plans that make repeat purchases (making it even more unlikely that a PBM could sneak a defective product under their noses). Moreover,

the evidence indicates that such laws are unnecessary because PBMs pass almost 90 percent of manufacturer rebates along to plan sponsors.

Drawing on the Federal Trade Commission (FTC) comments discussed below in this report, Shepherd concludes that the laws have no benefit and will impose significant direct costs and litigation costs on PBMs. She also mentions the possibility that PBM disclosure laws will reduce competition by blunting the incentive for pharmacies and manufacturers to give discounts.

D. Evidence from Other Industries

In a review of the literature, Robert Hahn and colleagues mentioned two other studies that found unexpected price increases following price disclosure.²⁹ First, Paul MacAvoy found that price-cost margins (a measure of profitability) in markets for long-distance telephone services increased from 1984 to 1997, despite a decrease in sales concentration.³⁰ MacAvoy attributed the increases to regulations established by the Federal Communications Commission that required carriers to offer plans under publically available tariffs.

Second, Stephen Fuller and colleagues found that rail rates for shipping grain in south-central states increased after implementation of 1986 legislation requiring that certain contract terms, including prices, be disclosed.³¹ In further analysis of the same legislation, John Schmitz and Stephen Fuller found that rail rates for shipping corn increased on routes with no direct barge competition while rates decreased on routes with substantial barge competition.³² They concluded that these patterns of rate changes "...may be the result of increased information combined with the highly concentrated nature of the rail industry."

E. Evidence in Favor of Price Transparency

Although the studies discussed above – especially the ready-mix concrete case – tend to tip the scales against price disclosure, a recent analysis points to the benefits of disclosing hospital charges.³³ Hans Christensen and co-authors studied the effects of state laws that require hospitals to report their average charges to agencies that make them available on public web sites. While acknowledging that disclosure of hospital charges is "...far from what proponents of healthcare price transparency would argue are optimal..." the authors maintain that charges are relevant for uninsured patients and insured patients who pay a fraction of the hospital's bill.³⁴

The authors focused on hospital charges for hip replacements, a relatively common, non-emergency procedure where it makes sense for patients to "shop around" before choosing a hospital. They found that charges for hip replacements fell by an average of 7 percent after disclosure laws became effective. To rule out the possibility that this reduction could have been caused by a coincidental factor rather than price disclosure, they studied the charges for appendectomies, a non-discretionary, emergency procedure. Price disclosure did not affect

charges for appendectomies, suggesting that disclosure was responsible for the drop in charges for hip replacements.

Further analysis indicated that the reduction in prices was concentrated in urban areas where competition among providers was more intense. The effect of price disclosure in urban areas was minus 7.6 percent, but the effect in rural areas was small and not statistically significant.

Next, the authors examined a data base that contained actual payments for hip replacements made by insured patients and their insurers. The relation between mandated disclosure of hospital charges and actual payments was small and only marginally significant. The authors attributed these weak results to the fact that insured patients pay only a small share of the total payment, making them insensitive to price. However, patients with coinsurance of at least 10 percent paid substantially less (between -9.6 and -14.4 percent) after disclosure than those with minimal coinsurance.

This study suggests that disclosure of hospital charges is associated with lower charges in more competitive areas and lower total payments by patients who are sensitive to prices.

Another recent study, by Sze-jung Wu and co-authors, lends support to the price transparency argument.³⁵ The authors studied a price transparency program for magnetic resonance imaging (MRI) that was implemented by AIM Specialty Health, a large specialty benefit management company. The prices for MRI scans can range from \$300 to \$3,000 within a given geographic area with no demonstrated differences in quality. To encourage them to use “high-value” (less costly or higher quality) MRI facilities, patients in an intervention group were informed of price and quality differences among facilities and given the option of selecting different providers. Patients from nonparticipating commercial health plans in similar geographic regions were the control group. The intervention was unique in that patients were contacted and informed that a high-value imaging facility was a practical choice instead of referring them to a web site.

The primary outcome was the change in cost from 2010 to 2012 (before and after the program) among intervention group patients compared with the change in cost among control group patients. The authors found a cost decrease of \$95 for the intervention group compared with an increase of \$124 for the control group – a net difference of \$219. This is despite the fact that one-third of the patients in the study had no cost sharing for their MRIs.

One factor driving the cost reduction was a notable shift away from hospital-based outpatient facilities to office-based or freestanding facilities (53 percent in 2010 to 45 percent in 2012) in the intervention group. This percentage was relatively unchanged in the control group.

The authors also found that patients from nonparticipating employer groups in the same markets as the intervention experienced a decrease in cost compared with the control group. They attributed this to increased provider competition in the intervention markets. However, it could have been caused by unobserved cost-reducing factors in the intervention markets that were unrelated to the transparency intervention.

III. Antitrust Analysis

The United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) are responsible for enforcing the antitrust laws of the United States. The DOJ enforces numerous laws, but primarily Sections 1 and 2 of the Sherman Act, which prohibit business practices in restraint of trade and monopolizing trade.³⁶ The FTC is charged with preventing unfair methods of competition and unfair or deceptive acts or practices that affect commerce.³⁷ As explained below, both agencies have evaluated the likely effects on competition of disclosing prices paid by buyers of an intermediate product.

A. 2010 DOJ Business Review Letter

In 2010 the DOJ issued a Business Review Letter in response to a request from a group of health care purchasers in California that included employers, public agencies, unions and health and welfare funds.³⁸ The purchasers were proposing to collect and analyze claims data from five large payers and 300 hospitals who had agreed to participate in the Hospital Value Initiative (HVI).

Under HVI an independent consultant would collect and analyze the data, develop index scores that would compare the relative cost and resource utilization of hospitals in California and distribute the index scores to purchasers, payers and hospitals. The request for a Business Review Letter asked DOJ if it would challenge the HVI on the grounds that it would have anti-competitive effects.

After reviewing the information provided by the purchasers' group, DOJ concluded that the HVI was not likely to have anti-competitive effects; rather, sharing information about the relative costs and resource utilization rates of California hospitals would help payers and purchasers make informed decisions when purchasing hospital services.

DOJ reached this conclusion on the basis of three salient findings:

1. No participating hospital, payer, or group purchaser would have access to the data submitted by any other participant;

2. The HVI reports would not disclose the prices that any participating hospital charged for its services;
3. Most important, no participant could infer from the reports the rates paid by any payer to any hospital.

With the price data protected by these conditions, DOJ concluded that the HVI reports would not pose anti-competitive threats, but would allow participants to better evaluate differences in costs and resources that hospitals use to treat comparable conditions.

DOJ did not disclose what it would have concluded if one or more of the conditions had not been met. But it is quite clear that their central concern was whether the HVI would release price data to the participants or allow prices to be inferred from the reports. By inference, if health plan and provider pricing data potentially made public under the Minnesota Government Data Practices Act were released by private parties, the DOJ likely would have serious concerns over the potential anti-competitive effects.

B. FTC Staff Comments

The FTC responds to requests for comments on the likely impact of proposed state legislation. In separate cases, the FTC has expressed concerns that disclosing prices paid by an intermediate purchaser might have anti-competitive effects.

In New Jersey General Assembly Bill 320 (A-320) and New York Senate Bill 58 (SB-58), the intermediate purchasers were pharmaceutical benefit managers (PBMs), who manage pharmacy benefits for health plans and self-insured employers. Bill 320 would have required PBMs to disclose to purchasers "...the nature, type and amount of non-purchaser remuneration..." that the PBM received.³⁹ SB-58 would have required PBMs to make substantial disclosures to health plans, including details of the rebates they receive from drug manufacturers.⁴⁰

While agreeing that consumers need accurate information on prices to make purchasing decisions, the FTC did not believe that health plans need any assistance in shopping for PBMs' services or that the information disclosed to health plans would remain confidential. The FTC also was concerned that the general obligations imposed on PBMs were overly broad and ambiguous and could lead to a presumption of fiduciary duties that go beyond a normal business contract.

Although relevant, these two cases did not focus specifically on price disclosure as did the DOJ's opinion regarding the VHI in California. The proposed New Jersey and New York laws were very broad, and they raised "red flags" that the respective laws were overly restrictive in many ways. For example, A-320 would have limited PBMs' ability to use mail order pharmacies and

to substitute less costly therapies. Consequently, the FTC's concern could be interpreted as opposing a broad package of regulations of which price disclosure was only one element.

The FTC clarified its position on price disclosure in a recent letter to the ERISA Advisory Council. In a section that refers to the New Jersey and New York cases, the FTC states: ⁴¹

Since 2005, FTC staff has analyzed a number of state legislative proposals involving mandatory transparency requirements and their likely effect on competition. These FTC staff comments have highlighted two particular types of concerns: (1) mandatory disclosure requirements may hinder the ability of plans to negotiate an efficient level of disclosure with PBMs; and (2) if such disclosures publicly reveal previously proprietary and private information about discounts negotiated with PBMs, disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers.

Based on this statement, it seems likely that the FTC would oppose mandatory disclosure of PBM prices, even if the proposal did not contain onerous restrictions on PBMs' business practices.

IV. Policy Options

A. Full Price Disclosure

Full price disclosure in a concentrated industry is likely to have adverse consequences. It can lead to provider collusion and reduce providers' incentives to discount prices. However, price disclosure for hip replacements was related to decreased hospital charges in more competitive markets.

Another factor to consider is whether patients will respond to the price information. This is not likely unless they face differences in cost sharing that require them to pay a portion of the higher prices.

B. Limited Price Disclosure

Should *any* prices be disclosed in a market with concentrated sellers and buyers? Cutler and Dafny recommend that plan-specific patient copayments should be disclosed: "Copayments, after all, are what patients actually pay."⁴²

However, Cutler and Dafny did not explain why copayments need to be disclosed. Many commercially-insured patients pay a flat copayment that is independent of the actual prices

negotiated by providers and health plans. For example, the office visit copayment may be \$25 for any provider in the plan's network. Out-of-network copayments typically are set at higher, but still fixed, levels. This information already is "disclosed" to the patient in his/her insurance plan booklet. Some Minnesota Health Care Program recipients are required to pay minimal copayments, but they are set by statute and do not vary between providers for the same service.

Provider price information would be useful to commercially-insured enrollees in "tiered" health plans whose copayments depend on the costliness of the providers they select. But information on providers' cost tiers already is available to enrollees in these plans (e.g. State of Minnesota employees in the Minnesota Advantage Health Plan).

Provider price information also would be useful for patients with deductibles in their coverage, but even patients in high-deductible health plans (HDHPs) will exceed the deductible immediately upon entering any hospital for an overnight stay. The most useful price information for patients with high deductibles would be the prices of physician office visits and tests.

Finally, provider price information would be useful for uninsured patients, but these are a small percentage of the Minnesota population. Furthermore, some providers discount prices to uninsured patients on a "one-off" basis. This type of information would be very difficult to collect because it is unique to each encounter.

Cutler and Dafny also suggest that reporting average reimbursement rates across all payers would be less likely to generate unfavorable consequences because such reports can "shroud" information about low prices. However, they note that "...though these programs may do no harm, they do not give patients information about the prices that they will actually pay for care."⁴³

This point was further explained by Morgan Muir and co-authors:⁴⁴

But, while the disclosure of average prices reduces price secrecy, such limited disclosures will not be sufficient to also affect patient healthcare decisions. In practice, average prices can depict such an expansive range that consumers are often unable to draw helpful price comparisons among providers. Further, limited disclosure cannot capture the many variables that affect price variation – including condition severity, geographic location, and quality of provider – that will inevitably affect price.

Muir and co-authors caution that "Market concentration and the negotiating power of providers must be addressed before price transparency can truly be effective."⁴⁵ But they also note that "...identifying this possibility and the market conditions that create it, can enable policymakers

to design around this concern.”⁴⁶ Antitrust policy can play a role by challenging mergers that increase concentration in health care markets.

Another option for limited price disclosure is to allow the prices negotiated by health plans and providers to be disclosed after a waiting period. This approach is used by the State of California, which exempts portions of a provider contract with Medi-Cal (the California Medicaid program) from disclosure for three years.⁴⁷ This option has three drawbacks. First, the prices could get “stale” during the three-year waiting period. Second, Medi-Cal patients, who do not pay any out-of-pocket costs, have no reason use the disclosed prices to select low-cost providers. Third, the prices negotiated by Medi-Cal are of limited use to patients covered by private insurers and by uninsured patients.

The flaw in the price transparency movement as currently designed is that most consumers do not have a reason to care about health care prices. Without a significant change in health insurance cost-sharing – for example, introducing much higher deductibles or coinsurance rather than flat copayments – disclosing prices to consumers is unlikely to be beneficial. In fact, consumers might gravitate toward expensive providers if they associate high prices with better quality.

In 2007, Paul Ginsburg noted that “...health plans have scarcely attempted to involve consumers in price shopping.”⁴⁸ He recommended greater use of coinsurance: “If the patient is responsible for coinsurance of 25 percent of what the insurer has negotiated with the provider, then the consumer will have an incentive to compare prices of providers, especially for outpatient services.”⁴⁹

Reference pricing (where the patient pays the difference between the price of the chosen provider and the price negotiated by the insurer with a low-cost provider) is another way to increase the value of price information. The Safeway grocery chain launched a pilot reference pricing program in 2009 to deal with the price of screening colonoscopies that ranged from \$848 to \$5,984 in one regional market. Safeway set a reference price of \$1,500 for the procedure and provided employees with a list of physicians who used facilities that charged less than the limit (physicians were paid by a uniform fee schedule that did not vary across facilities.) The success of the pilot led to a nationwide expansion of the program in 2010.⁵⁰

Muir and co-authors outlined steps that states could take to promote price transparency, given the current industry structure. Among these options, the state could pass legislation giving the state authority to certify health plans that provide the best value.⁵¹ The law would require insurers to disclose price information to the state agency in charge of certification rather than to the public. The state agency would use the price information, along with quality information, to rank the plans.

This proposal has some inherent difficulties. To implement the proposal, the state would need to create rankings for each product type offered by the health plans. For example, insurer A may offer the best PPO while insurer B offers the best HDHP. It is also possible that the best HDHP for one customer is not the same as for another customer (e.g. because of differences in the plans' networks in relation to the location of the patients). Such rankings would be complex. Furthermore, it is not clear why this type of ranking system should be a public responsibility rather than rather than a service provided by the private sector.

C. Other Disclosure Options

A more modest set of disclosures would include disclosing the following information:

1. Is my doctor or hospital in the network?

To control costs, many health plans are creating “narrow network” options that restrict the patient’s freedom to see any provider. This trend is encouraged by the Affordable Care Act, which limits plans’ ability to cut costs by trimming benefits or increasing cost-sharing levels. A recent report by McKinsey&Company found that 40 percent of plans’ networks on ACA exchanges are “ultra-narrow,” meaning that they contract with fewer than 30 percent of the hospitals in the plan’s market area.⁵² Fewer than half of the ultra-narrow network plans contract with an academic medical center. David Howard, a health policy expert at Emory University, recommends that CMS should ensure “...that plans make their provider lists readily accessible to consumers before they choose a plan.”⁵³ This would allow consumers to determine whether their preferred providers are in the plan’s network.

2. Does the doctor I want to see accept new patients?

Knowing that one’s preferred physician is in the network is of little value if that physician does not accept new patients. This information currently is difficult to obtain from the health plan and often is out of date or inaccurate.

Findings from the National Health Interview Survey in 2012 indicated that almost 90 percent of generalist physicians accepted new patients with private health insurance, but fewer than 75 percent accepted new patients with public (Medicare or Medicaid) coverage, and the proportion of specialists accepting new public patients was declining.⁵⁴

According to Andrew Bindman and Janet Coffman, “There is no systematic monitoring of whether physicians are willing to accept patients with Medicaid coverage. A common approach is to ask physicians through a survey. However, physician nonresponse and inaccurate reporting

can undermine the validity of the results.”⁵⁵ To overcome this problem, physicians could be required to disclose whether they are accepting new public or private patients, and this information could be made available to enrollees.

3. Will I be charged a facility fee?

Patients are increasingly obtaining tests and procedures in hospital outpatient departments, where they may be charged two fees: a professional fee for the service and a “facility fee” to cover the expenses of staff other than the physician, office rent, and other overhead. Hospitals have billed facility fees since at least 2000 when Medicare set billing standards for doctors employed by hospitals. Since then, facility fees have grown increasingly common as hospitals started buying the medical practices of local physicians and designating the physician’s office as an outpatient facility. Patients may find that the facility is not in the plan’s provider network, leaving them responsible for a large portion of the facility fee, which may exceed the professional fee for the service. Health plans could be required to inform patients that a separate facility fee will be charged and how much will be billed to the patient.

4. What is the quality of the provider I want to see?

The last item in the set of limited disclosures is disclosure of health care quality information. Consumers need quality information that is understandable, relevant to their conditions, and “actionable” in the sense that they can switch providers if they are dissatisfied with the quality of their current providers. According to the Minnesota Department of Health (MDH):⁵⁶

Minnesota’s 2008 Health Reform Law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. The goal is to create a uniform approach to quality measurement in order to enhance market transparency. The Minnesota Department of Health seeks to build on community standards and input in developing the measures.

However, only patchy information is available on the MDH web site to evaluate this initiative. The latest Minnesota Health Care Quality Report is dated from 2010. Minnesota Community Measurement, a nonprofit organization, hosts a web site (<http://www.mnhealthscores.org>) with information of the quality of care for the majority of Minnesota clinics. In December, 2014, information on the cost of caring for an average patient was added to the web site.⁵⁷

D. What Are Other States Doing?

The Health Care Incentives Improvement Institute has issued two “report cards” on state price transparency laws. The most recent, in 2014, graded every state based on a point system.⁵⁸

Points were awarded for having an all-payer claims data base, for the level and scope of price transparency laws (e.g. Does disclosure apply to provider charges or paid amounts? Are all providers covered?), and for the quality of the state's price transparency web site. Only two states, Maine and Massachusetts, had "B" grades, three were given "C"s, and the rest including Minnesota failed.

However, an examination of price disclosure laws in Maine and Massachusetts suggests that those states' efforts to disclose prices are surprisingly modest and similar disclosure programs are being implemented in Minnesota as well. In Maine, Public Law 332, which took effect on January 1, 2014, requires all health care practitioners to maintain and make available to patients a list of their charges for their most frequently-provided services and procedures. However, most payers do not pay charges, so this requirement does not tell patients the amount that their insurance company actually pays or the amount they will be responsible for.

New price transparency regulations for doctors and hospitals also took effect in Massachusetts on January 1, 2014. The law (Chapter 224) appears to impose stronger price disclosure than Maine. If asked by a patient, a provider must disclose the allowed amount or charge, including the amount of "facility fees," for an admission, procedure, or service within two days.⁵⁹ Additionally, providers are required to supply any information, such as CPT codes, that the patient's insurer needs to calculate their out-of-pocket costs.

Minnesota laws (Minn. Stat. §62J.81, .82, .823) contain requirements similar to those in Maine and Massachusetts. As in Maine, the law requires the development of a system for reporting charge information, including the average charge, average charge per day and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures. As in Massachusetts, health care providers must provide patients with an estimate of the cost of treatment and the cost that must be paid by the patient. Hospitals and outpatient surgical clinics must provide patients, their representatives or doctors with a cost estimate prior to treatment upon request.

To assess these laws, it is important to know if they are being implemented as intended. The evidence warrants some skepticism. National Public Radio followed a pregnant woman shopping for care in Massachusetts and found that she had a hard time getting more than a vague estimate of the cost of a vaginal delivery.⁶⁰ In Minnesota, representatives of the Government Accountability Office (GAO), posing as patients asking for the cost of common hernia repairs or colonoscopies, made random calls to a dozen health care facilities. Half could not get answers.⁶¹ Although this is a limited sample, it suggests that implementation of the law has been spotty.

Conclusion

The primary finding of this analysis is that classifying plan-provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets.

This conclusion is at variance with conventional wisdom, which holds that more information is better because it helps consumers shop for lower prices. However, in health care markets, patients do not face market prices and have little reason to shop for low-priced providers. In fact, MHCP patients might gravitate to higher-priced providers if they associate high prices with high quality.

Furthermore, a distinction must be made between price transparency for final consumers (e.g. patients) and price transparency at the health plan-provider level. When health plans learn that one provider is offering a low price, they may demand that other providers offer a similar price. This will reduce the incentive for all providers to offer low prices. Price disclosure also may facilitate collusion among providers. High levels of market concentration found in the health plan and provider markets in Minnesota would facilitate these outcomes.

Empirical evidence suggests that price disclosure in concentrated markets can lead to higher prices. The most notable example occurred in 1993, when the Danish Competition Authority required that ready-mix concrete prices be made public. Average prices rose by 15-20 percent following disclosure. Other studies have found similar price increases, although the evidence is not uniformly hostile to price disclosure.

The primary focus of price disclosure has been on the payment methodologies and rates that health plans have negotiated with providers. However, price disclosure may extend to the subcontractors that health plans use to conduct much of their business. Health plans subcontract to pharmacy benefit managers (PBMs), dental carriers and behavioral health organizations that “rent” their provider networks to the plans. Disclosing the terms of these contracts also has the potential to reduce competition.

The United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) have evaluated the likely effects on competition of disclosing prices paid by buyers of an intermediate product. The DOJ has indicated that it would have serious concerns over the potential anti-competitive effects of hospital price disclosure by private parties. FTC staff comments have highlighted concerns that mandatory disclosure may hinder the ability of health plans to negotiate an efficient level of disclosure with PBMs and that disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers.

More limited forms of price disclosure that do not have these likely adverse consequences are possible. For example, health plans could be required to disclose their patients' out-of-pocket expenses at different providers. But health plans can do this without legal compulsion. Even this limited form of price information will not help consumers shop for low prices if they do not face copayments that differ across providers.

These findings do not imply that consumers do not want information to help them make smarter health care purchases. Among the types of information that could be disclosed are the following: (1) Is my doctor or hospital in the network? (2) Does the doctor I want to see accept new patients? (3) Will I be charged a facility fee? and (4) What is the quality of the provider I want to see?

This economic analysis report is subject to several limitations. Primarily, the empirical studies reviewed in this report mostly pertain to disclosing prices to final consumers in non-health care industries. Health care is different from most industries in that intermediaries such as health plans play key roles in organizing the market and sharing the cost of care through insurance. These roles require negotiating prices with health care providers in a setting where both parties have some market power. The reason we do not offer a final opinion regarding the economic impacts of disclosing health plan-provider prices is that we don't have enough experience to judge the outcome.

Endnotes

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- ¹ Data on health plans' service areas are from the Minnesota Department of Health, "Health Maintenance Organizations" and "County-Based Purchasers," available at <http://health.state.mn.us>.
- ² The MSP metropolitan area comprises nine Minnesota and two Wisconsin counties. The Minnesota counties are Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington, and Wright.
- ³ U.S. Census Bureau, "State & County Quick Facts," available at <http://quickfacts.census.gov>.
- ⁴ American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2013.
- ⁵ U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2010, available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.
- ⁶ For example, if the market had five firms of equal size and any two of them merged, the HHI would increase from 2,000 to 2,800 – enough to warrant antitrust scrutiny.
- ⁷ Minnesota Department of Health, Licensing and Certification Program, 2011 Statistical Tables: Licensed, Certified, and Registered Health Care Facilities and Services, available at www.health.state.mn.us/divs/fpc/DirectoryTables.pdf.
- ⁸ Minnesota Department of Health, Health Economics Program, Minnesota Health Care Markets Chartbook, "Section 8: Health Care Providers and Service Availability," available at www.health.state.mn.us/divs/hpsc/hep/chartbook/section8.pdf.
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- ¹¹ George J. Stigler, The Theory of Price, 3rd Edition, New York: The MacMillan Company, 1966, 87-89.
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- ²² Møllgaard and Overgaard, 112.
- ²³ Morten Hviid and H. Peter Møllgaard, “Countervailing Power and Price Transparency,” Scandinavian Journal of Economics, 108:3 (October, 2006), 499-512.
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- ²⁵ David Cutler and Leemore Dafny, “Designing Transparency Systems for Medical Care Prices,” New England Journal of Medicine, 364:10 (March 10, 2011), 894-895. Most-favored nation clauses are prohibited in Minnesota by Minnesota Statutes §62A.64.
- ²⁶ Ibid., 894.
- ²⁷ Joanna Shepherd, “Is More Information Always Better? Mandatory Disclosure Regulations in the Prescription Drug Market,” Cornell Law Review Online, 99:1 (2013-2014), 1-22.
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Appendix II: RFI Responses

Patrick Hultman
Minnesota Department of Human Services (DHS)
Health Care Administration
PO Box 64984
Saint Paul, MN 55164-0984

Dear Mr. Patrick Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services. For the record, your request comes over the holidays which makes responding more difficult. I understand your department should have made this request much earlier in the year, as this important legislative report was due on December 21, 2014. You've asked four questions. **I am answering 4 of them.**

Q1, regarding transparency's impact on competition, prices and expenditures: The dollars received by health plans are taxpayer dollars. Today, no one has any idea how these taxpayer dollars are used, but an independent auditor expressed concerns in March 2013. Transparency is needed.

Q2, regarding transparency's impact on Medicaid, MinnesotaCare, purchasers of health insurance and patients: Transparent pricing creates markets and lowers prices. The Auditor says non-transparent contracts have been very profitable for health plans. Transparency could lead to more dollars for actual patient care and less for corporate profits.

Q3, regarding transparency's impact on existing administrative resources: Health plans demand administrative reporting from doctors and hospitals before they reimburse them. And an auditor has said the state hasn't critically reviewed health plan administrative charges. Contractor prices and use of taxpayer dollars must be transparent to taxpayers.

Q4, regarding transparency's impact on potential liability for releasing "trade secret" data: Health plans are not the first or only government contractors. Every contractor has to make sure data is protected as appropriate, but only as appropriate. Health plans should not be allowed to hide expenditure data from taxpayers using dubious claims of "trade secret".

Thank you for asking for my input. Be sure to include my comments in your required report to the Minnesota state legislature.

Sincerely,

Bill and Marcia Anderson
4818 Caribou Drive
Minnetonka, MN 55345
952-935-0000

I sent the original correspondence via email and was told to send it via postal mail. This is the age of the internet and how sad that you are unable to handle an email response.



December 31, 2014

Patrick Hultman
Minnesota Department of Human Services
Health Care Administration
PO Box 64984
Saint Paul, MN 55164-0984

Dear Mr. Hultman,

On behalf of Citizens' Council for Health Freedom (CCH Freedom), I am responding to the Minnesota Department of Human Services' Request for Information (RFI) on the treatment of data when private parties contract with a government entity for health related services. This RFI was requested to comply with a law enacted last session, a law that also requires transparency from health plans contracting with Minnesota state health programs.

First of all, DHS announced the RFI on December 15, 2014 in the Federal Register, asking for comments over a very congested holiday time, and far too late to meet the December 21, 2014 statutory deadline for getting the report to the Minnesota State Legislature. I certainly hope this was not an attempt to limit transparency of the request, to limit the number of responses DHS receives from the general taxpaying public (and impacted patients and doctors), or to limit the ability of concerned state legislators to be fully informed before session begins on January 6, 2015. Yet that is the most likely outcome.

