UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

June 29, 2015

The Honorable Joe Hoppe
Minnesota House of Representatives
543 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Melissa Hortman
Minnesota House of Representatives
237 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

Re: Amendments to the Minnesota Government Data Practices Act Regarding Health Care Contract Data

Dear Representatives Hoppe and Hortman:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] (collectively, "FTC staff") appreciate the opportunity to respond to your invitation for comment regarding the potential competitive impact of the recently enacted (but not yet fully implemented) amendments to the Minnesota Government Data Practices Act ("MGDPA"), which would classify health plan provider contracts as public data.[2]

FTC staff recognize the laudable goals of the MGDPA, including improving government accountability via increased transparency with respect to the use of public funds in government contracting.[3] Transparency regulation targeted to provide consumers with relevant information about the health care products and services they are buying, including cost information, has been enacted in 28 states.[4] While these laws can be procompetitive, the recent amendments to the MGDPA may require public health plans to publicly disclose competitively sensitive information, including information related to price and cost.[5] Such disclosure may chill competition by facilitating or increasing the likelihood of unlawful collusion,[6] and may also undermine the effectiveness of selective contracting by health plans, which serve to reduce health care costs and improve overall value in the delivery of health care services in Minnesota.[7] This risk of such harm is especially great if this information is accessible to competing health care providers, and in highly concentrated markets where competition among providers is already limited.[8]

Therefore, FTC staff generally concur with the economic impact analysis set forth in the Minnesota Department of Human Services report, which concluded that "classifying plan

provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets."[9] To safeguard against these and other potential harms, we respectfully urge the Minnesota legislature to consider whether limiting transparency to the types of information important to consumers might achieve the beneficial goals of the MGDPA while mitigating the risk of harm to competition and consumers. We recommend an approach that focuses on disclosing the kinds of data that are most useful to consumers when selecting health care services and providers, while minimizing the disclosure of information that is more likely to facilitate coordination or collusion among competitors.

I. INTEREST AND EXPERIENCE OF THE FTC

The FTC is an independent agency charged with maintaining competition and safeguarding the interests of consumers.[10] Competition benefits consumers through lower prices, higher quality products and services, improved access to services, and greater innovation. The agency protects competition through its enforcement and advocacy work. For several decades, the FTC has investigated the competitive effects of restrictions on the business practices of health care providers. The FTC and its staff have issued reports and studies regarding various aspects of the health care industry.[11] The FTC also often provides input to federal and state policymakers on the competitive implications of proposed laws and regulations affecting health care markets.[12]

The FTC and its sister agency, the U.S. Department of Justice's Antitrust Division (collectively, "the Agencies"), have developed policy statements on antitrust enforcement related to price information exchanges in health care markets. In general, the Agencies will not challenge the exchange of prices for health care services if the following conditions are satisfied:

1. the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);

2. the information provided by survey participants is based on data more than three-months old; and

3. there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than twenty-five percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.[13]

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing of a provider's individual interest in obtaining information useful in adjusting the prices it charges in response to changing market conditions against the risk that the

exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for health care services.[14]

In previous letters and comments, FTC staff have addressed the risks of broad information sharing in health care markets. For example, in a prior letter regarding proposed state regulations that would have imposed disclosure requirements on compensation and fees paid for pharmacy benefit manager ("PBM") services, we expressed concern that such public disclosures of information could reduce competition and increase prices to consumers.[15]

II. FACTUAL BACKGROUND REGARDING AMENDMENTS TO THE MGDPA

As described in your letter, the MGDPA is an "open records" law, the primary purpose of which is to provide greater accountability of government activities through public access to government data, pursuant to Freedom of Information Act requests.[16] Under the Act, "[a]ll government data collected, created, received, maintained or disseminated by any government entity shall be public unless classified . . . as nonpublic or protected nonpublic, or with respect to data on individuals, as private or confidential."[17]

The recent amendments would expand the MGDPA to cover all data collected by health maintenance organizations, health plans, and other health services vendors contracting with the State of Minnesota to provide health care services for Minnesota residents.[18] Specifically, the confidential terms and conditions of health plans' contracts with health care providers, including fees and reimbursement amounts, could become subject to public disclosure.[19] The Minnesota legislature exempted the production of any data related to public health plans, as well as health service vendor contracts with the state of Minnesota, until June 30, 2015. The stated purpose of this delayed enactment was to provide time for the Commissioner of the Minnesota Department of Human Services to conduct a study and submit a report on the public policy issues relating to application of the statute to the public health plans and the economic impact on the health care market.[20] That study concluded that classifying plan provider contracts as public data "would offer little benefit but could pose substantial risk of reducing competition in health care markets," [21] including by facilitating tacit collusion among competitors and disincentivizing provider discounts, thereby driving up prices to the level of the high-paying consumer.

