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P R O C E E D I N G S

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MS. MAJORAS: Good morning, and welcome to the third day of the Joint Department of Justice/FTC Health Care hearings. Happy to see that we have a number of hearty souls making it in through the snow this morning. I think we're all probably getting used to it.

My name is Deborah Majoras. I am Deputy Assistant Attorney General in the Antitrust Division and, as such, have supervisory responsibility over Litigation One, among other sections. And, of course, Litigation One has our health care lawyers.

This morning we're going to examine in detail the performance of the health care marketplace in Boston, Massachusetts. Now, as you know, we had also planned to examine the Little Rock, Arkansas, marketplace. And, thus, with apologies to Charles Dickens, our title, A Tale of Two Cities. But our friends in Little Rock, unfortunately, were iced in earlier in the week and, so, we're going to reschedule that session for a later time.

And while I doubt that today's session will be as melodramatic as our eponym, I don't know that we're going to start in on "The best of times and the worst of times," but I believe it will provide us a useful lens within which to examine the issues that we intend to

examine on a going-forward basis in the coming months.

Boston and Little Rock represent two different points on the spectrum of health care marketplaces in the United States. Now we selected these cities not because we somehow thought that they were end points on a spectrum or because we thought they were absolutely typical or atypical of marketplaces in metropolitan areas in the U.S. Rather, we just wanted to select a couple of cities where we could provide a real-world frame of reference for more narrowly targeted sessions later on in the hearings.

Naturally a lot of our future sessions will focus on close-up examinations of various sectors divided by, say, providers, payers and, within providers, hospitals, physicians and so forth. You've seen the agenda. But today's session -- and, of course, our rescheduled session -- allows us to discuss issues in all of these sectors within the context of Boston today, Little Rock later, permitting us to explore how these various components interact and interrelate with each other in actual markets.

Antitrust analysis, of course, is highly fact-specific, and as much as we can all agree on that, we have to continually remind ourselves of that, lest we get hijacked by naked theory. We can't appropriately enforce

the Federal antitrust laws or even advocate or set sound competition policy if we don't carefully examine facts that are presented to us by markets. So, as we begin these joint hearings, we thought this could be an appropriate way to set the framework.

Now the panelists themselves will decide -- and have decided, I'm sure -- what they think will be important to discuss, but I'll just say a few words about some things we can expect to hear about.

We're particularly interested in hearing the panelists' perspectives on whether competition is working or not in the particular market here today, Boston; their assessments of quality and price trends in the market; their views on consolidation among providers and payers in the market; and what impact, if any, that has had on cost, quality and price; and their thoughts on how they believe enforcement of the Federal antitrust laws -- and perhaps other regulatory requirements -- contributes, or not, to the delivery of better quality and lower prices for health care in these markets.

There are specific market characteristics in the two cities that we anticipate discussing, and I feel this need to give you a caveat now. First of all, when I say market, I obviously am not defining an antitrust market for any purpose in my remarks. It's just a

shorthand way to talk about these geographic regions, and when I say something to you about this market has this or that, I'm not saying that these are absolutely the facts if we had a future investigation ever or an enforcement action. So, I'm afraid I must say that to you.

So, first thinking about in Boston, the HMO penetration, which, as I understand, is around 50 percent and ranks among the highest in the country, although even in that city there has been some shift away from HMO health coverage. And HMO penetration is less in Little Rock.

And, so, as we look at these developments it may assist us in understanding the roles that HMOs, traditional insurance, coverage plans, and self-insurance play and how we ought to be defining health care markets -- health care coverage markets.

Another market characteristic to think about in Little Rock, later on, there have been indications that the expansion of specialty hospital services may be threatening the revenues of general, acute care hospitals and understanding how the opening of those single-specialty hospitals impacts the revenue and what the general, acute hospitals are doing to respond also will tell us a bit about how we should be defining markets and how we should be looking at competitive effects in

markets.

Another characteristic that is of interest -- and this is something that may differentiate Boston and Little Rock -- is that in Little Rock there's long been an alliance between Arkansas Blue Cross/Blue Shield and the Baptist Health System there, that has existed, like I said, for many years. And in Boston, on the other hand, hospitals have generally negotiated with payers without an alliance.

Understanding the competitive impacts of these alliances between multiple providers and also between providers and payers helps us understand how the alliances may affect the market power of the members and whether they may produce any competitive results in the form of higher prices or lower quality.

And in Boston several large hospitals have consolidated, which provides us with several issues; and, in particular, issues that we're going to discuss later in the hearings. Parties who propose hospital mergers frequently indicate that they anticipate considerable efficiencies from the merger that will benefit consumers and, of course, courts have, in some instances, accepted those arguments.

And in later hearings we intend to look at some consummated hospital consolidations to assess whether the

merged entities achieved the efficiencies. If so, why, why not, and so forth.