As your RFI declares, I expect to see this letter included in the report given to the key chairs and ranking committee members of the Minnesota State Legislature.

OVERARCHING STATEMENT OF SUPPORT FOR TRANSPARENCY:

CCH Freedom supports rigorous data transparency requirements for managed care health plans that receive taxpayer dollars, as required by the MN Government Data Practices Act, specifically Subdivision 11 of Chapter 13.05, and which are specifically required by the state legislature beginning on June 30, 2015. It is essential that state government has access to data validating proper use or revealing improper use of millions of dollars in taxpayer funds. There must be no repeal of the June 30, 2015 deadline requirement for data transparency by health plans.

Our responses to the 4 questions in the RFI are as follows:

Question 1 RE: transparency's impact on competition, negotiated prices and health care expenditures: The dollars received by health plans as pre-payment for health care services

are taxpayer dollars. In 2013, an independent auditor hired by your agency reported excessive profits, lack of critical review of health plans' administrative expenses and noted the lack of connection between the health plans' self-reported costs and reported patient encounter (clinical) data. Thus, no one outside of the health plans has any idea how many of the taxpayer dollars are actually being used for patient care, or how restrictive the reimbursements to physicians are in "negotiated" contracts. In our report on MinnesotaCare more than a decade ago, we learned that increased statutory reimbursement rates to health plans from the legislature were not actually required to transition into higher reimbursements for doctors and hospitals ("Distribution, Utilization, and Impact of the MinnesotaCare Provider Tax," CCHC (now CCHF), January 2000).

Question 2 RE: transparency's impact on government programs, purchasers of health insurance and patients (health care recipients/consumers): The pricing of most consumer products is highly transparent, creating a competitive market and lower prices. As proof, watch customers at any store using their phones to check out online product prices or prices at other stores for the product they wish to buy. Consider the cost of cash-only Lasix eye surgery. Watch people choose one gas station over the other. Any attempt to claim that adding transparency will cause prices to rise is a scare tactic. Health plans have profited from years of non-transparent contracts, doubling their "target operating margin" according to the independent auditor. It is time for taxpayers to see what they are actually paying for so they can make a determination as to whether the health plan's use is a misuse of taxpayer funds or a good use of the taxpayer's hard-earned dollars.

There may indeed be better, more transparent, more efficient, more patient-friendly, and less costly ways to run state government health care programs. Oklahoma, for instance, discovered they could save significantly by ending their contracts with health plans. In a 2009 report on the state SoonerCare program, the following was revealed:

"With sufficient resources and leadership commitment, state Medicaid agencies can manage care at lower costs than MCOs and with similar outcomes."

In addition, patient access to medical and dental care under state government programs has been damaged by poor reimbursements and excessive paperwork. More and more physicians are choosing not to care for patients in state programs run by managed care health plans at the same time that an independent auditor reports health plans are greatly exceeding expected profit margins. Access to patient care and the use of more of each taxpayer dollar for actual hands-on patient care will be improved by transparency of health plans expenditures, including administrative expenditures.

Question 3 RE: the transparent effect of complying with data requests on existing administrative resources for both public and private entities: Health plans demand extraordinary administrative reporting from hospitals and clinics before they ever

reimburse physicians and others for care, and when they refuse to reimburse or they refuse to authorize treatment, they require complex documentation or appeals processes.

Meanwhile the state's independent auditor says, "There did not seem to be any critical or diligent review of the administrative components going into the base rates" that the health plans are paid using state taxpayer funds. Thus, it appears the plans may be claiming excessive administrative expenses for profit purposes, something transparency should be able to correct. And like other government contractors, health plans under government contracts should expect and be required to answer data requests, including requests for direct evidence of proper use of taxpayer dollars. Furthermore, the plans have consistently overshot their targets for operating margin (profit), an amount the independent auditor found concerning.

Question 4 RE: transparency's impact on potential liability to government or private entities for releasing data subsequently found to be a trade secret: Government has many contractors, all under the same MN Government Data Practices Act, Chapter 13. As a contractor, receiving millions of taxpayer dollars, the health plans represent that they have proficiency in business operations, including proper accounting for use of dollars received and spent, as well as the ability to follow the law. Furthermore, they are expected to follow contractual obligations, of which transparency should be a priority in state government contracts. If they are unable to follow the law or unwilling to be transparent with the use of taxpayer dollars, health plans should not be in the business of government contracting. Health plans are not the first or only state government contractors. **Claims of "trade secret" should not be allowed to become shields against transparency requirements.** If so, Minnesota's health plans need to find another venue for their business – outside of the government. Millions of taxpayer dollars are at stake, and transparency is the only way the Minnesota taxpayer can find out where their dollars are going and the only way they can be protected from misuse of millions of taxpayer dollars by health plans.

A REMINDER: Minnesota health plans have been under investigation by the U.S. Congress and the federal government for potential misuse of taxpayer dollars. Complying with the transparency requirement under the MN Government Data Practices Act, as well as requiring such transparency in every state contract with a health plan, should be viewed as a priority. There must be no repeal of the June 30, 2015 transparency requirement.

Sincerely,

Twila Brase RN, PHN
President and Co-founder
Citizens' Council for Health Freedom
CCHFREEDOM.ORG
651-646-8935



January 6, 2015

Patrick Hultman
Minnesota Department of Human Services
Health Care Administration
PO Box 64984
Saint Paul, MN 55164-0984

ADDENDUM TO QUESTION 3 IN CCHF'S DECEMBER 31, 2014 RFI RESPONSE

Dear Mr. Hultman,

This letter is an addendum to our December 31, 2014 response to the DHS RFI regarding contracting for Minnesota Health Care Programs and the MN Government Data Practices Act. Please include it as part of our response to the RFI.

As an additional comment to **Question 3** (the transparent effect of complying with data requests): After I emailed you our response, you emailed back a request for six copies. But when I asked why, you said the request was actually a mistake in the RFI and so I responded "Good to know" and said I didn't plan to send additional copies as a result and asked if you intended to notify the public of the correction. But you didn't respond.

I later realized that I hadn't fully appreciated what you'd written in the email. After saying the six-copy requirement was "an oversight on our part and shouldn't have been included in the RFI," you'd added, "We're just sticking with what we made public." So I then emailed you to ask if DHS planned to reject any letters that didn't have six copies. You responded, "The RFI instructions provide details on how to respond. Please refer to that document for clarification."

I then asked for a simple yes or no but I got no response. Thus, I'm still unsure.

The issue of six copies is a big deal for the general public. It could limit the number of responses accepted by the Department for this RFI. For a health plan six copies is not a big deal. For a government agency six copies is not difficult. But for a mother in Moorhead, a dentist in Fairmont, or a worker in Bloomington, and many others, this actually makes a huge difference. They may or may not have a copier. They may or may not readily have needed stamps. Processing the six-copies request may require a trip to town with three children in tow. Furthermore, by the time they decide to write and email the letter of response, they may be out of time to deliver the six copies, especially if they do not live in

the Twin Cities or are uncomfortable driving downtown to drop them off to meet the deadline. They may not want to pay for overnighting the package of copies to get it there in time. In addition, if they noticed the six-copies request on page 3 of the RFI, it alone might be sufficient to discourage them from even submitting a letter.

The Department acknowledged its mistake adding the six-copies requirement, but I was not able to get a response regarding what the Department planned to do if they received an email or mailed letter of response to the RFI but not the six additional copies.

This is a simple transparency question, but we could get no answer.

The Department could have at least agreed to accept a single letter if that's all they got.

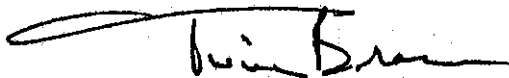
Therefore, our organization has additional concerns regarding **Question 3** of the RFI as a result of this interaction and, as noted in our December 31 response, the late posting of the Request for Information (one week before the *report* of RFI responses was due) as well as posting the RFI over the holiday season giving the public little time to respond.

In fact, the January 12, 2015 due date for public response is 6 days *after* the Minnesota legislature begins. The **report was due** to the legislature on December 21, 2014 -- 17 days *before* the legislature began. This mandated due date was likely given to the Department by the legislature to give members of the legislature sufficient time to digest the public's response before session began.

None of these actions by the MN Department of Human Services garners confidence that DHS is eager for public input on this issue or that it is willing to be transparent about any data request to the Department about this issue, even the simplest one.

This is all the more reason why, in response to **Question 3**, Citizens' Council for Health Freedom believes it's important that the State of Minnesota require by law and by contract that health plans, as major contractors funded by millions of dollars from taxpayers, respond to data requests under the Government Data Practices Act.

Sincerely,



Twila Brase, RN, PHN
President and Co-founder

Don Lee

1037 Beatrice St.
Eagan, MN 55121

T 651-454-2380

MNDHS@c.i.compute.com

January 2, 2015

Patrick Hultman
Minnesota Department of Human Services Health Care Administration
PO Box 64984
Saint Paul MN 55164-0984
E-mail: Patrick.Hultman@state.mn.us

Dear Mr Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services.

The RFI mentions members of the public, and it is as a member of the public that I respond. My standing is as a taxpayer, and voter. I am ultimately responsible for the behavior of my state government, and I am concerned about the direction of health care policy in Minnesota.

Below, I am addressing all 4 of the questions in the RFI.

The controversy over whether the contractors providing health care services for the state should disclose internal information is unavoidable. A competitive organization needs to keep some information about its business internals private for competitive reasons, and because some of the information it possesses internally is sensitive and/or personal. For instance, the salaries of employees is normally considered private and sensitive. Professional employees might be very unhappy if their salaries and benefits were disclosed publicly, especially if done wholesale across an organization.

On the other hand, the State of Minnesota has an obligation to maintain transparency in the expenditure of tax money. History is replete with examples of misuse and outright corruption when transparency has not been observed. Sunlight is the best - the ONLY - effective tool the public has to combat corruption and abuse.

Unfortunately, the current practice of DHS providing funds to private organizations to provide health care services, and then giving those organizations wide latitude to spend that money as they see fit, begs for trouble. Those organizations naturally want to keep their internals private. The public needs transparency to ensure that the money given to them is well spent. The questions in this RF

DHS RFI response

are almost irrelevant because it is not the details, but the general principles that are in conflict. You can't keep costs down without competition. You can't have vigorous competition without some level of secrecy. You can't spend tax money without transparency. Choose one, and only one: competition or transparency.

Minnesota's direction is toward a dominantly public model, and to suppress competition. That will lead to exploding costs and ultimately corruption and abuse - necessarily.

I submit two things:

1. The DHS should represent the taxpayer, not the vendors. Any hint that the DHS is leaning even slightly toward the vendors should be viewed with great suspicion. It is NOT the job of DHS to ensure success of the vendors. It is the job of DHS to spend tax money carefully and wisely. (DHS is in the role of buyer. A buyer does not go to management and argue that the vendor has kids in college and needs more money. A buyer puts pressure on the vendor to provide the service at the lowest possible cost. It is up to the vendor to make its case.)
2. There is an inherent conflict between the transparency that is absolutely required of a vendor with a state-funded budget, and the inherently sensitive and private nature of the data being handled by those who provide health services. As the state gets deeper into providing health services, directly or indirectly, to its citizens, the ability of its citizens to keep their private data private will necessarily decline. We can pretend that laws can be crafted to protect privacy by separating data about care from data about the provision of care, but this division is imaginary. If the money is provided to provide care, auditing the provision of care from start to finish is the only way to determine that it is being wisely spent. It is impossible to audit decisions made without seeing all the information used to make the decisions. In short, if you get your health care via public dollars, you should expect to lose your medical privacy.

These are my concerns, and I would like to see these concerns debated widely. Our current direction appears to be toward the DHS being more an intermediary than a taxpayer defender, and toward more and more State funding of health care, leading to the end of medical privacy.

Thank you for your service,

Sincerely yours,

Don Lee
Eagan, MN



January 12, 2015

Patrick Hultman
Minnesota Department of Human Services
Health Care Administration
540 Cedar Street
Saint Paul MN 55164-0984

Re: Request for Information concerning Contracting with Minnesota Health Care Programs
and the Minnesota Government Data Practices Act

Dear Mr. Hultman:

The Minnesota Association of County Health Plans (MACHP) is writing in response to the Department of Human Services' (DHS) Request for Information. MACHP represents Minnesota's three county-based purchasing plans – Itasca Medical Care, PrimeWest Health, and South Country Health Alliance. In addition, Southern Prairie Community Care and Arrowhead Health Alliance participate in MACHP as associate members.

Controlling costs and sustaining access to care are of central importance to the Minnesota Health Care Programs, and anything that could adversely impact either of those goals should be studied closely by legislators before finalizing state policy. While MACHP is continuing to analyze the many issues identified in the Request for Information, we offer the following recommendations to DHS as it designs and implements this study, which will be essential to informing the policy debate about price transparency.

First, we believe the study should address impacts relating both to the providers that serve health plan members and to the vendors that sell goods and services to the plans themselves. The impact on provider contracts is, of course, critical. MACHP believes that widespread knowledge of what health plans pay each specific provider will inspire some providers to demand higher rates when there is disparity in reimbursement paid by health plans to providers. Contrary to public perceptions of the private health plans, rates are the subject of genuine negotiation between CBPs and providers, and those negotiations will be impacted if providers have knowledge of what other providers receive. This may pose particular problems in rural areas, as we discuss below.

Beyond provider contracts, the issue of vendor contracts is also important, and we encourage DHS to make this part of its work. We believe some vendors will shy away from contracting with plans serving public health care program enrollees if the contracts they enter into are



made public. These contracts typically contain vendor proprietary and trade secret pricing information that they desire not to be made available to their competitors. Further, some vendors likely will not offer discounted pricing, if they know their prices will be open to review by existing or prospective customers.

Second, the DHS study should address whether and how rural health care markets would be impacted differently than metropolitan markets. The CBPs exclusively serve rural counties and, unlike metro counties, most rural Minnesota counties' health systems do not have competing local health care providers. Therefore, if these providers demand higher rates, CBPs and private health plans must meet their demands or risk losing local access to care and falling out of compliance with the state's health care access requirements. The CBPs practice reimbursement rate parity among their contracted providers as much as providers allow and reimburse higher than the DHS and Medicare fee schedules. However, if one health plan happens to pay, for example, a hospital anywhere in the state an even higher rate for whatever reason and the rate is made public, that rate now becomes the reimbursement benchmark other hospitals may demand from CBPs and the private plans. If the CBPs and private plans are forced to pay that higher rate in order to preserve access, it will drive up the costs of Minnesota's public health care programs.

Third, we ask that DHS study whether, if rates paid to providers under commercial programs increase, it will result in higher costs under public programs. CBP offers only public programs, and we are concerned that, if commercial provider rates increase, pressure may increase for payment of higher rates in the public programs, too.

Fourth, it will be important for the Department's study to address the potential impacts on value-based reimbursement, including total-cost-of-care arrangements and shared-risk-taking between health plans and providers. In pursuit of the Triple Aim, the State of Minnesota and CBPs are moving away from a pure fee-for-service payment model to one that provides incentives to providers to control costs while increasing quality. If greater knowledge of the rates health plans pay providers results in greater total costs, it may diminish the promise and impact of value based reimbursement structures (less available to distribute through a shared savings structure, for example).

Fifth, we urge DHS to make clear in its report what information CBPs and private plans already are reporting and where the public can access that information. There is greater transparency in the current system that many realize, and it is important for all stakeholders to understand fully what is already available. It's costly for health plans to prepare reports, and policy makers should not require additional reporting and disclosures to be made if the information is already available from other sources, or if the additional disclosure cannot clearly be shown to serve a



specific policy goal. If CBPs and private plans begin responding to many different individual requests for data, the costs and burdens of responding will drive up the costs of health care and administration and increase public program costs.

Finally, we urge DHS to be as specific as possible about what types of information, if disclosed, may have a negative impact on cost or access. This will allow policy makers to take a more limited and targeted approach – making information available that is directly relevant to the most compelling concerns, while recognizing the importance of limiting disclosure of information that might have harmful effects.

* * * * *

We appreciate your consideration of our comments, and we look forward learning the results of the DHS study. More research and analysis is needed to inform the policy debate underway at the Legislature, and the Department's study will contribute greatly. In the meantime, MACHP will continue our own analysis and engage actively in stakeholder conversations about these complex issues.

Sincerely,

Brett Skyles
MACHP Board of Directors Chairperson

Director, Itasca Medical Care
Itasca Resource Center
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Brett.Skyles@co.itasca.mn.us
(218) 327-5517

Transmitted by e-mail on January 12, 2014.
Also sent by U.S. mail on January 12, 2014.

To:
Patrick Hultman
Minnesota Department of Human Services
450 Cedar Street
St. Paul, MN 55164-0982
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From:
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As a taxpayer negatively impacted by the secret operations of HMO vendors which take our Medicaid money in Minnesota, I am pleased to submit information, in response to the DHS Request For Information, about the impact of changes regarding treatment of data when private parties—Minnesota’s HMOs-- contract with a government entity for health related services.

I received an instruction document from DHS when I participated in the DHS meeting held on December 29, 2015, to clarify issues and procedures in the DHS Request for Information. That instruction document refers to the 2014 Legislation which compels DHS to report on changes likely to result if HMO data were to be made publicly available in conformance with the new Minnesota law. Under “II. 2014 Legislation” in that document detailing the DHS Request for Information, I read the following: “DHS, in consultation with interested stakeholders . . . is required to study public policy issues and economic impact to the health care market related to the application of Minnesota Statutes 13.05, subd. 11 . . . “ Being a taxpaying stakeholder, I have important factual evidence to present which DHS needs in its consideration of the impact on the health care market regarding HMO inclusion in Minnesota’s public health programs. I am submitting documents of factual evidence about Medicaid programs from the states of Connecticut and Oklahoma, and from Ramsey County, Minnesota.

Both Connecticut and Oklahoma realized positive economic impacts in their health care markets when HMOs were eliminated from those states’ Medicaid programs. Medicaid costs to the taxpayers in those states went down as a result of the removal of HMO middlemen from public health programs. I am unaware of any Minnesota taxpayer who desires that Minnesota would fail to achieve similar impacts upon our state’s health care market as a result of our state government failing to follow the proven public policy examples from Oklahoma and Connecticut.

The HMOs’ claim to the Minnesota Legislature, predicting that health care costs will increase as a result of full accountability and transparency in their handling of our Medicaid tax funds, defies

ordinary American marketplace logic. The five and a half pages of printed comments submitted on December 15, 2014, to the Minnesota House Civil Law Committee by the HMO rep, Kathryn Kmit, presents the HMOs' claim that health care costs will increase as a result of HMO data transparency, but those pages are devoid of any facts or any case history to substantiate such a peculiar outcome happening anywhere.

In Connecticut, the cost of health care to taxpayers went down after that state no longer contracted with HMOs; the state reverted to having its government pay health care providers directly beginning on January 1, 2012. Since Connecticut health care costs are now a matter of public record, such information has been used in that state to improve public health programs. Beginning in January of 2012, Connecticut reports improved access by Medicaid patients to health care, an improvement in the quality of health care for those patients, and significant cost reduction in comparison to prior years when the state contracted with private HMOs to administer Medicaid programs.

See the online report from the Connecticut Department of Social Services titled "A Precis of the Connecticut Medicaid Program [2014]: <http://www.ct.gov/dss/lib/dss/powerpoint/MAPOC101014.pdf> Page 1 of that report establishes: "The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program." On page 2, one finds: "HUSKY Health enrollment is growing, care and satisfaction outcomes are improving, and costs are holding constant. . . . Connecticut Medicaid is one of the very few Medicaid programs whose expenditures have remained fairly constant."

On page 3, there is a chart of expenditure trends for Connecticut Medicaid versus U.S. Medicaid. It shows a change from FY 2012 to FY 2013, where the average enrollment in Medicaid for Connecticut was up 5.1%. From FY 2013 to FY 2014, the average enrollment was up 7.5%. Even though more people in Connecticut enrolled in Medicaid for these two years, the costs do not show such increases. Instead, significantly, the average per member per month cost in Connecticut decreased .7% compared to an increase of 7.6% in national Medicaid costs for FY 2012 to FY 2013. From FY 2013 to FY 2014, while the total national Medicaid spending increased 12.2%, in Connecticut it rose only 1.8%. Page 3 contains a description of the one-payer Medicaid model Connecticut uses: "By contrast to almost all other Medicaid programs throughout the nation, Connecticut Medicaid is not using any managed care arrangements and is structured as a managed, fee-for-service program."

On page 5, one reads the explanation for Connecticut eliminating HMOs from its public health programs: "Historically, Connecticut Medicaid used a mix of managed care and fee-for-service arrangements to provide services to beneficiaries. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for beneficiaries. Further, this lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally the Department received only incomplete encounter data

from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services.”

Page 7 of that report lists the positive results during the time Connecticut’s Medicaid has been unencumbered by HMOs. I have copied and pasted the results from that page here under the three headings in the report,” Access to Care,” “Utilization Management and Cost Effectiveness,” and “Care Coordination, Outcomes and Quality – all figures are for year 2013.”

-----Reproduction of page 7 begins here.-----

Access to Care

- Increased the number of Primary Care Providers (PCP) enrolled in Medicaid by 14.6% and increased the number of specialists enrolled in Medicaid by 11.4%.
- Recruited and enrolled 25 new practices into DSS’ Person-Centered Medical Home (PCMH) program.
- Increased the number of participating dentists in the CTDHP network to over 1,900, which is a 12.7% increase over the previous year.
- Connecticut Medicaid beneficiaries have the best access to dentists of any program in the country. A geo-access analysis shows that 100% of beneficiaries have the choice of at least two dentists within a 20 mile radius of their home; 99.7% have 2 providers available within a 10 mile radius; and 97.7% have 1 dentist available within a 5 mile radius.

Utilization Management and Cost Effectiveness

- Overall admissions per 1,000 member months decreased by 3.7%.
- Utilization per 1,000 for emergent medical visits decreased by 0.9%
- Utilization per 1,000 for non-emergent medical visits decreased by 13.7%.
- Utilization of dental restorative services has decreased by 2.5%.

Care Coordination, Outcomes and Quality – all figures are for year 2013

- Reduced emergency department (ED) usage for members engaged in the CHN Intensive Care Management (ICM) program by 15.1% and inpatient admissions by 50.7%.
- Reduced overall readmission rate within 30 days decreased by 2.9%.
- Reduced readmission rate by 44.4% for those members receiving CHN’s intensive discharge planning.
- Increased well child visits in the first 15 months of life (6 or more visits) by nearly 11% and the well child visits in the third, fourth, fifth and sixth year of life by over 5%.
- Increased children’s and adolescent’s access to primary care practitioners by 8%.
- Increased immunization rate for adolescents (Tdap/Td Total) by nearly 6%.
- Increased lead screening in children by nearly 6%.
- Increased Breast Cancer Screening by 4%.
- Increased the number and percent of children age 3 to 19 who received preventive dental care to 69% (HUSKY A) and 73% (HUSKY B).

- Improved outcomes for individuals served by the ValueOptions ICM program, including: a 72.7% reduction in total days in a confined setting; 73.5% reduction in psych days; a 69.2% reduction in inpatient detoxification days; and a 10.5% increase in total days in the community.
- Improved outcomes for individuals served by the BeneCare ICM program, including: a reduction in use of the Emergency Department for dental care to less than 5%; and an increase in utilization of preventative dental services by children served by HUSKY A and B from 36% in 2008 to 58% in 2013.

-----Reproduction of page 7 ends here.-----

I wish to draw attention to the Connecticut result of increased breast cancer screening (“Increased Breast Cancer Screening by 4%”) as an outcome of Connecticut being unencumbered by HMO interference in medical services. In Minnesota, note a news story about the effect of HMO involvement in medical services to Minnesota’s Medicaid patients. On March 13, 1994, the Minneapolis Star Tribune published a story which referred to cancer screening for women patients in Minnesota whose care was managed by HMOs. The news story, by Joe Rigert and Carol Command, appeared on page 1A and 12A. It’s headline was, “Study shelved after HMOs complained: A study that raised concerns about how well HMOs serve the poor fell on deaf ears at the Human Services Department.” The article’s first paragraph notes a key fact “. . . that women on Medicaid get far fewer cancer detection tests than women who can afford to pay their own HMO charges.” The article says the Star Tribune obtained a memo from a DHS staff member, and highlighted a quote from the memo attributed to an unspecified DHS staff person: “The memo also said that some HMOs ‘have a vested interest in keeping information from [the agency] because a large profit currently is being made which would be revealed if the data were submitted accurately in some areas.’ ” I cite the 1994 news article here because it indicates a profiteering motive attributed by a DHS staffer to Minnesota’s HMOs in the HMO preference, and the HMO action, to hide encounter data.

Another statistic from page 7 of the Connecticut report should be contrasted with the concern which Minnesota State Senator Tom Bakk expressed on the January 9, 2015, broadcast of Almanac on TPT TV; see and hear http://www.mnvideovault.org/mvvPlayer/customPlaylist2.php?id=27282&select_index=0&popup=yes#0. Senator Bakk remarked that dental care is very hard to access in Minnesota’s non-metro areas: “There’s a serious shortage of health care professionals in rural communities.” He anecdotally referred to shortages of dentists and doctors in non-metro areas, citing the fact that the retiring dentist in Ely, Minnesota, will leave that town with no dental services available. He remarked that from Ely, it is 50 miles away to either Cook or Virginia, Minnesota, for people in Ely to get to a dentist. However, the Connecticut evidence shows an abundance of dentists in Connecticut—price transparency has not impacted that market with reduced availability of dental care. On the contrary, page 7 of the Connecticut report shows that, in 2013, the number of dentists participating in the CTDHP network increased 12.7%. Next: “Connecticut Medicaid beneficiaries have the best access to dentists of any program in the country. A geo-access analysis shows that 100% of beneficiaries have the choice of at least two dentists within a 20 mile radius of their home; 99.7% have 2 providers available within a 10 mile radius; and 97.7% have 1 dentist available within a 5 mile radius.”

From the Office of the Legislative Auditor in Minnesota, we have information on the difficulties experienced by our state's dentists. That Office published a March 2013 "Evaluation Report Summary: Medical Assistance Payment Rates for Dental Services." It contains the following fact on page 3: "Most dentists who limit or cease serving MA recipients do so because of insufficient payments. Low payment rates were most often cited as the reason dentists have stopped treating MA patients, but there were other reasons, too. Recently imposed limits on MA dental benefits for non-pregnant adults mean there are fewer services for which dentists may be reimbursed. Dentists report that the payment is often insufficient relative to the amount of administrative work required to participate in MA." Perhaps, in Minnesota, making HMO payment data for dental care transparent could result in those prices going up. It is conceivable that the state might correct the very low HMO payment rate to dentists, establishing reasonable payments for dentists treating MA patients to ensure that more dentists would elect to treat that population. So, in this situation, compelling HMO price transparency might fulfill the current HMO prediction of a rise in prices. In this instance, I can heartily agree that MA prices ought to rise as a corrective mechanism to ensure fellow Minnesotans no longer suffer from inadequate access to dentistry. But equally conceivable to me, if Minnesota eliminated HMOs from handling payments to dentists, the lifting of the administrative work currently imposed on dentists by the HMOs might result in a cost-of-labor efficiency which in turn would not require a significant rise in costs.

