IN THE SUPREME COURT OF PENNSYLVANIA

No. 45 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,
Appellants,

v.

THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE,
Appellees.

BRIEF OF *AMICUS CURIAE* AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF APPELLEES

On Appeal from the Order of the Commonwealth Court in Case No. 1935 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098 (Eiseman I)

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IN THE SUPREME COURT OF PENNSYLVANIA

No. 46 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,
Appellants,

v.

AETNA BETTER HEALTH, INC., HEALTH PARTNERS OF PHILADELPHIA, INC., and KEYSTONE MERCY HEALTH PLAN,
Appellees.

BRIEF OF *AMICUS CURIAE* AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF APPELLEES

On Appeal from the Order of the Commonwealth Court in Case No. 1949 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098 (Eiseman I)

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IN THE SUPREME COURT OF PENNSYLVANIA

No. 47 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,
Appellants,

v.

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNITEDHEALTHCARE COMMUNITY PLAN, and HEALTHAMERICA PENNSYLVANIA INC. d/b/a COVENTRYCARES,
Appellees.

BRIEF OF *AMICUS CURIAE* AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF APPELLEES

On Appeal from the Order of the Commonwealth Court in Case No. 1950 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098 (Eiseman I)

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

Amicus Curiae America's Health Insurance Plans ("AHIP") is the national association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP's mission is to be an effective advocate for a workable legislative and regulatory environment at the federal and state levels in which our members can advance a health care system that meets the goals of consumers, employers, and public purchasers. AHIP advocates for public policies that expand access to affordable health care through a competitive marketplace that fosters choice, quality, and innovation.

AHIP members – which include six of the seven Medicaid Managed Care Organizations ("MCOs") in Pennsylvania, as well as other MCOs nationwide – have a strong and direct interest in the outcome of this case. As of Q3 2014, 66.5 million Americans, or roughly 21.2% of the total population, received Medicaid health benefits.[1] More than 66% of these Medicaid beneficiaries received Medicaid coverage from MCOs – reflecting an increase of roughly 27% in MCO

[1] Ari Gottlieb, Price Waterhouse Coopers, *The Expanded State of Medicaid in The United States: Private Medicaid Health Plans Crossing the Tipping Point* (Oct. 2014) at 4, *available at* http://www.mhpa.org/_upload/201412MHPADCBriefing.pdf.

enrollment from 2013.[2] In Pennsylvania, more than 80% of Medicaid beneficiaries are served by Medicaid MCOs.[3]

AHIP Medicaid health plan members participate in all 37 states plus the District of Columbia that have full-risk contracts with private health plans for comprehensive benefit coverage. As of 2012, AHIP members represented over 70% of the beneficiaries enrolled in Medicaid health plans. In short, Medicaid managed care accounts for a large and growing percentage of the business conducted by AHIP members, both in Pennsylvania and nationwide.

As discussed in detail below, the continued success of Medicaid managed care business in Pennsylvania and other states – and indeed, the public benefits that derive from an efficiently functioning Medicaid managed care market – depends in large part on the confidentiality of rates negotiated between MCOs and subcontractors ("MCO Rates"), or between subcontractors and providers ("Provider Rates").[4] AHIP therefore provides this *amicus* brief in support of

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[2] *Id.* at 9; *see also Managed Care*, U.S. Centers for Medicare and Medicaid Studies ("CMS") ("Approximately 70% of Medicaid enrollees are served through managed care delivery systems."), *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html.

[3] *See Managed Care in Pennsylvania*, CMS, *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/pennsylvania-mcp.pdf.

[4] Sometimes, Medicaid MCOs contract directly with health care providers. Though that fact scenario is not present here, the same confidentiality considerations apply.

Appellees, and urges this Court to affirm that records containing MCO Rates and Provider Rates should not be disclosed under the RTKL.[5]

SUMMARY OF ARGUMENT

Pennsylvania's Right-to-Know Law ("RTKL", 65 P.S. § 67.101 *et. seq.*) does not make publicly accessible highly sensitive, confidential rate information negotiated between two private companies. That is what the Commonwealth Court decided in its well-reasoned opinions in *Eiseman I* and *Eiseman II*, and this Court should affirm these decisions on appeal.

The RTKL, like its federal analog, the Freedom of Information Act ("FOIA," 5 U.S.C. § 552), recognizes that there are limits to what the public can access through governmental records requests. Chief among these limits are (1) a record must be in the government's possession (65 P.S. § 67.305) or in the hands of a government contractor and "directly relate[d] to the government function" that contractor is performing (65 P.S. § 67.506(d)) – which was the dispositive issue in *Eiseman II*; and (2) the records must not "constitute[] or reveal[] a trade secret or confidential proprietary information" (65 P.S. § 67.708(b)(11)) – which was the dispositive issue in *Eiseman I*.

[5] Given the interrelated issues in the appeals of *Department of Public Welfare v. Eiseman*, 85 A.3d 1117 (Pa. Commw. Ct. 2014) ("*Eiseman I*") and *Dental Benefit Providers, Inc. v. Eiseman*, 86 A.3d 932 (Pa. Commw. Ct. 2014) ("*Eiseman II*"), AHIP is filing identical copies of this *amicus* brief in both dockets before this Court.