All of these issues that I've just raised will be addressed in more general terms later in the hearing; but, again, addressing them here today, through a narrow lens, can help frame our discussion and anchor it for later.

Just a few words on the format for today's session. We will present for you a panel of five participants in or observers of the Boston health care marketplace. Each of those panelists, as I understand, will speak for about 10 minutes and give us their perspectives. And then both before and after those panelists speak we have two academic experts who are going to provide you more in-depth background on market dynamics and try to frame the panel discussion. And, then, we'll have two moderators who will moderate our panel discussion for the remainder of the time, and we intend to end today at about 12:15 p.m.

I would very much like to thank the panelists, the academic experts today for their participation and, of course, all of you for being here. We greatly appreciate the time that you're taking from your busy schedules to be here and share with us your perspectives, it's very useful.

So, with that, I'm going to turn your attention over to the moderators, and thank you, again.

MR. HYMAN: Thank you, Debbie. As Debbie said, we're going to start with the framing presentation by Professor Stuart Altman, then we're going to do presentations from the panelists, who will all come up after Stuart's done speaking, and then we'll do another framing presentation by Professor Fran Miller. Then we'll take about a 10-minute break, and then we'll have moderated panel discussion.

Just so you have a sense of where we're going, and our rule is short introductions, so, Stuart is the Sol C. Chaikin professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis, and he's got only one page here filled with his accomplishments, but they go on much longer than that -- we forced him to constrain it to one page, which you can read in our biography book. So, Professor Altman.

PROFESSOR ALTMAN: Thank you very much. It's a great pleasure to be here, and I look forward to this opportunity to talk about health care costs, both nationally and in the Boston and Massachusetts market. Forgive me for re-introducing myself, but I have spent most of my career worrying about national health care issues and the issue of rising health care costs has been

on my plate since the early 1970s.

But about two years ago the Government of Massachusetts and the State Legislature leadership asked me to co-chair a task force about the problems of Massachusetts health care system and, as a result of that effort, which took about 15 months, I became quite well aware of the special issues around Massachusetts. And much of what I will talk about this morning comes from that task force.

Two things I put in -- by the way, I tried to send many of you a copy of my presentation and there will be copies outside. In addition to the presentation I prepared today I have two appendices: one is the detailed task force report, for those of you who want to get a more in-depth understanding of the Massachusetts health care system and marketplace, I commend you to look at that; and the second is an article that I and my colleagues at Brandeis wrote and was published in the Health Affairs Website in January.

And let me say at the outset I do think that rising health care cost is as serious a problem today as it's been in our 30 years that I've been involved in it, and so I'm very concerned about how to get this under control, but the question that you've asked me to address today is to what extent is Boston unique and what are the

characteristics of Boston and Massachusetts in comparison to the U.S.

I don't think it's possible to talk about rising health care costs or what's going on in Massachusetts without doing a little history lesson, and very quickly I want to go back to the late 1980s and the middle '80s, which was a decade I call Halfway Competitive Markets and Ineffective Regulation. Essentially, it was an environment where sort of anything went.

We had a health care system that was growing rapidly. The insurance markets, while we had a lot of words called HMOs, effectively most of them were fee-for-service, very little constraints. This allowed a hospital system, in particular, which had substantial overcapacity to continue to function quite nicely because they were able to raise their rates to make up for the shortfalls. And one of the ways they were able to do it, even though the government, both at the Medicare/Medicaid level, was putting serious constraints on what they were spending, the private sector was just paying for whatever, essentially, the system felt it needed.

And those of us who have spent time in this industry -- and one of the things I did for 13 years was chair the Perspective Payment Assessment Commission -- we

looked at these hospital payment-to-cost ratios, which appear here. You'll see that the yellow and green lines, which is Medicare and Medicaid, were paying, essentially, either at or below what the average cost of care in the hospital. It was being made up by the private sector, which by 1992 was paying at 131 percent of their costs, which was giving the system a nice cushion.

And one can draw a similar conclusion in Boston and Massachusetts, although when we talk about Massachusetts you'll see that the private payer cost ratios were much lower than they were in the rest of the country.

Well, the good or bad old days of the 80s came to an end and by the mid-90s we had a bunch of things happening. We had the Clinton Health Care Plan. We had a lot of excitement about that, but more fundamental was a substantial shift in the insurance market. Employers faced with continued double-digit inflation during the 80s either forced, cajoled, incentivized -- did anything they could to get their employees into managed care -- and no place was that more successful than in the Boston, Massachusetts marketplace. Overall, depending on how you count it, some place between a third and 50 percent of the market moved into what we call tightly managed care.