The State of Oklahoma published a report on its success in lowering Medicaid rates and in keeping them low as a result of eliminating HMOs from their public health programs. See at the January 2009 document, "SoonerCare 1115 Waiver Evaluation: Final Report" at http://www.chcs.org/media/6492_SoonerCare_Report_-_Final_-_January_20091.pdf On page xv of that report, one reads that in 1995 Oklahoma outsourced its Medicaid program for its three large urban areas to five HMOs and named that program SoonerCare Plus. In 1996, the state offered a program called SoonerCare Choice for its rural areas. SoonerCare Choice assigned rural Medicaid enrollees to a primary care clinic. Through SoonerCare Choice, the state paid out Medicaid funds in two ways. It paid the primary care clinics a monthly administrative fee per Medicaid enrollee to coordinate the enrollee's care. It directly paid doctors and hospitals a Fee For Service to cover the cost of the enrollee treatments. Page xvi of the report relates that Oklahoma Health Care Authority, OHCA, began collecting data on Medicaid enrollee satisfaction on both those programs, SoonerCare Plus (HMO-administered) and SoonerCare Choice (primary care clinic-administered), in 1997. That data was published in 2003. That data showed, according to page xvi: "... the Choice program was performing about as well as the Plus program on most measures, and somewhat better on several of them." Also in 2003, the HMOs asked for a rate increase of 18% for 2004 (page xvi). But the state's counter-offer was for only 13.6%. On pages xvi and xvii, the report states: "During the negotiations, OHCA developed an analysis that indicated OHCA could operate the Choice program in the three urban areas at approximately one-quarter of the administrative cost of the Plus program and with one-quarter of the staff. In an emergency meeting in November 2003, the OHCA Board voted to end the Plus program as of December 31, 2003, and to replace it with the Choice program in all three urban areas. OHCA immediately began to transition all enrollees and their providers from the Plus to the Choice program and completed that effort in April 2004."

Evaluating the cost result of eliminating HMOs from Medicaid, the report states the following on pages xxii and xxiii:

“Cost

Medicaid costs per member in Oklahoma were substantially below the national average between 1996 and 2005. Among children and non-disabled adults, who account for approximately three-quarters of the enrollment in SoonerCare and in managed care programs in most other states, annual per-member costs in Oklahoma have been significantly below the national average every year between 1996 and 2005. Oklahoma’s per-member expenditures for those in the disabled eligibility category were also below the national average throughout the period, although by a smaller percentage than in the children and adult categories. Medicaid accounted for a smaller share of total state expenditures in Oklahoma between 1996 and 2005 than the national average and 19 comparison states. Medicaid has accounted for a substantially smaller share of total state expenditures in Oklahoma than the national average from 1995 to 2006, and a smaller share than in any of the 19 comparison states we examined. Medicaid represented 6.5 percent of state expenditures in Oklahoma in 1995, rising to nearly 10 percent in 2006. During that same period, the national average remained relatively stable, with Medicaid expenditures rising from around 12.5 percent of total state expenditures in 1995 to nearly 14 percent in 2006.”

The Oklahoma report uses the term MCO, which is equivalent to the term HMO.

-----On page xxv of the Oklahoma report, one finds: -----

“Managed Care Organizations (MCOs) vs. In-House Care Management

With sufficient resources and leadership commitment, state Medicaid agencies can manage care at lower costs than MCOs and with similar outcomes. Annual per-member costs in Oklahoma have been significantly below the national average for every year between 1996 and 2005, and in most cases below the average of states operating MCOs. Given the cost trajectory of Oklahoma's MCO contracts, and the limited competition that existed between companies at the time that the Plus program was terminated, it seems likely that SoonerCare would have been more costly to operate during the past four years had those contracts been maintained. Evidence from this evaluation suggests that provider participation and member outcomes have not been adversely affected as a result of the statewide expansion of SoonerCare Choice and termination of the MCO contracts, though we did find some evidence that preventable hospitalizations for diabetes and asthma may have increased. In states such as Oklahoma, where managed care penetration is low and turnover among MCOs is relatively high, MCOs’ key advantage—utilizing resources more flexibly—may have limited effectiveness in achieving better outcomes. The growing concentration of Medicaid managed care interest and capabilities in a relatively small number of multi-state private MCOs have prompted many states to look at state-managed PCCM, care management, and disease management programs as potential alternatives. Oklahoma has demonstrated that such programs have the potential to produce results that are as good as those produced by private MCOs, and perhaps better, if state Medicaid agencies have the

necessary resources and a commitment to truly manage care.”

Contrary to the HMO claim of costs going up in Minnesota as a result of mandatory transparency on price and other data, the Connecticut and Oklahoma successes show that data transparency can increase the ability of a state to make improvements in health care. One of those improvements is lower cost to the taxpayer.

In Ramsey County, citizen investigation into how an HMO interacts with the County in handling Medicaid money resulted in the County reducing an unnecessary tax on County property owners. Approximately half of \$800,000 in property taxes was eliminated when I and two other taxpayers complained. This came about in 2013 because four of us Green Party women residing in the County questioned the Ramsey County Commission Chairperson, Rafael Ortega, about how Medicaid money is handled in our County. We learned about a contract the County has with HealthPartners, the new owner-operator of Regions Hospital. That hospital used to be the public hospital for Ramsey County. On the website for Regions Hospital, <http://www.regionshospital.com/rh/about/index.html>, the hospital owner, HealthPartners, clearly delineates that Regions is a private hospital: “Established in 1872, Regions Hospital is a private, not-for-profit organization. The hospital provides health care services in St. Paul and its surrounding communities, as well as for patients who come from throughout Minnesota, western Wisconsin and other Midwestern states. Regions is part of the HealthPartners family of care.” Currently, under the terms of the contract, Regions Hospital pays rent to the County, according to a formula, to occupy the buildings and grounds of the former county hospital building. The inquiry from us Greens uncovered that Ramsey County has been taxing property owners for the purpose of making voluntary payments to Regions Hospital. However, imposition of that property tax contradicts the terms of the County contract with Regions Hospital. After uncovering that information on the contract, three of us Green Party citizens who reside in the County complained about this violation at a County budget hearing, and the County responded by cutting the amount we are taxed; unfortunately, the tax was not entirely eliminated.

Another aspect of the Regions-County contract specifies dollar amounts of indigent care for County residents that Regions is obligated to provide on an annual basis. The effect of obtaining data on whether indigent patients are residents of the County, or are merely claimed by the Regions Hospital to be residents of the County, would allow County taxpayers to determine if the contract was properly being discharged, or if non-qualifying indigent patients, who reside outside Ramsey County, were being improperly classified as qualified and being wrongfully counted to fulfill the terms of the contract. Recall the paragraph quoted above, in which the Regions Hospital website declares that its patients come from throughout Minnesota, Wisconsin, and other Midwestern States.

Further requests I made for data on how Medicaid money is handled in the County produced documentation from Ramsey County about the fact that DHS has instituted intergovernmental transfers between Regions Hospital, the County, and DHS. Even though Regions Hospital is not a government-owned and operated hospital, but is owned and operated by HealthPartners, a private entity, Regions Hospital receives intergovernmental transfers of funds from the federal government. The hospital then wires it to Ramsey County, then the County wires it to DHS. See

the December 9, 2013, e-mail to me (at the end of these comments from me) and attachment [DHS wire.pdf (137 KB)] from Kathy Kapoun of the Ramsey County Finance Department. Those documents describe this funds transfer procedure. As the County voucher form containing Invoice AA031GT0069 notes: "Ramsey County is a conduit between Regions Hospital and MN DHS. This wire is done to leverage Regions revenue to obtain increased revenue to obtain increased funding. Regions wired the funds to us on 11/1/13." That statement reinforces the statement Ms. Kapoun wrote to me: "Intergovernmental Transfers are the mechanism the State instituted to increase the state's share of Federal MA dollars as such they are the best source of information about how these types of transactions work." The DHS Request For Information refers to potential liability to government or private entities for releasing health related data. In the case of Ramsey County and HealthPartners, the data I received from Ramsey County about funding operations for health programs may expose those entities to liability for the manner in which MA funds are handled. There is a question of appropriateness for a private, nongovernmental entity to receive federal funds through intergovernmental transfer. The federal government compelled Minnesota to return to the federal government \$15 million of the \$30 million overpaid Medicaid funds which UCare had earlier refunded to the state government. In the case of Regions Hospital, the federal government may change the manner in which MA funds come into Ramsey County based upon the data I obtained.

I once again refer to the comments submitted by the HMO rep, Kathryn Kmit, on December 15, 2014, to the Minnesota House Civil Law Committee regarding information the HMOs wish to keep secret: ". . . will making this information public be in the best interest of consumers or not?" As a health care consumer, in which I provide the funds that my various levels of government use to pay for patients who need government-subsidized health care, the answer to this HMO question is a resounding, unqualified yes. Yes, DHS, yes, HMOS, yes, Minnesota Legislators, it is in my highest and best interest to have public disclosure of data on how HMOs spend my money. If HMOs do not wish to disclose what they do with my money, I recommend that they should submit a bid so steep for the Medicaid contracts that such bids will in effect price the HMOs out of Minnesota state consideration for being awarded those contracts. The examples from Connecticut and Oklahoma, a sloughing off of the overpriced services of HMOs, provide a much more attractive economic alternative to me. Minnesota health care consumers, that is, taxpayers and patients, will be much better off, as in Oklahoma and Connecticut, once we no longer allow HMOs to handle Medicaid funds.

For me as a Ramsey County resident intent on getting the best value for my tax dollars invested in the agreement between Ramsey County and the Health Partners hospital, I have a right to know how that money is accounted for. Are the terms of the contract the County has with the hospital being correctly met, or are improprieties happening, as I and my Green Party citizens uncovered with the improper tax assessment on property owners? Only by making encounter and payment data open to public scrutiny will I know if I am being cheated. The same situation applies to my state and federal tax dollars in the form of Medicaid funds. I cannot know if my fellow Minnesotans are getting complete and standard medical care from HMO overseers, or if they are being shortchanged, as the 1994 Star Tribune news story revealed in the case of inadequate cancer screening for women Medicaid patients.

A national expert from the Segal Company, hired by the state to review our Medicaid contracting, testified at a hearing of the Minnesota Legislature in April of 2013. I was in the hearing room when he admonished the Legislators that failing to obtain the data in question was putting our Medicaid patients at risk. That warning of patient peril has never left me.

I agree with the information and comments to DHS on this Request For Information submitted by Buddy Robinson on behalf of the Greater Minnesota Health Care Coalition. I am a member of two of the Coalition's member organizations, Minnesota Citizens Federation Northeast, and Seven County Senior Federation.

Response to MN DHS Request for Information regarding:

Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act

Greater Minnesota Health Care Coalition

Jan. 9, 2015

1. Currently, the State of Minnesota lacks three critical mechanisms, any one of which could enable it to know how much in public funds the HMOs are actually paying to medical providers for the low income programs Medical Assistance, MinnesotaCare and others. These three mechanisms are:

A. Full use of paid claims encounter data to tally and measure actual expenditures by each HMO for covered services by program enrollees. DHS states that it is receiving this data from the HMOs on a biweekly basis, and that it has been working to get data into a clean, useable state and begun integrating it into the rate-setting process; but that they have not finished this process. Currently, they are not able to fully use the paid claims data as a financial basis to set the HMO rates, and are not yet able to say when they will finally start to do so.

Full use of paid claims data is being done very successfully in other states -- in particular Pennsylvania and Tennessee -- and so, the relevant expertise is available if it is desired, and DHS should contract for that if that is needed. A Sept., 2014 report by the National Association of Medicaid Directors states that: "several states have sophisticated encounter data collection and validation approaches that allow them to analyze information within and across plans in their state Medicaid program." (p. 5) That same report, on page 13, refers to the X12/NCPDP transaction sets and CORE operating rules which, if a state chooses to require the use of them in its managed care contracts, provide a good means for obtaining and using paid claims encounter data for rate-setting purposes.

B. External, independent year-end audits to verify what actual medical and administrative expenses were paid by each HMO during each calendar year, and the true level of net income (profit.) Such full audits of the HMOs have never been performed for Minnesota's managed care Medicaid system. The Commerce Dept. conducted partial audits of administrative expenses only for the year 2011, and found several violations of law. The state has never conducted audits of the medical expenses for its managed care programs.

State officials have at times made reference to the CPA audits that the HMOs submit, which are conducted by firms selected and paid for by the HMOs themselves -- large national firms, some of which have been involved in financial fraud. The 2013 Segal report made reference to the HMOs' CPA audits as being fairly cursory and without adequate verification measures for data integrity. Many of the audit reports contain the disclaimer that the CPA firms are not vouching for the integrity of the data. Yet in the past, DHS has claimed that these audits amount to "verification."

In 2012, a statute was enacted to order the Office of Legislative Auditor (OLA) to contract with a qualified and independent auditing firm to conduct a full audit of calendar 2014 expenses (both medical and administrative) of the HMO contracts. The audit is also to determine whether any state or federal laws have been broken.

However, there is a question as to whether this mandate will be followed or not, since the Legislative Auditor, Jim Nobles, asked the legislature in 2014 to change the statute to let the OLA perform the examination in-house; give it the option of a less than full audit; and remove the requirement to see if any laws had been broken. Therefore, it remains to be seen if such a

full, external and independent audit will take place or not, for 2014 expenses. It is not known if the OLA will renew its request to amend the statute, which was unsuccessful last year. The OLA claims that it is currently undertaking an external audit, but only of administrative expenses.

The lack of audits or claims data is especially troubling for the Minnesota Senior Health Options (MSHO) program, which is funded roughly half by (1) Medicare Advantage payments directly from the federal government, and half by (2) Medical Assistance payments, from our state DHS. However, DHS only requires expense and net income financial reports that are combined from use of the two sources of funding. Therefore, DHS does not even have any breakdown of self-reported numbers from the HMOs for medical expense, administrative expense, and net income for the MSHO Medical Assistance revenue which DHS provides.

C. Public disclosure of the amounts that the HMOs pay medical providers, which would allow members of the public, including the health care providers themselves, to analyze and compare that they are being paid, compared to the publicly reported summary amounts that each HMO tells the state that it pays to providers for public program enrollees. A great deal of work and specific expertise would be entailed in tabulating and analyzing this data into a useful form, depending on the formats in which the data would be disclosed. It could provide a means to generate important calculations of the true medical expenses of the state programs, especially if DHS is not yet performing this function itself.

It is important to stress that it is precisely the lack of the first two mechanisms (proper use of paid claims data, or proper external, independent audits) which has generated interest and support for the third mechanism of public disclosure of paid reimbursements.

The first two mechanisms are the preferred, and more efficient, means for the state to finally learn what the true expenses are.

It is also critically important to obtain true payment data for the past two decades, either through paid claims data or through full external audits, in order to determine whether self-reported expense data has been artificially inflated to improperly receive extra public funding.

2. Competitive bidding has not proven to be a substitute for rates based on true medical expense data, in terms of financial efficiency.

DHS initiated a system based on competitive bidding in 2012. However, we see now that the profits (i.e., net income) of the HMOs for the state programs has risen to over 3% in 2013. The four big HMOs (Blue Plus, HealthPartners, Medica, and UCare) earned aggregate net income in 2013, from the state programs, of 3.37%, including investment income from financial reserves for the programs. This is over three times the target margin, which is about 1%. In dollar amounts, the margin above the target for 2013 is almost \$100 million. (See attachment)

In other words, if we hope that competitive bidding will serve as an alternative to exact knowledge of what the HMOs pay providers, in order to generate the proscribed revenue margin and maintain efficient use of public dollars, the bidding system has failed to meet that goal.

It is also worth noting that the total reported 2013 net income of these HMOs for the state's programs amounts to 77.6% of the HMOs' total net income for all product lines. This shows just how dependent the HMOs are on huge, excess profits from the state's programs.

3. The HMOs' payments to medical providers for the state's programs do not meet the definition of eligibility for trade secret protection.

The standard definition of eligibility for trade secret status is that protection is needed to prevent public disclosure of your payments, which would somehow let your direct competitors earn higher revenue, and you would lose revenue.

In the case of the Minnesota HMOs and the state programs, the HMOs' potential "competitors" are the other HMOs. If price disclosure were to somehow financially hurt the HMOs, it would have to result from one or more of them losing state business and others gaining by that same amount. Currently, with the state now using a bidding process, the decisions about which HMO has how much market share of the public programs is decided by the state, using a variety of factors.

If disclosure of the prices that the HMOs pay medical providers for the public programs were to somehow cause those medical providers to obtain higher reimbursements for their services, this would affect the HMOs equally, and not disadvantage one HMO at the expense of another competing HMO.

In addition, it would not hurt the HMOs financially in the long run. The state sets public program rates for the HMOs based on "actuarially sound" principles which provide for at least breaking even on the public business. In other words, higher medical expenses are directly passed onto the state and the taxpayers. And historically, before the state started using a bidding process in 2012, the HMOs were clearly not at risk in the public programs, despite the contracts being officially written as insurance risk contracts. As Governor Dayton himself said on radio in 2012, "they were basically cost-plus contracts."

Since the HMOs would not be financially harmed by this disclosure, or lose a competitive advantage to another HMO, they have no standing to claim trade secret status for the prices they pay to medical providers. It is interesting to note that through our two decades of managed care Medicaid, the HMOs have never been granted trade secret status by DHS. In all probability they never sought it, knowing that they wouldn't meet the definition.

4. The HMOs, in arguing to the legislature to keep their payment information secret, imply that this is necessary because of a real danger of collusion among the hospital-clinic systems.

The HMOs infer that these medical provider systems would collude to force the HMOs to give them higher reimbursements for the public programs, and that they would succeed because of the highly consolidated, weakly competitive market for these providers. Kathryn Kmit, a lobbyist for the MN Council of Health Plans, has pointed to letters from the Federal Trade Commission which argue against wholesale price disclosure of prescription drugs, on the theory it would provide incentives for pharmacies to collude to push for higher reimbursements, and for drug manufacturers to collude to minimize their discounts and rebates.

However, there is another sector which also poses a danger of collusion, because of its highly consolidated, weakly competitive market: The four big HMOs themselves (Blue Plus, HealthPartners, Medica, and UCare.) Per-person capitation rate formulas are set uniformly for all of the HMOs, based on an aggregation and averaging of the costs reported by the HMOs to the state. It is in their mutual self interest to have and report similar expense rates, since they all get paid by the state on the same formula, based on average expenses.. There is no history of any of the HMOs taking the initiative to "break ranks" with its so-called competitors to offer to operate the public programs at a cost below what the state was already paying. The track record of the managed care Medicaid rate setting in Minnesota, with huge overpayments, excess profits and excess reserves, points to the potential of anti-trust collusive activity in terms of Medicaid rate fixing. Furthermore, the results of the competitive bidding that DHS conducted for 2012 rates resulted in some re-allocation of market share among the four big HMOs, but did not result in variations in the per-payment ("capitation") amounts that each HMO received, based on their respective bids. These are still based on the average of all the reported costs.

One other area for collusive activity also needs to be examined, which is collusion between some hospitals or clinics and some HMOs. HMOs have the ability, if they wish to

use it, to force down the payments to a particular hospital or clinic, to deliberately cripple it financially and cause it to be bought out by a different provider. For the HealthPartners HMO, which also owns its own hospitals and clinic, this could be an especially large temptation.

5. Looking more closely at the potential of collusion among the hospital-clinic groups, there are some specific incentives against collusive activity:

(a) The HealthPartners system of hospitals and clinics would not likely collude with other hospital-clinic systems to force higher reimbursements from the HMOs overall, because that could financially hurt the HealthPartners HMO, owner of the HealthPartners facilities.

(b) The University of Minnesota system of hospitals and clinics would not likely collude with other hospital-clinic systems to force higher reimbursements from the HMOs overall, because that could jeopardize the profits of the UCare HMO, which routinely gives multi-million dollar donations to the U of M medical system.

These donations, which the U of M is very dependent upon, have totaled over \$85 million, with \$36 million of that just in 2010 through 2013. The donations from UCare to the U of M are not surprising, given that the U of M Dept. of Medicine is, according to IRS regulations, the parent organization of the UCare HMO.

6. A famous study of collusion among Danish mixed-concrete companies might seem to argue against transparency, but it is important to look at the points the study makes:

The 1997 case study by Albaek, Mollgaard, and Overgaard describes how, after the Danish government required disclosure of mixed-concrete prices, average prices and overall cost rose, until disclosure was repealed a few years later. Their theory explaining this is that:

- (1) The concrete companies colluded as a price-fixing cartel, but didn't have full means to police and enforce the agreed-upon prices among all the concrete companies.
- (2) Despite the cartel activity, some members broke ranks by secretly giving discounts to some customers, in order to grab a larger market share – and the other cartel members did not know this was happening, or who was doing it.
- (3) When the government required disclosure, however, the other cartel members discovered the betrayals, and secretly – somehow – got the rogue companies back in line.
- (4) The result was the ending of the secret discounts to some customers, and an increase in the average prices being paid, and overall costs.
- (5) The Danish concrete situation involved two very large dominant firms, plus a collection of much smaller ones. The two large ones were the key cartel members, and originators of the price-fixing. The firms that “broke ranks” via lower prices were some of the small ones.
- (6) When the government required disclosure, it is very likely that the two large firms were able to impose discipline on the small rogue firms by saying: *“You have to raise your prices to where we tell you, or else we will wage a price war and drive you out of business. We have the deep pockets to do that, and you don't stand a chance.”*

Note the implications for the DHS study: If we are to worry about the “Danish concrete effect,” then we have to assume the following things about the Minnesota situation:

- (1) The hospital-clinic systems– or at least the ones in the Twin Cities area – are in fact now operating as a price-fixing cartel, and do not compete significantly regarding the public program reimbursements that they get from the HMOs.
- (2) One or more of the large hospital-clinic systems in the Twin Cities is in fact agreeing now to exceptionally large discounts; and the others are unaware of this and they are unable to enforce their cartel price-fixing; or, one or more systems could easily decide to agree to larger discounts, and the others wouldn't know it.

- (3) Price disclosure would enable the other cartel members to discover the extra-large discounts granted by the “rogue” hospital system, and force that system to get back in line; and as a result, overall costs would rise.

Is this kind of cartel price-fixing by the hospital-clinic systems happening in the Twin Cities area (and/or elsewhere)? Would self-policing of cartel prices be inhibited by public disclosure of prices, or are they doing a good enough job of policing themselves to ensure that no one breaks ranks? And more important, if there is a suspicion of cartel collusion and anti-trust activity which is making costs artificially high right now, shouldn't that be the largest concern of all?

Aspects of the situation in Minnesota:

- (1) In contrast to the Danish concrete situation with two very large dominant firms plus a collection of much smaller ones, we have in Minnesota not just two large, dominant hospital clinic systems, but several large hospital-clinic systems, which collectively hold the vast majority of the market. Meanwhile, many of the small hospitals are primarily in rural areas, and some of them are publicly owned.
- (2) As mentioned earlier, it is not in the interest of any of the HMOs to procure extra-low prices from any hospital-clinic system for the public programs, because those amounts – if accurately reported to the state – would hold down the state program reimbursements to all of the HMOs, because the state payments are based on average prices. Moreover, the HMOs are so dominant in the Twin Cities area that it is unlikely that unusually low reimbursements by one HMO would be unknown to the other HMOs.
- (3) For commercial policy business, the HMOs clearly do negotiate with the hospital-clinic systems to trade discounts for volume, and these kind of provider network separations are increasing. However, that is a separate process from the state programs, where there are no restricted or tiered networks. It would not make sense to do so, since it is the state which “purchases” this coverage, not individual enrollees or businesses.
- (4) If there were to be a market leverage effect of price disclosure raising costs, it would be more likely to occur not in the Twin Cities, but instead in rural areas where there is only one small hospital or clinic serving a geographic area. Most of the rural areas are served by County Based Purchasing (CBP) systems. Disclosure of what providers are paid by the CBPs might increase their costs. The CBPs negotiate with providers for the amounts they pay them, and these are not public.

Most important, with the CBPs, we do not have the financial data integrity problem we see with the private HMOs: The CBP systems, being public entities, have full transparency of their financial dealings. There is no concern that they could be reporting to the state inflated medical expenses, hidden by secret data and lack of independent auditing. Furthermore, the CBPs are using public dollars much more efficiently than the private HMOs, and an example of this is that they pay dentists high enough rates to garner adequate participation and access – something that the private HMOs could easily do as well, but choose not to. **It is important for the legislature to not think of the publicly-owned CBP systems in the same category as the private HMOs. The CBPs' special circumstances deserve special consideration and unique treatment.**

7. A critical question, which drives the momentum for HMO price transparency, is the persistent suspicion of inflated financial reports and huge overpayments:

The 2008 report by the OLA on managed care program administrative expenses noted that the HMOs were earning greater margins than intended, and DHS had no explanation for this.

The 2012 report “Who was minding the store?” by the Greater MN Health Care Coalition pointed to the logic that inflated financial reports, protected by a lack of external auditing or use

pointed to the logic that inflated financial reports, protected by a lack of external auditing or use paid claims data, had to be the explanation for net margins three to four times the target amount built into the rates.

The 2013 Segal Company report corroborated much of what was in the 2012 GMHCC report, and pointed to the relationship between the lack of verified payment data and the excessive net margins. A Segal consultant testified to the legislature: "Either the methodology is suspect, or the data is suspect, or both."

The 2014 DeWeese report corroborated GMHCC's assertion that the managed contracts were historically given on what effectively was a no-risk, cost-plus basis – despite the fact that these contracts were written up as risk contracts.

The federal Dept. of Justice and Health & Human Services Office of Inspector General are still deeply involved in their investigation, which commenced in Jan. 2013, which is based on suspicion of financial fraud by the HMOs in submitting artificially inflated medical expense numbers. GMHCC estimates that the grand total of inflated expense and payment from the state, going back to the early 1990's, could be as much as one billion dollars. If it were recovered, about half would go each to the state and federal government.

For further information, see GMHCC's attached timeline chart and notes.

8. There is a very simple and practical solution to the nagging dilemma of uncertainty of how public funds are used for these programs, which is for the state to set standard reimbursement rates for each medical service for public program enrollees, and to make those amounts publicly available.

Under this method, instead of each HMO performing its own negotiations with each hospital-clinic group, the state would negotiate with the health care providers. The state would have much better bargaining leverage, on behalf of the entire universe of program enrollees, than any of the HMOs could possibly have. You can see this dynamic on a national scale: Medicare, because of its huge purchasing power, ends up paying medical providers on average about 11% less than what the insurance companies achieve in their negotiations with providers.

If the state were setting the reimbursement amount directly, there would be little need to have managed care contracts with the private HMOs. There are very useful lessons from what some other states have done, in deciding to switch from managed care Medicaid contracted out to insurance companies, to a different system of primary care management. In this alternative model, providers are paid on a Fee For Service system by the state, but primary care medical homes are designated as the coordinators of services, and paid a per-person coordination fee.

