CPR & HCI3 Release State Price Transparency Report Card with Appendix by The Source

Catalyst for Payment Reform (CPR) and the Health Care Incentives Improvement Group (HCI3) just released the third edition of the Report Card on State Price Transparency Laws. The report highlights the five states that received non-failing grades, all of which received different grades from 2014: New Hampshire (A), Colorado (B), Maine (B), Vermont (C) and Virginia (C). A key feature of the report is *Appendix I: An Analysis of Popular Legal Arguments Against Price Transparency*, authored by The Source's editors, Jaime S. King and Anne Marie Helm. We thank CPR and HCI3 for the opportunity to collaborate on this important publication! The full text of our appendix is below.

An Analysis of Popular Legal Arguments Against Price Transparency

Introduction

Efforts to advance price transparency in health care often run into legal obstacles that make it difficult to obtain and share the information with consumers, other health care entities, or government agencies. Health care providers and insurers often argue that pricing information may not be made public because it is (1) confidential by contract, or (2) protected as trade secret. Market dynamics exacerbate the extent to which these entities are able to keep the information out of third parties' hands—i.e., the bigger the provider or insurer, the better chance it has of holding onto its price information. In response to these legal barriers to disclosure, states have begun to prohibit the inclusion of certain contractual provisions that inhibit transparency. In addition, antitrust enforcement provides a means to promoting price transparency. This appendix details these legal barriers to price transparency, and the best ways to address them.

Contractual Barriers

_In health care provider-insurer contracts, three types of clauses inhibit price transparency: (1) non-disclosure agreements, or "gag clauses;" (2) anti-tiering/anti-steering clauses|and (3) most favored nation's clauses. These clauses, which typically allow a provider or insurer to mandate how pricing information is determined and/or shared, are best understood in context. Typically, the amount of market leverage a provider or insurer has is directly correlated with its ability to impose these contractual provisions on other parties.

Non-Disclosure Agreements/"Gag Clauses"

Non-disclosure agreements ("NDA") or "gag clauses" are frequently used in contracts between insurers and health care providers to require that both parties keep the negotiated provider rates confidential, i.e., any party that shared the information would breach the contract. NDAs have two main effects. First, they deny third parties, including the government and individual consumers, access to pricing information that could influence their choice of providers and insurers. Second, they facilitate the ability of "must-have" providers to negotiate above-market rates, driving up costs overall.[1] Further, NDAs between hospitals and medical device manufacturers can keep valuable price information from physicians that prescribe device use, which can lead to inefficient treatment choices.[2]

Anti-Tiering/Anti-Steering Clauses

Anti-tiering or anti-steering clauses in insurer-provider contracts also inhibit price transparency. Provider organizations often use these clauses to prevent insurers from creating incentives for their insureds to choose high value alternatives. Although anti-tiering and anti-steering clauses do not directly prohibit the disclosure of price information, they limit the overarching goal of price transparency initiatives – to enable patients to choose providers based on cost and quality.

Most-Favored Nation ("MFN") Clauses

In an insurer-provider contract, a most-favored nation's clause promises that the provider will not give an equal or more favorable price to any other insurer. Insurers often request a MFN clause as part of an agreement to pay a dominant provider organization an above-market rate. Although these clauses have less to do with price

transparency than with the prices themselves, they raise transparency concerns in a couple of key ways. First, MFN clauses often mandate the disclosure of rates negotiated with competing insurers, so that the insurer holding the protection can ensure it is receiving the best price. Second, they hinder rate disclosure to consumers, as neither party wants to reveal the above-market rate. Last, unless these clauses are eliminated from provider-insurer contracts, price transparency measures will not be able to reduce health care costs because the MFN's control over pricing will trump consumers' ability to affect prices by shifting demand.

How to Address:

Legal challenges to these contractual provisions come in two forms: (1) statutory bans on their use, and (2) antitrust enforcement that either specifically targets these clauses, or more generally addresses the market imbalances that give rise to their use by dominant firms. States have begun to outlaw these clauses in a variety of ways. For example, California banned gag clauses relating to cost information in insurer-hospital contracts in 2011, and expanded that prohibition in 2013 to cover all healthcare providers.[3] More recently, a gag clause ban[4] was introduced in Missouri, but failed to pass in February 2014. Elsewhere, including in New Mexico[5], consumer groups are advocating gag clause bans as part of a price transparency agenda. As for MFN clauses, 18 states have already enacted bans, and two have pending legislation.[6] MFN clauses have also been the subject of several successful antitrust suits brought by the Department of Justice against dominant insurers. Antitrust enforcement aimed at curbing anticompetitive mergers also must be used to prevent dominant firms from using their leverage to demand contract terms that stymie transparency and competition. The government should be especially wary of the potential for dominant providers to skirt statutory bans and specific enforcement efforts by imposing implied or outside-the-contract arrangements for best pricing guarantees.

Trade Secrets Protection

In addition to contract-based confidentiality provisions, providers and insurers often assert that negotiated price information is a protected trade secret under the law. Whether information is a trade secret is a matter of state law|but, because forty-

seven states have adopted the Uniform Trade Secrets Act, some level of consistency in legal principles exists across those states. To qualify as a trade secret, (1) the secrecy of the information must provide a competitive advantage to its owners, and (2) the owners of the information must make an effort to maintain its secrecy. Whether information qualifies under these elements is a fact-specific determination left to the courts. In other words, unilateral designations made by the owners of the information do not guarantee protection. The types of information courts often protect as trade secret include formulas, techniques, designs, and processes not generally known or easily ascertainable by others.[7] Only under very limited circumstances do courts grant trade secret protection to price information.[8] Generally, those circumstances involve courts providing trade secret protection to promote vigorous competition between rivals|not, as we see in health care, to take advantage of the consumer's lack of pricing information.

