**MAINE HEALTH DATA ORGANIZATION:**

**Payments, Antitrust, Secrecy, and Transparency**

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1. ANTITRUST/UNFAIR TRADE ACT

Price transparency in health care is a recent innovation in the US. Maine has been a leader in APCD data collection and price transparency, but has only been collecting such data since 2003, and making it public in a user friendly format for a few years.

In contrast, antitrust laws have been enforced on the federal level since the 1890s. This was well before health insurance existed, physicians gained professional status, and hospitals were able to provide reliable treatment. Antitrust laws are designed to protect and encourage open competition between businesses or sellers of any product or service. Competition provides a powerful incentive for businesses to find ways to increase efficiency, lower prices and improve the quality of their products or services. **In a healthy competitive marketplace, consumers have the widest choice of products and services at the lowest prices.** The corollary for businesses in a competitive market is generally less profit per unit or service sold. Thus for businesses there is constant friction between maximizing profits and being competitive by offering consumers the best products at the lowest price.

When businesses restrict competition by agreeing to fix prices, allocating markets, or engaging in other anticompetitive activity, the benefits of competition (lower prices and increased quality of products and services) erode. Federal antitrust/unfair trade laws forbid and punish this kind of anti-competitive behavior. Maine has its own antitrust and unfair trade practices laws, which are modeled on federal statutes. Maine’s antitrust laws prohibit:

1. Contracts, combinations or conspiracies in restraint of trade;
2. Monopolization offenses;
3. Mergers and acquisitions which tend to substantially reduce competition; and
4. Unfair methods of competition, as well as unfair acts and practices in the conduct of trade or commerce.

Maine’s Monopolies and Profiteering Act (10 MRS Chapter 201, §§1101-1110) governs the first three and our Unfair Trade Practices Act (5 MRS Chapter 10, §§205-A-214) governs the fourth. These laws cover the health care industry. The AG’s Office has brought a number of actions involving provider mergers, price fixing, market allocation, and “concerted refusal to deal.”

Antitrust enforcement at the federal level is done by the Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”). These agencies pursue cases similar to those the state takes action on. In addition the FTC reviews state actions and legislation to assess whether they think it will help or hinder competition.

Some activities by competitors are deemed so harmful that they are considered per se violations – it does not matter whether or not the activities actually have a harmful effect on competition; the effect is presumed. These generally include price fixing, allocation of customers, markets or territories, bid-rigging, and some forms of boycotts. However, there must be some kind of agreement (contract, combination or conspiracy) involved. So, even for price-fixing, tacit conduct is not enough to prove an antitrust violation. *See, e.g., In re: Text Messaging Antitrust Litigation,* 782 F.3d 867 (7th Cir. 2015).

1. MHDO AND PRICE TRANSPARENCY

Price transparency laws tend to clarify pricing disparity between providers, within providers for different payers, and between commercial payers. Because the purpose price transparency provisions are to hold down the price of health care, and hence health insurance costs, they can be unpopular with both providers and payers. Recently data submitters to MHDO have questioned the antitrust implications of such pricing clarity.

The purposes of MHDO are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports, as provided in section 8712. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. 22 MRS §§8703(1). MHDO is charged with promoting public transparency of the quality and cost of health care in Maine. 22 MRS §§8712. The reports mandated by §8712, include reports on “payments for services rendered by health care facilities and practitioners to residents of the state…” Section 8712 has been added to and rearranged several times including by PL 2009, c. 350 “An Act to Protect Consumers and Small Business Owners from Rising Health Care Costs.”

Section 8712 Reportscurrently says:

**“1.** **Quality.**  The organization shall promote public transparency of the quality and cost of health care in the State in conjunction with the Maine Quality Forum… **2.** **Payments.**  The organization shall create a publicly accessible interactive website that presents reports related to **payments for services rendered by health care facilities and practitioners to residents of the State**. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be **constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors**. …”

Thus Maine’s law requires that prices paid by individual commercial carriers for services rendered by healthcare facilities and practitioners to residents of the state be made publically available.[[1]](#footnote-1)

III. ANTITRUST/UTA AND MHDO DATA

Problems arise when exchange of pricing information is used as part of a mutual agreement or understanding to influence prices. Most information exchanges are competitively neutral or even pro-competitive. Benefits include that it allows consumers to better shop by price and gets competitors to compete on price. As one commentator said it is hard to compete on price if you do not know what a competitor’s price is. Also, price transparency may have a self-auditing effect when competitors see how well others are performing.