Partly as a result of that, the marketplace

substantially changed. Most importantly the flow of dollars in inpatient care, which had been rising consistently during the '80s, took a sharp drop. You can see on this chart in that green checkered world, inpatient spending went from plus four percent a year in 1993 to almost a negative over five percent by 1997. Jumping ahead a little bit, you'll see that this trend has changed substantially since 1997, and we're, again, seeing upticks -- substantial in some cases -- upticks in inpatient care.

When we add that to outpatient care, which had grown significantly and continuously during the '90s, you'll see that that continues to grow and we've had some increased spending for physicians and, then, finally, we had the big granddaddy, which is prescription drug spending.

Now, along with the increase -- the reduction, particularly, in use of the inpatient hospitals based on serious financial pressure on them began to consolidate and began to cut back their bed capacity. Overall in the U.S., you saw almost 11 percent reduction between 1990 and 1999. The reduction in Massachusetts and in Boston was substantially greater at 25 percent in Massachusetts and 28 percent in Boston.

By the way, I will talk almost interchangeably

between Massachusetts and Boston. I don't want to give you the impression for those of you who are not from Massachusetts or Boston that everything that happens in Massachusetts is in Boston. On the other hand, having lived there now for 25 years, I'm not yet -- I don't yet qualify as a native -- I still get lost a third of the time, but I've learned that the health care marketplace in Massachusetts is attracted very sharply to Boston.

It's not surprising for people who are 20-30-40 miles outside of Boston to bypass a half a dozen community hospitals to come into the inner city of Boston. Much different than -- I've lived in New York, Los Angeles, San Francisco, Washington -- it's a different marketplace. So, talking about -- sometimes I feel the need to talk about Massachusetts as well as Boston.

Now, we are -- and I know it's an important issue for you -- is the whole issue of mergers. There's no question that during the mid-1990s around the United States mergers became a very active parlor game around the country. You can see on this chart that in 1996 we hit a high of 776 hospitals were involved with about 235 deals, and you can see in this chart that the merger activity has substantially slowed as we move through this decade.

And we also saw this merger activity hit Massachusetts, as well. Again, reaching a high point in 1996, and in this you can see that there were a whole bunch of activities going on. There were closures, there were mergers, there was contract affiliation. And, so, Boston and Massachusetts paralleled the country. Again, what's important to notice is that that activity has substantially lessened since the mid-1990s.

So, that -- well, let's go back. We're in the mid-1990s, bed capacity is being reduced, hospitals are feeling a pinch and, just to show that we do recognize that there are physicians in this country and we should take them into account, we at the task force heard from the Massachusetts Medical Society about the situation of physicians.

And we have a -- if not a unique situation -- it's pretty close to being interesting -- it's clearly very interesting -- on the one hand there are lots of physicians practicing in Massachusetts. We have a lot of very fine medical schools and many physicians don't want to leave Mother Church too far away, and, so, not only do they get trained in Massachusetts but they stay and practice. As a matter of fact, we have more physicians per capita than any other state which I'll show you in a minute.

Now, the Massachusetts Medical Society, on the other hand, made it very clear that our physicians are not happy and fat and content, and that their income is declining, particularly when you adjust it for the fact that we have a very significant cost of living. They showed us that their income is declining, but, as I pointed out, our task force looked at it and said, yes, that's true, but it's also true that we have a very ready supply of physicians in the state. And while we didn't take a position one way or the other, except to be concerned about what Medicaid was paying physicians, we didn't choose to make that a high priority in terms of changing the situation.

Now, let me turn to hospital bed capacity in Boston. If you look in 1993, we had 35 hospitals -- by the way, Boston, which is Suffolk County, but as I pointed out, you just think of Boston as being this little enclosed capsule isn't the right way, in my view, to look at it. Now, I know there are very sophisticated models that one can use, but I didn't do that. Instead, I just combined, for purposes of this analysis, two counties -- Middlesex and Suffolk -- and, for those of you who are not familiar with it, Middlesex is a substantial community and it involves a number of communities that surround Boston and everyone divvies it

up a little differently. So, this includes Suffolk and Middlesex.

There were 35 hospitals in those two counties in 1993, with a total of about 9,600 beds. Of that 9,600, about 48 percent were teaching hospital beds and the remaining were nonteaching beds. And one of the most dramatic -- there were several things that happened between 1993 and 2000, today, 2001. One, the number of hospitals declined by 10, from 35 to 25; the number of beds declined from 9,600 to 6,900 or 7,000, but there was a substantial shift. While there was a 48 percent decline in the number of nonteaching hospital beds, there was only a five percent reduction in teaching hospitals, so that the teaching hospital beds in the Boston area has gone from 48 percent to 63 percent.

We are in love with our teaching hospitals. We use them for everything, and when I say "we," I'm talking about "we" as consumers. And this is -- it's just the nature of Massachusetts health care, and if you are looking at teaching hospitals' spending per capita in 1998, which our task force looked at, we spent $168 per capita, where the rest of the country spent $42 per capita.