The potential scope and impact of the amendments are broad. Minnesota provides health care services to more than 1.1 million low-income, disabled, and senior Minnesotans through programs jointly funded by the State and the federal government, including Medical Assistance (Medicaid) and MinnesotaCare, at an annual cost of over $9.8 billion.[22] The State contracts with eight managed care health plans, including five health-maintenance organizations ("HMOs") and three county-based purchasing plans ("CBPs") (collectively, "the Health Plans"). When the current exemption expires on June 30, 2015, it appears that the amendment will make available for public disclosure a wide range of confidential information about the Health Plans, including the terms of agreements they have reached with health care providers. For example, the Health Plans may be required to disclose financial reports (i.e., income and expense reports, utilization reports, administrative spending data, third-party liability information and payments to providers by category of service) and patient encounter data (i.e., recipient and provider information, dates

of service, procedure and diagnosis codes, and the amount paid for services) for all patients covered by the Plans.[23] In addition, the Health Plans may be required to disclose data from their subcontractor agreements with health care providers, including pricing information, provider reimbursement rates, salaries, payment methods, and rebate or discount information.

III. ANALYSIS OF THE POTENTIAL COMPETITIVE IMPACT OF THE AMENDMENTS TO THE MGDPA

Many types of information exchanges serve legitimate purposes and do not violate the antitrust laws.[24] The Agencies typically are more concerned when information exchanges or disclosures promote the sharing of sensitive information among competitors. This may facilitate their ability to coordinate or collude to fix prices, allocate markets, or engage in other conduct that harms competition. As explained below, FTC staff believe the MGDPA amendments may promote a level of transparency that creates a significant risk of anticompetitive harm, and a level that may be greater than needed to satisfy the State's legitimate policy goals, particularly given that Minnesota, through its all-payer claims database, may provide consumers with the types of detailed service-level cost and quality data needed to make informed decisions about health care plans. Meanwhile, it is unclear whether the disclosures mandated by the MGDPA amendments would give consumers sufficiently useful information to generate benefits that would outweigh the risk of harm to competition.

In particular, FTC staff are concerned that the amendments likely would lead to public disclosure of fees, discounts, and other pricing terms that typically are negotiated in confidence between health care providers and health plans. Disclosure of these types of information among competing providers likely would undermine the effectiveness of selective contracting, a key mechanism used by health plans to drive down health care costs and improve overall value in the delivery of health care services.

A. Increased Transparency May Benefit Health Care Consumers by Promoting More Informed Decision Making in a Competitive Marketplace, If The Right Kinds of Information Are Disclosed

Studies show that consumers benefit from information about the relative costs and quality of health care providers and the services they provide.[25] Increased access to this information not only helps consumers become better health care shoppers, but also spurs greater competition among providers on price and quality dimensions.[26] As Dr. Paul Ginsburg explained before the U.S. Senate Committee hearing:

> [C]onsumers should know more about the products and services they are buying and what they cost, even in situations where someone else is paying. Some of the interest in price transparency on the part of policy makers reflects this important shared value. But the chief goal of price transparency initiatives is to encourage competition among providers on the basis of both price and quality of care. To the extent that consumers choose higher-value providers, they will save money and get higher-quality care. And, if enough consumers act on the basis of price and

> quality information, providers will feel significant market pressure to reduce prices and increase the quality of care. Such a market level effect will benefit all who use and pay for care.[27]

To be most meaningful, price information should reflect an individual consumer's desired health care coverage—including specific out-of-pocket expenditures for specific procedures and services—so that the consumer can make informed decisions when selecting a provider or choosing among treatment options.[28] Moreover, as the above-quoted testimony from Dr. Ginsburg implies, consumers cannot adequately evaluate price information without considering quality; that is, information on price alone is likely to be less helpful to consumers when selecting many procedures and services. Presenting information in a format and medium that is understandable to consumers poses significant challenges.

We therefore encourage the Minnesota legislature to consider the extent to which the MGDPA amendments will lead to disclosure of the kinds of information most likely to help consumers harness the benefits of competition. For example, the Minnesota legislature should consider whether price transparency, standing alone, is likely to be sufficient to control spending and improve quality.

As a general matter, inherent uncertainties surround information in health care markets.[29] Consumers rarely have as much information as providers about their conditions and treatment alternatives. This asymmetry may hamper traditional market forces of supply and demand, which may lead to inefficient distribution of services.[30]

Moreover, in order to counter existing information asymmetries, consumers need information about future prices and coverage. Consumers typically become aware of their health care costs *after* receiving care, such as when they receive an explanation of benefits from their insurer or a bill from their provider—in other words, when the information is no longer useful to evaluate prospective choices. Health care price and quality information that is transparent to consumers *before* they receive health care services is far more likely to be useful to them. Specifically, it is more likely to reduce consumers' search costs, allow for more informed comparison-shopping among health care providers and health plans, and help them in anticipating their out-of-pocket health care costs.[31] The ability to assess the anticipated cost of care is especially important due to the increased prevalence of high-deductible health plans and other forms of consumer cost sharing.[32] These factors not only affect a consumer's current expenditures, but also influence the extent to which a consumer may bear future costs from poor health care choices or worse outcomes.[33]