These limits are particularly important in the Medicaid managed care context. Medicaid managed care is designed to provide for the Medicaid program the savings and efficiencies of a competitive private health insurance market. Unlike in traditional fee-for-service Medicaid where payments to providers are fixed by regulation, rates paid to providers under Medicaid managed care are negotiated, in the case at bar, between private MCOs and private subcontractors ("MCO Rates") and between private subcontractors and private providers ("Provider Rates").[6] In other words, the rates that are the subject of the instant appeals are negotiated entirely between private actors. Thus, as a threshold matter, their disclosure would not serve the stated purpose of government transparency laws to "shed . . . light on the conduct of any Government agency or official." *U.S. Dep't of Justice v. Reporters Comm. for Freedom*, 489 U.S. 749, 773 (1989) (applying FOIA).

As in the private health insurance marketplace, maintaining the confidentiality of negotiated price terms is critical to realizing the benefits of a competitive Medicaid managed care market. Such price terms are the epitome of confidential terms of dealing in privately negotiated transactions. First, as the Court highlighted in *Eiseman I*, negotiated "rates represent significant investments by each MCO, based on efficiencies, provider specialties and

[6] In some other instances not present here, rates are directly negotiated between MCOs and health care providers.

breadth of provider network, [and] quality of care." 85 A.3d at 1130. Indeed, the payment terms themselves often reflect not just numbers, but incentive provisions intended to promote quality improvement and cost containment. If these rate structures were disclosed to competitors, this would diminish the value of the MCO's investment, and risk the very sort of "substantial harm to the competitive position" of MCOs the RTKL was expressly written to prevent. 65 P.S. § 67.102.

Second, confidential rate terms keep Medicaid costs down. With confidential rates, MCOs and their subcontractors are able to negotiate favorable payment arrangements with providers, which, in turn, they are able to bring to bear in their own contracts with the Commonwealth. If providers knew each other's negotiated rates, the MCOs and their subcontractors could lose their negotiating leverage, and the higher provider costs that would result could ultimately be passed on to the Medicaid program in the form of higher bids for contracts with the Commonwealth. In effect, this disclosure would, in the name of transparency, facilitate the very anticompetitive effects that the antitrust laws are designed to prevent.

Third, confidential rates promote choice for Medicaid beneficiaries. As the Commonwealth Court recognized in *Eiseman I*, MCOs generally have "small margins of profitability" in Medicaid managed care business. 85 A.3d at 1130.

If providers knew each other's rates, and an MCO's costs to provide Medicaid managed care rose, this could prompt an MCO to simply discontinue its participation in the Medicaid managed care program. In Pennsylvania, the result could be a reduction in the number of MCOs available in each region of Pennsylvania from which Medicaid beneficiaries choose (which currently range from three to five, depending on the region). The result would be more limited options for Medicaid enrollees.

Sharing provider rates with the general public is not the norm in market-based health care programs. For example, in both the Medicare Advantage program (Medicare Part C) and the Medicare prescription drug program (Medicare Part D) – which involve private contractors negotiating contractual rates with providers and, with regard to Medicare Part D, with drug manufacturers as well – negotiated rates are *not* a matter of public record and are *not* made available by CMS, notwithstanding that the health plans are paid with public funds. *Eiseman I* and *Eiseman II* followed this well-established pattern.

To be sure, were MCO Rates and Provider Rates disclosed, they could be the subject of scholarly study, as *amicus* Dr. Daniel Polsky suggests. But the legislature in the RTKL recognized that the value of transparency must yield to the interests of private actors and of the public at large in protecting confidential proprietary information and trade secrets. Indeed, that is particularly important

here, where Dr. Polsky offers only notional ideas of what he would do with confidential rate information were it disclosed, and no explanation of why disclosure to the public at large through the RTKL is needed to meet those goals.

For the reasons discussed by the Commonwealth Court, and amplified by Appellees' brief and the arguments below, this Court should affirm the Commonwealth Court's decision to deny Appellants' request to access private, confidential records containing MCO Rates and Provider Rates on the grounds identified by the Commonwealth Court in *Eiseman I* and *Eiseman II*, or because Provider Rates, like MCO Rates, constitute "confidential proprietary information" and "trade secrets" exempted from disclosure under the RTKL.[7]

ARGUMENT

I. The RTKL Limits Access to Confidential Proprietary Information and Trade Secrets of Private Actors.

As the Commonwealth Court in *Eiseman I* recognized, "the current RTKL contains a presumption of openness as to any records in an agency's possession." 85 A.3d at 1123. But contrary to the "maximum access" the Pennsylvania NewsMedia Association ("NewsMedia") argues the RTKL provides, this presumption can be overcome by important competing considerations. *See*

[7] The Court in *Eiseman II* did not reach the question of whether Provider Rates constitute "confidential proprietary information" or "trade secrets" under the RTKL because it already rejected Appellants request for access on other grounds. 86 A.3d at 942.

NewsMedia *Amicus* Br. at 6. Indeed, two such considerations are particularly relevant here.

First, to warrant disclosure under the RTKL, a record must be in the actual or constructive possession of a governmental agency, or be "in the possession of a party with whom the agency has contracted to perform a governmental function on behalf of the agency, and which directly relates to the governmental function." 65 P.S. §§ 67.305, 67.506(d), 67.901. This requirement – which the Commonwealth Court applied in *Eiseman II* – exists because the RTKL is "designed to promote access to *official government information*." *Office of the Governor v. Bari*, 20 A.3d 634, 645 (Pa. Commw. Ct. 2011) (emphasis in original, internal citations omitted). In other words, like its federal analog, the FOIA, the purpose of the RTKL is to inform citizens about the operations or activities of the government – a purpose that is "not fostered by disclosure of information about private [entities] . . . that reveals little or nothing about an agency's own conduct." *McDonnell Douglas Corp. v. U.S. Dep't of the Air Force*, 375 F.3d 1182, 1193 (D.C. Cir. 2004) (quoting *Reporters Comm.*, 489 U.S. at 773).

