CHCF Policy Brief

The Secret of Health Care Prices:
Why Transparency Is in the Public Interest

In 2018, to collect information on the cost of health care in California, state lawmakers passed a law tasking the Office of Statewide Health Planning and Development (OSHPD) with the design and creation of a state Health Care Cost Transparency Database, or what is more generically called an all-payer claims database (APCD).[1] California's APCD may collect information about amounts paid for health care services, including data about negotiated rates between insurance plans and providers. Many health care providers and payers seek to maintain the confidentiality of these paid amounts as trade secrets, claiming their secrecy provides a competitive advantage. Yet, the public has begun to demand greater price transparency in health care.

While some negotiated prices may constitute trade secrets in some circumstances, trade secret law is extremely fact specific, and no court has definitively ruled that negotiated health care rates constitute trade secrets. Furthermore, even if a court finds that certain price information constitutes a trade secret, that protection is not absolute. State freedom of information acts and free speech protections can allow disclosure of trade secrets when disclosure of that information is in the public interest. California can allow or require disclosure of such information, including negotiated rates for health care services, in the public interest as long as the state articulates the conditions and policies for disclosure at the time of data collection and follows state and federal patient privacy statutes.

This policy brief is a companion to *The Secret of Health Care Prices: Why Transparency Is in the Public Interest*. For the full report visit **www.chcf.org/publication/secret-health-care-prices**.

Price Transparency in Other States

When is disclosing negotiated rates in the public interest? Economists and antitrust enforcers have theorized about how disclosure of negotiated rates in health care markets could facilitate price collusion and drive price increases;[2] and in rare circumstances, in other industries and other countries, mandated transparency reports have allowed tacit collusion. To date, however, no US state with an existing APCD has experienced competitive harm, and, in fact, a decade of public disclosure of negotiated health care rates in New Hampshire resulted in increased competition and reduced prices for health care services.[3] Although, in some markets, disclosure of negotiated health care rates could theoretically result in price collusion and increased prices.[4] Concerns over disclosure of negotiated rates for health care services in California are likely overstated and can be mitigated by proper safeguards. Furthermore, the procompetitive effects of APCDs are likely to outweigh any anticompetitive harms.

State APCDs vary significantly in their legislation and regulation governing APCD data release, as well as their current and planned price dissemination practices. Research on 18 states with mandatory data collection programs shows that states have the legal authority to collect and, in many cases, disclose negotiated rates (see Table 1, page 2). All states with active APCDs collect information about paid amounts and release reports of aggregated information, but a few states, including Maine and New Hampshire, disclose plan- and provider-specific median paid amounts for the most commonly used health care services on publicly accessible websites. California can draw on the experiences of other states in implementing best practices for collection and dissemination of pricing data. These best

Table 1. Data Elements Most Commonly Available for Release by APCDs

	AR	CO	CT	DE	ME	MD	MA	MN	NH	OR	RI	UT	VT	WA
Paid amount (plan)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Allowed amount	✔	✔	✔			✔	✔		✔	✔	✔		✔	
Capitation / Prepaid amount (fee-for-service equivalent amount)	✔	✔	✔	✔	✔		✔		✔	✔	✔	✔	✔	✔
Charge amount	✔	✔	✔	✔		✔	✔		✔	✔	✔	✔	✔	✔
Cost sharing (copay, coinsurance, deductible)	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔
Dispensing fee amount	✔	✔		✔	✔		✔		✔	✔	✔	✔	✔	✔
Ingredient cost / List price	✔	✔		✔	✔		✔		✔	✔	✔	✔	✔	✔
Postage amount (for pharmacy)		✔		✔	✔		✔		✔		✔	✔	✔	✔

Notes: This table excludes Florida, Hawaii, Kansas, and New York, which do not have a data dictionary or data release manual available online. For Minnesota, the "paid amount" field identifies the sum of all plan and member payments for encounters within this record's utilization category.

practices include disclosure of certain categories of data on a publicly accessible website, limits on disclosures to protect certain kinds of information, reliance on a data release committee to review data requests and prevent inappropriate disclosures, and employment of data use agreements (DUAs) to restrict the ways requesters can use information.

Recommendations for California

To further the legislative intent of increased transparency in health care pricing, research on other states' experiences with their own APCDs supports the following recommendations for California:

1. **OSHPD should provide all data submitters with clear information and policies regarding data release prior to data collection.** Data collected from other state agencies may be subject to confidentiality agreements and require amendments to the Knox-Keene Act and California Public Records Act.