Like patent law, trade secret protection developed as a means to encourage innovation and to promote competition and economic growth. Unlike patent law, trade secret protection lasts indefinitely (until disclosure). Historically, trade secret protection furthered its policy goals by preventing employees from disclosing valuable information to the competition, protecting companies' ability to develop new and innovative products, and promoting entry into the market place by new competitors. None of these goals is served by concealing health care prices from consumers, government agencies, or preventing disclosure more generally. Indeed, concealing negotiated price information serves little purpose other than protecting dominant providers' ability to charge above-market prices and insurers' ability to avoid paying other providers those same elevated rates. Accordingly, there has been a growing recognition that trade secret protection in health care is being misused—raising health care prices without offering any upside.

How to Address:

As with contractual barriers to transparency, trade secret barriers to negotiated health care prices may be addressed through both legislation and litigation. First, states should avoid codifying confidentiality or conferring any specific trade secret protection for negotiated health care prices in provisions of health related legislation. Second, states should establish a public interest exemption to trade

secret protection through legislation, which would permit the state to require disclosure of information when necessary to promote the public good. Access by states to negotiated rate information that has profound effects on their citizens' well-being would fall clearly within such an exemption. As for private litigation, plaintiffs should challenge and courts should continue to scrutinize assertions of trade secret protection with a reluctance to spread the doctrine to health care prices.

Best Price Transparency Legislation

Over the last several years, numerous states have passed legislation designed to make health care prices more accessible to patients. The most effective patient-focused legislation provides price information that is directly relevant to the patient's decision. Averages, median billed prices, charge master charges, and usual and customary charges often vary widely from what an individual patient will actually be expected to pay, which substantially lowers the utility of the information.

The most promising price transparency legislation requires that health care providers and insurance plans provide patients with:

- **A good-faith estimate of the patient's out of pocket expenses that are specific to the patient's insurance plan, health care needs and health care provider.**

The estimate should include patient and plan specific co-pay or coinsurance and deductible information, as well as an explanation of standard prices and the potential range of variable expenses. If the patient is uninsured, the estimate should include both the average allowable reimbursement the provider accepts for the procedure from a third party, as well as the amount the particular patient will be billed.[9]

- **Quality information on individual physicians and providers.**

The utility of price information increases greatly when paired with quality assessments of providers. As quality measurement improves and more information becomes available, states should collect and disseminate this information to patients to facilitate health care decision-making.

- **Access to this information in real time via a website, personal electronic device, or Electronic Medical Record system.**

Price and quality information is only useful if it patients can access it easily and in real-time. States should either provide or require insurance companies to provide this information to patients through a website with personal device capability and interoperability with EMRs. States currently offer or propose to offer this information to patients in many different ways. Some states, including Washington and Massachusetts (WA SB 6228, MA Ch 224) have passed legislation that would require insurance companies to provide this information directly to patients. Kansas requires insurance companies to provide all patient cost and provider reimbursement information to providers upon request in the form of a "real time Explanation of Benefits" (HB 2688). Whereas, Colorado offers this information to patients via its All Payer Claims Database.

Conclusion

Over the last several years, states have become more aware of the problems associated with a lack of price transparency in health care. In order to be effective, price transparency initiatives must provide accessible and actionable information to decision-makers in a timely manner. While legal barriers hindered initial efforts to promote price transparency, states can address many of these barriers through legislation and litigation. Legislation can prohibit clauses in provider-insurer contracts that would obscure health care prices, as well as ensure that trade secret protection is not used in ways that harm the public interest. Patient-focused price transparency legislation can help ensure that all patients have real-time access to a good-faith estimate of the expected costs of the procedure to the patient based on his or her health care needs, insurance plan and choice of health care providers.

Litigation can be used to challenge anticompetitive practices that lead to the occlusion of health care prices. State efforts to promote price transparency must also be accompanied by efforts to reduce the market leverage and anticompetitive behaviors that enable dominant providers and insurers to drive up health care costs overall.

[1] Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep*

Payment Increases from Insurers Suggests Policy Remedies May Be Needed, 31 HEALTH AFF. 973, 973 (2012).

[2] GOV'T ACCOUNTABILITY OFFICE, GAO-12-126, MEDICARE: LACK OF PRICE TRANSPARENCY MAY HAMPER HOSPITALS' ABILITY TO BE PRUDENT PURCHASERS OF IMPLANTABLE MEDICAL DEVICES 29–31 (2012).

[3] *See* SB 751 and SB 1340, creating and amending CA Health &amp|Safety Code § 1367.49 of and CA Ins. Code § 10133.64.

[4] SB 847.

[5] *See* http://www.thinknewmexico.org/homepage.html.

[6] "Legislative Topics: Most Favored Nations Clauses," The Source Blog, March 19, 2015 (available here).

[7] *See, e.g., Minnesota Mining &amp|Mnfg Co. v. Pribyl,* 259 F.3d 587 (7th Cir. 2001).

[8] *See, e.g., Pepsico v. Redmond*, 54 F. 3d 1262 (7th Cir. 1995).

[9] (Minn. Stat. § 62J.81)