Second, the RTKL exempts from disclosure records that "constitute[] or reveal[] a trade secret or confidential proprietary information." 65 P.S. § 67.708(b)(11). "Confidential proprietary information" is defined in the RTKL as

"[c]ommercial or financial information received by an agency: (1) which is privileged or confidential; and (2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information." 65 P.S. § 67.102. This requirement – which the Court relied on in *Eiseman I* – also echoes the FOIA, which similarly exempts from disclosure "trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential." 5 U.S.C. § 552(b)(4).[8]

In their primary briefs, Appellees have ably argued why the Commonwealth Court was correct in ruling that Provider Rates fail to meet the RTKL's requirements for government possession or access to third party records, and why MCO Rates are exempt from disclosure as "confidential proprietary information" and "trade secrets" under the RTKL (though not addressed by the Court in *Eiseman II*, this exemption would also apply to Provider Rates). AHIP does not rehash these arguments here. Rather, AHIP offers this *amicus* brief to provide additional context for why the purposes of the RTKL and the interests of the public are best served by continued confidentiality of records containing MCO Rates and Provider Rates, which it respectfully submits further support the conclusion that access to such records under the RTKL should be denied.

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[8] *See also* Department of Justice Guide to the Freedom of Information Act (2009), at 263 (the intent behind this exemption is to safeguard companies' government submissions from the "competitive disadvantage that could result from disclosure"), *available at* http://www.justice.gov/oip/doj-guide-freedom-information-act.

II. Disclosure of MCO Rates and Provider Rates Would Not Serve the Core Purpose of Governmental Transparency Laws.

The fundamental purpose of governmental transparency laws like the RTKL and FOIA is to "inform citizens about 'what their government is up to.'" *McDonnell Douglas*, 375 F.3d at 1193 (quoting *Reporters Comm.*, 489 U.S. at 773). The MCO Rates and Provider Rates at issue here, though, are negotiated between *private* entities. The government is not involved in the negotiations, and thus there is little insight to be gained about the activities *of government* from disclosure of these rates.

To understand why this is so, one must first understand how Medicaid managed care differs from traditional fee-for-service Medicaid. Under traditional fee-for-service Medicaid, providers provide health care services to Medicaid enrollees, and are paid by the state on a fee-for-service basis.[9] The rates for each service are set by the government, and payments are made based on these rates directly from the government, or a fiscal intermediary administrative contractor acting on the government's behalf, to each provider.[10]

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[9] *See Fee-for-Service*, CMS, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html (describing fee-for-service Medicaid).

[10] *See id.*

Beginning in 1996, Pennsylvania became one of the first states to adopt Medicaid managed care.[11] Unlike fee-for-service Medicaid, under a Medicaid managed care system, the state does not establish provider reimbursement rates and does not contract with providers. Rather, the Commonwealth, through the Department of Human Services ("DHS," which was formerly the Department of Public Welfare ("DPW")), contracts with private MCOs to provide health benefits to the state's Medicaid population.[12] MCOs are paid under these contracts through competitively bid "Capitation Rates" – fixed fees paid to the MCO by the state on a per member, per month basis. 85 A.3d at 1121. The MCOs – or in this case, subcontractors contracted with the MCO – then negotiate payment terms directly with providers to establish a provider network. These MCOs then compete with one another for Medicaid enrollees – in part based on the composition of the network they can establish[13] – just like they would in the private health insurance market. *See id.* at 1129 ("[T]he actual competition in the relevant market among the five MCOs is apparent. . . . As the

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[11] *Managed Care in Pennsylvania*, CMS, *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/pennsylvania-mcp.pdf. Pennsylvania calls its Medicaid managed care program "HealthChoices."

[12] Pennsylvania is currently divided into five HealthChoices Zones, one of which is serviced by five MCOs, three of which are serviced by four MCOs, and one of which is serviced by three MCOs. *See* http://www.enrollnow.net/PASelfService/en_US/bycounty.html.

[13] MCOs also often distinguish themselves through additional programs such as vision care or nutritional counseling that are not part of the standard Medicaid covered services. *See, e.g.*, http://www.enrollnow.net/PASelfService/pdfs/English/SE%20English_1page.pdf.

MCOs compete for market share, gain for one means loss for another." (citing R. 413a, 499a, 509a)).

The negotiations between an MCO and a provider – or in the instant case, between MCOs and subcontractors, who in turn contract with providers – are private negotiations between private parties. *See Eiseman I*, 85 A.3d at 1121 (describing MCO Rates); *Eiseman II*, 86 A.3d at 935 (describing Provider Rates). The government is not involved in the negotiations, and the MCO bears all of the risk if the payments it negotiates from subcontractors and/or providers exceed the Capitation Rates it is paid by the state.