When Oklahoma decided in late 2003 to end its managed care contracts with insurance companies in urban areas and use the medical home coordination model instead, this was based in part on an assessment that it would cut administrative costs by 75%. They were also able to completely switch their system successfully in a very short time, of three months.

In 2011, Connecticut decided to end its managed care contracts and use a system similar to Oklahoma, which started January, 2012. The reported financial results show a 2% decrease in per-person Medicaid expenditures – in contrast to national averages going up by 7%.

Attachments:

- 1) 2013 Public program net income for the big four HMOs
- 2) Timeline chart of the secret prices – overpayment issue
- 3) Notes to accompany the timeline chart

Contact: Buddy Robinson, Co-Coordinator, Greater MN Health Care Coalition, 47 N. Park St., Mora MN, 55051 Email: buddy@citizensfed.org Telephone (Duluth): 218-727-0207

Supplementary Response to MN DHS Request for Information regarding:

Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act

Greater Minnesota Health Care Coalition

Jan.12, 2015

*** NOTE: These supplementary comments are in addition to the main body of response comments submitted by GMHCC, dated Jan. 9, 2014.**

We have three additional areas to comment on regarding data disclosure:

1. Data disclosure is needed for the Regions Hospital – Ramsey County – DHS arrangement for Inter-Governmental Transfers which are being used to obtain additional federal Medicaid dollars.

A unique supplementary payment arrangement has been going on for a number of years between HealthPartners (owner of the Regions Hospital business), Ramsey County, and the MN Dept. of Human Services. In this arrangement, Regions – which is a private hospital – has been receiving extra Medicaid payments from DHS, with the co-operation of Ramsey County as a financial conduit. This amounts to a money-laundering scheme. **Public disclosure of documents regarding this arrangement need to be made fully available to the public, the media, and to the legislature.**

The federal General Accounting Office (GAO) has noted that nationwide, there are examples where publicly owned hospitals are receiving additional Medicaid money, using a loophole in the federal regulations. First, note that Medicaid payments to hospitals and clinics are typically 50% federal funds, and 50% state funds. The GAO points out that the additional payments to public hospitals are supposed to be covering the hospitals' true expenses. However, in many cases the following system is followed, which amounts to an abuse of Medicaid money:

- (1) The state Medicaid agency provides the extra Medicaid payment to the public hospital.
- (2) The public entity (usually a county) which owns the hospital then returns half of the amount back to the state agency, using a mechanism called an Inter-Governmental Transfer.
- (3) The state agency puts this money in the state Medicaid funds.

In this way, the money “rebated” by the local government unit to the state serves to refund the state’s 50% contribution to the Medicaid program. The state budget is not out any additional dollars, and the hospital benefits by pocketing half of the total Medicaid funds - the federal half. This arrangement technically is legal, although it probably shouldn’t be.

In Minnesota, this arrangement is used for Hennepin County Medical Center (HCMC). HCMC is a public hospital, owned and controlled by Hennepin County, which has full financial responsibility for all the revenue and all the liabilities. So, it is legal for HCMC to do this.

This arrangement is also used for Regions Hospital in St. Paul. However, there is a problem: HealthPartners HMO, the owner of the Regions Hospital business, cannot rebate to MN DHS half of the extra Medicaid money, for one simple reason: Regions is not a public hospital. So instead, each month Regions wires \$500,000 to Ramsey County, which in turn promptly wires \$500,000 to MN DHS. The purpose of having Ramsey County wire this money to DHS is

in order to provide the money via an Inter-Governmental Transfer process, which is needed for this scheme. What this means, however, is that HealthPartners, Ramsey County, and DHS are all pretending that Regions is a public hospital, when in fact it is not. The state legislature, which has put this arrangement in statute, has incorrectly listed Regions as a public hospital, in the same category as HCMC. Ramsey County owns most of the Regions Hospital facilities, but it leases these to HealthPartners. Ramsey County does not own the Regions Hospital business, does not receive its revenues, and does not possess its liabilities. On HealthPartners own website, it refers to Regions as part of its system and a “nationally recognized private hospital.” In its filings to the Securities and Exchange Commission, for issuing bonds, HealthPartners lists Regions as one of the divisions of its business.

Ramsey County’s payment vouchers say in black and white: **“Ramsey County is a conduit between Regions Hospital and DHS. This wire is done to leverage Regions revenue to obtain increased revenue to obtain increased funding. Regions wired the funds to us on [date].”** The monthly invoice by DHS to Ramsey County for \$500,000 says on it: “Monthly managed care IGT [Inter-Governmental Transfer].”

There is apparent confusion in the minds of Ramsey County officials and state legislators regarding the status of Regions, which once upon a time was a true publicly-owned county hospital, but no longer is. The arrangement of using Ramsey County as a conduit to transmit money from Regions back to DHS is clearly a charade intended to let Regions obtain extra Medicaid funds it isn’t entitled to. While this does not cost either the state or Ramsey County money (but costs the federal government about \$6 million per year), the public ought to be made aware that this is both wrong and it violates federal law, and full public disclosure of documents about this arrangement is needed.

2. Data disclosure is needed for Ramsey County’s “voluntary contributions” to Regions Hospital for indigent care.

Ramsey county is giving HealthPartners/Regions some of its own money in a different, separate arrangement, and there needs to be full disclosure of this arrangement and all relevant financial records. Ramsey County makes regular payments to HealthPartners/Regions for the ostensible purpose of helping to pay for the medical care of indigent Ramsey County residents. This is rationalized via a provision in Region’s lease with Ramsey County for the hospital property: HealthPartners/Regions is supposed to be providing a certain amount of indigent care to county residents in lieu of cash payments for the lease. If the value of the indigent care exceeds this amount, then Ramsey County agrees to pay the remainder to HealthPartners/Regions, on a voluntary basis.

One may question why Ramsey County officials would want to provide these voluntary contributions of county taxpayer funds to the enormously wealthy HealthPartners conglomerate at all, and county taxpayers have complained. The County Board has reduced the amounts of the payments in response to the complaints, but the payments keep being made.

An important question for Ramsey County is whether the accountings that HealthPartners have given the County, upon which the payments have been based, are accurate or not. **If the true value of the indigent care is less than what HealthPartners has been claiming, then Ramsey County and its taxpayers may have been providing contributions that were larger than justified, or maybe even not justified at all.** Full public disclosure of all of

HealthPartner's financial information regarding Regions Hospital and Ramsey County can help resolve this question.

3. There is an issue which does not directly relate to public disclosure of HMO data regarding the public programs, but it merits the attention of the legislature, media, and the public:

Since the concern about disclosure of HMO payment data, and the concern for artificially inflated prices, is at the heart of the legislature's discussion on data practices, it is important to be aware of a similar price-inflation phenomenon happening in a different sector: **The inflation of employee medical bills which are presented to self-insured corporations by the insurance companies they hire which serve as their third-party administrators.**

This was recently revealed in a federal court case in Michigan. Blue Cross Blue Shield of Michigan was found guilty of self-dealing and violating its ERISA fiduciary duties, by secretly tacking on extra "administrative charges" to the employee medical bills which it submitted to the Hi-Lex Controls company for payment. In other words, they inflated what they presented to the company as the medical bills of its employees, and kept the extra for themselves. Blue Cross was ordered to pay over \$6 million to Hi-Lex, covering 17 years of this deception.

In its defense, Blue Cross had a witness from the Milliman actuary company testify that these "extra fees" were standard practice throughout the insurance industry.

Attached is the Appeals Court ruling of May, 2014, upholding the judgment against Blue Cross Blue Shield of Michigan. Last fall, the US Supreme Court denied certiorari, letting the Appeals Court decision stand as the law of the land.

Full awareness and knowledge of this case is needed in Minnesota, because:

- (1) Self-insured companies, and self-insured units of government, should start asking questions of their third-party administrators to see if this deception is happening here or not.
- (2) If this kind of deception and illegal self dealing is going on in Minnesota, then it raises questions about the Health Plans here; the interlocking finances between their HMO divisions and other divisions; and the likelihood that secret HMO payment data is hiding inflated expenses for the state's public programs.

Attachments:

- 1) Ramsey County voucher to DHS; DHS invoice to Ramsey County
- 2) May 2014 Federal Appeals Court Ruling on Blue Cross Blue Shield Michigan case

Contact: Buddy Robinson, Co-Coordinator, Greater MN Health Care Coalition, 47 N. Park St., Mora MN, 55051 Email: buddy@citizensfed.org Telephone (Duluth): 218-727-0207

Patrick Hultman
MN DHS Health Care Administration
PO Box 64984
St. Paul MN 55164-0984

Re: RFI Contracting with Minnesota Health Care Programs and
The Minnesota Government Data Practices Act

Dear Mr. Hultman,

I attended the December 29th Public Q&A session regarding the above referenced RFI. At that session I questioned whether or not DHS had obtained written legal opinions regarding legality of the above for alleged health plan "trade secrets" from the office of CMS, the office of the US Attorney in Minneapolis or from Lori Swanson, the Minnesota Attorney General. I have searched on line and have been unable to find where similar activity has been allowed in any other state at this time. Without finding another such example; this appears to me to be a backdoor request for an exemption from Federal regulations.

Is this a legal request as far as Federal regulations are concerned? Does this meet the current Federal requirements of TINA? (Truth in Negotiations Act) Why should the legislature "waste the time" to consider the "trade secrets extension" if they do not have such written legal opinions to fall back to?

Does the "trade secrets" extension meet all the requirements of Federal "Pay to Play" legislation? This appears to be a variation of Pay to Play; instead of advising public pension funds, the health plans are advising public health funds. Where is the written legal opinion supporting the position taken by the health plans?

I would like to close with this statement from ethics expert Michael Josephson:

"Any decision which depends on secrecy is ethically dubious."

Thank you for taking my comments.



Dated: 1-12-2015

James Grotz
"a concerned Minnesota taxpayer"

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JOHN E. DIEHL
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January 10, 2015

Minnesota Department of Human Services
Health Care Administration
540 Cedar Street
St. Paul, Minnesota 55164-0984

Attn: Patrick Hultman

Re: Request for Information:
Contracting with Minnesota Health Care Programs and the Minnesota Government Data
Practices Act

Dear Mr. Hultman:

I am writing to offer comments in response to the above-referenced RFI¹. My comments are organized according to the four specific questions that were posed, with the following preface.

The public purpose in “health care policy” is to enhance the geographic and financial accessibility of quality health care service for all Minnesotans. So as to achieve this purpose, the provision of health care and health services financing are very highly regulated, yet those regulations are meaningless and ineffective without information and the resources to interpret and act on the information.

There is a pervasive belief (reflected in a myriad of state and federal laws) relating to government affairs and private transactions that *transparency* is a good thing, and there is no reason to doubt the validity of that principle in the current context. A new approach, the creation of more transparency, may require accommodation in some areas, but that is not a reason to not proceed.

The specific RFI’s seem to be premised on the notion that all related laws should and will remain unchanged, which is *not* a valid premise. If this strategy creates “unintended” negative

¹ My comments are based on my experience as the person responsible for drafting and passing the state law relating to Nonprofit Health Service Plan Corporations, the person responsible for drafting, securing passage of and implementing the Minnesota HMO Act (1973), and 40 years in the practice of law in which I have represented medical providers, hospital providers and health plans in a wide range of activities, including the development and documentation of the business relationships between health plans and providers.

consequences, there should be accommodations to avoid that. It is imperative that the state seize this unparalleled opportunity to develop tools for more effective business negotiations and regulation which will occur only with greater transparency. If other rules need to be changed, or if special rules should be developed for these areas of operation, then the laws should be shaped so as to facilitate this transparency.²

1. The impact of making agreements between health plans and health care providers publically available on : i) competitiveness in the provider and health plan markets including new market entry; ii) negotiated prices; and iii) health care expenditures overall including health care spending trends for consumers paying premiums.

Comments: First, information about the existence of a provider contract, i.e., what providers are “under contract,” should have no negative impact on any of the specified areas. (Competitiveness, price negotiation and health spending.)

Second, I do not think there would be any negative impact from the disclosure of the contracts themselves *except* for the payment rates (payment methodology should be public). There may be non-economic terms that a health plan may not want the public to know about, such as anti-disparagement provisions, competitive restrictions, etc., but regulators and the public should know about this. In my opinion, this disclosure will have no *negative* impact on competition, price and health spending. However, for personal privacy reasons this should not extend to employment agreements between an entity and its employees.

Third, the public availability of actual payment rates would, in my opinion, have mixed results. On the positive side, it would make rate negotiations more business-like and equitable;³ it would expose anomalies that should be of interest to antitrust regulators (because price disparities would later reveal inappropriate

² Such “special provisions” may relate to restrictions on access specific provider rates; or limitations on the audience to which these data are available; special terms regarding the process for accessing data, e.g., from a single centralized source; and, certainly, for bearing the reasonable costs of releasing these data.

³ At present a health plan knows everything about a hospital or medical provider, but providers know virtually nothing about their health plan “business partner.” And, while health plans are well-intentioned, up-standing businesses, I am personally aware of enough incidents/anecdotes of health plans using false or incomplete information in negotiations, that one must conclude that, at the least, the individuals involved were either ignorant and incompetent, or dishonest. Sunshine clears up these problems.

arrangements or extraordinary provider market-power); and would probably have a moderating effect of overall costs.⁴

The only negative impact, in my opinion, is that it would be so disruptive to the entire process that it would create short-term (two to five years) of chaos. The health care system is chaotic enough without this, so for this reason alone I would not include individual payment rates in the data that would be made public. However, I would call for the availability of these data to the appropriate regulators on a periodic “on demand” basis, i.e., without a prerequisite of valid suspicion of wrong-doing.

2. Any effect of disclosing information used in contracting with a government entity for health related services upon: i) state or local government programs; ii) purchasers of health insurance; and iii) health care recipients and consumers.

These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

Comments: Assuming my limitations on public disclosure as set forth under Paragraph 1, above, I would envision *no* adverse effects on state or local government programs, private or public purchasers of “health insurance,” or on health care “recipients and consumers.”

On the other hand, I would speculate that there would be many positive outcomes in all areas. I am unaware of the availability of actual data, so these comments are based on theoretical models, as noted above, but I believe that some payment rates under Medical Assistance and Minnesota Care (which, as I understand it, are the same) may be slightly increased in those areas where current payments result in below-cost payments. For large health care systems and high volume services, I assume that the payment rates are presently manageable from the health plans perspective and profitable from the providers perspective, so I would see very little change in most of the system. I would see absolutely no change in the willingness of providers to participate in Medical Assistance and Minnesota Care, since that participation is essentially mandated and since I would see no specific

⁴ I would expect that rates would increase for small providers, but that would make them stronger competitors and would allow them to reduce prices on their non-governmental arrangements.

adverse impact from the transparency in health plan operations. Obviously, some health plan may be embarrassed to have their operations subject to public scrutiny and they may be less enthusiastic about being vendors to the state under these rules. On the other hand, in recent history, this has been an important source of operating surplus and theoretically a health plan would elect to continue in profitability lines of business (assuming that this has been profitable and, perhaps with cost adjustments in nonhealth care activities this will remain profitable). And, if health plans are not interested the state will resume a more active role.

3. The effect of complying with health related data requests on existing administrative resources for both public and private entities.

Comments: The effect of complying with data requests could be a costly, disruptive addition to the operation of health plans and related parties. In this regard, I would suggest two things. First, as I read Minn. Stat. § 13.05, Subd. 11, there should be broader concern than just the cost of compliance with the collection and release of information; Chapter 13 imposes a wide range of duties and requires compliance with a rather elegant set of regulations that may make sense for a truly governmental entity, but that should be made inapplicable to data requests from government “contractors.”

Second, I feel that the requirement that a person requesting data must pay the reasonable cost of collection and dissemination, and I think that there should also be other mechanisms adopted as a part of this important strategy to allow access to data without having these inquiries be costly and disruptive. I would suggest that the statutes specify a process by which data must be assembled and formatted and provided to the governmental entity, which, in turn, could provide it to the inquiring members of the public, subject to payment for the reasonable costs less incurred. Stated differently, transparency will be a big benefit to our system and public confidence in our system, so anticipated problems should not stand in the way of transparency; the changing law should simply provide ways to mitigate, manage or avoid those problems as we establish transparency.

4. Potential liability to government or private entities for releasing health related data made public under state law and subsequently found to be trade secret.

Comments: I can imagine that threats of liability for the violation of trade secrets have been advanced, although have never been a party to such claim, I have never seen such an action, and I have never heard of such an action. To the extent that this a threat, however, I would urge that this be managed by a statutory declaration that certain categories of data do *not* constitute a “trade secret.”

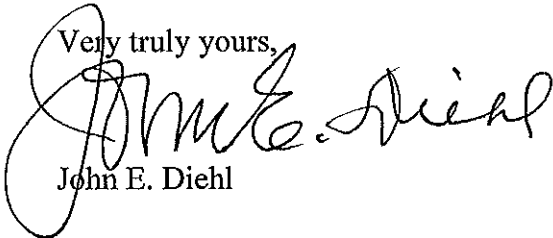
Your invitation asked that, to the extent possible, we incorporate research evidence or specific examples to support the stated points of view, and I would offer one additional comment on this point. First, because of confidentiality provisions in provider contracts and general ignorance of

the details of this system, even among those who are experienced and heavily involved in Medical Assistance and Minnesota Care make it very difficult to provide these additional supporting references. In my case, I have alluded to specific examples of which I am aware, but I am not at liberty to publicly reveal those facts. If there is interest, those matters can be explored further with appropriate legal preparation.

Our current private health services financing system is dominated by self-insured employee health benefit plans (which would be largely unaffected by these matters); Medical Assistance, Minnesota Care and Medicare (which have historically been governmental operations and always subject to public scrutiny until the massive outsource strategy began); and by health services financing/delivery systems regulated under Minnesota Statutes Chapters 62C and 62D. For compelling but very different reasons, when those laws were enacted in 1971 and 1973, respectively, there were virtually no financial regulations developed as a part of those regulatory systems. There have been changes in those aspects of these regulatory systems in the intervening years, but these plans are still characterized, in my opinion, by the lack of financial regulation and public accountability in the area of financial operations. I believe that the time has come for that to change and I believe that his opportunity to establish complete transparency in the economics of our health care system is an essential first step to these necessary changes.

Thank you for the opportunity to offer my views on this important topic.

Very truly yours,



John E. Diehl

Cell Phone: 612-251-0612

January 5, 2015

Patrick Hultman
Minnesota Department of Human Services (DHS)
Health Care Administration
PO BOX 64984
St. Paul, MN 55164-0984

Dear Mr. Patrick Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services. For the record, your request comes over Christmas which makes responding more difficult. I understand your department should have made this request much earlier in the year, as this important legislative report was due on December 21, 2014. You have asked four questions. I am answering, regarding transparency's impact on Medicaid, MinnesotaCare, purchasers of health insurance and patients: Transparent pricing creates markets and lowers prices. The Auditor says non-transparent contracts have been very profitable for health plans. Transparency could lead to more dollars for actual patient care and less for corporate profits.

Thank you for asking for my input. Be sure to include my comments in your required report to the Minnesota state legislature.

Sincerely,



Mark A. Sellner
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Minnesota Council of Health Plans' Response to Request for Information: Contracting with Minnesota Health Care Programs And the Minnesota Government Data Practices Act

Introduction

The Minnesota Council of Health Plans (“Council”) appreciates the opportunity to respond to this Request for Information (“RFI”). The Council is committed to working with all stakeholders to create a more transparent health care system that helps consumers make the best possible decisions about accessing care. However, it is also critical to preserve market balances and not disclose information that will compromise the competitiveness and affordability of our health care system.

Council members share the following policy concerns relating to possible consequences of broad disclosure of health plan and health care provider agreements:

- Reduced competition, which will increase market rates and, therefore, both consumer and employer premiums;
- Decreased access to services and barriers to advancing the Triple Aim;¹ and
- Greater administrative burden without providing meaningful information to consumers.

The following responses to the questions posed in the RFI provide additional details regarding these concerns.

Response to Question #1(i and ii): The impact of making agreements between health plans and health care providers publically available on the competitiveness in the provider and health plan markets including new market entry and on negotiated prices.

The Council has serious concerns with the impact on the competitive marketplace of making agreements between health plans and health care providers publicly available. Provider payment information and other sensitive contract terms attributable to specific health plans and providers should not be subject to disclosure under the Minnesota Government Data Practices Act (“MGDPA”).²

¹ The Triple Aim is an approach to improve the health of the population, enhance the patient care experience, and reduce/control the cost of care. The goal of the Triple Aim is to optimize health, care and cost. INST. FOR HEALTHCARE IMPROVEMENT, *IHI Triple Aim Initiative* (Jan. 12, 2015), <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>.

² These comments are responses to the questions in the RFI and are intended to address broad policy issues raised in the RFI. Although the Council, by responding to this RFI, makes no interpretation of Minn. Stat. § 13.05, subd. 11, the Council explores such a hypothetical situation to analyze and illustrate the economic impact throughout this RFI solely to answer the questions presented. These comments are not intended as legal or statutory interpretation of what amended Minn. Stat. § 13.05, Subd. 11, may or may not require health plans to disclose about their provider contracts.

Reduced Competition

Consumers need information on both quality and cost to make value-based selections of the right provider and treatment. Focusing on price alone obscures the fact that true value in health care arises from the relationship between quality and cost. The Federal Trade Commission ("FTC") has noted that disclosure of cost information is not necessarily going to make the market more favorable for consumers.³ In fact, such disclosure can significantly decrease market competition, which is a concern not just of the FTC, but also of the U.S. Department of Justice.⁴

Disclosure of payment rate information attributable to specific health plans, providers and vendors would inhibit the ability of health plans to support the Triple Aim. Plans could not control costs and provide cost-savings benefits to Minnesota taxpayers or businesses by negotiating favorable rates with providers and vendors. For example, if Provider A were to review contract rate information available through the MGDPA and observe that Provider B has a 5% higher contracted rate, Provider A could threaten to terminate its contract with the health plan unless the health plan increases its contract rate by 5%. It is likely this would force a price increase for Provider A ("shadow pricing"), but also possible that it could force the health plan to drop Provider A from its network, which has implications for consumer access and quality.

Increased Costs

A situation analogous to the disclosure of health plan agreements with providers was addressed by the FTC in response to a request for comments on the likely competitive effects of a bill that would shift regulatory authority over Mississippi's Pharmacy Benefit Manager ("PBM") companies from the Insurance Commissioner to the Board of Pharmacy. In its reply, the FTC said, in part:

The bill empowers the Pharmacy Board to regulate PBMs and may impede PBM's ability to negotiate effectively contracts with pharmacies that save money for Mississippi health plans and consumers. Second, the Pharmacy Board would have vague and potentially unlimited authority to demand disclosures of sensitive

³ As stated by the Federal Trade Commission, charged with ensuring competition and eliminating anti-competitive practices in industry, "There is no theoretical or empirical reason to assume that consumers require sellers' underlying cost information for markets to achieve competitive outcomes." Letter from Federal Trade Commission to Nellie Pou, New Jersey Assemblywoman, 35th District, (April 17, 2007) available at http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nellie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf [hereinafter "FTC Letter to Pou"].

⁴ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), available at <http://www.justice.gov/atr/public/guidelines/0000.htm>.

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PBM business information without any confidentiality protections, which could restrict PBMs ability to negotiate contracts with pharmaceutical manufacturers and pharmacies to provide the best prescription drug programs and prices for Mississippi consumers.⁵

Researchers Cutler and Dafny also highlight the risk that disclosure of negotiated rates between payers and providers could raise costs instead of lowering them:⁶

The effort to promote cost-consciousness in health care is both noteworthy and laudable. Just as in other industries, consumers need to know what they are on the hook for when they purchase medical care. *But complete transparency of prices negotiated between payers and providers could raise costs instead of lowering them, especially in markets where there is some degree of pricing power and where consumers are imperfect decision makers. As in so much of medical care, the best of intentions can go awry if the plan is not thoroughly or correctly executed.*⁷ (Emphasis added.)

The authors go on to state:

*So the sunshine policy [disclosure of all prices paid to every provider by every payer of every service] would create a perverse incentive for the hospital to raise prices (on average), and as a result its rivals could do the same. This adverse effect of price transparency would arise only in cases in which the buyer or supplier in question had some leverage (market power), but such leverage is fairly common in health care settings, including many local hospital markets.*⁸ (Emphasis added.)

These concerns are further reinforced in a report from the Healthcare Financial Management Association ("HFMA") Price Transparency Task Force, which suggests that confidentiality of pricing negotiations motivates competition and that perfect exchange of information may facilitate market collusion.⁹

⁵ FTC Letter to Pou, *supra* note 3.

⁶ David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 N. ENG. J. MED. 894, 894 (Mar. 10, 2011).

⁷ *Id.*

⁸ *Id.*

⁹ HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, PRICE TRANSPARENCY IN HEALTH CARE, REPORT FROM THE HFMA PRICE TRANSPARENCY TASK FORCE 11 (2014), available at: <http://www.hfma.org/Content.aspx?id=22305>.

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Several other empirical economic studies show transparency policies to be associated with higher prices and the risk of tacit collusion or coordination, which are both anti-competitive behaviors.¹⁰

The FTC has acknowledged that the absence of publicly accessible proprietary business information incentivizes aggressive bidding.¹¹ The corollary argument is that coordinated interaction “can blunt a firm’s incentive to offer customers better deals by undercutting the extent to which such a move would win business away from rivals” and “can enhance a firm’s incentive to raise prices by assuaging the fear that such a move would lose customers to rivals.”¹²

To provide an analogy from outside of health care, when building a school, a general contractor will contract with various subcontractors and prepare a bid. Steel is necessary in the construction but public access to how much the subcontractor paid for the steel, or how much the steel producer paid for the iron ore does not increase competition in the market. The contract-awarding entity has access to this information during the bidding process, and this information remains concealed from competing bidders for the purpose of increasing competition. Absent the knowledge of how competitors paid for necessary materials and other proprietary business information, bidders have a powerful incentive to bid aggressively for the contract.¹³

The same economic theory, acknowledged on numerous occasions by the FTC in its discussions of health care market legislation, applies to the relationship of the information maintained by the health plans in the preparation and execution of their contracts with the Minnesota Department of Human Services (“DHS”) to administer the Minnesota Health Care Programs (“MHCP”). It should be noted, however, that unlike the construction example described above, the health plans are required by state law to bid for their business with the state every year, and the subcontractors (i.e., providers, PBMs, etc.) maintain relatively constant from year to year.

¹⁰ Letter from Federal Trade Commission, to the Honorable James L. Seward, New York Senator, 51st District n.23 (Mar. 31, 2009) available at http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-james-l.seward-concerning-new-york-senate-bill-58-pharmacy-benefit-managers-pbms/v090006newyorkpbm.pdf. See, e.g., Stephen W. Fuller et al., *Effect of Disclosure on Price: Railroad Grain Contracting in the Plains*, 15 W. J. AGRICULTURAL ECON. 265 (1990), Maura P. Doyle & Christopher M. Snyder, *Information Sharing and Competition in the Motor Vehicle Industry*, 107 J. POL. ECON. 1326 (1999). See also D. Andrew Austin & Jane G. Gravelle, Congressional Research Service Report to Congress, *Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector* 3 (Apr. 29, 2008), available at <http://fas.org/sgp/crs/misc/RL34101.pdf>. Tacit collusion occurs when entities agree to participate in a certain strategy without explicitly saying so.