And, so, one cannot talk, at all, about Boston, Massachusetts, without talking about teaching hospitals,

and we have a lot of them. And, as a matter of fact, in that period, we had 10 separate, full-service teaching hospitals at the beginning of the decade, and through a series of mergers the number was reduced to six.

So, six is still substantial, it's not like they have one gigantic teaching hospital or teaching hospital system, we have a number, and you're going to hear from several of them today.

Now, with all this going on and with our love for teaching hospitals and hospitals in general, you would have thought Massachusetts hospitals were just raking in the bucks. And, depending on how you look at it, the answer is, well, a little bit, but in terms of margins -- now, of course, in the world of not-for-profits, I'm well enough to know that margins are a tricky issue, and I'm not here to give you a long lecture on margins, but this is what we have to look at in terms of the difference between revenue and expenses.

And you'll see in this chart 9 that the margins in the U.S., for hospitals in general, decline quite substantially from fiscal 1996 through fiscal 2000, in part because of managed care pressures, but more importantly because of the Balanced Budget Act, which was passed by the Federal Government in 1997 and began to operate, and now has sort of crawled up a little bit

around the country to someplace between 2.4 and -- the 2.2 is an approximate for 2002 -- we're still sort of -- not we, the AHA is getting clearer data on that.

But what is dramatic is the difference in margins between Massachusetts and the rest of the country. Massachusetts has traditionally been a low margin state in terms of hospital margins, and you'll see here it went from a +.6 in 1996 to a -1.5 by 1998, and it sort of bopped around at those negative numbers. And, by the way, that was one of the reasons why the task force was established in 2000. And, now, you know, has had a very dramatic rise and is now at .02 percent.

So, yes, our hospitals are in better shape today than they were in 1998, but hospitals in Massachusetts are not sort of putting away large amounts of money in terms of excess margins.

Now, what's happened to the insurance market? The most dramatic impact -- and, by the way, the staff asked me to look at the U.S. as well as Massachusetts -- is in my view a substantial shift in preferences away from managed care, particularly from what we think of as tightly formed managed care, which we call HMOs. PPOs will tell you they do a little managed care, but I would call it managed care light; some would say they would call it service in drag. It depends on which side of the

issue you look at it. But no question about it -- look what happened -- between 1993, where PPOs were around 25 percent of the market, they are now 50 or more percent of the market. HMOs, which reached a high point of 30 or 33 percent for the first time in 2002, has fallen.

And this is a very dramatic change. We in Massachusetts have had a much larger percentage of our insurance market in HMOs. But here, too, the world has changed in terms of how they operate and you have two of our best known, Tufts Health Plan and Harvard Pilgrim, the presidents from both, and I'll let them speak for themselves.

So, the market has changed. Now, one chart I didn't show you, and I will put it in my final, is the HMO net profit margins. The reason why the task force began -- and I know this is painful for Charlie Baker to hear, to remind him of the past -- but one of our most beloved and larger HMOs, the Harvard Pilgrim Health Plan, reached very sizable negative margins in 1999 and was -- I don't know what the technically correct word -- whether they were bankrupt -- Charlie used another term for us -- but they were not in great financial shape. The state was very worried about it. The Governor was very worried about it. Everybody was very worried about it, including the Attorney General in our state, and that's what led to

the task force.

In my chart, which I will put on the web, the margins was a -8.7 for Harvard Pilgrim; Fallon was at -2.3 and Tufts was sort of -- and HMO Blue, which is the other two -- were sort of barely making it. Things in the HMO market have turned around. But, again, the margins are not super high, but they are much better than they were then. So, that's the market.

And, again, why are we here today? One of the reasons why we're here today is that premiums have, after reaching a low point in terms of growth in 1996, are growing at double digit. While a lot of my other economist friends like to believe this is all very temporary, I'm not super optimistic that it's so temporary unless something is done to change it.

And we in Massachusetts, while we didn't hit the 15 percent, are equal, you know, are seeing double-digit increases, as well, 10, 11, 5 and 12, estimated, for 2003.

Now, with all this going on and all this money flowing into hospitals and the system, the question is, what's going on with respect to hospital margins. And let's focus on Boston. Again, this is the Suffolk and Middlesex markets. And you'll see here in this chart that if you look at Boston their hospital margins have

been consistently below zero, -2.5 in 1998 to -3 and so on, and in 2002 was about zero, -0.4.

Again, breaking it into the nonteaching/ teaching, and this is a serious issue, our teaching hospitals have sort of a slightly above zero at .67. Our nonteaching hospitals, while they've improved substantially from a -5.3, are still in the negative category of 1.8.

So, now we come to where we're heading. Now, these low margins are really quite surprising because the general impression that one would have is that Massachusetts and Boston is a very high cost, high spending, health care system, and it's worth spending just a few minutes to look at it. The task force spent a lot of time on this issue. If we're such a -- why aren't our margins better for both our hospitals and our insurance companies? Are our costs so much higher? And, so, we looked at it.