Inadequate information transparency is just one factor that may hinder the efficient allocation of high quality medical care. In a 2011 study on transparency in health care markets, the U.S. Government Accountability Office noted several factors that make it difficult for consumers to obtain accurate price and quality information for health care services before selecting and receiving medical care, including: (1) the difficulty of predicting necessary health care services in advance; (2) billing from multiple providers in and out of network; (3) the variety of insurance benefit structures; and (4) contractual obligations that prevent insurers and providers from making their negotiated rates available to the public.[34] At the February 2014 FTC workshop, *Examining Health Care Competition*, participants discussed the importance of price

and quality transparency, but noted that the effectiveness of price transparency depends critically on the intended recipient of the information, the context in which the information is being shared, and how the information is presented.[35]

FTC staff are aware of numerous ongoing price and quality transparency efforts, at both the state[36] and federal level.[37] These efforts are focused on ameliorating informational asymmetries and aligning financial incentives to empower consumers to make better choices.[38] Several states, including Minnesota, have enacted mandatory or voluntary all-payer claims databases that compile the kinds of detailed service-level cost and quality data that are most useful to consumers.[39] We believe that there are superior means of providing consumers with needed information without the risk to the competitive process posed by classifying health plan provider contracts as public data.

B. Potential Anticompetitive Risks of Data Transparency

Regardless of whether health care consumers in fact find greater transparency of price and quality information to be useful, health care providers may find increased access to each other's prices and other competitively sensitive information to be quite useful. While some uses could be competitively neutral, there is a significant risk that competing providers could use this information in an anticompetitive manner to the detriment of health care consumers, public health plans, and the State itself. Notably, disclosure of competitively sensitive information may enable providers to determine whether their pricing is above or below their competitors' prices, to monitor the service offerings and output of current or potential competitors, and to increase their leverage in future contract negotiations. This risk increases in markets with fewer providers. Therefore, we urge the Minnesota legislature to consider the extent to which the MGDPA amendments might facilitate precisely those types of information exchanges most likely to raise antitrust concerns.

1. Information Exchanges May Increase the Likelihood of Coordination or Collusion among Competitors

The MDHS Report warns that, due to high levels of concentration in Minnesota health care markets, "disclosure [of competitively sensitive information] may reduce the incentive for all providers to offer low prices and may facilitate collusion among providers."[40] FTC staff have expressed this same concern about increased prices bid by providers after price transparency in several previous advocacies regarding price transparency regulations by state and federal entities.[41]

As a general matter, several factors affect the likelihood that the disclosure of firm-specific competitively sensitive information—such as prices, costs, output, and contract terms—will result in coordination or collusion among competitors. These factors include whether there are a relatively small number of competitors in a given market[42] and the ability of those few competitors to accurately monitor each other's transactions.[43] The Agencies' information exchange guidelines explain that market concentration is an important barometer in gauging the level of antitrust concern associated with increased transparency.[44] The MDHS Report concludes that the hospital markets in Minnesota are highly concentrated, such that increased information

exchanges among competitors could facilitate the exercise of market power and exacerbate coordination or collusion.[45]

Thus far, empirical evidence regarding the competitive effects of these types of price disclosures in selective contracting in health care markets is limited;[46] however, several empirical studies of other industries have shown transparency of prices and other competitively sensitive information to be associated with higher prices.[47] These studies suggest a degree of caution may be warranted in Minnesota, given that the State's health care markets exhibit many of the risk factors typically associated with harmful effects from coordination or collusion, including: (1) a limited number of market participants; (2) high entry barriers; (3) infrequent entry or expansion; (4) high market share of some market participants; (5) reliance on the same providers to bid on the same or similar contracts on a regular basis; and (6) a steady or increasing rate of demand for services.

2. Broad Transparency May Impede the Ability of Health Plans to Selectively Contract with Health Care Providers

There is substantial risk that greater price transparency in concentrated health care markets may impede, rather than enhance, the ability of the Health Plans in Minnesota to selectively contract with health care providers and to negotiate lower reimbursement rates.[48] The MGDPA amendments, once made effective, would likely require the public disclosure of the Health Plans' proprietary business information, including plan structure and contracted fee schedules. If hospitals, doctors, PBMs,[49] group purchasing organizations ("GPO"),[50] and other suppliers of medical products and services know the precise details of prices, rebates, and discount arrangements offered by their competitors to the Health Plans, providers' incentives to agree to negotiated discounts may be lessened. The potential for price increases by hospitals, caused by the chilling of competition due to price transparency, were discussed at the recent FTC health care workshop. For example, one panelist stated:

> [L]ow brand name hospitals who are typically paid less are now able to see how much the high brand name hospitals are being paid. The low brand name hospitals actually have a new tool to drive up their payment rates. So you actually have an upward pressure in payment from price transparency.[51]

In a selective contracting environment where health care providers do not know each other's prices, providers are more likely to bid aggressively – offering lower prices – to ensure they are not excluded from selective networks, because exclusion could substantially decrease their service volumes and revenues. In contrast, if providers have better knowledge regarding each other's prices, they will not need to bid as aggressively to ensure network inclusion. The lower-priced providers, in particular, are likely to bid higher than they would have otherwise, and overall prices are likely to go up as a result of this reduced price competition. Therefore, unmitigated data disclosures could ultimately raise the prices that Minnesota consumers pay for health care services.[52]

3. Mandatory Disclosures May Have a Chilling Effect on Willingness to Contract with the State

Mandatory disclosure of price, financial, and other confidential business information by entities that contract with the State may reduce the willingness of those entities to enter into such contracts.[53] For example, providers for whom state contracts represent a small percentage of their output may find that it makes sense to curtail further state contracts rather than forfeit confidentiality of their fees and other sensitive information.[54]

IV. CONCLUSION AND RECOMMENDATIONS

We recognize the legitimate public policy goal of an open government, leading to the enactment of laws designed to ensure public access to records of government bodies at all levels, including state health plan contracts. Transparency regulations aimed at providing consumers with information about health care quality and costs can be procompetitive and have been enacted in 28 states. However, given the concomitant risk of significant anticompetitive harm from information-sharing among competitors, we urge the Minnesota legislature to carefully weigh the benefits and costs of the MGDPA amendments requiring the disclosure of confidential terms in health care services contracts.

In particular, we encourage the Minnesota legislature to consider which types of information are likely to be the most useful to Minnesota health care consumers as they compare and select health care providers and services—such as actual or predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or providers. At the same time, we urge caution in mandating public disclosure of plan specifics and negotiated fee schedules between the Health Plans, hospitals, and physician service entities, which may harm competition and consumers by facilitating coordination or outright collusion on prices or other terms, especially in highly concentrated markets.

We appreciate the opportunity to provide our input on the competitive implications of the MGDPA amendments. We hope our comments will be of assistance as you consider these issues.

Respectfully submitted,

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[1] This staff letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission or any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

[2] Letter from the Hon. Joe Hoppe and the Hon. Melissa Hortman, Minn. House of Representatives, to Deborah Feinstein, Director, Bureau of Competition, Federal Trade Commission (Jan. 16, 2015) [hereinafter Hoppe/Hortman Letter]. *See* MINN. STAT. § 13.387 (2014) (amending Minnesota Government Data Practices Act, MINN. STAT. § 13.05, subdiv. 11 (1974)), *available at* https://www.revisor.mn.gov/statutes/?id=13.05.

[3] The fundamental purpose of government transparency laws is to "inform[] citizens about 'what their government is up to." McDonnell Douglas Corp. v. U.S. Dep't of Air Force, 375 F.3d 1182, 1193 (D.C. Cir. 2004) (citation omitted). The MGDPA, "together with statutes such as the Open Meeting Laws, . . . the campaign finance and public disclosure laws, . . . and public proceedings of the judiciary, are part of a fundamental commitment to making the operations of our public institutions open to the public." Prairie Island Indian Cmty. v. Minn. Dep't of Pub. Safety, 658 N.W.2d 876, 883−84 (Minn. Ct. App. 2003).

[4] *See* Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Healthcare – Challenges and Potential Effects*, 364 NEW ENG. J. MED. 891, 892-93 (2011). This article concludes that:

> Price-transparency initiatives will have to address several major challenges if they are to have the desired effect. First, it's not clear which prices to report: although average unit costs . . . are the most readily available, personalized, episode-level costs would be more meaningful to patients . . . . Moreover, meaningful information about quality must be delivered alongside prices so that patients can make decisions by comparing care choices on both dimensions.

For list of state legislation requiring health care price transparency, *see* NAT'L CONFERENCE OF STATE LEGISLATURES, TRANSPARENCY AND DISCLOSURE OF HEALTH COSTS AND PROVIDER PAYMENTS: STATE ACTIONS (updated Jan. 2015), *available at* http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx#Legislation. *See infra* note 36.

[5] We do not express an opinion on the threshold question of statutory interpretation as to what the MGDPA amendments would require Health Plans to disclose.

[6] *See, e.g.,* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 15 (2000) [hereinafter COLLABORATION GUIDELINES], *available at* https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-doj-issue-antitrust-guidelines-collaborations-among-competitors/ftcdojguidelines.pdf. Those guidelines state:

> Other things being equal, the sharing of information relating to price, costs, output, or strategic planning is more likely to raise competitive concern than the sharing of information relating to less competitively sensitive variables. Similarly, other things being equal, the sharing of information on current operating and future business plans is more likely to raise concerns than the sharing of historical information.