¹¹ FTC Letter to Pou, *supra* note 3, at 11.

¹² U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 7 (2010), available at <http://ftc.gov/os/2010/08/100819hmg.pdf>.

¹³ FTC Letter to Pou, *supra* note 3, at 11.

Decreased Access

Just as disclosure of negotiated rates could lead to increased market prices and, therefore, increased premiums, it could also lead to consumer access issues. If plans cannot afford to contract at higher rates demanded by providers, or choose not to pass these increases on to consumers, they may be forced to drop providers, which could threaten the ability to meet network adequacy requirements, and ultimately, lead to provider access challenges for consumers.

The Council also has serious concerns with health plans' ability to negotiate confidential business terms in certain subcontracts if these subcontracts were to become publicly available. Health plans typically hold a number of direct or indirect subcontracts with private companies, sole source providers, and large, national entities. These subcontracts enable plans to deliver the services required by their customers, including the State of Minnesota, and provide critical access to health care services for their members. Application of the MGDPA to the subcontracts health plans enter into to facilitate management of MHCP may have a chilling effect on health plans' ability to enter into business relationships with needed vendors.

In particular, the PBM and health care clearinghouse markets are dominated by a limited number of companies, as are certain IT functions. These vendors have considerable investments in intellectual property and proprietary business processes. Most of these contracts contain stringent confidentiality provisions which are not negotiable. We are concerned that if such subcontracts were to be accessible, plans would not be able to obtain contract terms supporting vital business processes while at the same time requiring wide-ranging disclosures to the public. If plans were not able to negotiate terms with their first-choice vendors, it is not clear whether other quality vendors could be located and what the pricing impact would be.

For example, pharmaceutical and device companies have pricing terms subject to strict confidentiality provisions. Some products, such as the multiple sclerosis treatment copaxone (Teva) and the HIV drug raltegravir (Merck) are sole source products needed to meet current standards of care with no alternative suppliers. Health plans are not in a position to leverage contract terms with rate transparency, as the number of Minnesota health plan members taking these drugs is dwarfed by the number of persons taking these drugs globally.

Finally, making agreements between health plans and health care providers publicly available may create barriers to finding certain types of providers willing to treat MHCP patients. In a number of areas (e.g., specialty dental), health plans have extreme difficulty finding providers to treat MHCP members, even without additional MGDPA disclosure requirements. Putting additional burdens on already reluctant providers could decrease network access. For example, if a specialty dental provider were required to respond to a MGDPA records request from a member of the general public, this could further discourage the provider from seeing MHCP

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members, and quickly spread to other providers in the community, inhibiting already tenuous access.

Response to Question #1 (iii): The impact of making agreements between health plans and health care providers publically available on health care expenditures overall including health care spending trends for consumers paying premiums.

The health care marketplace is much more complex than a traditional marketplace where individual buyers and sellers interact to set a price for a desired good or service. The special characteristics of the health market also make it difficult to apply empirical evidence gathered from other markets.¹⁴

The health care marketplace is unlike most other marketplaces in which participants bid on contracts with the State of Minnesota:

1. The health care marketplace has a limited number of participants with generally high barriers to entry. New health plans, care systems, hospitals, pharmacy benefit managers, health care clearinghouses and other similar entities do not freely enter and leave the health care marketplace on a regular basis.
2. Some of the participants in the health care marketplace have a near-monopoly on the services they provide through market dominance or patent protection, or operate in an environment with very limited competition. For example, a number of hospitals and physician groups are sole source providers in certain regions of the state and many manufacturers of medical devices and pharmaceuticals are the beneficiaries of patent protection.
3. Health plans rely on the payment rates in provider and vendor contracts to bid repeatedly on the same or similar contracts with the DHS and other state agencies.
4. Unlike other state contractors, health plans are required to participate in state public health care programs and, therefore, could not withdraw from the public program marketplace if broad disclosure requirements present a competitive threat or disrupt their business operations.
5. Health plans administering programs for MHCP members are heavily regulated and already submit extensive data to regulators through regular reporting, routine audits, and responses to inquiries. Thus, the public policy rationale for disclosure of information already regulated and overseen by government agencies is less clear than for other government contractors.

¹⁴ Austin & Gravelle, *supra* note 10.

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6. Health plans administering programs for MHCP members are paid on a capitated basis and incur full financial risk. Any cost over-runs are borne by health plans and not the state. Therefore, information about the prices plans pay to providers is not needed by public members for "watch-dog" purposes in the context of health plans administering MHCP.
7. The buyer is represented by more than just the consumer. Most Minnesotans obtain their health insurance coverage either through their employer or from a government entity.¹⁵ Consumers covered through employer-sponsored insurance ("ESI") typically pay a fraction of the cost of the premium with the employer paying the remainder. Indeed, many employees are unaware of how much their health insurance actually costs until they seek to buy coverage in the individual market.

In the unique market described, health plans play a critical role in protecting the consumer from the dominant market power of providers. On behalf of its members, a health plan negotiates with a variety of hospitals, physicians and others to develop a network of all types of providers that enrollees are likely to need. In exchange for an overall reduced reimbursement¹⁶ to the provider, the health plan is able to assure a certain volume of patients to that provider.

Barriers to Advancing the Triple Aim

As pressure increases to "bend the cost curve," health insurers and providers have been collaborating to develop new payment reform and care delivery models that will reduce health care costs, improve quality of care, and improve patient outcomes and experience. Unlike the old fee-for-service ("FFS") paradigm, by purchasing services with individual providers based on a negotiated and agreed upon rate for a certain volume of patients, health plans are now able to leverage lower prices for greater value on behalf of consumers.

Consumers covered through ESI can choose from a variety of products with variable benefit designs and varying levels of financial responsibility. The availability of these options is driven by proprietary arrangements between plans and providers. If health carriers were required to reveal confidential information about new payment reform models, the incentive for providers to participate would be removed.

Moreover, provider rate sheets are limited in terms of their value toward achieving total cost of care arrangements and other payment reform models. Price, or the total amount a provider expects to be paid by payers and patients for health care services (as distinguished from negotiated charges or costs), is an important component of consumers transparency, but it is not the only information needed to make informed decisions.

¹⁵ Minn. Dep't of Health Econ. Program, Distribution of Minnesota Population by Primary Source of Insurance Coverage, 4 (2012), available at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section2.pdf>. Population estimates are from the U.S. Bureau of Census, June 2013. MA is Medical Assistance, MNCare is MinnesotaCare, MCHA is Minnesota Comprehensive Health Association, and PCIP is Pre-Existing Condition Insurance Plan.

¹⁶ Reimbursement rates are calculated based on the supply of providers in the geographical area, the quality of the providers, and the unit cost.

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According to the HFMA:

Price transparency information should be paired with other information that defines the value of services for the care purchaser. Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.¹⁷

Disclosing contract rates will not achieve meaningful transparency as described above, and carries with it a number of market risks.

With respect to payment transformation, allowing negotiated rates developed by insurers with their networked providers to be public would make it more difficult for health insurers to secure discounts from providers in exchange for the higher market volume of patients. This would result in insurers having to pay higher reimbursement rate to providers, which in turn results in higher premiums for consumers. This could make the cost of coverage prohibitive for some consumers resulting in more uninsured.

Question #2 (i): Any effect of disclosing information used in contracting with a government entity for health related services upon state or local government programs. These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

The same policy considerations outlined in response to Question #1 (reduced competition, increased costs, decreased access, and barriers to advancing the Triple Aim) generally apply to government programs.

In 2012, nearly 14 percent of Minnesotans received health care through state public programs.¹⁸ Minn. Stat. § 62D.05, Subd. 4, benefits the State of Minnesota by requiring health plans to provide managed care coverage for enrollees in state public programs. Consumers benefit because they are able to access care through a health plan's broad network of providers. In terms of access to health care services, this has helped to reduce disparities facing lower-income individuals and families. Providers benefit because they see an increased volume of patients and are reimbursed typically at a higher rate than under Medicaid FFS.¹⁹

The ultimate result for the state is budget stability and predictability. In fact, in the September 2013 report to the Legislature on the Value of Managed Care, it states:

¹⁷ HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, *supra* note 9, at 2.

¹⁸ Minn. Dept. of Health, Health Economics Program. Minnesota Health Care Markets Chartbook, available at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section2.pdf>. This figure does not include Minnesotans covered under the federal Medicare program or TriCare program.

¹⁹ MINN. DEP'T OF HUMAN SVCS., PROVIDER PAYMENT AND REIMBURSEMENT RATES 31(Jan. 2011), available at <http://archive.leg.state.mn.us/docs/2011/mandated/110202.pdf>.

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Minnesota's FFS performance measurement and quality improvement infrastructure is underdeveloped in comparison to the programs in place for managed care. Given all of these quality differences between the two systems, it would appear that managed care is able to deliver stronger health outcomes, and therefore stronger potential value, than what can be expected from the FFS system.²⁰

If information about how much each health plan reimbursed its providers were disclosed, it would remove any leverage the health plan had as a purchaser of services on behalf of its enrollees. Not only would this likely have a negative effect on the cost of coverage for persons covered through state public programs, but it would also have a negative effect on the cost of coverage for persons covered in the commercial market. The loss of that leverage would translate back to the state of Minnesota in the form of higher costs for state public health care programs.²¹

If the MGDPA were fully applied to state health care vendors, it would also have an impact on the cost of procurement for the state of Minnesota. While Chapter 13 allows the cost of responding to data practices requests to be charged back to the requestor, the costs of defending the classification of data cannot be charged to the requestor. The cost of defending the classification of data would be significant for health plans and some state vendors and, therefore, increase procurement costs for the state. Costs would also increase for the Minnesota Department of Administration to conduct administrative hearings regarding data classification.

Question #2 (ii): Any effect of disclosing information used in contracting with a government entity for health related services upon purchasers of health insurance. These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

The costs of DHS public programs are based in part on medical cost trends experienced in our marketplace. If provider rates increase in an environment where public data on contracted rates could be leveraged in negotiations by lower-cost providers, medical cost trends would increase and negatively impact Medical Assistance and MinnesotaCare budgets.

Disclosure of reimbursement rates for state public programs could have a negative effect not only on the cost of coverage for persons covered through state public programs, but also on the

²⁰ PUBLIC CONSULTING GROUP, REPORT ON THE VALUE OF MINNESOTA HEALTH CARE PROGRAMS (MHCP) MANAGED CARE, AS COMPARED TO FEE-FOR-SERVICE (Sep. 24, 2013), available at <http://archive.leg.state.mn.us/docs/2013/mandated/130704.pdf>.

²¹ Efforts to extend the burdens of public law procedural and disclosure requirements to private entities inevitably reduce the economic and administrative advantages that originally led government agencies to privatize or contract out previously public services." Mark Fenster, *The Opacity of Transparency*, 91 IOWA L. REV. 885, 919 (2006) (citing Dan Guttman, *Governance by Contract: Constitutional Visions; Time for Reflection and Choices*, 33 PUB. CONST. L.J. 321, 345 (2004)).

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cost of coverage for persons covered in the state employee and public employee health insurance programs. That is because the same concerns about consumer access to providers, affordability of payment rates, and decreased market competition would be present in programs for persons covered in the state employee and public employee health insurance programs.

Question #2 (iii): Any effect of disclosing information used in contracting with a government entity for health related services upon health care recipients and consumers. These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

Impacts on prices: As stated earlier, if information about reimbursement rates paid to providers were required to be disclosed as discussed in this question, this could affect prices. If provider A knows what provider B is getting paid, provider A will be incented to seek the same or a higher reimbursement rate ("shadow pricing"). Moreover, cost-saving market reforms could be discouraged as health plans and providers are entering into more and more arrangements that support the Triple Aim through accountable care, total cost of care, and other forms of contracting that are increasingly innovative.

Impacts on access to providers: We believe there would be greater difficulty in finding certain types of providers willing to treat MHCP patients if negotiated contract terms were made public as described above. In a number of areas (e.g., specialty dental), health plans already have extreme difficulty finding providers to treat MHCP members.

Impacts on total contract budgets of public health care purchasers: Health insurers and providers have been collaborating to develop new payment reform and care delivery models that will reduce health care costs, improve quality of care, and improve patient outcomes and experience. Disclosing information used in contracting with a government entity for health related services will stifle payment reform and care delivery/product innovation efforts intended to benefit consumers.

Willingness of health plans and providers to participate in public health programs: Under Minn. Stat. § 62D.04, Subd. 5, health plans would still be required to participate in state public programs but providers could hold out from participating in a health plan's network unless their terms of reimbursement were met.

Question #3: The effect of complying with health related data requests on existing administrative resources for both public and private entities.

The Council has the following concerns around possible increased administrative burdens:

- There could be increased administrative and litigation costs incurred as a result of repeated MGDPA requests from members of the public.

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- Some data requests already received by health plans appear to have been sent in an attempt to obtain information that could be used by the requesting party in possible litigation. Because health plans, providers and vendors lack the protection of the Tort Claims Act enjoyed by the state (see Minn. Stat. § 3.736), requiring health plans, providers and vendors to respond to “fishing expeditions” for meritless claims masquerading as MGDPA requests has the potential to divert resources from our key goal of increasing access to health care for all.

Monetary expense, use of critical IT resources, and time taken away from existing reporting functions are all likely costs. Plan resources are not unlimited, so to divert time and attention into new disclosure requirements could short change other areas such as reform implementation, quality improvement, and so forth – all of which benefit consumers.

It is also important to note that public program plans and providers already provide substantial information to both the state of Minnesota, and to enrollees. Plans providing public program services report to DHS on many contract parameters and are accountable for results under existing reporting requirements.²² Plans that provide coverage as part of an employee benefit package provide substantial information to enrollees that will help them make meaningful choices about their care or coverage.

Question #4: Potential liability to government or private entities for releasing health related data made public under state law and subsequently found to be trade secret.

Certain plan subcontracts with private entities (in addition to providers) include provisions around confidentiality as previously stated. These entities are not directly contracting with the state but could be impacted by data disclosure, leading to government liability, private liability, or both.

Conclusion

The rates used in the Minnesota public health care programs, and the premiums in the commercial market, reflect the underlying costs of health care, which include physician charges, hospital pricing, prescription drugs, costs for medical diagnostics and devices, and the costs of managing and administering services.²³ Making agreements between health plans and health care providers publicly available would have negative consequences on competition and raise the cost of health care.

²² Minn. Dep't of Human Svcs., Minnesota Health Care Programs 2013 Total Payments to Managed Care Plans, by Program for calendar year 2013, *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_160127.

²³ Austin & Gravelle, *supra* note 10, at 4.

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Health plans negotiate on behalf of their public health care program and commercial members with providers, and health plans have many contracts with vendors and contractors to facilitate a member's access to care. The application of the MGDPA to health plans, that are obligated under licensure requirements to contract with the state for the administration of public health care programs, would have a chilling effect on the ability of health plans to secure quality vendors and subcontractors.

The ultimate result is that options for the acquisition of certain drugs, devices, and other benefits of the health plans may be limited for Minnesota state public program members who may then not have access to the same quality of health care as non-government health plan members. This may result in inequity between a health plans' commercial members and public program members, who have vendors of different quality. Not only would quality and cost in access to certain drugs or services be limited, but provider access would be threatened as well.

Finally, Minnesota state law already accounts for an appropriate amount of price and cost transparency for the state, taxpayers, and health plan members. Adding more administrative burdens on plans and providers without facilitating meaningful and easy-to-understand transparency that takes into account quality of care and other relevant information beyond negotiated rates would be counterproductive for consumers of health care and for market reforms.



January 12, 2014

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RE: Request for Information: Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act

Dear Mr. Hultman:

On behalf of the Minnesota Medication Association (MMA), I am pleased to provide comments in response to the above-referenced request for information. In brief, the MMA supports public disclosure of Minnesota Health Care Programs (MHCP) data for two primary reasons – 1) as a fundamental mechanism by which to ensure public accountability for how taxpayer dollars are spent, and 2) as an essential element for greater health care transparency more broadly, which is aimed at improving the functionality of Minnesota’s health care system.

In response to the four questions posed by DHS, the MMA offers the following comments:

Question 1: The impact of making agreements between health plans and health care providers publically available on: i) competitiveness in the provider and health plan markets including new market entry; ii) negotiated prices; and iii) health care expenditures overall including health care spending trends for consumers paying premiums.

The frequent concern raised amid proposals for payment transparency is that prices and overall spending could increase. Given current health care spending levels and trends, that is a reasonable concern. However, it is important to remember the targeted nature of the proposed disclosure – the information subject to disclosure would be limited to data associated with MHCP and not data associated with other commercial relationships. In addition, growth in total expenditures for MHCP are naturally limited based on legislative actions, such as eligibility

levels, covered benefits, and total appropriations. Total spending is further constrained by the contracted rates set by the Minnesota Department of Human Services that are paid to the managed care organizations. Finally, it is not at all clear that current spending levels are appropriate to meet the health care needs of Minnesotans served by Minnesota Health Care Programs. Perhaps total spending should be reduced, but perhaps total spending is insufficient to adequately meet current needs. Policymakers, researchers, physicians, and enrollees have a vital interest in fully understanding how managed care organizations spend public dollars so they can more accurately target and/or invest MHCP dollars.

Evidence as to the actual effect of transparency on prices and total spending is quite limited, with railroad and concrete industries most often used to show price increases.^{1,2} Subsequent studies, however, have questioned either the underlying data³ or the size and duration of the study. The effect in health care, in particular, is not clear and is likely based on levels market concentration.

Minnesota's health insurance market is extremely concentrated, meaning they have significant power to negotiate and hold down prices. In fact, an analysis by the American Medical Association has found that Minnesota's health insurance market is "highly concentrated" based on the Herfindahl-Hirschman Index (HHI), a measure of market concentration used by the US Department of Justice and Federal Trade Commission.⁴ The Duluth, Rochester and St. Cloud metropolitan statistical areas (MSAs) are also "highly concentrated" and the Minneapolis-St. Paul-Bloomington MSA is considered "moderately concentrated" but falls just below the highly concentrated level.⁴ This insurer market concentration is not likely to diminish as a result of the disclosure provision.

With respect to the impact of the data release on competitiveness and market entry it is worth considering the role of "Rule 101" (M.S. 256B.0644 and M.R. 9505.5210). Rule 101 effectively serves to limit market concentration among physicians and other health care providers. Although Rule 101 also applies to Minnesota HMOs, the already concentrated market for insurers in Minnesota provides them with significant (and greater) bargaining power relative to the physician and other health care provider market.

It is not clear to the MMA that the proposed disclosure would have any impact on market entry for physicians and other health care providers, as the current market entry pathway is limited primarily due to education, training, and licensure standards. It is also difficult to imagine that disclosure would serve as any meaningful barrier to entry for other insurers, given the historically limited pace of new entrants into the Minnesota insurance market.

¹ Fuller S, Ruppel, F, Bessler D. Effect of Contract Disclosure on Price: Railroad Grain Contracting in the Plains. *Western Journal of Agricultural Economics*, 15(2): 265-271, 1990. Schmitz J, Fuller S. Effect of Contract Disclosure on Railroad Grain Rates: An Analysis of Corn Belt Corridors. *Logistics and Transportation Review*, 31(2): 97-124, 1995.

² Albaek S, Mollgaard P, Overgaard PB. Government-Assisted Oligopoly Coordination? A Concrete Case. *Journal of Industrial Economics*, 45(4):429-443, 1997.

³ Wolfe KE, Linde WP. The Carload Waybill Statistics: Usefulness for Economic Analysis," *Journal of the Transportation Research Forum*, 36(2): 26-41, 1997.

⁴ American Medical Association. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2013 Update. 2013.

Question 2: Any effect of disclosing information used in contracting with a government entity for health related services upon: i) state or local government programs; ii) purchasers of health insurance; and iii) health care recipients and consumers. These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

The MMA urges the department to focus its lens of analysis principally on how improved disclosure of information can improve services for Minnesota Health Care Program enrollees. The MMA submits that the disclosure of MHCP agreements between health plans and health care providers is critical to improve the understanding of the relationship between rates paid and access to care. There is fairly clear evidence to indicate the importance of Medicaid rates on physicians' and other providers' willingness to treat Medicaid patients as well as on the level of engagement with the Medicaid population within a medical practice.⁵

Question 3: The effect of complying with health related data requests on existing administrative resources for both public and private entities.

The MMA has some concern about the costs to physician practices in complying with frequent and/or broad requests for data. To limit such burdens, the MMA urges the state to consider the establishment of a hierarchical or progressive disclosure requirement, such that those closest to the government function would be expected to release data before those further downstream. In addition, the MMA believes that private entities should be able to charge a reasonable fee on those requesting data.

Question 4: Potential liability to government or private entities for releasing health related data made public under state law and subsequently found to be trade secret.

The MMA is concerned that many of the current contracts between managed care organizations and physicians do not separate terms and conditions for MHCP business from other commercial business. As such, disclosing such agreements could require very complex redaction efforts. The MMA urges the state to indemnify contractors and subcontractors who in good-faith release the requested data.

Conclusion

Creating greater transparency in the health care system is difficult work. Minnesota Health Care Program enrollees and Minnesota taxpayers, however, deserve to know that state dollars are spent

⁵ See, for example, Wilk A, Jones D. To Extend or Not Extend the Primary Care "Fee Bump" in Medicaid. *J. of Health Politics, Policy and Law*, 39(6): 1263-1275, 2014. Zuckerman S, Goin D. How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees. Kaiser Commission on Medicaid and the Uninsured, 2012. Berman S, Dolins J, Tang S, Yudkowsky B. Factors that Influence the Willingness of Primary Care Pediatricians to Accept More Medicaid Patients. *Pediatrics* 11(2):239-48, 2002. Coburn A, Long S, Marquis S. Effects of Changing Medicaid Fees on Physician Participation and Enrollee Access. *Inquiry* 36(3):265-79, 1999.

in ways that maximize access to care, quality of care, and efficiency in care and administrative processes. That analysis is not possible given the current limitations on data availability. The MMA strongly supports the extension of current law to health care contracts as called for in Minnesota Statutes § 13.387. The MMA is confident that the narrow nature of this disclosure, combined with other market, legal and legislative forces will protect against any untoward consequences.

Thank you for your consideration of these comments. Should you have additional questions, please feel free to contact me or Janet Silversmith, MMA Director of Health Policy.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Jacobs", written in a cursive style.

Donald M. Jacobs, MD, FACS
MMA President

MINNESOTA COALITION ON GOVERNMENT INFORMATION

Response to Department of Human Services Request for Information (RFI)

Through the following comments, the Minnesota Coalition on Government Information (MNCOGI) is responding to the Department of Human Services (DHS) RFI on “Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act.” We understand that these comments will be synthesized into a larger report to be presented to the Minnesota Legislature regarding data-related impacts on public health care program costs.

MNCOGI’s comments generally respond to questions 2 and 3 posed in Part IV of the RFI. These questions deal with impacts related to the effect of disclosing information, and the impacts of complying with data requests. Beyond speaking to questions 2 and 3, our comments will also discuss the policy implications of a “public” classification for certain Health Maintenance Organization (HMO) data.

HMO data and the "welfare system"

Minnesota Statutes, Chapter 13 states that all Minnesota government data is presumed to be public unless otherwise classified by state or federal law. Due to this construction, Chapter 13 contains multiple sections that regulate various types of government data, and provide specific classifications for those data sets.

One section of Chapter 13 governs data related to the “welfare system.” Minn. Stat. 13.46 defines the welfare system to include DHS, plus a variety of state hospitals, nursing homes, and welfare agencies. In addition to those public entities, the welfare system is also defined to include:

“... other entities under contract to any of the above agencies to the extent specified in the contract.”

Such a definition extends to the HMOs that administer Minnesota’s public health care programs, thus subjecting those entities to Chapter 13 (at least to the extent that those entities are performing services under contract).

"Welfare system" data under Chapter 13 includes both "data on individuals"

(as defined by 13.46 Subd. 1(a)) and "data not on individuals" (as defined by 13.46 Subd. 6).

Under 13.46, Subd. 2, "data on individuals" is generally classified as "private" data, and is subject to regulation as to its use and dissemination. "Vendors of services" are not considered to be "individuals" under 13.46 Subd. 1(a).

Under 13.46, Subd. 6, "data not on individuals" (vendor and other non-individual data) is generally classified as "public" with certain statutory exceptions. Despite the public classification of this data, HMOs have relied on language in DHS-HMO contracts (see section 14.3.3 of 2008 DHS contract BO6778 for an example) to argue against the release of HMO-related public program business data. HMO representatives have contended that their only obligations regarding welfare system data are to ensure the security and privacy of data - not to facilitate access. (See, generally, testimony of Kathryn Kmit, Minnesota Council of Health Plans, at an April 25, 2014 joint hearing of the House Civil Law and Health and Human Services Finance committees.)

Discussions about enacted (as well as proposed) changes to Minnesota law that deal with the disclosure of government contractor data have spurred the legislature to examine the impact of the public release of certain HMO business data relating to government programs. As such, MNCOGI's comments speak only about public access to certain "data not on individuals" as defined by Minn. Stat. 13.46, Subd. 6.

HMO administrative, provider payment data

The HMOs that administer Minnesota's public health care programs utilize public funds that are measured in the billions of dollars. Specific sets of business and organizational data are able to reveal how those public funds are used by the private entities that manage them.

For instance, data on administrative expenses and provider payments are important to a full understanding of how taxpayer monies are utilized in the execution of public health care programs. Administrative and provider expenditures constitute the bulk of the expenses paid out in the course of administering such programs. Subtracting those expenses from the "capitated" block payments paid to HMOs for public program management provides an understanding of how much public money is involved in the

provision of health care, and how much of each “capitated” payment remains after health care services have been rendered.

It should be noted that some of this data currently exists as "public" data. Aggregate totals of administrative and provider expenses for public programs have long been available in HMO financial reports filed with the Minnesota Department of Health (MDH). However, specific, granular-level detail is not available in those same reports.

Access to granular-level administrative expense details would provide a more complete understanding of the composition of the publicly reported aggregate totals, and whether those totals included expenses that were indeed germane to public program work. Likewise, access to granular provider payment information would permit a more complete picture of publicly reported aggregate expenses, and whether those expenses were accurate and reasonable.

Historically, DHS and MDH have been involved in collecting administrative expense and provider data (see, generally, Minn. Stat. 256B.69 and Minn. Stat. 62D.08). Starting in 2014, the Office of the Legislative Auditor was also tasked with hiring a third-party auditor to review public program administrative expenses (see 256B.69 Subd 9d). While agency and auditor oversight is appropriate, MNCOGI has urged that granular-level administrative and provider payment data be made publicly available so that Minnesota citizens (including the press) can undertake their own reviews, just as they are able to do with other collections of consequential government data through Chapter 13 access.

Impact of public access, and public access precedents

MNCOGI provides no estimates for hard costs related to the public availability of administrative and provider payment data for HMO-administered public health care programs. However, as a point of comparison, MNCOGI would highlight the extensive nature of business data already publicly available in connection with other government contracts. Cost details, including costs in bids, are routinely made public after private entities have responded to requests for proposals (RFPs) for government business (see Minn. Stat. 13.591).