For purposes of the instant appeals, this fact is significant because it means that disclosure of MCO Rates and Provider Rates would not "contribute significantly to public understanding of the operations or activities of the government" – the "core purpose" of government transparency laws. *McDonnell Douglas*, 375 F.3d at 1193 (quoting *Dep't of Defense v. FLRA*, 510 U.S. 487, 495 (1994)). The MCO is the only party in the chain of contracts that is in direct privity with the government. Thus, it is the Capitation Rates negotiated between the MCO and the government that provide the window into how the government is spending taxpayer money. MCO Rates and Provider Rates, by contrast, disclose instead the "internal workings of [a] contractor," which, as the D.C. Circuit held in *McDonnell Douglas*, "shed little if any light upon the 'agency's

performance of its statutory duties.'" 375 F.3d at 1193 (rejecting FOIA request for downstream cost information of a contractor selling airplane maintenance and repair services to the Air Force) (quoting *Bibles v. Or. Natural Desert Ass'n*, 519 U.S. 355, 356 (1997) (per curiam)); *see also Munger, Tolles & Olson LLP v. U.S. Dep't of the Army*, Case No. CV 13-06890, 2014 U.S. Dist. LEXIS 158097, at *20 (C.D. Cal. Nov. 6, 2014) ("[C]ases confirm that large-scale financial information, such as overall contract pricing, is usually available for disclosure because it lets the public know how agencies are spending taxpayer money. But more specific financial information is often protected from disclosure, because revealing it would give competitors an unfair peak into the company's operations."). This Court should follow this *McDonnell Douglas* precedent and deny use of the RTKL to access rate negotiations that do not involve the government.[14]

[14] For this same reason, the NewsMedia's argument that affirming *Eiseman I* and *Eiseman II* would allow government agencies and contractors to "thwart public access [to rate information] by contract or subcontract" rings hollow. NewsMedia *Amicus* Br. at 5. It is the Capitation Rates between the government and MCO – which are not at issue in the instant appeal – that provide insight into how the government is spending taxpayer money. Nothing about keeping MCO Rates or Provider Rates confidential "thwarts" this transparency. Moreover, as the Commonwealth Court found in *Eiseman II*, "[t]here is no evidence [here that] DPW sought to circumvent the RTKL by placing records of its activities into the hands of a third party." 86 A.3d at 939; *see also Office of Budget v. Office of Open Records*, 11 A.3d 618, 623 (Pa. Commw. Ct. 2011) (rejecting request for records where there was no evidence of an "attempt[] to play some sort of shell game by shifting these records to a non-governmental body"). Thus, the NewsMedia's argument is moot in the instant case in any event.

III. Keeping MCO Rates and Provider Rates Confidential Benefits the Public and Private Business.

MCO Rates and Provider Rates should also be kept confidential because confidentiality is critical to an efficiently functioning Medicaid managed care market. In the Medicaid managed care context, both the public and private business benefit from this confidentiality.

A. Confidential Rates Promote Investment, Innovation, and Competition.

First, confidentiality of rates is important because it promotes investment, innovation, and competition in the Medicaid managed care market. As Appellees' expert, Dr. Miller, testified, information on rates is "valuable in the industry because of the investment required to maintain a competitive edge in gaining enrollees. The rates represent significant investments by each MCO, based on efficiencies, provider specialties and breadth of provider networks, quality of care, and, presumably small margins of profitability." 85 A.3d at 1130. The Commonwealth Court described this testimony as "most persuasive," before reaching its conclusion in *Eiseman I* that MCO Rates constitute confidential proprietary information and trade secrets that should be held confidential. *Id.* at 1131.

In this respect, both Dr. Miller and the Commonwealth Court have it right. An MCO depends on setting rates to the Commonwealth such that enough

money is collected in capitation payments to cover the costs of payments to subcontractors and providers as well as administrative costs and overhead. In today's complex health care marketplace, the calculations underlying the provider and subcontractor payment are often performed by MCOs using proprietary tools and programs that they have developed over a number of years and at great expense. The contracts ultimately entered with subcontractors and providers also reflect significant time and energy dedicated to provider negotiations, and confidential business judgments of the MCOs based on, among other things, provider availability, network requirements, and MCO costs.[15] The bottom line is that negotiated rates do require "substantial investment" by the MCOs, and the tools MCOs use to generate them are highly sensitive and critical to their business model.

Moreover, the pricing terms that result from these proprietary formulas and negotiations are not just numbers. Rather, contracted rate terms today often involve incentive and "pay for performance" provisions intended to promote quality improvement while also containing costs. This is a critical aspect of

[15] Any argument that the records sought by Appellants are stale rings hollow, since the models used to generate rates from 2008 to 2012 may very well be the same or similar to those in contracts still in effect today. These models, if disclosed, would give an unfair window into business judgments and competitive factors that have relevance and value in current negotiations.

innovation in the evolving health care marketplace.[16] If MCOs were compelled to disclose these confidential pricing terms, it could discourage the very innovation and investment in the health care marketplace that regulators are hoping to promote. *See Giurintano v. Department of General Services*, 20 A.3d 613, 616-17 (Pa. Commw. Ct. 2011) (denying access to a company's proprietary list of "high quality interpreters" because disclosure of that information would allow "competitors to gain the fruits of [the company's] labor.").