Now, there's a lot of controversy about this. If you look at health care expenses per capita in Massachusetts and the U.S., you'll see that on a per capita basis we were about almost $4,900 in 1998 and the U.S. was about $3,760, $3,800.

Now, there's a lot of reasons why these unadjusted figures are not the right numbers to look at.

First of all, Massachusetts is the largest, on a per capita basis, benefactor of biomedical research funding, funded primarily by NIH. We are also a major teaching activity here in Massachusetts in terms of particularly graduate medical education, where the Federal Government, through its Medicare program, pays substantial amounts of money for it.

So, it's really not correct just to use those unadjusted rates because those include this Federal money. Because what you're trying to do, it seems to me, is to look at what we as citizens of Massachusetts pay for our health care. So, one should adjust for that.

There's also a question of other expenses and the question of whether one should adjust, and I believe you should, for a differential cost of living. And, so, this is a very crude adjustment for all health expenditures, and I wouldn't want you to sort of hold my family hostage to these exact numbers because trying to adjust them is tricky.

But I think the general conclusion is that when you do the adjustments, two things happen: the gap between Massachusetts and the U.S. shrinks substantially. Massachusetts is still above, but it's now above in the 10 to 15 percent range, not the 30 percent range that is suggested there. My own view is that not only does the

Federal Government pay for research and education but that sums of money, unknown to most of us, is put into the bills of Massachusetts residents.

And, so, the question is, do we want that? And what I believe and watch, whether you like it or not, is that Massachusetts residents and politicians and employers, while they would not like to pay as much, are filled with a tremendous amount of pride and actually see a lot of economic advantage to this engine that we get out of our teaching hospitals and our biomedical education.

And, so, I don't see -- and the task force grappled with this a lot -- and by the way, it was a lot of people from all over the state, it included all the industries, and I didn't hear a lot of testimony that says, you know, we would be better off, you know, with all due respect, since they're not here, if we became Little Rock. There was just not a lot of talk about that, and the question was, well, okay, we are what we are, but can't we do it better?

And we did talk about whether, in fact, it made sense for -- you can see, by the way, you can see us using this. Look at Massachusetts outpatient hospital utilization. Is that we use our hospitals and our outpatient like many other parts of the country use their

physician offices and clinics. You can see our outpatient business per thousand, first of all, is significantly higher than the U.S. and is jumping. In 2001 I had a very sharp rise.

So, it's a marketplace that we use. Nevertheless, the question is whether we could do a better job. And the issue is going to be whether we can deal with this.

So, on the one hand we are spending more money for teaching and research. We are a high cost area in general. One of the mitigating factors, though, that needs to be taken into account, is the fact that our payment-to-cost ratios are lower. And look at them. Where in Massachusetts Medicaid paid $.75 on the $1.00; Medicare is $.99 on the $1.00 and, most importantly, private payers in 1999 paid less than 100 percent.

Now, you can't make it up in volume when everybody's paying you less than your costs, so that was a problem, and particularly when you're comparing Massachusetts to the rest of the country -- 96 versus 112.

Again, Massachusetts' premiums, just to show the other side of the coin, also are higher than the rest of the country, but they're in the same ballpark as that 10 to 15 percent. You can see these are HMO premium

rates and this shows you the premiums that were paid in metropolitan areas. If you compare Massachusetts to the U.S. average, you will see that in comparison there is a difference of about 10 percent, which -- so we have a lot of convening evidence to say that Massachusetts, on a per capita basis, when you make the appropriate adjustments, is about 10 to 15 percent higher.

And, as I said, the reason is is that we do -- our market for a very long time has been dominated by our more expensive and many of us, many of our citizens believe, higher quality health system. And we also have a lot of specialists. And, so, it's a different market than the rest of the country.

In our task force, we strongly urged both the state government, through Medicaid, private employers and anybody who would listen to us, that we needed, where possible, to shift patients into the community hospitals. Our problem is the following, and I hope you've gotten a flavor of it. Our community hospital system in Massachusetts is in very poor shape. Financially, it's -- it's -- as I showed you, the numbers are not positive. The number of beds that have closed, in -- during the period of time that the task force was in operation, three community hospitals were on the verge of bankruptcy.

And in every case, the government, and through the help of other hospitals came in and saved them. In the case of one hospital in Everett, it was incorporated into the Cambridge Health Alliance and allowed to get a higher reimbursement rate. Out in Salem, there was a combining of hospitals; out in Waltham, a real estate developer.