A recent MDH request for applications for medicinal cannabis manufacturers (published September 5, 2014) noted that price and cost

information submitted by private sector entities would be public information once the applicant was registered, and would not be liable to withholding as trade secret information “under any circumstance.”

The public release of certain private sector business data related to government programs has many precedents. There are also precedents for the release of certain business data related to licensed health care enterprises. Minnesota's Commissioner of Administration has released multiple Data Practices Advisory Opinions on such matters, including the following examples:

Example 1: In 2001 the Commissioner of Administration issued an opinion (Opinion 01-052) holding that Delta Dental (a subcontractor to HMO Blue Cross/Blue Shield) was obligated to release certain data related to subcontract work conducted under the auspices of the state’s “PMAP” public health care program. In that opinion, the Commissioner opined that Delta Dental had to provide the name of a particular orthodontist who reviewed a patient file and denied coverage.

Example 2: In 1998, an attorney for Community Coordinated Health Care (CCHC) sought an advisory opinion about the status of CCHC data provided to the state as part of an application to become an Accountable Provider Network under Minn. Stat. 62T. Such data included lists of provider networks, agreements with providers, contracts for services with third parties, and projected income statements. In Opinion 98-050, the Commissioner opined that such data did not qualify for trade secret protection since it did not meet all the trade secret criteria set out in Minnesota law. In particular, the data did not constitute a “formula, pattern, compilation, program, device, method, technique, or process,” and thus was available as public data.

Example 3: In 2005, a public requester sought financial data from Resource Training Solutions (RTS), a Minnesota service cooperative operating a health insurance pool. RTS was an entity subject to Chapter 13. The requester sought “ledgers containing all income and expenditures listing the names, amounts, and services provided by each vendor or entity.” In Opinion 05-011, the Commissioner opined that such granular-level provider expense data was public, and should be provided to the requester.

Minimal burden in providing compiled information

Some of the discussion surrounding access to public program-related HMO data has centered around questions of whether there will be undue burdens placed on HMO entities to compile and provide such data to public requesters.

In regard to administrative expenses and provider payment data, MNCOGI would note the following. Currently, administrative expenses, provider payment details, and related data are required to be compiled and provided to DHS under Minn. Stat. 256B.69. Since January of 2014, such data must be provided to DHS on a quarterly basis (see Minn. Stat. 256B.69 Subd. 9c.) Thus, HMOs already compile regular, comprehensive data sets related to public programs. Once compiled for submission to DHS, such data sets could be transmitted to public requesters much in the same way that they are transmitted to the agency, with minimal additional work.

Benefits of data access to the State of Minnesota

Prior to recent decades, administrative expense and provider payment data related to public health care programs were considered to be public. This was the case when public programs were administered directly by the state, instead of by private, third-party intermediaries. Such data were made available to the public for the classic purpose of using transparency to help prevent waste, fraud, and abuse in the handling of public funds. MNCOGI believes that important public health care program data should be available in the same way - and for the same purpose - today. In closing, MNCOGI suggests that any hard costs pertaining to HMO data access must be measured against the reduction of liabilities and costs related to possible waste, fraud, and abuse that can result from a lack of public oversight.

Submitted on January 8, 2015

Matt Ehling
Chair, Legislative Issues Committee
Minnesota Coalition on Government Information
c/o Helen Burke
4246 Grimes Ave. S.
Edina, MN 55416
651-335-2037
mncogi@gmail.com

January 5, 2015

Patrick Hultman
Minnesota Department of Human Services (DHS)
Health Care Administration
PO BOX 64984
St. Paul, MN 55164-0984

Dear Mr. Patrick Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services. For the record, your request comes over the holidays which makes responding more difficult. I understand your department should have made this request much earlier in the year, as this important legislative report was due on December 21, 2014. You have asked four questions. I am answering, regarding transparency's impact on competition, prices and expenditures: The dollars received by health plans are taxpayer dollars. Today, no one has any idea how these taxpayer dollars are used, but an independent auditor expressed concerns in March 2013. Transparency is needed.

Thank you for asking for my input. Be sure to include my comments in your required report to the Minnesota state legislature.

Sincerely,



Patricia A. Sellner
4935 Weston Lane North
Plymouth, MN 55446
763-383-0672



January 12, 2015

Patrick Hultman
Minnesota Department of Human Services
Health Care Administration
PO Box 64984
540 Cedar Avenue
Saint Paul, MN 55164-0984

RE: Request for Information: Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act

Dear Mr. Hultman:

Thank you for the opportunity to provide input about impacts if certain subcontractor information held by health plans was subject to full, real-time disclosure under the Minnesota Government Data Practices Act (MGDPA).

UCare's mission is to help people of all ages, incomes and abilities overcome barriers to accessing health care, and to improve the health of our members. We believe our mission would be advanced if our members had an increased understanding of the healthcare system through meaningful price and quality transparency.

However, efforts to expand the availability and accessibility of data should be balanced by the potential risks associated with transparency of competitive information. In pursuing policy proposals to support price and quality transparency, we should not compromise the affordability the health care marketplace or impose unreasonable administrative burdens on those organizations providing coverage and care.

Support for Consumer Price Transparency in the Healthcare Marketplace

UCare is committed to working with all stakeholders to provide patients with a more transparent health care system that helps consumers make informed decisions about accessing care. A dialogue should be undertaken through a deliberative public process where all interests and concerns can be fairly heard. In our view, this information should include:

- Total estimated price of the service;
- A clear indication of whether a particular provider is in the health plan's network, and information on where the consumer can locate a network provider;
- A clear statement of the patient's estimated out-of-pocket payment responsibility; and

- Other relevant information related to the provider or the specific service sought, such as clinical outcomes, patient safety, or patient satisfaction scores should be linked wherever possible to price information.

UCare is pleased to offer the following responses to the questions posed in the RFI:

1. The impact of making agreements between health plans and health care providers publically available on: i) competitiveness in the provider and health plan markets including new market entry; ii) negotiated prices; and iii) health care expenditures overall including health care spending trends for consumers paying premiums.

RESPONSE

UCare believes that the unrestricted applicability of the MGDPA to the health care marketplace would have a significant, negative impact on competition without providing meaningful transparency to key stakeholders. More specifically, UCare believes that the real-time disclosure of provider payment information and other sensitive contract terms attributable to specific health plans and providers should not be subject to disclosure under the MGDPA.

Attached to this letter as Attachment "A" is a compilation of research and policy analysis related to health care price transparency. Please refer to the cites from the Department of Justice, the Federal Trade Commission, and other policy analysts for raising similar concerns about the potential disruptive and anticompetitive impacts of disclosing prices negotiated between payers and providers.

2. Any effect of disclosing information used in contracting with a government entity for health related services upon: i) state or local government programs; ii) purchasers of health insurance; and iii) health care recipients and consumers.

These effects could include, but are not limited to, impacts on prices, access to providers, total contract budgets of public healthcare purchasers, and willingness of health plans and providers to participate in public health care programs. State programs and budgets of particular interest include the Medical Assistance and MinnesotaCare programs and the state employee and public employee health insurance programs.

RESPONSE

The disclosure of current payment rate information attributable to specific health plans, providers and vendors would inhibit the ability of health plans to control costs and provide cost-savings benefits to Minnesota taxpayers through negotiating favorable rates with providers and vendors.

For example, if Provider A were to review contract rate information available through the MGDPA and observe that Provider B has a 5% higher contracted rate, Provider A could threaten to terminate their contract with UCare unless UCare increases their contract rate by 5%. Overtime, the prevailing market rates would likely increase.

UCare has worked diligently to attempt to keep health care costs low and provide meaningful value to state public program recipients and taxpayers. The State of Minnesota and its taxpayers have benefitted from UCare's efforts through the attainment of lower costs in the state public programs competitive bid process. As described above, UCare believes that full, real-time disclosure of provider- and plan-identifiable payment rate information would impede these efforts.

In addition, due to the nature of our business, UCare holds a number of direct or indirect subcontracts with large entities, sole source providers, and large, national entities with whom we have little negotiating leverage. Many of the entities are necessary to enable us to run our business or provide critical access to health care services for our members.

For example, the pharmacy benefit manager (PBM) and health care clearinghouse markets are dominated by a limited number of companies, as are certain IT functions (e.g., Microsoft). Most of these contracts contain stringent confidentiality provisions which are not negotiable. We are concerned that we will not be able to obtain contract terms requiring wide-ranging disclosures to the public, as Minnesota health care programs business is a small portion of these entities' national book of business. If we were not able to negotiate terms with our first-choice vendors, it is not clear if other quality vendors could be located with the same level of services and competitive pricing.

Similarly, pharmaceutical and device companies have pricing terms subject to strict confidentiality provisions. Some of these products -- for example, the multiple sclerosis treatment copaxone (Teva) and the HIV drug raltegravir (Merck) -- are sole-source products needed to meet current standards of care with no alternative suppliers. UCare is concerned that we will not be able to get MGDPA payment rate transparency terms in contracts with these companies, in light of our limited leverage with sole-source providers with significant global volume.

It is not clear what we are expected to do if we cannot get the required MGDPA term into contracts with these entities. Is the expectation that we will not contract with these companies? If yes, then Minnesota health care programs members will not be able to access these drugs and devices, some of which are standards of care. Alternatively, will there be some other process for critical sole source subcontractors who will not agree to abide by the MGDPA?

In a number of areas (e.g., specialty dental), it is very challenging to find providers to treat Minnesota health care programs members, even without the additional MGDPA burdens. Depending on how the open records requirements are interpreted and how deep into the subcontractor chain these requirements apply, we are concerned that putting additional burdens on already reluctant providers will decrease network access. For example, if a specialty dental provider were required to respond to a MGDPA records request from a member of the general public, this would act as a disincentive for a provider to see Minnesota health care program members. Word of the issue could quickly spread to other providers in the community, further inhibiting already tenuous access.

3. The effect of complying with health related data requests on existing administrative resources for both public and private entities.

RESPONSE

In addition to the concerns over the effects of the disclosure of contract terms and payment rates, UCare is also concerned about potential administrative and litigation costs incurred as the result of repeated MGDPA requests. UCare is committed to keeping its administrative costs low so that as many resources as possible can be used to provide member care and improve the health of our community.

Looking at requests for contracts alone, we have over 4,000 provider and vendor contracts and the production of these documents, particularly if substantive review or redaction were required, would require an extraordinary amount of internal and external resources, including the likely assistance of outside counsel in an amount that far exceeds our current expenditures. This is money that, we believe, would be better spent on programs that improve the health of UCare members and our community. Diverting resources to respond to MGDPA requests would require extensive staff resources and hinder our goal of keeping administrative costs low.

In addition, it is expected that some requests would be motivated to seek to force UCare to disclose information that could be used by the requesting party in frivolous litigation. Because health plans, providers and vendors lack the protection of the Tort Claims Act enjoyed by the state (see Minn. Stat. § 3.736), requiring health plans, providers and vendors to respond to “fishing” expeditions for meritless claims masquerading as MGDPA requests has the potential to divert resources from our key goal of increasing access to health care for all.

4. Potential liability to government or private entities for releasing health related data made public under state law and subsequently found to be trade secret.

RESPONSE

A determination of potential liability cannot be determined without specific details regarding the health-related data in question and the circumstances surrounding the release.

UCare appreciates your consideration of our comments.

Sincerely,



Ghita Worcester
Senior Vice President, Public Affairs and Marketing
UCare

ATTACHMENT "A"**Research Evidence and Policy Analysis Related to Health Care Price Transparency**

1. **Statements of Antitrust Enforcement of Policy in Health Care, issued by the U.S. Department of Justice and the Federal Trade Commission, August, 1996.** <http://www.justice.gov/atr/public/guidelines/0000.htm> Statement # 6 concerns Provider Participation in Exchanges of Price and Cost Information. The statement set for the conditions under which providers can use information derived from price and compensation surveys to price their services more competitively, and to offer compensation that attracts highly qualified personnel. Statement #6 also notes, however, that without appropriate safeguards, information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services.
2. **FTC Staff Letter to the Honorable Mark Formby, Mississippi House of Representatives, Concerning Mississippi Senate Bill 2445 and the Regulation of Pharmacy Benefit Managers** <http://www.ftc.gov/policy/policy-actions/advocacy-filings/2011/03/ftc-staff-letter-honorable-mark-formby-mississippi> The Federal Trade Commission (FTC) responded to a request for comments on the likely competitive effects of a Mississippi bill that would shift regulatory authority over Pharmacy Benefit Managers companies from the Insurance Commissioner to the Board of Pharmacy. In its reply, the FTC said, in part: The bill empowers the Pharmacy Board to regulate PBMs and may impede PBM's ability to negotiate effectively contracts with pharmacies that save money for Mississippi health plans and consumers. Second, the Pharmacy Board would have vague and potentially unlimited authority to demand disclosures of sensitive PBM business information without any confidentiality protections, which could restrict PBMs ability to negotiate contracts with pharmaceutical manufacturers and pharmacies to provide the best prescription drug programs and prices for Mississippi consumers.
3. **Price Transparency in Health Care: Report from the Health Care Financial Management Association, 2014.** Policy analysis includes different price transparency frameworks for different care purchasers: insured patients; uninsured and out-of-network patients; employers; and referring clinicians. Reports notes that price transparency may have unintended consequences that may need to be addressed as greater transparency takes hold. These include the impacts of transparency on price negotiations within the business-to-business marketplace between health plans and providers and providers' ability to provide societal benefits.
4. **Designing Transparency Systems for Medical Care Prices, David Cutler, Ph.D. and Leemore Dafny, Ph.D., The New England Journal of Medicine, March 10, 2001.** The authors acknowledge that efforts to promote cost-consciousness in health care is noteworthy and laudable, however, they also note that complete transparency of prices negotiated

between payers and providers could raise costs instead of lowering them, especially in markets where there is some degree of pricing power and where consumers are imperfect decision makers.

5. **Does Price Transparency Improve Market Efficiency: Implications of Empirical Evidence in Other Markets for the Health Sector**, D. Andrew Austin and Jane G. Gravelle, Congressional Research Service. CRS Reports for Congress, RL34101. July 24, 200 <http://fas.org/sgp/crs/secretary/RL34101.pdf> Discusses why the special characteristics of the health market make it difficult to directly apply empirical evidence of price transparency in other markets.
6. **All Payer Claims Databases: Issues and Opportunities for Health Care Cost Transparency in New Jersey**, Magda Schaler-Haynes, J.D., M.P.H. Rutgers Center for State Health Policy. May 2013. <http://www.cshp.rutgers.edu/Downloads/9990.pdf> Because health care costs drive health insurance premiums, health claims data is required for complete analysis of insurance rates. Indeed the widespread unavailability of health cost information is suggested to be a more significant factor in health care price disparities than either case complexity or quality variability. Price obscurity is also suspected to provide market advantages to carriers and providers. *The reaction of providers to transparency initiatives is unknown, but there is evidence to suggest providers may raise prices in response to mandated disclosure of negotiated rates.* To avoid such unintended consequences and to maximize APCD potential, decisions regarding the type and context of price information disclosed should consider potential impacts on provider markets.
7. **How Price Transparency Could End Up Increasing Health-Care Costs**, Peter Ubel, *The Atlantic* (April 9, 2013) <http://www.theatlantic.com/health/archive/2013/04/how-price-transparency-could-end-up-increasing-health-care-costs/274534/> Price transparency may also cause prices to rise by reducing health-care providers' willingness to bargain with insurance companies. Currently, the price any given hospital charges for, say, a hip replacement will vary depending on which insurance company is paying for the service. A given hospital might have negotiated a higher fee from Aetna than from Blue Cross. Now suppose that legislation required hospitals to make all these negotiated rates public. Do you think Aetna is going to stand by and pay more money for a hip replacement than Blue Cross? Of course not. It's going to demand the same deal. If price transparency made such negotiations public, then no hospital in its right mind would offer a discount to one insurance company unless it was willing to offer that discount to everyone. Price transparency could be a huge impediment to price negotiations.

January 5, 2015

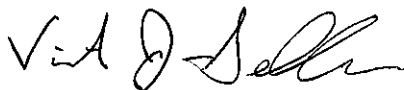
Patrick Hultman
Minnesota Department of Human Services (DHS)
Health Care Administration
PO BOX 64984
St. Paul, MN 55164-0984

Dear Mr. Patrick Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services. For the record, your request comes over the holidays which makes responding more difficult. I understand your department should have made this request much earlier in the year, as this important legislative report was due on December 21, 2014. You have asked four questions. I am answering, regarding transparency's impact on existing administrative resources: Health plans demand administrative reporting from doctors and hospitals before they reimburse them. And an auditor has said that the state has not critically reviewed health plan administrative charges. Contractor prices and use of taxpayer dollars must be transparent to taxpayers.

Thank you for asking for my input. Be sure to include my comments in your required report to the Minnesota state legislature.

Sincerely,



Vincent J. Sellner
4935 Weston Lane North
Plymouth, MN 55446
763-383-0672

Wayne Kallestad

From: "Wayne Kallestad" <mrwaynek@msn.com>
To: <Patrick.Hultman@state.mn.us>
Sent: Wednesday, December 31, 2014 3:59 PM
Subject: RFI Comments

Patrick Hultman
Minnesota Department of Human Services (DHS)
Health Care Administration
PO Box 64984
Saint Paul, MN 55164-0984

Dear Mr. Patrick Hultman,

I am responding to the December 15, 2014 DHS Request for Information on the treatment of data when private parties, specifically managed care plans, contract with a government entity for health related services. I understand your department should have made this request much earlier in the year, as this important legislative report was due on December 21, 2014. For the record, your request comes over the holidays which makes responding more difficult.

You've asked four questions. I am answering 4 of them.

Q1, regarding transparency's impact on competition, prices and expenditures: The dollars received by health plans are taxpayer dollars. Today, no one has any idea how these taxpayer dollars are used, but an independent auditor expressed concerns in March 2013. Transparency is needed.

Q2, regarding transparency's impact on Medicaid, MinnesotaCare, purchasers of health insurance and patients: Transparent pricing creates markets and lowers prices. The Auditor says non-transparent contracts have been very profitable for health plans. Transparency could lead to more dollars for actual patient care and less for corporate profits.

Q3, regarding transparency's impact on existing administrative resources: Health plans demand administrative reporting from doctors and hospitals before they reimburse them. And an auditor has said the state hasn't critically reviewed health plan administrative charges. Contractor prices and use of taxpayer dollars must be transparent to taxpayers.

Q4, regarding transparency's impact on potential liability for releasing "trade secret" data: Health plans are not the first or only government contractors. Every contractor has to make sure data is protected as appropriate, but only as appropriate. Health plans should not be allowed to hide expenditure data from taxpayers using dubious claims of "trade secret".

Be sure to include my comments in your required report to the Minnesota state legislature.

Sincerely,

Wayne Kallestad
PO Box 270994
Vadnais Heights, MN 55127

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 14a0100p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

HI-LEX CONTROLS, INC., HI-LEX AMERICA, INC.,
and HI-LEX CORPORATION HEALTH AND WELFARE
BENEFIT PLAN,

Plaintiffs-Appellees/Cross-Appellants,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant-Appellant/Cross-Appellee.

Nos. 13-1773/1859

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit
No. 2:11-cv-12557—Victoria A. Roberts, District Judge.

Argued: March 19, 2014

Decided and Filed: May 14, 2014

BEFORE: KEITH, SILER, and ROGERS, Circuit Judges.

COUNSEL

ARGUED: Robin Springberg Parry, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., for Amicus Curiae. James J. Walsh, BODMAN PLC, Ann Arbor, Michigan, for Appellant/Cross-Appellee. Perrin Rynders, VARNUM, Grand Rapids, Michigan, for Appellees/Cross-Appellants. **ON BRIEF:** James J. Walsh, G. Christopher, Bernard, Rebecca D’Arcy O’Reilly, BODMAN PLC, Ann Arbor, Michigan, for Appellant/Cross-Appellee. Perrin Rynders, Aaron M. Phelps, Stephen F. MacGuidwin, VARNUM, Grand Rapids, Michigan, for Appellees/Cross-Appellants. Robin Springberg Parry, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., Ronald S. Lederman, Gerard J. Andree, SULLIVAN, WARD, ASHER & PATTON, P.C., Southfield, Michigan, for Amici Curiae.

OPINION

SILER, Circuit Judge. The Hi-Lex corporation, on behalf of itself and the Hi-Lex Health & Welfare Plan, filed suit in 2011 alleging that Blue Cross Blue Shield of Michigan (BCBSM) breached its fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) by inflating hospital claims with hidden surcharges in order to retain additional administrative compensation. The district court granted summary judgment to Hi-Lex on the issue of whether BCBSM functioned as an ERISA fiduciary and whether BCBSM's actions amounted to self-dealing. A bench trial followed in which the district court found that Hi-Lex's claims were not time-barred and that BCBSM had violated ERISA's general fiduciary obligations under 29 U.S.C. § 1104(a). The district court also awarded pre- and post-judgment interest. We **AFFIRM**.

I.

Hi-Lex is an automotive supply company with approximately 1,300 employees. BCBSM is non-profit entity regulated by the state of Michigan that contracts to serve as a third-party administrator (TPA) for companies and organizations that self-fund their health benefit plans.

Since 1991, BCBSM has been the contracted TPA for Hi-Lex's Health and Welfare Benefit Plan (Health Plan). The terms under which BCBSM served as the Health Plan's TPA are set forth in two Administrative Services Contracts (ASCs) the parties entered into in 1991 and 2002, respectively. The parties renewed those terms each year from 1991 to 2011 by executing a "Schedule A" document.

Under the ASCs, BCBSM agreed to process healthcare claims for Hi-Lex's employees and grant those employees access to BCBSM's provider networks. In exchange for its services, BCBSM received compensation in the form of an "administrative fee" – an amount set forth in the Schedule A on a per employee, per month basis.

In 1993, BCBSM implemented a new system whereby it would retain additional revenue by adding certain mark-ups to hospital claims paid by its ASC clients. These fees were charged

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in addition to the “administrative fee” that BCBSM collected from Hi-Lex under a separate portion of the ASC. Thus, regardless of the amount BCBSM was required to pay a hospital for a given service, it reported a higher amount that was then paid by the self-insured client. The difference between the amount billed to the client and the amount paid to the hospital was retained by BCBSM. This new system was termed “Retention Reallocation.”

The fees involved in this new system have been termed “Disputed Fees” by the district court. They include:

- A. Charges for access to the Blue Cross participating provider and hospital network (Provider Network Fee);
- B. Contribution to the Blue Cross contingency reserve (contingency/risk fee);
- C. Other Than Group subsidy (OTG fee); and
- D. a retiree surcharge.

Hi-Lex asserts that it was unaware of the existence of the Disputed Fees until 2011, when BCBSM disclosed to the company in a letter the existence of the fees and described them as “administrative compensation.”

Following the disclosure, Hi-Lex sued BCBSM, alleging violations of ERISA as well as various state law claims. The district court dismissed the company’s state law claims as preempted, but granted Hi-Lex summary judgment on its claim that BCBSM functioned as an ERISA fiduciary and that BCBSM had violated ERISA by self-dealing. Furthermore, after a nine-day bench trial, the district court ruled that BCBSM had violated its general fiduciary duty under § 1104(a) and that Hi-Lex’s claims were not time-barred. The court awarded Hi-Lex \$5,111,431 in damages and prejudgment interest in the amount of \$914,241.

BCBSM asserts that the district court erred by (1) finding the company was an ERISA fiduciary, (2) ruling that BCBSM had breached its fiduciary duty under ERISA § 1104(a), (3) holding that BCBSM had conducted “self-dealing” in violation of ERISA § 1106(b)(1), and (4) concluding that Hi-Lex’s claims were not time-barred. Hi-Lex cross-appealed, arguing that the district court abused its discretion by ordering an insufficient prejudgment interest award.

II.

We review a district court's summary judgment rulings de novo. *Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 722 F.3d 861, 865 (6th Cir. 2013) (*Pipefitters IV*). The same standard applies when this court reviews "a district court's determination regarding ERISA-fiduciary status." *McLemore v. Regions Bank*, 682 F.3d 414, 422 (6th Cir. 2012). After a bench trial, a court's legal conclusions are reviewed de novo while its factual findings are reviewed for clear error. *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 448 (6th Cir. 2002).

III.

A. BCBSM's ERISA Fiduciary Status

A threshold issue in this case is whether BCBSM functioned as an ERISA fiduciary for Hi-Lex's Health Plan. In relevant part, ERISA provides that

a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan *or* exercises any authority or control respecting management or disposition of its assets, . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added). The term *person* is defined broadly to include a corporation such as BCBSM. *Id.* § 1002(9). In *Briscoe v. Fine*, we found this statute "impose[d] fiduciary duties not only on those entities that exercise *discretionary* control over the disposition of plan assets, but also impose[d] such duties on entities or companies that exercise 'any authority or control' over the covered assets." 444 F.3d 478, 490-91 (6th Cir. 2006). Applying that standard, we recently held that BCBSM functioned as an ERISA fiduciary when it served as a TPA for a separate client under the same ASC terms at issue here. *See Pipefitters IV*, 722 F.3d at 865-67. In that case, we found that BCBSM functioned as an ERISA fiduciary with respect to hidden OTG fees that it unilaterally added to hospital claims subsequently paid by the Pipefitters Fund. *Id.* at 866-67.

BCBSM argues that the decisions in *McLemore*, 682 F.3d at 422-24, and *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 616-19 (6th Cir. 2003), support its right to collect fees per the terms of its contract with Hi-Lex. In *Seaway*, however, we qualified our holding by

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noting that while simple adherence to a contract's term giving a party "the unilateral right to retain funds as compensation" does not give rise to fiduciary status, a "term [that] authorizes [a] party to exercise discretion with respect to that right" does. 347 F.3d at 619. Acknowledging this, BCBSM argues that it exercised no discretion with respect to the Disputed Fees because they were part of the standard pricing arrangement for the company's entire ASC line of business. The record, though, supports a finding that the imposition of the Disputed Fees was not universal. The district court cited an email in which BCBSM's underwriting manager, Cindy Garofali, acknowledged that individual underwriters for BCBSM had the "flexibility to determine" how and when access fees were charged to self-funded ASC clients. Moreover, Garofali admitted during testimony at trial that the Disputed Fees were sometimes waived entirely for certain self-funded customers. *See also Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 213 F. App'x 473, 475 (6th Cir. 2007) (*Pipefitters I*) (noting that self-insured clients were not always required to pay the Disputed Fees). The district court did not err in finding that the Disputed Fees were discretionarily imposed.¹

BCBSM also attempts to distinguish this case from *Pipefitters IV* by arguing that the funds which paid the Disputed Fees were Hi-Lex's corporate assets, not "plan assets" subject to ERISA protections. In *Pipefitters IV*, corporate funds from several employers were first pooled together in a trust account, the Pipefitters Fund, which then remitted funds to BCBSM in its capacity as a TPA. In this case, the funds Hi-Lex sent to BCBSM in its role as TPA came not from a formal trust account, but from a combination of the company's general funds and Hi-Lex employee contributions.