Risks include potential collusion on prices. It could make it simpler for competitors to communicate about mutually acceptable levels of pricing. Of course, as discussed above, there would have to be an agreement made by the competitors to make it illegal. Even without overt price-fixing or illegal conduct price transparency may lead to price uniformity at the highest level. (i.e. tacit collusion). While this would be unfortunate, it is not illegal. Ironically, any tacit collusion would likely appear in the MHDO data and on the price compare website.

In 1996, the DOJ and FTC issued the Statements of Antitrust Enforcement Policy in Health Care. These statements are aimed at providers. Statement 6 (Provider Participation In Exchanges Of Price and Cost Information) applies to prices charged and compensation paid by health providers. All of the Statements in this policy had to do with joint *provider* activity which was rapidly developing at that time. The feds noted both good and bad potential:

“Participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. 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. Purchasers can use price survey information to make more informed decisions when buying health care services. Without appropriate safeguards, however, 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. A collusive restriction on the compensation paid to health care employees, for example, could adversely affect the availability of health care personnel.”

In most of those 9 statements, the USDOJ and FTC gave health care providers guidance in the form of antitrust “safety zones.” These safety zones describe conduct (of the providers) that the enforcement agencies “will not challenge under the antitrust laws, absent extraordinary circumstances.” The agencies specifically note in the introduction “some parties have interpreted the safety zones as defining the limits of joint conduct that is permissible under the antitrust laws. This view is incorrect.” Thus even for information amongst providers, these criteria do not “forbid” information exchanges that fall outside these parameters.

For Statement 6 the Safe Harbor should meet the following criteria:

(1) managed by a third-party

(2) based on data more than 3 months old; and

(3) at least five providers reporting data, no individual provider’s data represents more than 25 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.

These policy statements are just that – policy –not requirements. As discussed above the Maine legislature has made its own policy statement on price transparency and the MHDO by the requirements in sections 8703 and 8712. The federal policy does not forbid or limit MHDO’s data releases.

1. MHDO AND STATE IMMUNITY DOCTRINE

As a general matter, state activities are not subject to state or federal anti-trust review, anyway. The states can and do make laws that have some anti-competitive effects to achieve what a state may believe is a greater good. Under the US Supreme Court decision in *Parker v. Brown*, 317 US 341 (1943), state and municipal authorities are exempt from federal antitrust lawsuits. This immunity covers action taken pursuant to a clearly expressed state policy. When a state approves and regulates certain conduct, even if it is anticompetitive, or potentially anticompetitive under FTC or DOJ standards, the federal government must respect the decision of the state. [[2]](#footnote-2)

MHDO as an independent state agency is protected under this doctrine. This doctrine can also apply to provide immunity to non-state actors, such as MHDO Board members if a two-pronged test is met: (1) the challenged conduct/restraint is clearly articulated and affirmatively expressed as state policy; and 2) there must be active supervision by the state of the policy or activity.[[3]](#footnote-3) *North Carolina State Bd. of Dental Examiners v. FTC,* 574 US \_\_\_(2015).

In Maine, price transparency is a stated purpose of the MHDO. 22 MRS §8712. The MHDO advances clearly articulated policies to collect data on prices and make that available on its public website, and to anyone who requests it and meets all of the many conditions of Chapter 120.

The MHDO Board supervises the activity of the MHDO, but unlike “self-regulating” professional Boards, this Board is evenly split between providers (sellers) and payers (buyers). The MHDO Board consists of 9 provider seats and 9 payer seats (4 consumers, 3 employers, 2 third-party payers). In addition there is 1 designee of DHHS, and 1 designee of Dirigo Health. Finally, there is a designee of DPFR, who does not vote and serves in a consultative capacity. The MHDO is advised by the Attorney General, a separate state agency. 22 MRS §8703(5). Its Data Release Rules, Chapter 120, are major-substantive, meaning there is the opportunity for legislative review before they became effective. So there is active supervision by the state.