See also U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 6 (1996), *available at* https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf [hereinafter HEALTH CARE STATEMENT 6].

[7] *See* FED. TRADE COMM'N STAFF LETTER TO CENTERS FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH AND HUMAN SERVICES 5-6 (Mar. 7, 2014) (citing Alan T. Sorensen, *Insurer Hospital Bargaining: Negotiated Discounts in Post Deregulation Connecticut,*51 J. INDUS. ECON. 469 (2003); Vivian Y. Wu, *Managed Care's Price Bargaining with Hospitals*, 28 J. HEALTH ECON. 350 (2009); Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any-Willing-Provider' Regulations,* 20 J. HEALTH ECON. 955 (2001)), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf [hereinafter CMS LETTER].

[8] *See supra* note 6.

[9] HEALTH CARE ADMIN., MINN. DEP'T OF HUMAN SERVICES, HEALTH CARE CONTRACTING AND THE MINNESOTA GOV'T DATA PRACTICES ACT 4 (2015), *available at* http://mn.gov/dhs/images/Health_Plan_Data_Report.pdf [hereinafter MDHS REPORT].

[10] Federal Trade Commission Act, 15 U.S.C. § 45 (2006).

[11] *See generally* FED. TRADE COMM'N, COMPETITION IN THE HEALTH CARE MARKETPLACE, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care.

[12] *See* FTC STAFF COMMENT TO THE ERISA ADVISORY COUNCIL (Aug. 19, 2014), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-erisa-advisory-council-u.s.department-labor-regarding-pharmacy-benefit-manager-compensation-fee-disclosure/140819erisaadvisory.pdf [hereinafter ERISA COMMENT]; FTC STAFF LETTER TO THE HON. JAMES SEWARD CONCERNING N.Y. SENATE BILL 58 ON PHARMACY BENEFIT MANAGERS (PBMS) (Mar. 31, 2009), *available at* https://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 [hereinafter NY LETTER]; FTC STAFF LETTER TO THE HON. NELLIE POU CONCERNING N.J. A.B. A-310 TO REGULATE CONTRACTUAL RELATIONSHIPS BETWEEN PBMS AND HEALTH BENEFIT PLANS (Apr. 17, 2007), *available at* https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nelie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf [hereinafter NJ LETTER]; CMS LETTER, *supra* note 7. *But see* LETTER FROM COMMISSIONER JULIE BRILL TO ERISA ADVISORY COUNCIL (Aug. 19, 2014) [hereinafter BRILL DISSENT LETTER] (dissenting due to concerns that staff's conclusions were based on outdated information), *available at* https://www.ftc.gov/system/files/documents/public_statements/579031/140819erisaletter.pdf.

[13] *See* HEALTH CARE STATEMENT 6, *supra* note 6, at 50.

[14] *See id.*

[15] *See* ERISA COMMENT, *supra* note 12; NY LETTER, *supra* note 12; NJ LETTER, *supra* note 12; BRILL DISSENT LETTER, *supra* note 12.

[16] *See* Hoppe/Hortman Letter, *supra* note 2.

[17] MINN. STAT. § 13.03, subdiv. 1; *see* MINN. STAT. § 13.37.

[18] MINN. STAT. § 13.387.

[19] *See supra* note 5.

[20] *See* MDHS REPORT, *supra* note 9, at 4.

[21] *Id.*

[22] *Id.* at 7.

[23] *See id.* at 14. This comment is limited to competition concerns. We note, however, that disclosure of some of this information may raise privacy concerns as well. For the purposes of this comment, we assume that the Minnesota legislature and regulators will appropriately take privacy into account.

[24] *See* COLLABORATION GUIDELINES, *supra* note 6, at 15; HEALTH CARE STATEMENT 6, *supra* note 6.

[25] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-791, HEALTH CARE PRICE TRANSPARENCY: MEANINGFUL PRICE INFORMATION IS DIFFICULT FOR CONSUMERS TO OBTAIN PRIOR TO RECEIVING CARE 2 (2011), *available at* http://www.gao.gov/assets/590/585400.pdf [hereinafter GAO REPORT]. *See generally* Fed. Trade Comm'n Workshop, *Examining Health Care Competition*, *available at* https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition.

[26] *See* Christopher Whaley et al., *Association Between Availability of Health Service Prices and Payments for these Services*, 312 JAMA 1670, 1670–76 (2014).

[27] *High Prices, Low Transparency: The Bitter Pill of Health Care Costs: Hearing Before the S. Comm. on Finance*, 113th Cong. 8 (2013) (statement of Paul B. Ginsburg, Ph.D., Center for Studying Health System Change and National Institute for Health Care Reform), *available at* http://www.finance.senate.gov/imo/media/doc/Ginsburg%20June%2018%20Senate%20Finance%20Hearing%20Transparency.pdf.