Department of Labor regulations state that employee contributions constitute plan assets under ERISA once they are "segregated from the employer's general assets." 29 C.F.R. § 2510.3-102(a)(1). Thus, the health care contributions deducted from Hi-Lex employees'

¹Counsel for BCBSM acknowledged as much during oral argument in *Pipefitters IV*. "But Your Honor, again, I really need to stress, getting caught up in the *Hi-Lex* case I think is a mistake because the fees are totally different. It's not ... that ... those are about fees where there is discretion." Oral Argument at 22:28, *Pipefitters IV*, 722 F.3d 861 (6th Cir. 2013).

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paychecks and sent to BCBSM to pay claims and administrative costs qualify as plan assets.² See U.S. Dep’t of Labor, Advisory Op. No. 92-24A, 1992 WL 337539, *2 (Nov. 6, 1992) (AO 92-24A) (“all amounts that a participant pays to or has withheld by an employer for purposes of obtaining benefits under a plan will constitute plan assets”); see also *United States v. Grizzle*, 933 F.2d 943, 946-47 (11th Cir. 1991) (finding that plan assets may be composed of employee contributions even before their delivery to the plan). BCBSM correctly notes, though, that employee contributions represented only a fraction of the funds it received from Hi-Lex and those contributions first began in 2003—several years after the Disputed Fee compensation system was initiated. The pertinent question, then, is whether the *employer* contributions that Hi-Lex sent to BCBSM must also be considered plan assets.

“[T]he assets of an employee benefit plan generally are to be identified on the basis of ordinary notions of property rights.” AO 92-24A at *2. Under this analysis, “the assets of a welfare plan generally include any property, tangible or intangible, in which the plan has a beneficial ownership interest.” *Id.* Making the plan assets’ determination “therefore requires consideration of any contract or other legal instrument involving the plan, as well as the actions and representations of the parties involved.” *Id.* Furthermore, the “drawing benefit checks on a TPA account, as opposed to an employer account, may suggest to participants that there is an independent source of funds securing payment of their benefits under the plan.” *Id.*

In this case, the Summary Plan Description (SPD) – which ERISA requires to be distributed to plan participants³ – establishes that Hi-Lex’s intention was to place plan assets for its self-funded Health Plan with BCBSM in its capacity as TPA. The SPD specifically notes that Hi-Lex “is not [a] direct payor of any benefits” and “no special fund or trust” exists from which self-insured benefits are paid.⁴ Instead, the SPD states that a TPA (designated later in the document as BCBSM) has been hired, and it “reviews [plan participant’s] claims and pays

²BCBSM’s contention that it lacked notice of any employee contributions in the funds it received from Hi-Lex is not supported by the record. The Summary Plan Description (SPD) states that Hi-Lex and its employees “share the cost of participating in the Plan.”

³See 29 U.S.C. § 1024(b).

⁴ERISA permits this arrangement. See 29 U.S.C. § 1103(b).

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benefits from the money we provide.” Moreover, although the SPD gives final claims determination to Hi-Lex, the document makes clear that enrollees must make their initial benefit claims to BCBSM, which has both the funds and the discretion to pay claims.⁵ The language in the ASC does nothing to alter the understanding that BCBSM in its role as TPA would be holding funds to pay the healthcare expenses of Plan beneficiaries – a group the ASC terms “enrollees.”⁶ Indeed, the quarterly statements received by Hi-Lex show that the funds it sent to BCBSM were, predictably, spent covering the health expenses and administrative costs of plan beneficiaries.

While BCBSM attempts to characterize its arrangement with Hi-Lex as a service agreement between two companies – with no thought toward ERISA and its protections – that argument is unavailing. The SPD contains an entire section disclosing plan beneficiaries’ rights under ERISA, including the right to sue “the fiduciaries” (plural) if they “misuse the Plan’s money.” If BCBSM’s interpretation of the parties’ arrangement were accurate, there would only be a single fiduciary, Hi-Lex, the named Plan Administrator. Additionally, although the ASC lacks any specific reference to plan assets, it does recognize that BCBSM may have certain responsibilities “under ERISA” that it cannot contract around.⁷ Furthermore, in practice, BCBSM annually submitted data to Hi-Lex especially designed for use on the company’s ERISA-mandated DOL 5500 forms.⁸ Collectively, these “actions and representations” establish that BCBSM, Hi-Lex and the company’s employees all understood that BCBSM would be holding ERISA-regulated funds to pay the health expenses and administrative costs of enrollees in the Hi-Lex Health Plan. As a result, Hi-Lex’s Plan beneficiaries had a reasonable expectation of a “beneficial ownership interest” in the funds held by BCBSM.

⁵ BCBSM maintained exclusive check-writing authority over the Comerica Bank account into which Hi-Lex’s funds were wired as mandated by the Schedule A.

⁶ Although the ASC was made between the “Group” (Hi-Lex) and BCBSM, its provisions regarding health claims processing and payment correlate with those found in the SPD.

⁷ A fiduciary is established under ERISA by a party’s functional role and that responsibility cannot be abrogated by contract. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993); *Briscoe*, 444 F.3d at 492.

⁸ The Form 5500 Series is required by the Department of Labor to fulfill certain reporting requirements under ERISA’s Titles I and IV.

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BCBSM makes much of the fact that neither it nor Hi-Lex had a separate bank account set aside exclusively for the funds intended to pay enrollee health expenses. BCBSM cannot, however, cite any case law requiring such an arrangement for the existence of ERISA plan assets. Our court has found that plan assets *can* exist when a company directly funds an ERISA plan from its corporate assets and the contracted TPA holds those funds in a general account. See *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1036 (6th Cir. 1993) (finding that Blue Cross was a fiduciary “because [it] could earmark the funds that Libbey-Owens-Ford allocated to the plan”).

Finally, trust law, which BCBSM acknowledges should guide the court in its fiduciary analysis, favors Hi-Lex’s position.

When one person transfers funds to another, it depends on the manifested intention of the parties whether the relationship created is that of trust or debt. If the intention is that the money shall be kept or used as a separate fund for the benefit of the payor or *one or more third persons*, a trust is created.

Restatement (Third) of Trusts § 5 cmt. k (2003) (emphasis added); see also *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989) (noting the value of trust law in interpreting ERISA’s responsibility provisions). Thus, while a formal trust was never created in this case, common law supports the conclusion that BCBSM was holding the funds wired by Hi-Lex “in trust” for the purpose of paying plan beneficiaries’ health claims and administrative costs. Accordingly, the district court did not err in finding that BCBSM held plan assets of the Hi-Lex Health Plan and, in doing so, functioned as an ERISA fiduciary.

B. ERISA’s Statute of Limitations

A separate threshold issue in this case involves ERISA’s statute of limitations for actions brought under 29 U.S.C. §§ 1104(a) and 1106(b). “[T]he statute requires that a claim be brought within three years of the date the plaintiff first obtained ‘actual knowledge’ of the breach or violation forming the basis for the claim.” *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 548 (6th Cir. 2012). “‘Actual knowledge’ means ‘knowledge of the underlying conduct giving rise to the alleged violation,’ rather than ‘knowledge that the underlying conduct violates ERISA.’” *Id.* (quoting *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003)). However, the statute provides an

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exception for a case involving “fraud or concealment,” extending the filing period to a date no later than six years after the time of discovery of the violation. *See id.*; 29 U.S.C. § 1113.

In this case, the district court found that Hi-Lex obtained knowledge of the Disputed Fees in August 2007⁹ – a finding the company does not dispute. Since Hi-Lex filed suit in June 2011, it must avail itself of ERISA’s “fraud or concealment” exception or its action is time-barred. BCBSM asserts that the district court erred by not finding that Hi-Lex had actual knowledge of the Disputed Fees before August 2007 or, alternatively, that the company’s failure to exercise due diligence led to its lack of knowledge regarding the fees.

1. Timeframe for Actual Knowledge

There is no evidence in the record that any ASC signed before 2002 contained language pertaining to the Disputed Fees. The Schedule As from 1995 to 2002 contained a single sentence that BCBSM contends relates to the Disputed Fees: “Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate.” This statement, however, did not appear in the “Administrative Charge” section of the document where other recurring expenses related to BCBSM’s compensation are located. It also omitted the critical fact that the Disputed Fees would be retained by BCBSM as additional compensation and not paid to hospitals.

In 2002, language was added to the ASC that BCBSM contends further explains the Disputed Fees:

The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

This language, though, is similarly opaque and misleading. *See Pipefitters IV*, 722 F.3d at 867.

The phrase “ordered by the State Insurance Commissioner” is not accurate because the Insurance Commissioner neither ordered BCBSM customers to pay these fees nor had the authority to do so. Additionally, because the phrase “Amounts Billed” is defined in the ASC to mean “the

⁹The district court held that Hi-Lex should have discovered the Disputed Fees when a “Value of Blue” pie chart that depicted the charges was presented to the company as part of an annual settlement meeting with BCBSM on August 21, 2007.

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amount [Hi-Lex] owes in accordance with BCBSM's standard operating procedures *for payment of Enrollees' claims*," this term provides no notice that BCBSM will be retaining additional administrative compensation from these charges.¹⁰ Furthermore, even to the extent that the contract documents provide some hint about additional fees, those documents describe only what *might* happen in the future. Every year, however, Hi-Lex received DOL 5500 certification sheets from BCBSM which purported to show the administrative compensation that BCBSM was *actually* receiving. The 5500 Forms, though, indicated that BCBSM was not retaining any administrative compensation beyond that clearly delineated in the ASC and Schedule As.¹¹ **The district court did not err in finding that Hi-Lex gained knowledge of the Disputed Fees beginning in August 2007.**

2. Fraud or Concealment Exception

Unless ERISA's "fraud or concealment" exception applies, Hi-Lex's action is time-barred because it was filed in June 2011, more than three years after the company acquired knowledge of the Disputed Fees. Other circuit courts have split when interpreting the scope of the fraud or concealment exception. *Compare Larson v. Northrop Corp.*, 21 F.3d 1164, 1174 (D.C. Cir. 1994) (finding that § 1113 requires a defendant to have actively engaged in concealment), *with Caputo v. Pfizer, Inc.*, 267 F.3d 181, 192-93 (2d Cir. 2001) (holding that the fraud or concealment provision applies to actions for breach of fiduciary duty in which the underlying action itself sounds in fraud). We have not yet taken a position on these two competing interpretations. *See Cataldo*, 676 F.3d at 548-51 (noting that an "open question" exists in the Sixth Circuit on the scope of the fraud or concealment exception). To resolve this case, though, it remains unnecessary for us to take sides because, **as the district court found, BCBSM breached its fiduciary duty by committing fraud and then acting to conceal that fraud.**

¹⁰Language in a Schedule A from 2006 did note that "[a] portion of [Hi-Lex's] hospital savings has been retained by BCBSM" to cover provider network costs. However, even assuming that language provided actual knowledge to Hi-Lex, it did so within the 6-year statute of limitations period under ERISA's "fraud or concealment" exception.

¹¹In the certifications provided by BCBSM to help prepare DOL 5500s, the Disputed Fees were included on the line for "Claims Paid." The "Administration" section that should have included all administrative fees listed only those fees disclosed by BCBSM. Lines for "Other Expenses" and "Risk and Contingency" were either marked zero or not applicable each year.

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BCBSM committed fraud by knowingly misrepresenting and omitting information about the Disputed Fees in contract documents. Specifically, the ASC, the Schedule As, the monthly claims reports, and the quarterly and annual settlements all misled Hi-Lex into believing that the disclosed administrative fees and charges were the only form of compensation that BCBSM retained for itself.

BCBSM also “engaged in a course of conduct designed to conceal evidence of [its] alleged wrong-doing.” *Larson*, 21 F.3d at 1172. After rumors emerged that BCBSM had “hidden fees” in the early 2000s, representatives from BCBSM told various insurance brokers that customers got 100% of the hospital discounts and that “Blue Cross does not hold anything back.” BCBSM made similar assurances to Hi-Lex, stating in an annual renewal document, “Your BCBSM Administrative Fee is all-inclusive.” BCBSM also gave a misleading response to a Request for Proposal (RFP) issued by Hi-Lex by denying that it charged “Access Fees.” This response helped sustain the illusion that BCBSM was more cost-competitive than other TPAs who responded to the RFP. Finally, the Form 5500 certification sheets that BCBSM provided to Hi-Lex every year concealed the additional administrative compensation that was being taken in the form of the Disputed Fees.

3. Due Diligence

A common requirement of both the *Caputo* and *Larson* standards for determining “fraud or concealment,” is that an ERISA plaintiff’s failure to discover a fiduciary violation must not have been attributable to a lack of due diligence on his part. *See Larson*, 21 F.3d at 1172 (finding that plaintiffs must not have been on notice about evidence of a fiduciary breach, “despite their exercise of diligence”); *Caputo*, 267 F.3d at 192-93 (holding that “plaintiffs’ action [was] timely because it was brought within six years of when, with due diligence, they should have discovered the fraud”).

BCBSM argues that Hi-Lex failed to exercise due diligence because the company’s finance officials, Thomas Welsh and John Flack, did not thoroughly read the 2002 ASC or the annual Schedule A renewal documents. While that assertion is accurate, it represents an incomplete picture of the actions of those officials. The district court found that “Welsh carefully reviewed all financial reports from BCBSM” and maintained that “financial data in a

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master spreadsheet.” Moreover, after a healthcare consultant, hired by Hi-Lex, raised a question about ambiguous language in the Schedule A, “Welsh diligently followed up with BCBSM, only to never get a response.” Later, Hi-Lex’s RFP specifically asked TPAs whether they charged any “Network Access/Management Fees” or “Other Fees” and BCBSM answered “N/A.” Hi-Lex officials reasonably relied on their consultant who interpreted that response to mean there were no Disputed Fees in addition to BCBSM’s disclosed Administrative Fees. When Flack assumed the CFO role from Welsh, he continued to review the monthly claims reports from BCBSM and record the data into the master spreadsheet. As before, though, none of those reports gave any indication that claims included administrative fees paid to BCBSM. The district court did not err in finding that Hi-Lex acted with diligence in reviewing the administrative costs of its health plan until BCBSM presented its Value of Blue Report in August 2007.

Moreover, if Hi-Lex had not acted diligently, the Supreme Court has held that when a “discovery of the facts constituting the violation” provision exists in a statute of limitations, courts must also examine whether “a hypothetical reasonably diligent plaintiff would have discovered [those facts].” *Merck & Co. v. Reynolds*, 559 U.S. 633, 646-47 (2010). The district court correctly found that such a company would not have discovered the Disputed Fees until August 2007.

The contract documents (ASC and Schedule As until 2006) fail to reference or explain the Disputed Fees in a way that a reasonable reader would understand that those fees involved additional compensation for BCBSM. Indeed, BCBSM’s own account manager, Sandy Ham, who read and signed multiple Schedule As from 1999 to 2005, testified that she did not understand anything about the Disputed Fees, including their existence. Additionally, six insurance brokers, who had years of experience working with self-funded customers, testified at trial that they had no understanding of the fees until 2007 when BCBSM began disclosing more information. If health industry experts and BCBSM’s account manager – who was tasked with explaining contract documents to customers – did not understand that the Disputed Fees were being authorized by contract documents, then a “reasonably diligent” CFO could not be expected to know about them. Besides the contract documents, BCBSM made discovery of its Disputed

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Fee practice more difficult for a hypothetical diligent customer by not separately accounting for those fees in its monthly, quarterly, and annual claims reports or in the information sheets it provided to help customers prepare DOL 5500 Forms. Finally, according to BCBSM's own survey of its self-insured customers, a substantial majority – 83% – did not know the Disputed Fees were being charged.

The claims in this case did not violate ERISA's statute of limitations because Hi-Lex can validly invoke the extended six-year period permitted by the fraud or concealment exception.

IV.

A. § 1106(b)(1)

A fiduciary with respect to an ERISA plan “shall not deal with the assets of the plan in his own interest or for his own account.” 29 U.S.C. § 1106(b)(1). As interpreted by this court, that statute contains an “absolute bar against self dealing.” *Brock v. Hendershott*, 840 F.2d 339, 341 (6th Cir. 1988). Because this case involves the same ASC, same defendant, and same allegations, our decision in *Pipefitters IV* controls with respect to the § 1106(b)(1) claim. *See Pipefitters IV*, 722 F.3d at 868 (holding that BCBSM's use of fees it discretionarily charged “for its own account” is “exactly the sort of self-dealing that ERISA prohibits fiduciaries from engaging in”).

BCBSM argues it is entitled to present a “reasonable compensation” defense under 29 U.S.C. §§ 1108(b)(2) and (c)(2). In support, it cites *Harley v. Minn. Mining & Mfg. Co.*, 284 F.3d 901, 908-09 (8th Cir. 2002). However, the majority of courts that have examined this statutory interpretation issue have held that § 1108 applies only to transactions under § 1106(a), not § 1106(b). *See, e.g., Nat'l Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 93-96 (3d Cir. 2012); *Patelco Credit Union v. Sahni*, 262 F.3d 897, 910-11 (9th Cir. 2001); *Chao v. Linder*, 421 F. Supp. 2d 1129, 1135-36 (N.D. Ill. 2006); *LaScala v. Scrufari*, 96 F. Supp. 2d 233, 238 (W.D.N.Y. 2000); *Daniels v. Nat'l Emp. Benefits Servs., Inc.*, 858 F. Supp. 684, 693 (N.D. Ohio 1994); *Donovan v. Daugherty*, 550 F. Supp. 390, 404 n.3 (S.D. Ala. 1982); *Gilliam v. Edwards*, 492 F. Supp. 1255, 1262 (D.N.J. 1980); *Marshall v. Kelly*, 465 F. Supp. 341, 353 (W.D. Okla. 1978). The Department of Labor agrees with these courts. *See* 29 C.F.R. § 2550.408b-2(a)(3) (ERISA “section 408(b)(2) does not contain an exemption from acts described in section 406(b)(1)”).

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We decline BCBSM's invitation to apply the reasonable compensation provisions found in §§ 1108(b)(2) and (c)(2) to the self-dealing restriction in § 1106(b)(1).

B. § 1104(a)

ERISA imposes three broad duties on qualified fiduciaries: (1) the duty of loyalty, (2) the prudent person fiduciary obligation, and (3) the exclusive benefit rule. *Pirelli Armstrong Tire Corp.*, 305 F.3d at 448-49. Collectively, these duties serve the goal of ensuring that ERISA fiduciaries act "solely in the interest of [plan] participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Our analysis of the § 1104(a) claim in *Pipefitters IV* is again determinative for this case. *See* 722 F.3d at 867-69. There, as here, when a "fiduciary uses a plan's funds for its own purposes, . . . such a fiduciary is liable under § 1104(a)(1) and § 1106(b)(1)." *Id.* at 868 (citing *Guyan Int'l, Inc. v. Prof'l Benefits Adm'rs, Inc.*, 689 F.3d 793, 798-99 (6th Cir. 2012)).

V.

After ruling for the plaintiffs in this case, the district court awarded prejudgment interest in accordance with 28 U.S.C. § 1961. Although ERISA does not require a prejudgment interest award to prevailing plaintiffs, this court has "long recognized that the district court may do so at its discretion in accordance with general equitable principles." *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576, 585 (6th Cir. 2002) (quoting *Ford v. Uniroyal Pension Plan*, 154 F.3d 613, 616 (6th Cir. 1998)).

Hi-Lex asserts that the district court abused its discretion in two respects: (1) the court failed to make specific findings of fact with respect to its decision regarding prejudgment interest, and (2) the § 1961 interest calculation undercompensates Hi-Lex for the lost interest value of the Disputed Fees.

Hi-Lex, through its expert, Neil Steinkamp, was the only party to offer testimony regarding prejudgment interest. BCBSM relies on its critique of Steinkamp's analysis, noting that he produced no evidence to support his conclusion that Hi-Lex would have invested the savings from the Disputed Fees in corporate bonds. The district court's relevant factual finding was that Steinkamp's prejudgment interest rate computation would overcompensate Hi-Lex for its loss. Moreover, Hi-Lex's contention that *Drennan v. Gen. Motors Corp.*, 977 F.2d 246 (6th

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Cir. 1992), requires reversal on this point is incorrect. That case stands for the proposition that a district court errs by not making findings of fact when deciding *whether* to award discretionary prejudgment interest. The issue here is whether the court made sufficient findings with respect to its prejudgment interest *calculation*.

In *Schumacher v. AK Steel Corp. Ret. Accumulation Pension Plan*, we held that

[a] proper determination of pre-judgment interest involves a consideration of various case-specific factors and competing interests to achieve a just result. While we have upheld awards of pre-judgment interest calculated pursuant to 28 U.S.C. § 1961, a mechanical application of the rate *at the time of the award* amounts to an abuse of discretion.

711 F.3d 675, 686 (6th Cir. 2013) (emphasis added). The *Schumacher* court found that a district court's use of a single rate – 0.12% – calculated at the time of the award under § 1961 represented an abuse of discretion.

In this case, however, the district court did not use a single rate in calculating the prejudgment interest. Instead, the court utilized a blended rate for each of the 17 years during which the Disputed Fees were charged – a range from 6.13% to 0.14%. Thus, on the \$5,111,431 damages award, the district court calculated the prejudgment interest at \$914,241. Because the district court avoided a mechanical application of § 1961, it did not abuse its discretion in calculating the prejudgment interest award.

VI.

For the foregoing reasons, we **AFFIRM** the judgment of the district court.

MN HMO state program net income, 2013 highlighted

HMO	Item	MSHO	SNBC-MA	PMAP	MnCare	Total	%
Blue Plus	Total Revenue	316,815,216		410,345,344	194,978,949	922,139,509	
	Net Income Gain or Loss	27,106,091		33,636,604	11,249,163	71,991,858	
	Net Income Percentage					0.078070463	7.80%
HealthPartners	Total Revenue	107,044,000		341,858,000	90,569,000	539,471,000	
	Net Income Gain or Loss	10,078,000		1,585,000	1,745,000	13,408,000	
	Net Income Percentage					0.024853977	2.48%
Medica	Total Revenue	306,824,913	261,864,474	562,241,704	109,962,673	1,240,893,764	
	Net Income Gain or Loss	-2,496,474	5,665,256	-2,515,944	-2,454,790	-1,801,952	
	Net Income Percentage					-0.00145214	-0.14%
Ucare	Total Revenue	297,509,326	222,418,885	788,118,453	164,178,589	1,472,225,253	
	Net Income Gain or Loss	1,762,001	4,507,776	30,047,033	21,103,094	57,419,904	
	Net Income Percentage					0.039002119	3.90%
Grand Total 2013	Total Revenue					4,174,729,526	
	Net Income Gain or Loss					141,017,810	
	Net Income Percentage					0.033778909	3.37%

Percent of total 2013 net income:

The four HMOs' reported total 2013 state public program net income was \$141.017 million.

Their grand total reported net income of all lines of business for 2013 was \$181.651 million.

The net income from the state's public programs constituted 77.6% of all of their net income.

Notes:

All figures are from the HMOs' Minnesota Supplement Report #1 forms.

"Total Revenue" is line item 8 on the MN Supplement Report #1.

"Net Income Gain or Loss" is item 30 on the MN Supplement Report #1. It includes investment income.

Information compiled by: Greater Minnesota Health Care Coalition



Medical Assistance Payment Rates for Dental Services

Minnesota's payment policies and methods to reimburse dental providers are poorly coordinated and inconsistently applied across Medical Assistance programs.

Key Facts and Findings:

- Minnesota provides more dental benefits in its state Medicaid program (called Medical Assistance, or MA) than required by federal law. Still, dental services represent just 3 percent of MA program expenditures.
- Minnesota uses a myriad of policies and methods to reimburse MA dental providers. These payment methods and policies are poorly coordinated and inconsistently applied across MA programs.
- Minnesota's MA fee-for-service rates for paying dentists were lower in 2012 than in 2000, and lower than rates of most other states. In addition, the rates are based on an adjustment to 1989 dentist charges and not the costs of current dental services.
- Managed care organizations that contract with the state for MA often reimburse their dental providers more than the fee-for-service base rates, although the differences are sometimes small.
- Although the share of Minnesota dentists participating in MA has been steady in recent years, many dentists report that they have limited or ceased treating MA enrollees due primarily to low state payments.

- Some low-income individuals—particularly those with special needs or located in sparsely populated areas—face challenges accessing MA dental providers.

Key Recommendations:

- The Department of Human Services (DHS) should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits.
- DHS should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.
- The Legislature and DHS should better coordinate payment policies and rate-setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental services.
- The Legislature and DHS should implement a separate benefit and payment structure for Minnesota's Medical Assistance population with special needs.
- DHS should more closely monitor Medical Assistance recipients' access to dental services.

Minnesota's fee-for-service dental payment rates rank relatively low among states.

Report Summary

Minnesota's Medicaid program—called Medical Assistance (MA)—is Minnesota's largest publicly funded health care program. It provided medical and dental services to 910,000 individuals in 2011. Federal Medicaid law requires dental services for children, but states can provide additional benefits. Minnesota requires that some limited dental services be made available to adults.

The state's 2011 expansion of MA eligibility to additional low-income individuals affected program costs. Spending for dental services totaled about \$131 million in 2011—a 9-percent annual increase since 2006. However, when considering changes in enrollment, average spending grew just 2 percent annually.

Like other MA health care services, MA dental services are provided through both fee-for-service and managed care programs. DHS administers dental services through fee-for-service, primarily for individuals who are disabled or have special needs. In 2012, DHS also contracted with eight managed care organizations (MCOs) to provide MA health care and dental services through several managed care programs.

Minnesota's fee-for-service dental rates are not based on the current costs and resources needed to provide dental care.

Federal law requires that MA payment rates be consistent with efficiency, economy, and quality of care. The rates also must be sufficient to enlist enough providers so that care and services are available to the extent that care and services are available to the general population. The federal Centers for Medicare & Medicaid Services allows states some flexibility to determine how much to pay MA

dentists. Minnesota's Legislature authorizes the method for setting MA fee-for-service base rates for dental services.

Minnesota's fee-for-service base rates for most dental procedures are based on how much dentists charged in 1989. (The most recent across-the-board rate increase was a 3-percent increase in 2000; however, the 2011 Legislature imposed a 22-month, 3-percent reduction in the rates.) In contrast, Minnesota uses Medicare cost-based reimbursement principals to determine and update payment rates for physicians and some other health care providers. Unlike dental fee-for-service rates, the Medicare-based rates are more closely related to the actual costs of providing care.

According to national research, Minnesota's fee-for-service rates have ranked in the lower one-third of all states, and Minnesota's rates today are lower than they were a decade ago. Minnesota's 2012 rates were mostly lower than those of neighboring states. For example, North Dakota paid an average of 185 percent of Minnesota's rates for select procedures, while Wisconsin paid an average of 104 percent.

Minnesota supplements its fee-for-service rates with other payments, but payment policies and eligibility criteria vary.

In lieu of increasing its fee-for-service base rates, Minnesota uses several types of targeted payments and other approaches to determining payment amounts. These payment policies and the related payment rates were each independently developed through state or federal law, DHS policy, or negotiation between the managed care organizations and their dentists. That is, the state's payment policies for dental services were not developed through a systematic, coordinated

Minnesota’s Medical Assistance payment policies were not systematically developed to ensure that MA patients across the state have access to a dentist.

assessment of rates to achieve a goal of dentist participation and patient access statewide.