MHDO board members are also entitled to tort immunity under the Maine Tort Claims Act (“MTCA”), 14 M.R.S. Ch. 741.  The MTCA includes board members within the definition of state employees covered by the Act.  Section 8102(1) defines “employee” to include any person acting on behalf of a governmental entity in any official capacity, whether compensated or not.  The term “governmental entity” includes the State. 14 MRS §8102(2).  The term “State” includes boards and commissions. 14 M.R.S. §8102(4).  Thus, MHDO Board members are entitled to all of the immunities under the MTCA, and generally the State would provide a legal defense for any tort claims arising against board members. 14 M.R.S. §§8111; 8112. These protections apply so long as MVB members are acting within the course and scope of their employment and not acting in bad faith. 14 M.R.S. §8112(1)-(3).

The MTCA also limits personal liability of any board member for negligent acts or omissions to $10,000, and the state would pay that amount so long as Board members were acting within the scope of their work on the Board. 14 M.R.S. §8104-D.

Although it may be overdoing it, the MHDO will add an indemnification clause to the MHDO DUA saying that the data recipient will indemnify MHDO for any liability that may result from the recipient’s violation of law.  MHDO has also agreed to include a Provision that reminds the data recipient that misuse of the MHDO released data for anti-competitive behavior such as collusion on price is a violation of law. The MHDO will report any such violation in the use of its data to the appropriate authorities.

1. PROPRIETARY/CONFIDENTIAL INFORMATION

Another claim sometimes made by payers is that certain data elements are trade secrets. Maine law says:

"Trade secret" means information, including, but not limited to, a formula, pattern, compilation, program, device, method, technique or process, that:

A. 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; and

B. Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.” 10 MRS §1542(4). An entity asserting the argument would have to meet this standard in court to get an injunction preventing such a release. Data submitters are given time to pursue such a course, before MHDO releases data that has been objected too.

A related argument is that the data is confidential or “proprietary data” as defined in new Chapter 120, Section 2(33). Proprietary data is data submitted to the MHDO by a data provider that has not been made available to the public and if made available to the public will directly result in the data provider being placed in a competitive economic disadvantage. This is derived from soon-to-be-replaced Chapter 120, Section 2(C)(3)- Confidential Clinical Data. When a data submitter makes such a claim to the MHDO, they have the burden to show the data is privileged or confidential. If they do not, MHDO can decide to release the data. Chapter 120, Section 7(D). After such a decision by the MHDO, the data submitter has several days to get a court injunction to prevent the release of such data. This argument has been raised a few times but so far data submitters have not sufficiently supported their claims of confidentiality.

1. This statute is in accord with other price transparency efforts. Section C of the DirigoHealth legislation enacted new 22 MRS §1718 requiring hospitals and ambulatory surgery centers to provide to requesting individuals, the average charge for any inpatient service or outpatient procedure provided by the hospital or surgical center. In addition, 24 MRS §2987 (which has since been updated and moved to 22 MRS §1718-A) makes similar requirements of health care practitioners for prices the practitioner charges clients directly when there is no insurance coverage, or coverage is denied. [↑](#footnote-ref-1)
2. Taken from [https://www.law.cornell.edu/wex/state­\_action\_antitrust\_immunity](https://www.law.cornell.edu/wex/state_action_antitrust_immunity) and Wikipedia on Parker immunity doctrine. [↑](#footnote-ref-2)
3. For another example Maine has the Hospital and Health Care Providers Cooperation Act (22 MRS Chapter 405-A). “The Legislature finds that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will facilitate cost containment, improve quality of care and increase access to health care services. This Act provides processes for state review of overall public benefit, for approval through certificates of public advantage and for continuing supervision. It is the intent of the Legislature that a certificate of public advantage approved under this chapter provide[s] state action immunity under applicable federal antitrust laws.” 22 MRS §1842. [↑](#footnote-ref-3)