Here, non-disclosure is particularly warranted because, in the highly competitive Medicaid managed care market (*see Eiseman I*, 85 A.3d at 1129), access to rate data could allow competitors to erode an MCO's market position. As United Healthcare Community Plan President Heather Cianfrocco testified:

> [I]f [competitors saw United's rates] they could use that to potentially negotiate different amounts and get potentially preferential treatment from the Department of

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[16] The goal of "pay for performance" initiatives such as those adopted by Pennsylvania for Medicaid MCOs and by CMS for the Medicare shared savings program is to revamp "how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations instead of merely volume." Proposed Rules for the Medicare Shared Savings Programs: Accountable Care Organizations, 76 Fed. Reg. 19528, 19530 (Apr. 7, 2011); *see also* Michael H. Bailit, *Pay-for-Performance in the Medi-Cal Managed Care and Healthy Families Programs: Findings and Recommendations* (Aug. 2009) (containing discussion of Medicaid MCO pay for performance programs in several states, including Pennsylvania), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PayForPerformanceInMediCalPaper.pdf. Contracts between MCOs and providers increasingly incorporate quality and cost control incentive provisions in an effort to achieve these goals. *See* Harold D. Miller, *Measuring and Assigning Accountability for Healthcare Spending: Fair and Effective Ways to Analyze the Drivers of Healthcare Costs and Transition to Value-Based Payment*, Center for Healthcare Quality & Payment Reform (Aug. 2014), *available at* http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.

> Public Welfare for business . . . . They could determine cost structure, other unique programs or other trade secrets that I use to ensure that I provide managed care services in a manner that meets the needs of the Department and is still profitable.

R. 382a. As discussed in more detail in the following section, providers could also gain negotiating leverage from knowing rates MCOs offered to other similarly situated entities.

As the RTKL makes clear, confidential information is exempt from disclosure if it "would cause substantial harm to the competitive position of the person that submitted the information." 65 P.S. §§ 67.102, 708(b)(11). *see also Dahlgren v. Department of General Services*, OOR Dkt. AP 2009-0631 at 8-9 (Sept. 10, 2009) (denying access to "negotiated manufacturer pricing for pharmaceuticals" where disclosure would allow competitors to "refine pricing in an effort to win away business."); *Zeshonski v. Pa. Dept. of Health*, OOR Dkt. AP 2011-0698 at 10 (July 20, 2011) (protecting from disclosure fees charged and costs incurred by health care provider); *see also Nat'l Parks & Conservation Ass'n v. Kleppe*, 547 F.2d 673, 684 (D.C. Cir. 1976) (denying disclosure under FOIA where [d]isclosure [of concessioner's sensitive financial information] would provide competitors with valuable insights into the operational strengths and weaknesses of a concessioner, while the non-concessioners could continue in the customary

manner of 'playing their cards close to their chest.'"). That "substantial harm to . . . competitive position" is just what would accrue if disclosure of MCO Rates or Provider Rates were ordered here. This concern applies for MCOs, subcontractors, and health care providers as well.

B. Confidential Rates Keep Medicaid Costs Down.

Second, confidential rates help keep Medicaid costs down, yielding significant benefits to the public and fulfilling the goal of the Medicaid managed care program. The logic underlying this conclusion is simple – with confidential rates, MCOs are able to drive a harder bargain with subcontractors (or with providers directly), and subcontractors are able to drive a harder bargain with providers where they are involved. Because MCO costs are lower, MCOs are able to bid lower Capitation Rates to the government. This nets out to lower overall costs to the Medicaid program, and savings to the taxpayer. According to one study, these savings equated to $5.0 to $5.9 billion for Pennsylvania taxpayers from CY2000 to CY2010, with even larger savings of $8.3 to $10.2 billion projected from CY2011 through CY2020.[17]

If, by contrast, MCO Rates or Provider Rates were made public and every health care provider and subcontractor knew how much each MCO was paying to every other health care provider and to what rates all competing providers had

[17] *See An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program,* The Lewin Group (May 2011), *available at* http://www.lewin.com/publications/Publication/439/.

agreed with subcontractors, MCOs would lose bargaining leverage they might have in negotiations with the intermediary subcontractors, and subcontractors would be impaired in negotiations with providers. Subcontractors and providers would be able to insist upon more favorable price terms offered to other subcontractors and providers (by that plan or by others), and bargain to rate terms that were ultimately higher than what would have been agreed to in a confidential negotiation. The end result would be higher costs for MCOs, which in turn would negatively impact the Medicaid program.

This is not merely a theoretical concern. Government authorities have long recognized this potential public harm in announcing limits to the disclosure of rate information in other contexts, including government health care programs. For example, when CMS released Medicare Part D claims data (which relates to prescription drug usage under Medicare), it specifically excluded "rebate and other price concessions data" from disclosure. 73 Fed. Reg. 30664, 30668 (May 28, 2008). CMS explained that continued confidentiality was needed because the drug benefit was based on a "competitive business model," and the release of such "commercially or financially sensitive data" could "negatively impact Part D sponsors' ability to negotiate for better prices, and ultimately affect the ability of sponsors to hold down prices for beneficiaries and taxpayers." *Id*.

Similarly, the Federal Trade Commission ("FTC") recognized that disclosure of rates could increase costs in the analogous context of Pharmacy Benefit Management (PBM) rate negotiations. While acknowledging consumers' need for "accurate information on price and quality to make efficient purchasing decisions," the FTC has stated "[t]here is no theoretical or empirical reason to assume that consumers require sellers' underlying cost information for markets to achieve competitive outcomes."[18] Similar to here, in the PBM context, the FTC recognized that disclosure provisions "dilute incentives to bid aggressively" and thereby potentially "undercut the most efficient pharmacy network contracts, leading to higher prescription drug prices" – or in this case, overall health care costs to consumers.[19]

Indeed, the antitrust laws themselves posit that there is public benefit to be derived from competitors not knowing each other's pricing terms. As federal

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[18] Letter from FTC Office of Policy Planning, Bureau of Competition, and Bureau of Economics to NY State Senator James L. Seward Concerning NY Senate Bill 58, at 5-6 (Mar. 31, 2009), *available at* http://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; *see also* Letter from FTC Office of Policy Planning, Bureau of Competition, and Bureau of Economics to Assemblywoman Nellie Pou, N.J. General Assembly at 12 (Apr. 17, 2007), *available at* http://www.ftc.gov/be/V060019.pdf.