2. **OSHPD should create a data release committee and declare that all information submitted to the APCD will be released in accordance with data release guidelines at the discretion of the data release committee.** To avoid any claim of trade secret misappropriation, OSHPD should inform data submitters that decisions regarding confidentiality and data release will be made by the data release committee to avoid the expectation that labeling data as confidential will prevent disclosure of that data.

3. **The data release committee should establish guidelines for data release that weigh competitive effects and public interest.** Specifically, the committee should release data only when the pro-competitive effect of the data release or the public interest outweighs the anticompetitive effect.

4. **The data release committee should implement a tiered data release policy, which would base oversight and access to data on the data requested and the nature of the requester.** The committee should review requests for data containing negotiated payment amounts on the basis of the nature of the entity making the request, the justification for the request, the proposed usage of the data, the nature of the information requested, the requesting entity's technical and physical safeguards for maintaining the security of the data files, and whether the entity has misused data or violated prior data use agreements.

For example, a tiered data release policy could include these provisions:

- ***Tier 1:*** *Data release to the public.* OSHPD releases price reports and other consumer- or policy-relevant findings on a publicly available website. Some aggregated and/or anonymized data should also be available to the public.[5]
- ***Tier 2:*** *Data release to academic or governmental entities.* The committee should presume data requests from academic or governmental agencies to be procompetitive. These requests should be limited to the minimum data sets necessary to conduct the proposed research and subject to a DUA that would allow only anonymized or aggregated data to be included in published study results without committee approval.
- ***Tier 3:*** *Data release to private entities or industry participants.* Industry participants and other private entities may request additional data from the APCD. The committee should consider comments from other industry participants and competitors before releasing data. Released data should be the minimum amount needed based on the reason for the request, and the requester should be required to demonstrate why the aggregated and anonymized data are insufficient for the requester's intended use.

To streamline data review, the committee could consider allowing the committee chair to review Tier 2 requests or Tier 3 requests that do not include negotiated rates. The committee chair could then approve these requests or pass them on to the committee for further review.

5. **The data release committee should establish a data use agreement that provides requirements for accessing data.** The DUA should require that the data be used only for the approved use, that the recipient keep all nonpublic data confidential unless nonconfidentiality is approved by the committee, and that the recipient of the data implement appropriate privacy and encryption protections. The DUA should establish civil monetary penalties for using the data in illegal ways, including misappropriation, intentional and unauthorized data release, and price-fixing or collusion, and should exclude offending individuals, institutions, and companies from accessing APCD data for up to 10 years or more. The DUA should include procedural guidance for inadvertent data release and require data recipients to indemnify the state of California and OSHPD for any misuse or misappropriation of released APCD data.

6. **OSHPD or its designee should monitor annual claims data for anticompetitive behavior.** OSHPD should look for evidence of tacit collusion or price shadowing, especially in highly concentrated markets, and should remove data from public display if anticompetitive effects are found.

Endnotes

1. Cal. Health and Safety Code §§ 127671(a), (c).
2. David Cutler and Leemore Dafny, "Designing Transparency Systems for Medical Care Prices," *New England Journal of Medicine* 364 (Mar. 10, 2011): 894, doi:10.1056/NEJMp1100540; Anna D. Sinaiko and Meredith B. Rosenthal, "Increased Price Transparency in Health Care — Challenges and Potential Effects," *New England Journal of Medicine* 364 (Mar. 10, 2011): 892, doi:10.1056/NEJMp1100041; see also Marina Lao (director, Office of Policy Planning, Fed. Trade Commission) et al. to Minnesota Representatives Joe Hoppe and Melissa Hortman, June 29, 2015 (hereinafter "FTC Minnesota Letter"), www.ftc.gov (PDF) (citing other examples such as railroad grain, automaker marketing, long distance telephone, and inland water transportation).
3. Zach Y. Brown, "Equilibrium Effects of Health Care Price Information," *Review of Economics and Statistics* (forthcoming), published ahead of print, doi:10.1162/rest_a_00765.
4. Svend Albæk, Peter Møllgaard, and Per B. Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," *Journal of Industrial Economics* 45, no. 4 (1997): 429, econpapers.repec.org; David P. Byrne and Nicolas de Roos, "Learning to Coordinate: A Study in Retail Gasoline," *Amer. Economic Review* 109, no. 2 (Feb. 2019): 591, doi:10.1257/aer.20170116.
5. The research presented in this brief demonstrates that the committee would have the authority to release provider- and plan-specific prices on a public website; still, the committee should consider competitive effects when deciding to release negotiated rate data on the public website, especially in highly concentrated markets.

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The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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