My concern is that the government, at the state level, is not in a financial position to help them anymore. I don't know what's going to happen, so that if we are going to see a better balance between community hospitals and teaching hospitals, it can only occur if the community hospitals get stronger. Our managed care -- and I don't want to speak for them, and I appreciate what -- if -- be interested what they say. I do think our managed care companies, during the '90s, tried to shift patients. I think they ran into a buzz saw of opposition, from us as patients and from our physicians.

And we did not see the employers in our system react in ways -- you have to understand the employer market in Massachusetts. It is not dominated by big manufacturing companies: General Electric, General Motors and so on. It is a small high-tech industry and wrapped around an insurance and an academic institution. And it's -- for the most part, it's been an employer

population that is more concerned about producing, you know, whatever, biomedical breakthroughs and education than it is telling their employees where to go. And, so, when the managed care industry tried to shift us out of our teaching hospitals, they got blasted.

So, the bottom line here is Boston is unique in a lot of ways, and I've tried to give you a flavor for that. The Massachusetts health market and its consumers are unique, and my sense is that the forces that are pressing health care costs around the country are pressing them in Massachusetts.

And our article goes into great detail. Technology, the fact that our managed care industry has seriously deteriorated, partly -- mainly because we as consumers and politicians beat them up so much, they want to tell their kids what they do. And, so, they finally decided they were going to sort of, you know, become nicer and gentler and smile more.

And the third part of the puzzle, which is troubling, is that our community hospitals, who I would have counted on to see a better balance, are in serious financial shape. And I do -- the one good news about this whole thing is that the key reason why I believe hospitals have generated market power over the last five years is because of the substantial decline in bed

capacity, and that occurred in every market. Yes, it occurred partly as a result of mergers, but it just -- there was an implosion of the marketplace. So, if you're sitting there at 90, 95 percent capacity, you can afford to be a little more aggressive in terms of your pricing.

I see that turning around. There is an increased capacity booming around this country. I have other slides, which I didn't bring with me, that shows number of beds in this country are growing. Also, the number of inpatient, as I showed you, is growing. And it would not surprise me, like the real estate market, five years from now we could wind up with an environment of over-capacity and a much more robust marketplace.

But right now, the balance of power has definitely shifted in favor of the providers. And, you know, with all due -- I'm not a lawyer and I'm not an anticompetitive expert, but I don't think it's a result of anticompetitive forces as the result of ten years of declining capacity. And, as I said, over time that probably will even itself out, but right now, we're sort of still in the middle of it.

Thank you very much.

(Applause)

MR. HYMAN: Thank you. I'd like to call up the rest of the panel now and we can get started with that.

MR. KRAMER: Good morning. I'm Steve Kramer. I'm a staff lawyer with the Antitrust Division, representing the Department of Justice. With me is a counterpart at the FTC, Mike Cowie, who is an assistant branch director there, representing that organization today.

We have a distinguished group here, and I'd like to introduce them in the order in which I chose them to speak, I guess violating one of the precepts that generally speakers here speak in alphabetical order. I thought that we'd try to interweave the perspectives a little, rather than hearing from two health care planners first and going upstream then to the providers.

First, I'd like to introduce Dr. James Mongan, President and CEO of Partners Health Care in Boston. Next I'd like to introduce Charles Baker, President and CEO of Harvard Pilgrim Health Care Group. Third I'd like to introduce Charles Welch, M.D., representing the Mass Medical Society as its President. Next I'd like to introduce J. Mark Waxman. Mr. Waxman is President and General Counsel of CareGroup, Inc. Next I'd like to introduce Dr. Harris Berman, who is CEO of Tufts Health Plan. And, finally, as David mentioned, Professor Fran Miller of the Boston University School of Law will offer somewhat of a retrospective on some of the remarks made.

And then Mike and I will start up asking some questions after -- I think we'll take a break before Professor Miller to give her a chance to organize some of her thoughts. And then after she's done, Mike and I will ask some questions after we give the panelists an opportunity to respond to any remarks that they might like to respond to. And I would ask the panelists, in the interest of time, to try not to exceed ten minutes.

So, with that, let me ask Dr. Mongan, please, on behalf of Partners, to present his statement.

DR. MONGAN: Thank you, Steve. I'm Dr. Jim Mongan, President of Partners Health Care. And I appreciate the opportunity to appear today to give you our thoughts on Boston health care and on Partners.

Partners is an integrated academic health care system, which was formed to add value to the patient care, teaching, research and community missions of our founding institutions, the Brigham and Women's Hospital and Massachusetts General. This morning, I'd like to review what Partners has accomplished over the past nine years. And then I'll address two issues: market dynamics in Boston and health care costs in Boston.

But let me start with a brief history of the formation of Partners. A decade ago, we began to see the traditional academic/medical centers no longer provided

the best structure for care, teaching and research. Services were shifting rapidly to an outpatient basis and inpatient stays were growing shorter. Our hospitals looked like giant intensive care units. Although among the very best in the world at providing complex care, these hospitals were no longer an adequate platform for the range of care our patients need. They gave students only a quick glimpse of the sickest patients and they provided a very narrow base for important research. And they were becoming less relevant to their surrounding neighborhoods.