[19] Letter from FTC Office of Policy Planning, Bureau of Competition, and Bureau of Economics to Mississippi Representative Mark Formby, at 7 (Mar. 22, 2011), *available at* http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-mark-formby-mississippi-house-representatives-concerning-mississippi/110322mississippipbm.pdf (responding to proposed state legislation that would allow state pharmacy board to obtain PBM rates, discounts, and other financial information and disclose that information to third parties).

antitrust authorities have recognized, "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." Statements of Antitrust Enforcement Policy in Health Care, U.S. Dep't of Justice and FTC, at Statement 6, Provider Participation in Exchanges of Price and Cost Information, *available at* http://www.justice.gov/atr/public/guidelines/0000.htm. Department of Justice and FTC guidance therefore only sanctions sharing of price information for health care services among providers when it is in response to a survey managed by a third party (*i.e.*, the survey price information submissions would not go directly to a competitor), when "no individual provider's data [would] represent more than 25 percent [of any statistic] on a weighted basis," and when the "information . . . is sufficiently aggregated such that it would not allow recipients to identify the prices charged . . . by any particular provider." *Id.* Here, the *public* dissemination of rate information that Appellants seek would put price data directly into the hands of competitors with no aggregation or de-identification at all. In other words, critical conditions for price data to be safely shared would not be met. It would be highly contradictory to warn against antitrust liability on one hand for competitors sharing sensitive pricing information, while on the other hand construing state law to require making that very same data available through the RTKL.

The bottom line is that the Medicaid managed care market operates more effectively when rates are kept confidential, similar to what consumers would expect in the private insurance market on which Medicaid managed care is based. The result of these market efficiencies is lower costs for the MCOs, which ultimately translate into lower Medicaid costs for the taxpayer.

C. Confidential Rates Protect Choice for Medicaid Beneficiaries.

For similar reasons, maintaining the confidentiality of rate data and pricing terms ultimately preserves choice for Medicaid beneficiaries. As the Commonwealth Court acknowledged in *Eiseman I*, MCOs often experience "small margins of profitability" on Medicaid managed care business. 85 A.3d at 1130. If MCOs lose negotiating leverage with subcontractors or providers, and those entities are able to negotiate more favorable deals, MCO costs could increase beyond what MCOs could recover in Capitation Rates. In such a scenario, an MCO could very well choose to exit the Medicaid managed care market altogether. This could reduce the number of Medicaid managed care options available to Medicaid beneficiaries, which currently number between three and five, depending on the region of Pennsylvania affected.[20] In any such scenario, competition in the market – and hence, the choices available for Medicaid enrollees to obtain health care benefits – would be diminished.

[20] *See* http://www.enrollnow.net/PASelfService/en_US/bycounty.html. If a beneficiary does not select a plan, the beneficiary is assigned to a plan by the Commonwealth.

In addition, MCOs compete in part via innovative provider compensation incentive arrangements, intended to enhance quality and access to care, while also containing costs.[21] If each plan's tools and privately negotiated contracts implanting these tools were required to be disclosed to its competitors, the RTKL could put a damper on this type of innovation, which enhances consumer choice via the diversity of approaches used to pursue the Commonwealth's own objectives.

IV. Confidential Rates Are the Norm in Market-Based Health Care Systems.

Recognizing the benefits that confidential rates afford, confidentiality in provider rates is the norm in market-based health systems like Medicaid managed care. Medicare Advantage – also known as Medicare Part C – provides a particularly analogous example. Medicare is a federal program that pays for certain health care expenses for people aged 65 and older and for qualifying disabled persons. Under the Medicare Advantage program, like Medicaid managed care, CMS contracts with private health plans to furnish covered health care benefits. This program, like Medicaid managed care, is designed to deliver Medicare covered benefits by engaging commercial health plans to provide coverage for beneficiaries, and then relying on competition among plans to benefit both the government and program beneficiaries. 70 Fed. Reg. 4588, 4696-97 (Jan.

[21] *See supra* note 16.

28, 2005) (Medicare Advantage implements a "competitive bidding process more similar to that used by FEHB and large employers to obtain high-quality, stable plan participation").

In this setting, CMS has made clear that it considers provider rate information to be proprietary to Medicare Advantage plans, and presumptively *not* subject to public disclosure under FOIA.[22] The logic of this decision is the same one that applies here – the Medicare Advantage program functions effectively and saves the government money when there is healthy competition, and where Medicare Advantage plans can bring that competition to bear through aggressively negotiated provider agreements.

CMS similarly refuses to disclose pricing information in the Medicare Part D Prescription Drug program. Under Medicare Part D, like Medicare Advantage and Medicaid managed care, the government again contracts with private plans to administer a public benefit – in this case, prescription drug plans for Medicare beneficiaries. These plans in turn negotiate with drug manufacturers and pharmacies for favorable pricing terms, and plans set bid amounts based on the pricing terms they can negotiate with those manufacturers and pharmacies.

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[22] *See* Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2013, at 3-4 (May 23, 2013), *available at* http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html.