For example, the Legislature made one type of supplemental payment—“critical access” payments—available to dental providers in 2002. We estimated that about 17 percent of dentists worked for clinics that were eligible to receive critical access payments in 2011. DHS also pays all fee-for-service dentists an additional 2 percent of the fee-for-service rate (as reimbursement for Minnesota’s provider tax) and pays community clinics an additional 20 percent, but MCOs are not required to make similar payments. It is difficult to determine whether any of the state’s supplemental payments supplant rates otherwise negotiated between dentists and MCOs.

On average, dental payments by MCOs exceeded Minnesota’s fee-for-service rates, although the differences were sometimes small.

MCOs—and not DHS—determine how much they pay their dental providers. The MCOs often have used the fee-for-service rates as the starting point for setting rates, but MCOs often pay dentists in their network more. For example, the median MCO payment per dental procedure for the Prepaid Medical Assistance Program was 121 percent of the fee-for-service rates. On average, MCOs paid dentists more for the services they provided to MA enrollees with special needs. They also paid higher rates to specialists.

Historically, DHS has added “dental trend” increases into the payments made to MCOs to cover forecasted increases in the price of dental services. However, many dentists were sometimes reimbursed by MCOs at payment rates that were at or near the fee-for-service base rates, and the fee-for-service rates have not increased since 2000.

The share of dentists participating in MA has not changed much since 2006, due partly to newly licensed dentists enrolling in MA.

In Minnesota, dental providers have the option to participate in Medical Assistance and treat MA enrollees. State law requires that dentists who treat public employees must provide dental care to individuals who are enrolled in MA (or other public health care programs).

Between 2006 and 2011, about 65 percent of dentists licensed in Minnesota served at least one MA enrollee. However, dentists’ MA patient caseloads greatly varied and the proportion of dentists with large caseloads increased during this time period. On the other hand, 24 percent of dentists responding to our survey said they stopped serving MA patients after 2010.

Among all MA recipients, individuals with special needs and those in sparsely populated areas have had particular difficulties finding dental providers. According to dentists and other stakeholders, the scope of benefits and payment rates are inadequate relative to the amount of time and resources necessary to appropriately care for individuals with special needs.

Most dentists who limit or cease serving MA recipients do so because of insufficient payments.

Low payment rates were most often cited as the reason dentists have stopped treating MA patients, but there were other reasons, too. Recently imposed limits on MA dental benefits for non-pregnant adults mean there are fewer services for which dentists may be reimbursed. Dentists report that the payment is often insufficient relative to the amount of administrative work required to participate in MA. Administrative costs could be reduced

Total payment rates for MA dental services varied considerably among dental providers.

if DHS would improve its automated information system (MN-ITS) to better facilitate provider inquiries about patients' treatment histories and eligibility for care. Without upgrades to MN-ITS, restrictions on benefits are likely to be poorly implemented.

DHS also should better communicate to dental providers the service authorization criteria and rationale for benefit changes and exclusion of dental coverage. The Dental Services Advisory Committee was established as a venue to address these and other issues; we think the department should make better use of this venue.

The Legislature and DHS should better coordinate payment policies and rate setting for Medical Assistance dental services.

Minnesota's array of payment policies and rate-setting practices for MA dental services has likely had opposing and negative outcomes for the state and its MA recipients. The state's approach of targeting higher payments to certain dental providers has likely improved access for many MA recipients in some parts of the state. However, not all dental providers are eligible for higher payments, the

cumulative payment rates vary, and many dentists are often reimbursed at the relatively low fee-for-service rates.

For more transparency and equity in payments, the Legislature should increase the fee-for-service base rates. Any increases should relate to the costs for providing services and should occur in a measured and incremental way, one that monitors the impact of rate increases on both dentist participation and MA recipient access. DHS also should coordinate these increases with other rate setting and payment policies—such as those applied through managed care—to ensure that the fee-for-service rate increases supplement and do not supplant other payments.

To address concerns about the impact of recent benefit restrictions on individuals with special needs (and long-term costs to the state), DHS should develop separate benefit coverage and payment rates for serving this population. Many of these individuals have limited ability to care for themselves and they often need more expensive, specialized dental care. Higher payments for treating these individuals should help facilitate their access to dental care.

Summary of Agency Response

In a letter dated March 4, 2013, Minnesota Department of Human Services Assistant Commissioner Scott Leitz said the department supports the report's key recommendations and understands that "the rate structure for dental services has changed frequently and that clarity in these structures will be important as we manage dental services for our participants." He said the department has begun to address the issues identified in the report, and the department has included a rate increase proposed in the Governor's biennial budget. He also said the department has created a new "chief rates officer" position to address rates for dental and other health care services, and to consider the relationship of rates to adequate access in both the fee-for-service and managed care program. The assistant commissioner noted that other factors also may impact access, and the department supports the need to monitor the impact of all efforts on access to services.

The full evaluation report, *Medical Assistance Payment Rates for Dental Services*, is available at 651-296-4708 or: www.auditor.leg.state.mn.us/ped/2013/madentalrates.htm



Business Unit: BA
 Voucher ID: 00007407

Voucher
 Accounts Payable

Report ID: RMAP19

Voucher Header Information

Entered Dt: 07.Nov.2013 Invoice ID: AA03IGT0069 Invoice Dt: 21.Oct.2013 Vendor ID: 0000109017 Vendor Name: DEPARTMENT OF HUMAN SERVICES
 Budget Status: Valid Group ID: 0000002223 Address: DHS-COST OF CARE, ATTENTION CASHIER, PO BOX 64835, ST PAUL, MN 55164-0835
 Origin: ONL Preparer: JULIE.VENAGLIA
 Gross Amt: \$500,000.00 Sales Tax: \$0.00 Use Tax: \$0.00 Vendor Withd: N
 Service From: Service To:

Authorized by: _____
 Pay Method: Wire Transfer

Voucher Line Information

Line #	Description	Merch Amt	Inv Item I	Unit Price	1099	PO Business Unit/ Receipt BU	PO Id/ Receipt Nbr	PO Type
1		\$500,000.00			N			

Distribution Line Information

Line #	Account	Fund	Dept	Program	Class Fld	Client Id	Project	Activity	Client Name	Bud Rel	Project ID	Merch Amt	Asset
1	541301	35701	210390	00000						1990		\$500,000.00	N

Account Name: Refunds & Reim Clearing
 Department Name: Co Mgr Finance Trust/Agency

Payment Comments-Check Stub
 RAMSEY COUNTY IS A CONDUIT BETWEEN REGIONS HOSPITAL AND MIN DHS. THIS WIRE IS DONE TO LEVERAGE REGIONS REVENUE TO OBTAIN INCREASED REVENUE TO OBTAIN INCREASED FUNDING. REGIONS WIRED THE FUNDS TO US ON 11/1/13.

Voucher Comments

I declare that the above material and/or services have been received, are for Ramsey County, allowed by law, and approved for payment.

Authorization _____ Date _____

November 1, 2013

Julie:

Intergovernmental wire transfers will take place with Regions Hospital and the State Department of Human Services on November 1, 2013. There is a wire into Ramsey County and then out to DHS. PR & R has been instructed to receipt in the monies into:

314461 35701 210390 0000 1990 (Bdgt Pd)

The incoming money is as follows:

Regions paying Ramsey County \$ 500,000

We then turn around and wire transfer this money to DHS. We have to account for this wire. The following is the information:

Wires out:

To DHS \$ 500,000

The expenditure code is:

541301 35701 210390 0000 1990 (Bdgt Pd)

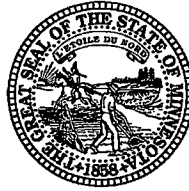
The State's Vendor number is 0000109017
Regions must have a number but don't know what it is.

Thanks,

Rich



DEPARTMENT OF HUMAN SERVICES
 SWIFT - AR UNIT
 PO BOX 64940
 ST. PAUL, MN 55164-0940
 United States
 651/431-3788



State of Minnesota
 INVOICE

Customer No: 000000016565500
 Payment Terms: Due in 12
 Due Date: 11/2/2013
 Invoice: AA03IGT0069
 Invoice Date: 10/21/2013

Bill To:
 RAMSEY COUNTY
 HUMAN SERVICES
 160 E KELLOGG BLVD
 ATTN JOSEPH LANASA
 ST PAUL MN 55101-1425

Handwritten: PAY 11/1

Purchase order:
 Page: 1 of 1

AMOUNT DUE: 500,000.00 USD

Original

For billing questions, please call: 651-431-3769

Line	Description	Quantity	UOM	Msg	Unit Amt	Net Amount
1	MONTHLY MANAGED CARE IGT	1.00	EA		500,000.00	500,000.00
MONTHLY MANAGED CARE IGT						
Subtotal:						500,000.00

AMOUNT DUE: 500,000.00 USD

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.
 When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.
 This information is available in alternative formats to individuals with disabilities by calling 651-431-3769. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848.
 For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Bill To:
 RAMSEY COUNTY
 HUMAN SERVICES
 160 E KELLOGG BLVD
 ATTN JOSEPH LANASA
 ST PAUL MN 55101-1425

Customer No: 000000016565500
 Payment Terms: Due in 12
 Due Date: 11/2/2013

Address Change? If yes, check box.
 Write correct address on back. →

Please Remit To:
 DEPARTMENT OF HUMAN SERVICES
 SWIFT
 PO BOX 64835
 ST. PAUL MN 55164-0835

AMOUNT DUE: 500,000.00 USD

Amount Remitted

H5509 000000016565500 0 AA03IGT0069ZZZZZZZZZZ 5 0050000000

Subtotal: 1 Internal Wire Transfer Credit(s)
\$5,115,625.00

Incoming Fedwire(s)

Jen
↓

<u>Dollar Amount</u>	<u>Transaction Details</u>
\$500,000.00	PAR NUMBER: 131101016844 FED REF: 019329 DATE/TIME RECEIVED: 11/01/2013 10:25:27 AM ORIGINATOR: D000000001008098 REGIONS HOSPITAL ATTN. DAVID BITTNER 640 JACKS ON ST ST PAUL MN 55101-2502 SENDING BANK: 121000248WELLS FARGO SF* WELLS SF RECEIVING BANK: 091000022US BANK MINNESOTA* BENEFICIARY BANK: USBKUS4TXXX BENEFICIARY: /180111025276 RAMSEY COUNTY GENERAL ACCT BENEFICIARY REF: 000007422 ORIGINATOR TO BENEFICIARY INFO: REGIONS HOSPITAL TO RAMSEY COUNTY ATTN. RIC HARD KOOP RE. IGT FUNDING IMAD: 2013110111B7031R019329 CAPTURE DATE:00000000

Receipt into :

314461 35701 210390 00000 1990 (Bdst)

Subtotal: 1 Incoming Fedwire(s)
\$500,000.00

From - Regims

Book Transfer Credit(s)

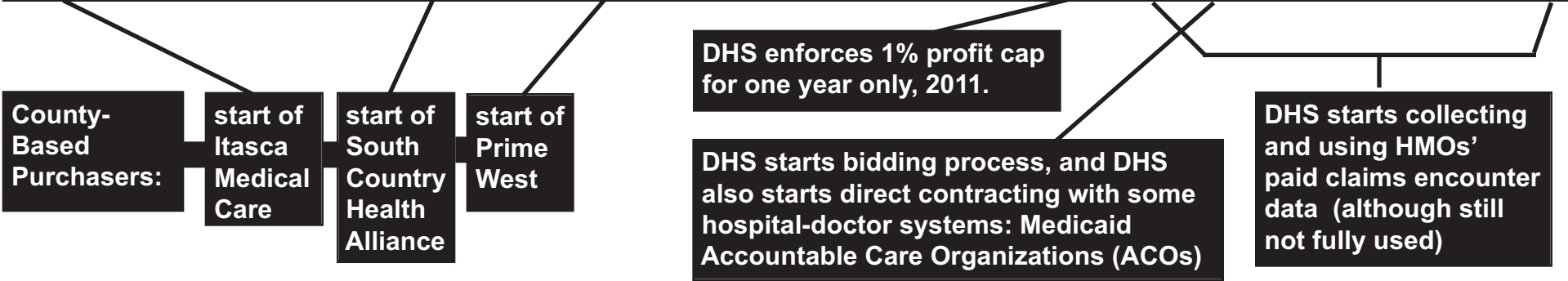
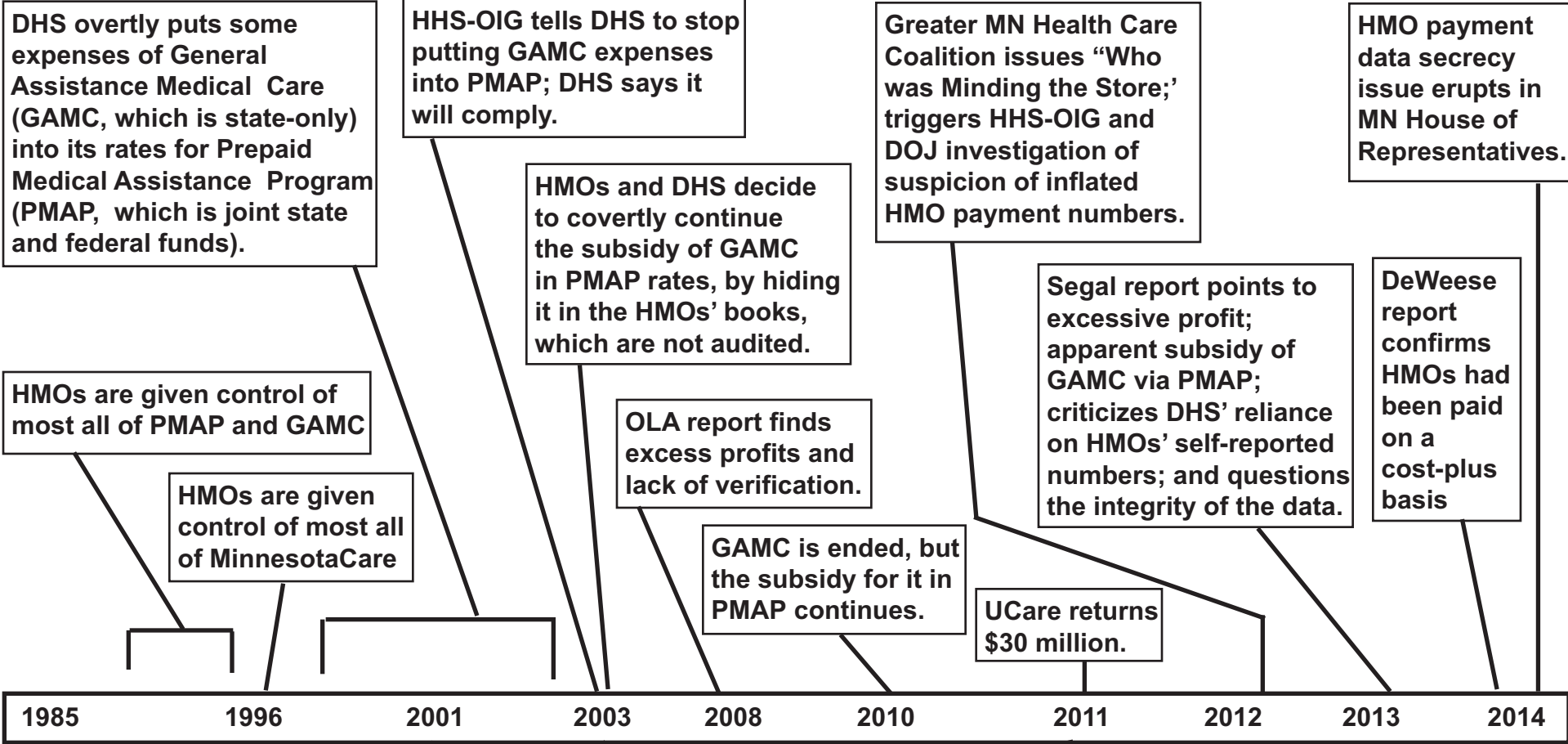
<u>Dollar Amount</u>	<u>Transaction Details</u>
\$518,595.54	SPT BOOK TRANSFER FROM DDA 104757160676 Bank Reference: 07:05:45 CIB 131101
\$19,769.36	SPT BOOK TRANSFER FROM DDA 104790263388 Bank Reference: 06:47:49 CIB 131101

Subtotal: 2 Book Transfer Credit(s)
\$538,364.90

Cash Vault Deposit(s)

<u>Dollar Amount</u>	<u>Transaction Details</u>
\$34,458.30	IMMEDIATE FUNDS: 10,826.89/ 1 DAY FLOAT: 23,631.41/ 2 DAY FLOAT: 0.00/ 3 OR MORE DAY FLOAT: 0.00/ CUSTOMER DEPOSIT Bank Reference: KB1804 STP9795216818
\$4,081.54	IMMEDIATE FUNDS: 3,083.00/ 1 DAY FLOAT: 989.54/ 2 DAY FLOAT: 9.00/ 3 OR MORE DAY FLOAT: 0.00/ CUSTOMER DEPOSIT Bank Reference: KB1769 STP9794519427
\$3,550.00	IMMEDIATE FUNDS: 2,805.00/ 1 DAY FLOAT: 745.00/ 2 DAY FLOAT: 0.00/ 3 OR MORE DAY FLOAT: 0.00/ CUSTOMER DEPOSIT Bank Reference: KB1769 STP9794519264

Issue Timeline of: Minnesota managed care programs; overpayment of HMOs; questions of inflated payment data; and secrecy of data



DHS = Mn Dept. of Human Services. HHS-OIG = US Dept. of Health & Human Services, Office of Inspector General
 OLA = Mn Office of Legislative Auditor DOJ = US Dept. of Justice
 Chart by: Greater MN Health Care Coalition

Notes for chart of time line of HMO overpayment, data inflation, and data secrecy issues:

(1) Box which says "HHS-OIG tells DHS to stop putting GAMC expenses into PMAP; DHS says it will comply": Nov. 10, 2003 Letter by US Dept. of Health & Human Services Office of Inspector General to DHS Commissioner Kevin Goodno: "the State agency included administrative costs and a profit factor for its State-funded Prepaid General Assistance Medical Care program in the actuarial rate calculations for the Program in 2001 and 2002. This was contrary to Federal cost principles... the State agency needs to change its rate setting process by excluding costs from other programs."

(2) Box which says "HMOs and DHS decide to covertly continue the subsidy of GAMC in PMAP rates, by hiding it in the HMOs' books, which are not audited:" This decision to continue the subsidy and hide it is not an overtly-documented fact, but there are a couple of documents which give some indication of this, plus several references in subsequent years (including testimony to the legislature, and in the Segal report) about PMAP rates being intentionally generous in order to compensate for underpayment of GAMC.

(3) Box which says "GAMC is ended, but the subsidy for it in PMAP continues:" UCare's CEO Nancy Feldman explicitly stated this in a March 16, 2011 letter to legislators: "Historically, DHS set rates for General Assistance Medical Care [which] resulted in health plan losses which were offset by higher Medical Assistance payments. When GAMC moved out of managed care in mid-year 2010, Medical Assistance rates were not lowered to reflect this overpayment."

(4) Box which says "UCare returns \$30 million:" It deliberately does not say "donate," since UCare's auditors and CEO originally said that the payment was clearly a return of excess profit from 2010, even though they later changed the story to "free will donation to help the state budget." The fact that DHS ended up giving half of it to CMS shows that it was in fact return of excess payment; and DHS itself even later claimed that the money was a return of excess profit.

(5) Box which says "DeWeese report confirms HMOs had been paid on a cost-plus basis:" This report did not make the point very strongly or fully explicit, but instead made a passing, parenthetical reference to it in one passage. It is a critically important, because DHS had always insisted over the years that it was paying the HMOs on a risk contract (insurance) basis, where the HMOs were in danger of suffering losses as well as enjoying profits. Gov. Dayton himself, in July of 2012, said on MPR that the contracts had been cost-plus. If the contracts were officially done on a cost plus basis, then annual auditing would have to had been done, as required by federal rules. However, by calling them risk contracts, the state was under no federal obligation to do any outside auditing.

Appendix III: Health Plan Data Held by DHS and Relevant Classifications

Description of Data	Classification and Reporting Requirements Under:	Classification of Data under Chapter 13
DHS - MCO Contracts		
DHS's executed contracts with managed care organizations	MN R. 9500.1459	public
Health Plan Administrative Cost Data		
Administrative spending for state health care programs	MN Stat. 256B.69 Subd. 9a	nonpublic
Financial Data		
Financial Statements	MN Stat. 256B.69 Subd. 9c	nonpublic
Financial statement footnotes	MN Stat. 256B.69 Subd. 9c	nonpublic
Income statement by program	MN Stat. 256B.69 Subd. 9c	nonpublic
Quarterly profitability by program and population group	MN Stat. 256B.69 Subd. 9c	nonpublic
Medical liability summary by program and population group	MN Stat. 256B.69 Subd. 9c	nonpublic
Services versus payment lags by program for hospital services, outpatient services, physician service, or other medical services, and pharmaceutical benefits.	MN Stat. 256B.69 Subd. 9c	nonpublic
Utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services.	MN Stat. 256B.69 Subd. 9c	nonpublic
Pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services	MN Stat. 256B.69 Subd. 9c	nonpublic
subcapitation expenses by population group	MN Stat. 256B.69 Subd. 9c	nonpublic
third-party payments by program	MN Stat. 256B.69 Subd. 9c	nonpublic
all new, active, and closed subrogation cases by program	MN Stat. 256B.69 Subd. 9c	nonpublic
all new, active, and closed fraud and abuse cases by program	MN Stat. 256B.69 Subd. 9c	nonpublic
Medical loss ratios by program	MN Stat. 256B.69 Subd. 9c	nonpublic
Administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies	MN Stat. 256B.69 Subd. 9c	nonpublic
revenues by program, including investment income	MN Stat. 256B.69 Subd. 9c	nonpublic
nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the health plan to providers and vendors for administrative services under contract with the plan	MN Stat. 256B.69 Subd. 9c	nonpublic

Description of Data	Classification and Reporting Requirements Under:	Classification of Data under Chapter 13
individual level provider payment and reimbursement rate data	MN Stat. 256B.69 Subd. 9c	nonpublic
provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process	MN Stat. 256B.69 Subd. 9c	nonpublic
data on the amount of reinsurance or transfer of risk by program	MN Stat. 256B.69 Subd. 9c	nonpublic
contribution to reserve by program	MN Stat. 256B.69 Subd. 9c	nonpublic
Non-State Plan Adjustments (services provided that are not included in the Medical Assistance State Plan)	Section 9.10.3 of Managed Care Contract	public
Health Plans Claims Data		
Personally Identifiable Information (e.g. patient name)	MN Stat. 256B.69 Subd 9	nonpublic
Claim details (e.g. procedure codes, provider information)	MN Stat. 256B.69 Subd 9	public
Claim payment information (amounts paid and allowed per claim)	MN Stat. 256B.69 Subd 9c	nonpublic

Health Plan Data Held by Regulatory Agencies

State law also restricts the release of certain health plan financial data collected or maintained by regulatory agencies. Regulation of health insurance and other health claims payers in the state is conducted by two separate agencies. The Minnesota Department of Health (MDH) licenses and regulates Health Maintenance Organizations (HMO) and County-Based Purchasers (CBPs). The Minnesota Department of Commerce licenses and regulates insurance companies.

Both agencies organizations receive or collect financial and rate data to fulfill their regulatory functions. Rate filings are nonpublic data until filings become effective. Financial statements information on from the health plans and working papers obtained in the course of financial examinations, market analysis and audits are classified as not public.

The section below identifies Minnesota Statutes that classify health plan rate filings or other health plan financial data collected or maintained by the Commerce Department and the Minnesota Department of Health as confidential, protected nonpublic, private or nonpublic information.

1. Minn. Stat. §60A.03, subd. 9: Confidentiality of Information

Any information collected by the Commerce Department in the course of supervision or examination of insurance companies, including work papers and related correspondence, is classified as confidential. The Commissioner is authorized to make public only the final report of an insurance company. Nothing in this subdivision prohibits the Commissioner from disclosing the content of information protected under this subdivision with the insurance department of another state, the National Association of Insurance Commissioners (NAIC), and the National Association of Securities Dealers if the recipient of the information agrees in writing to hold the data as nonpublic in a manner consistent with this subdivision.

2. Minn. Stat. §60A.031, subd. 4(f): Examinations

All working papers, recorded information, and documents produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination of an insurance company, or in the course of a market analysis, must be given confidential treatment and are not subject to subpoena. For purposes of this section, "market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports, such as the NAIC Market Conduct Annual Statement, or other sources in order to develop a baseline profile of an insurer, to review the operation or activity of an insurer, or to identify patterns or practices of insurers licensed to do business in this state that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

3. Minn. Stat. §60A.08: Classification of insurance filing data

All forms, rates and related information filed with the Commissioner under section 62A.02 and 62C.14 shall be nonpublic data until the filing becomes effective.

4. Minn. Stat. §60A.1291: Annual Audit

Every insurance company doing business in Minnesota, unless otherwise exempt, must have an annual audit of the financial activities of the most recently completed calendar year performed by an independent certified public accountant and shall file a report of this audit with the Commissioner. Subdivision 14 of this statute classifies the work papers of the independent certified public accountant as confidential. Work papers may include audit planning documents, work programs, analyses,

memoranda, letters of confirmation and representation, management letters, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the audit of the financial statements of an insurer and that support the accountant's opinion.

5. **Minn. Stat. §60A.135, subd. 4: Confidentiality of Certain Transactions**

Reports filed with the Commissioner pursuant to sections 60A.135 to 60A.137 must be held as nonpublic data, are not subject to subpoena, and may not be made public by the Commissioner, the National Association of Insurance Commissioners, or other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains. However, the Commissioner may publish all or part of a report in the manner the Commissioner considers appropriate if, after giving the affected insurer notice and an opportunity to be heard, the Commissioner determines that the interest of policyholders, shareholders, or the public will be served by the publication.

6. **Minn. Stat. §60A.57: Access and Use of Risk Based Capital (RBC) Information**

The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the Commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the Commissioner for rate making nor considered or introduced as evidence in any rate proceeding nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write. This statute incorporates by reference Minn. Stat. §60A.67, which classifies RBC reports, RBC plans and any corrective order as nonpublic data.

7. **Minn. Stat. §60A.93: Insurance Regulatory Information System**

All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the Commerce Department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department.

8. **Minn. Stat. §62E.13: Classification of PPO agreement data**

The law previously regulating the Minnesota Comprehensive Health Association (MCHA) includes a provision under subdivision 11 that states if an MCHA writing carrier uses its own provider agreements for MCHA's preferred provider network in lieu of agreements exclusively between the MCHA and the providers, then the terms and conditions of those agreements are nonpublic data as defined in section 13.02, subdivision 9.

9. **Minn. Stat. §62D.03, subd. 4(g) – [Minnesota Department of Health Data]**

A copy of each contract binding major participating entities and the health maintenance organization must be submitted with the application for certificate of authority to establish an HMO. Contract information filed with the Commissioner of Health shall be confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon the request of the health maintenance organization.