[28] *See, e.g.,* Sze-jung Wu et al., *Price Transparency for MRIS Increased Use of Less Costly Providers and Triggered Provider Competition*, 33 HEALTH AFF. 1391, 1391–98 (2014), *available at* http://content.healthaffairs.org/content/33/8/1391.long.; *see also* HEALTHCARE FINANCIAL MANAGEMENT ASS'N, RECOMMENDATIONS FOR IMPROVING PRICE TRANSPARENCY, RECOMMENDATION 3 (Mar. 10, 2015), *available at* http://www.hfma.org/content.aspx?id=28797; GAO REPORT, *supra* note 25, at 2.

[29] *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963) (arguing that medical care markets, unlike markets for other infrequently purchased goods, such as cars or houses, are characterized by extremely high levels of uncertainty about the consequences of purchasing particular goods or services for any particular patient).

[30] *See, e.g.,* Selma J. Mushkin, *Toward a Definition of Health Economics*, 73 PUB. HEALTH REP. 785, 787 (1958); *See* Arrow, *supra* note 29, at 951 ("Because medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is necessarily very much greater than that of the patient, or at least so it is believed by both parties."); Deborah Haas-Wilson, *Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information*, 26 J. HEALTH POL. POL'Y & L. 1031 (2001).

[31] *See generally* GAO REPORT, *supra* note 25.

[32] *Id*. at 2; Uwe E. Reinhardt, *Health Care Price Transparency and Economic Theory*, 312 JAMA 1642, 1642 (2014) ("[C]onsumer-directed health care so far has led the newly minted consumers of US health care (formerly patients) blindfolded into the bewildering US health care marketplace, without accurate information on the prices likely to be charged by competing organizations or individuals that provide healthcare or on the quality of these services.").

[33] Economists argue that poor choices in selecting health care risk greater consumer harms than in most other markets because in addition to high prices and poor quality, consumers face the increased risk of lost income, increased pain, suffering, and death. *See* Arrow, *supra* note 29, at 949.

[34] GAO REPORT, *supra* note 25, at 12. All these factors make estimating costs challenging. In the survey, a knee replacement estimate from 19 hospitals ranged in price from $33,000 to $101,000. *Id.*

[35] Fed. Trade Comm'n Workshop, *Examining Health Care Competition*, *available at* https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition. In his most recent study, Dr. Ginsburg recommends three specific narrowly-tailored price transparency policy initiatives:

- Use of state all-payer health claims databases ("APCDs") to report hospital prices to make employers more aware of price differences and realize savings from narrower provider networks and tiered benefits, by increasing pressure on high-price hospitals to reduce or justify their prices, and by informing the discussion of policy options for controlling costs;
- Require electronic health record systems to provide prices to physicians when ordering diagnostic tests so that they are aware of the cost of the services they are ordering; and
- Require all private health plans to provide personalized out-of-pocket expense information to enrollees.

See Chapin White et al., *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending* (May 2014), *available at* http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf.

[36] National Conference of State Legislatures, *Transparency and Disclosure of Health Costs and Provider Payments: State Actions*, (updated Jan. 2015), *available at* http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx. The 28 states that have enacted health care cost transparency legislation include Arizona, Arkansas, California, Colorado, Delaware, Florida, Illinois, Indiana, Kentucky, Maine, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Vermont, Washington, and Wisconsin.

[37] At the federal level, the U.S. Department of Health & Human Services provides price and quality information for health plans competing in the health exchanges marketplace. Likewise, the CMS Health Care Consumer Initiative also encourages consumer access to price and quality information. CMS is committed to increasing access to its Medicare claims data through the release of de-identified data files available for public use. On April 9, 2014, CMS released physicians' Medicare claims data—including billed charges and total payments—to the public. This unprecedented release of data was done to empower patients with a new way to make decisions about their health care. *See* Centers for Medicare and Medicaid Services, Medicare Provider Utilization and Payment Data: Physician and Other Supplier (updated June 1, 2015), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html; *see also* Centers for Medicare and Medicaid Services, Basic Stand Alone (BSA) Medicare Claims Public Use Files (PUFs) (updated Feb. 28, 2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/BSAPUFS/index.html?redirect=/BSAPUFS/03_Inpatient_Claims.asp.

[38] Price transparency was encouraged in 2006 by an Executive Order that directed agencies to make relevant information available to consumers in a readily useable manner to ensure that Federal healthcare programs promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers. Exec. Order No. 13,410, 71 Fed. Reg. 51,089 (Aug. 28, 2006), *available at* http://www.gpo.gov/fdsys/pkg/FR-2006-08-28/pdf/06-7220.pdf; *see* also *High Prices, Low Transparency; The Bitter Pill of Health Care Costs: Hearing Before the S. Comm. on Finance*, 113th Cong. 8 (2013) (statement of Paul B. Ginsburg, Ph.D., Center for Studying Health System Change and National Institute for Health Care Reform), *available at* http://www.finance.senate.gov/imo/media/doc/Ginsburg%20June%2018%20Senate%20Finance%20Hearing%20Transparency.pdf.