CMS explicitly withholds from public disclosure any Medicare Part D data that would permit external parties to determine what a specific plan pays to a particular pharmacy or what rebates are paid by particular drug manufacturers. *See* 73 Fed. Reg. 30664, 30668 (May 28, 2008). Explaining this policy, CMS stated: "Because the Medicare drug benefit is based on a competitive business model, to release commercially or financially sensitive data to the public could negatively impact Part D sponsors' ability to negotiate for better prices, and ultimately affect the ability of sponsors to hold down prices for beneficiaries and taxpayers." *Id.* This same logic applies to the MCO Rates and Provider Rates at issue in the instant appeals.

The Pennsylvania legislature, as well, has recognized the competitive importance of keeping provider rates and discounts confidential. As just one example, the legislature, through statute, established the Pennsylvania Health Care Cost Containment Council, an independent state agency tasked with collecting data and creating reports to address health competition and cost containment. 35 P.S. § 449.1 *et seq.* In this statute, which contemplated disclosure of health care cost data to the Council by private actors, the legislature expressly directed that such "raw data disclosing discounts or allowances between identified payors and providers" be kept confidential and not publicly disclosed under the RTKL. 35 P.S. § 449.10. In fact, the statute provides for large fines or imprisonment for anyone knowingly

releasing such data from the council. *Id*. It would seem highly contradictory for the legislature to emphasize the highly confidential nature of negotiated rates in one setting to the tune of imposing large fines for any violation, while at the same time the courts are asked to construe the RTKL as authorizing the disclosure of this same information. The clear conclusion is that the Pennsylvania legislature, like other government authorities considering market-based health care systems, recognizes the value of competitive rate information, and had no intention of making such information subject to the RTKL.

Indeed, the HealthChoices template contract (R. 680a-849a) itself recognizes that the government and the MCOs did not contemplate disclosure of negotiated rates with subcontractors or providers. The contract, consistent with federal requirements, singles out information on one specific type of arrangement, particular types of "physician incentive plans" – *i.e.*, financial incentive arrangements whereby physicians are placed at financial risk for the cost of services that they do not directly provide – as subject to disclosure to members and the government upon request. (R. 812a). The fact that the HealthChoices contract specifically called out information on these physician incentive plans to be disclosed, but not the rates and other rate arrangements entered by MCOs with subcontractors or providers where doctors are not at risk for other providers' services, provides further evidence that these rates were not contemplated for

disclosure by the government or the MCOs when the contract was made. *See Dep't of Transp. v. Mosites Const. Co.*, 494 A.2d 41, 43 (Pa. Commw. Ct. 1985) ("the mention of particular items implies the purposeful exclusion of other items of the same general character").

Amicus curaie Dr. Daniel Polsky attempts to counter this clear recognition of confidentiality by pointing to the recent disclosure of Medicare claims payment data by CMS. *See* Polsky *Amicus* Br. at 10-11. But this argument is inapt. The claims data released by CMS in this disclosure related to *the Medicare-fee-for service* program only.[23] In this program, rates paid to providers are set by the government, and are already a matter of public record.[24] In other words, they are not the product of private negotiations, and they are not of competitive value in the market. Put simply, this example has no bearing on whether *privately* negotiated MCO Rates and Provider Rates in a *competitive* Medicaid managed care marketplace are confidential and also subject to protection from disclosure as a trade secret.

Market-based health care systems respect the competitive value of negotiated rates with subcontractors and providers and protect such rates from

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[23] *See Medicare Provider Utilization and Payment Data: Physician and Other Supplier*, CMS, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html.

[24] *See Fee Schedules - General Information*, CMS, *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html.

disclosure, at least in disaggregated form. The Commonwealth Court in *Eiseman I* and *Eiseman II* followed this well-established precedent, and this Court should affirm this sound judgment on appeal.

V. Dr. Polsky Overstates the Benefits of Disclosed Rate Information.

In his *amicus* brief, Dr. Daniel Polsky argues that rate data would enable research on ways to expand health care access, improve quality of care, and contain costs, and would foster greater cooperation between academics and the government on health care policy. Polsky *Amicus* Br. at 2-9. AHIP recognizes that consumers can derive value from cost related information, and has worked with its member organizations to make available cost calculators to allow consumers to estimate out-of-pocket costs for specific services, cost-sharing obligations under their plan (such as co-pays and deductibles), and the relative cost of receiving care at different providers.[25] These tools are devised and implemented to provide significant utility to plan members while minimizing the potential for undermining competition between plans or providers.

But contrary to what Dr. Polsky implies, there is no "scholarly interest exception" under the RTKL. Were this Court to hold otherwise, the exception

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[25] *See, e.g.*, Milliman, Inc., Comprehensive Assessment of ACA Factors that Will Affect Individual Market Premiums in 2014 (2013), *available at* http://www.ahip.org/MillimanReportACA2013/; *see also* Aetna Member Payment Estimator, *available at* http://www.aetna.com/individuals-families-health-insurance/tool/member-payment-estimator.html. AHIP members also offers tools to help consumers identify where they can find health care services by specialty and locality. *See id.*

would swallow the RTKL whole, since researchers could no doubt perform studies on any disclosed information. However, as discussed above, the legislature determined that "confidential proprietary information" and "trade secrets" of private entities are expressly *exempted* from disclosure under RTKL, notwithstanding whether Dr. Polsky or other scholars might find that information academically interesting, or whether anyone else in the public sphere might want to see that information. 65 P.S. § 67.708(b)(11); *see also FBI v. Abramson*, 456 U.S. 615, 631 (1982) (through FOIA, "Congress . . . created a scheme of categorical exclusion"). Dr. Polsky nowhere addresses why the interests of scholars would somehow trump this clear, statutory protection.