We believed that we needed a new model of care to address these shifts. It would include not only great ICUs, but also a small number of community and specialty hospitals and a network of physicians. This model, which we've adopted, has allowed us to protect and enhance our underlying mission.

With regard to patient care, we are better able to meet the range of our patients' needs, from acute through chronic illness. We're working cooperatively to improve the quality of care, and we're addressing the cost of care by efficiencies of scale and by use of the most appropriate settings for treatment.

In the cost area, by consolidating back office operations, pooling our purchasing and benchmarking

staffing and length of stay across our hospitals, we've held the increase in our cost-per-case to an average of just under 3 percent per year. Adjusted for inflation, we've actually reduced cost-per-case by an average of 2.3 percent per year.

We're moving care to lower-cost locations through partnerships like the one between Brigham and Women's Hospital and Faulkner Hospital and through the cardiac surgery partnership between Mass General and Salem Hospital.

Now, as far as quality is concerned, both Brigham and Women's and Mass General are world-famous for very high-end care, or "great saves", as one physician said. But having a system, and not just an acute hospital, provides an opportunity to manage the care of our patients over time. In areas like diabetes, hypertension and congestive failure, we're beginning to take this long view of our patients' health and to make significant advances in disease management.

With regard to teaching, having a system has allowed us to build even stronger residencies and fellowships, merging 23 training programs, to expose trainees to a broader variety of faculty and patients. We've also developed new community-based training settings that are more relevant to the world many of our

trainees will practice in.

With regard to research, having a broad and stronger base has allowed us to make a $50 million investment in genetics research, which over the next decade we hope will benefit every person in this room. Our prep program spreads research to the community, giving more than 200 community patients access to new treatments previously available only at academic centers.

And finally, with regard to care of the community, we forged 16 new partnerships with urban health centers, and we're providing access to care to 200,000 patients at those centers, or three times as many as when Partners was formed. Our overall commitment to the under-served totals $100 million each year. Beyond that, we've stabilized three failing community hospitals, two of which likely would have closed without our support. And in addition, we've sustained threatened specialty services by adding 120 psychiatric beds while others closed theirs and by shoring up fragile home health and rehabilitation services.

So, now that I've described the rationale behind the formation of Partners and the results we've achieved so far, let me turn directly to questions regarding the economic impact of health systems in Boston.

First, let me address the market dynamics of Eastern Massachusetts. We've long been a national center of healthcare and, as such, are home to three medical schools, 15 teaching hospitals and 31 community hospitals. Almost 50 percent of our insured patients are covered -- residents are covered by HMOs. Our caregivers and payers are overwhelmingly not for profit. Our state officials take an active role in healthcare and both the current Massachusetts Attorney General and his predecessor have actively enforced the public charities and competition aspects of healthcare.

Regarding market concentration, I point to the results of a Robert Wood Johnson Foundation study of healthcare in 12 U.S. cities. This analysis shows that in terms of hospital concentration, Boston is the least concentrated city of the 12. Also, as measured in this study by the Herfendahl index, Boston is the only city of the 12 that is rated non concentrated in terms of hospitals. Within this diverse medical environment, Partners cares for 21 percent of the area's patients.

And, finally, I'd like to turn to the issue of healthcare costs in Boston. I'll say a word about hospital costs in two different contexts, and then an even more important word about health insurance premiums. With regards to hospital costs, I'll deal first with a

piece of data which is widely misused, that is raw per capita hospital cost data, as opposed to the overall healthcare cost data Stuart used.

Raw per capita hospital cost data, showing Massachusetts' costs to be 40 percent above the national average. But this raw data wildly exaggerates the burden of healthcare on Massachusetts' employers and consumers. To accurately portray the impact, this raw number should be adjusted by four factors. First, you should subtract research costs funded by NIH, industry and national health organizations. Leaving these dollars in the per capita cost base implies that if we succeed in winning a $10 million AIDS research grant, for example, we have somehow become more of a burden to residents of Massachusetts. And that, of course, is not the case.

Second, on the same rationale, you should take out Federal graduate education payments to our institutions. Third, you should take out dollars paid by out-of-state patients who bring dollars into Massachusetts. And the final adjustment is for the higher wages our state pays across all industries. So, the bottom line, with these adjustments, our per capita hospital expenditures dropped to a much more modest 12.9 percent above the national average, a differential arguably offset by the benefits of excellent patient care

and a burgeoning biotech industry.

And even this 12.9 percent is overstated, as our somewhat higher use of hospital outpatient services simply shifts to another cost category in other states. And whatever remains in per capita hospital cost differential does not relate to hospital inefficiency. In fact, Medicare data actually shows that comparing costs per discharge on a wage and case mix adjusted basis, Massachusetts is less costly than their national counterparts. We can take pride in the fact that we provide excellent care at no higher cost.