[39] Eleven states, including Minnesota, have established databases that collect health insurance claims information from all health care payers (including private health insurers, Medicaid, children's health insurance and state employee health benefit programs, prescription drug plans, dental insurers and self-insured employer plans) and put the data into a statewide information repository, referred to as "all-payer claims databases" ("APCDs"). *See, e.g.,* Minnesota's All Payer Claims Database (APCD), MINN. DEP'T. OF HEALTH, http://www.health.state.mn.us/healthreform/allpayer/. These databases collect eligibility and service-level claims data to make cost, use, and quality comparisons among health plans and health providers. The purpose of these APCDs is to inform cost containment and quality improvement efforts. APCDs are also available in Colorado, Kansas, Maine, Maryland, Massachusetts, New Hampshire, Oregon, Tennessee, Vermont, and Virginia. Three other states (Connecticut, Rhode Island, and Arkansas) are in the early stages of data collection; three other states (Hawaii, California and New York) are initiating development of APCDs, and 21 more states are considering APCD legislation. However, is still too early to determine whether APCDs can help states control costs. *See* National Conference of State Legislatures, All-Payer Claims Databases – Health Cost Containment (updated Oct. 2013), http://www.ncsl.org/research/health/collecting-health-data-all-payer-claims-database.aspx; MINN. Div. HEALTH POL'Y, MINN. DEP'T. OF HEALTH, MINNESOTA ALL PAYER CLAIMS DATABASE WORKGROUP REPORT TO THE MINNESOTA LEGISLATURE - 2014 (2015), *available at* http://www.health.state.mn.us/healthreform/allpayer/APCDwkgrpFinalRpt2015Jan.pdf; *see also* Minnesota's All Payer Claims Database (APCD) Frequently Asked Questions, MINN. DEP'T. OF HEALTH, http://www.health.state.mn.us/healthreform/allpayer/faq.html.

[40] MDHS REPORT, *supra* note 9, at 4.

[41] *See, e.g.,* ERISA COMMENT, *supra* note 12; NY LETTER, *supra* note 12; NJ LETTER, *supra* note 12; BRILL DISSENT LETTER, *supra* note 12.

[42] The risk of anticompetitive harm from facilitating practices of information sharing is greatest in concentrated product markets. *See* Susan DeSanti & Ernest Nagata, *Competitor Communications: Facilitating Practices or Invitations to Collude? An Application of Theories to Proposed Horizontal Agreements Submitted for Antirust Review*, 63 ANTITRUST L.J. 93, 97 (1994); *see also* Reinhardt, *supra* note 32, at 1642.

[43] *See* Kai-Uwe Kuhn, *Fighting Collusion: Regulation of Communication Between Firms*, 16 ECON. POL'Y 169, 170 (2001) ("The notion that communication is central to collusion is without doubt part of the general folklore of competition policy at least going back to Adam Smith."); Svend Albaek, Peter Mollgaard & Per Overgaard, *Government Assisted Oligopoly Coordination? A Concrete Case*, 45 J. INDUS. ECON. 429, 430 (1997) ("At least since Stigler's seminal article, [industrial organization] literature has stressed the importance for (tacitly) colluding oligopolists of observing firm-specific transactions prices of their rivals and rapidly detecting changes in these. Otherwise, collusion is prone to break down.").

[44] *See* COLLABORATION GUIDELINES, *supra* note 6; HEALTH CARE STATEMENT 6, *supra* note 6.

[45] The MDHS Report states that the hospital markets in Minnesota are highly concentrated statewide, and individual metropolitan areas have even higher market concentrations. In the Twin Cities, the three largest providers—Allina Health, Fairview Health Services and Mayo Clinic—control nearly 30% of all the hospital beds in the state as well as potentially 43% of the physician services. The Report notes that 51 counties are served by only one hospital. *See* MDHS REPORT, *supra* note 9, at 21. Further, the MDHS Report warns that high levels of market concentration found in the hospital and provider markets in Minnesota would facilitate anticompetitive outcomes from increased transparency. *Id.*

[46] *See, e.g.*, David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 NEW ENG. J. MED. 894, 894 (2011) ("There is only limited research on the effects of transparency initiatives for medical prices. Two recent studies found no effect of hospital price transparency in New Hampshire or California, but these analyses were (of necessity) limited to 1 or 2 years of post-initiative data.").

[47] *See, e.g.*, Albaek et al., *supra* note 43 (publishing of concrete prices resulted in 15-20% price increases); Stephen W. Fuller et al., *Effect of Disclosure on Price: Railroad Grain Contracting in the Plains*, 15 W.J. AGRIC. ECON. 265 (1990); *see also* Maura P. Doyle & Christopher M. Snyder, *Information Sharing and Competition in the Motor Vehicle Industry*, 107 J. POL. ECON. 1326 (1999) (finding evidence that automakers respond strategically to production announcements by rivals).