The research goals set forth by Dr. Polsky provide a particularly weak basis for contravening the exemption. Dr. Polsky does not articulate a specific research proposal, nor does he explain why the issue he is generally interested in (*e.g.*, the relationship between payment to providers and quality of service) requires access to identifiable rate information on a provider-specific basis. Moreover, he does not explain why disclosure is needed *to the public at large* of commercially sensitive plan and provider pricing data, without limitation and without any acknowledgement of the commercial harm it could cause.

Were Dr. Polsky to have a particular research proposal, it is entirely possible that data needed to carry out his research could be obtained from a source other

than the RTKL in an aggregated or de-identified format that would lessen the potential for competitive harm. CMS, for example, regularly makes available to researchers information on the Medicare and Medicaid programs for projects CMS deems to be reputable and valid.[26] CMS formats and makes available such information so that it is suitable for research, while obtaining agreement from the researcher that he or she will not further release the individually identifiable or commercially sensitive plan or provider level pricing data provided.[27]

Indeed, a quick review of Dr. Polsky's desired research goals reveals that significant information is already publicly available. As one example, public data already exists on the proportion of payments made by the state to managed care organizations are flowing to providers. Polsky *Amicus* Br. at 9. A publicly available report delineates by state the average Medicaid MCO Medical Loss Ratios – the metric used to determine the percentage of revenue that is spent by a plan on medical expenses, administrative expenses, or profit.[28]

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[26] The list of protocols used by CMS to respond to requests for information can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Researchers.html.

[27] *Id.*

[28] *See Medicaid MCO Average Medical Loss Ratios*, Kaiser Family Foundation, *available at* http://kff.org/other/state-indicator/medicaid-mco-average-medical-loss-ratios/. Pennsylvania's average Medicaid MCO Medical Loss Ratio is 93% – higher than all but a handful of other states. *Id.* Significant information is also already made available by the state on the quality of services available through each MCO on a comparative basis – another one of the topical areas of interest Dr. Polsky identifies. *See, e.g.*, 2013 HEDIS Rate Chart (Dec. 10, 2013), *available at* http://www.dhs.state.pa.us/cs/groups/webcontent/documents/communication/s_002206.pdf;

As another example, Dr. Polsky states that an MCO's low provider reimbursement rates might discourage providers from participating in the MCO's network, and thereby reduce access by Medicaid beneficiaries to care. Dr. Polsky does not explain why rate data for individual providers would be necessary to research that question. The contract between the Commonwealth and the plans imposes detailed obligations regarding the size, geography, and composition of the plan's provider network.[29] Within that framework, plans have flexibility to negotiate reimbursement to assure the necessary access while pursuing the parallel objects of quality and cost containment. Revealing negotiated rates would not, in this environment, inform public policy on access issues since all plans are already required to have networks that meet the established requirements.[30]

HEDIS: Health Effectiveness Data and Information Set, *available at* https://www.humanservices.state.pa.us/HEDIS_Health_Choices/HealthChoices.html.

[29] *See* R. 783a-784a ("Provider Network"). A lot of data is already available on these and other standards on a state-by-state basis. *See* Medicaid Managed Care Market Tracker (at http://kff.org/state-category/medicaid-chip/). Data from this site shows that Pennsylvania generally exceeds the median standards in such categories as maximum number of enrollees per primary care provider, and is best in the nation for others, *e.g.*, maximum permitted wait time for routine care. Enrollment information is also publicly available, *see id*., and managed care entities must file provider network updates with the state on a monthly basis. *See* R. 827a ("Provider Network"). This data would enable analysis of whether access standards are being met.

[30] As discussed above, disclosing rate information could jeopardize the scope of a plan's network. Providers could use the same publicly available information to seek the highest rate that is being paid to any of their competitors, thus enabling MCOs to negotiate discounts only in exchange for a higher level of anticipated volume that would require a narrower provider network.

There is always more research that could be done with more information, but that common-sense observation does not overcome the categorical proscription on disclosure of confidential data in the RTKL. This Court should reject Appellants' request for public access to records with MCO Rates and Provider Rates, notwithstanding what Dr. Polsky's notional suggestion of what he could do with such data.

CONCLUSION

Confidential MCO Rates and Provider Rates are at the core of an efficient Medicaid managed care market. They represent private price terms developed by private actors in a marketplace designed to mimic the private insurance market. They also reflect proprietary information whose confidentiality promotes innovation, investment, and competition in the market, and contributes to the overall cost savings to the Medicaid program that Medicaid managed care has generated. The bottom line is that neither the purpose of the RTKL, nor the interests of the public or private businesses would be served by disclosing this highly sensitive, confidential pricing information. For the reasons discussed above and those expressed in the brief of Appellees, AHIP urges this Court to affirm the Commonwealth Court's denial of Appellants' request for records under the RTKL on the grounds identified by the Commonwealth Court, or because Provider

Rates, like MCO Rates, constitute "confidential proprietary information" or "trade secrets" exempted from disclosure under the RTKL.

January 20, 2015 Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the 16,500 word limit established by Pa. R.A.P. 2135.

Dated: January 20, 2015

/s/ Jeffrey Poston
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CERTIFICATE OF SERVICE

I, Jeffrey Poston, hereby certify that on January 20, 2015, I caused to be served this *Amicus Brief* by electronic mail and first class mail (2 copies per recipient) to:

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