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 MGDP

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

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

quality information, providers will feel significant market pressure to reduce pri

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

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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

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.

[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 322

[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-

[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. SeeNational Conference of State Legislatures, All-Payer Claims Databases –

[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, 117 COLUM. 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,

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, u 15 EASUREMM2(T)-1B 2 >sure