[48] *See* Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of `Any-Willing-Provider' Regulations*, 20 J. HEALTH ECON. 955 (2001); Jonathan Click & Joshua D. Wright, *The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures*, 17 AM. L. ECON. REV. 1 (2014).

[49] PBMs negotiate with drug manufacturers for discounted fees and rebates based on restricted formularies. In prior advocacies on proposed state regulations that would have imposed disclosure requirements on compensation and fees paid for PBM services, FTC staff previously has expressed concerns that such public disclosures of information could reduce competition and increase prices. *See* ERISA COMMENT, *supra* note 12; NY LETTER, *supra* note 12; NJ LETTER, *supra* note 12; BRILL DISSENT LETTER, *supra* note 12; *see also* FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (2005), *available at* https://www.ftc.gov/sites/default/files/documents/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report/050906pharmbenefitrpt_0.pdf; Richard G. Frank, *Prescription Drug Prices: Why Do Some Pay More Than Others Do?*, 20 HEALTH AFF. 115, 125 (2001); Ernst R. Berndt, *Pharmaceuticals in U.S. Health Care: Determinants of Quantity and Price*, 16 J. ECON. PERSP. 45 (2002), *available at* http://www.jstor.org/stable/3216914.

[50] Similarly, GPOs and health insurance companies negotiate discounts based on selective network design to encourage use of certain lower priced vendors. These confidential negotiations are a primary means by which these market participants control costs. The prices charged by the same supplier to different customers can vary substantially depending on numerous market factors and relative negotiating leverage. For example, news articles report substantial discounts were negotiated by Express Scripts, one of the largest prescription benefit managers in the country, for one of two newly approved hepatitis C drugs that have a list price in the U.S. of $84,000 per patient per year, in exchange for exclusive formulary listing. *See, e.g.* Tracy Staton, *Sorry, Gilead. AbbVie Cuts Exclusive Hep C Deal with Express Scripts*, FIERCEPHARMA, Dec. 22, 2014, http://www.fiercepharma.com/story/sorry-gilead-abbvie-cuts-exclusive-hep-c-deal-express-scripts/2014-12-22; Caroline Humer, *Express Scripts to Cover AbbVie HepatitisC Drug, Drops Gilead Treatment*, REUTERS, Dec. 22 2014, http://www.reuters.com/article/2014/12/22/express-scripts-abbvie-hepatitisc-idUSL1N0U50M120141222.

[51] *See* Fed. Trade Comm'n Workshop, *Examining Health Care Competition*, *supra* note 35, Tr. at 82 (Statement of Aron Boros, Exec. Director, Center for Health Information and Analysis). Further discussion among workshop panelists revealed that price transparency can support certain benefit designs and contracting practices that may result in high-priced hospitals reducing their rates. In such situations, it is possible that these rate reductions may offset the upward pricing pressure from the low-priced hospitals. At the workshop, Dr. Paul Ginsburg stated:

> [S]trictly from an economic theory point of view, I'd be most concerned with the higher priced providers basically being discouraged from experimenting with cutting their prices because they wouldn't gain as much market share if their competitors knew about it. But the anecdotes [discussed at the workshop] seem to be more about the low priced hospitals' ignorance about how their prices compared with others. These are the risks and hence the reason for using the transparency cautiously.

Id. at 84 (Statement of Paul Ginsburg, Norman Topping Chair in Medicine and Public Policy, University of Southern California).

[52] *See, e.g.*, MDHS Report, *supra* note 9, at 102, (Letter from UCare to Patrick Hulman) ("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.").

[53] MDHS Report, *supra* note 9, at 83 (Appendix).

[54] *See id.* (Minn. Council of Health Plans' Response to Request for Information: Contracting with Minnesota Health Care Programs and the Minnesota Government Data Practices Act). This public comment by the Minnesota Council of Health Plans argued that putting additional disclosure barriers on already reluctant specialty dental providers could further discourage these providers from seeing Minnesota Medicare and Medicaid patients, resulting in shortage of already tenuous dental services. MN Community Measurement collects and reports cost

data for medical groups based on 1.5 million patients, representing the $8 billion in total care costs paid by both patients and their health insurance plans in 2014. The four Minnesota health plans that provided cost data to MN Community Measurement are Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and PreferredOne. They perform quality and price metric calculations for the State and would be subject to the same disclosure requirements, potentially chilling their ability to perform their obligations. *See* MN COMMUNITY MEASUREMENT, http://mncm.org and, for it data collection practices, *see* Data Collection and PQRS, MN COMMUNITY MEASUREMENT, http://mncm.org/services-solutions/data-collection-and-pqrs/.