To pull all of this together, the proof of the impact of health costs on consumers should lie in health insurance premiums. As you will see attached to my written testimony, we've compiled data on Massachusetts' premium costs from five respective sources: three from the private sector and two from the public. In raw dollars, they show that our premium costs range from 7 percent to 13 percent above average.

But Stuart stopped one step too soon. When adjusted for wages, our premiums range from 4 percent less to 3.6 percent more than on average. And on average, there is no difference at all in insurance premiums in Boston compared to other cities.

And now one final point on market dynamics.

There appears to be an urban legend that our health systems somehow beat up the payers in Boston and won huge increases in payments. Again, attached to my testimony are two charts. The first shows that private insurer payments to Massachusetts hospitals in the '90s were far lower than the national average. For Partners, from 1996 through 2000, our average annual HMO payment increase was just 1.5 percent per year. Despite urban legend to the contrary, the fact is that payment increases under our new contracts grew an average of only 5.6 percent a year. For private payers overall, we are now just about back to the national average, with respect to our payment-to-cost ratios.

So, in summary, let me simply restate my major points. Partners demonstrates on a daily basis the value added to its founding hospitals' mission of patient care, teaching, research and community service. Provider concentration in the Boston area is low, and the large number of hospitals fosters a healthy level of competition. Boston healthcare costs, appropriately adjusted, are very close to the national average.

Thank you for the opportunity to appear before you this morning.

MR. KRAMER: I now ask Charles Baker, please, to present.

MR. BAKER: You know, I can just do this from here. Does it matter?

MR. KRAMER: That's fine.

MR. BAKER: Good morning. For the record, my name is Charles Baker. I currently serve as the President and Chief Executive Officer of Harvard Pilgrim Health Care, which is a Massachusetts-based non-profit health plan. We and our affiliates -- Harvard Pilgrim Health Care of New England and Harvard Vanguard Medical Associates -- provide health insurance coverage and health care services to about 900,000 people in Massachusetts, New Hampshire and Maine.

Our largest operations are in Massachusetts, where we represent about 25 percent of the private health insurance market -- or about 12 percent of the covered population, if you include the Medicaid and Medicare population, as well. Our clinical effectiveness and member satisfaction scores consistently rank among the very best in the United States and we have a long history of clinical and service innovation.

I appreciate the opportunity to be here today to discuss competition and regulation in health care in the Boston marketplace. And while you may or may not have known this when you asked me to speak today, I do have some history on this issue, having served as a state

official in the early 1990s, when many of these mergers took place, which was prior to becoming a market participant. Some would say that's the equivalent of having the grenade that you throw on one end of the boat roll back down and blow up on you when the boat shifts.

As a regulator, I served as Undersecretary of the Massachusetts Executive Office of Health and Human Services from 1991 to 1992, and then as Secretary of Health and Human Services from '92 through '94. In this role, I oversaw a number of state agencies, including the Department of Public Health, and signed off on the Department's decision to approve the initial hospital merger and Massachusetts General Hospital and Brigham and Women's Hospital that created the Partners Health Care System. I was over at the Office of Administration and Finance when the Beth Israel and Deaconess Hospital merger that created CareGroup was consolidated and was not directly involved in that decision.

We signed off on the Brigham and Mass General merger in 1994, despite their obvious size and status in the Boston health care marketplace for three reasons. First, the market appeared to be moving toward an environment in which health plans would affiliate with one or more integrated care delivery systems, and then compete with each other based on the quality, service and

cost of their networks. The Brigham Women/Mass General merger seemed pretty consistent with that overall direction.

Mass General had just recruited several high profile physicians away from the Brigham, raising the possibility of an upward cost spiral, in which each hospital, rather than sharing talent and technology in a particular marketplace, would feel obligated to build or buy their own. The Brigham and Mass General merger was deemed as a way to avoid this "medical arms race."

And, third, Brigham was intimately aligned with Harvard Community Health Plan -- which was the precursor to the plan that I represent today -- and it was hard to imagine a merger with Mass General doing much to change that existing relationship.

Partners went on to develop Partners Community Health Care, Inc., PCHI so called, an extensive primary care and multi-specialty care physician network, and also acquired several other community and specialty hospitals and community health centers. In fact, in mid 1992, there was significant discussion that Partners would, at some point, seek approval from state officials to offer health insurance products, using their own network to compete with others in the marketplace. Other provider organizations were considering similar initiatives.

Some eight to ten years later, this seems kind of quaint, given the direction in which the market's moved since that time. In between, the consumer decided that he or she did not want to be constrained by network structures that were institutional in nature, and many individual providers shared and voiced similar views. In addition, state and federal laws were enacted that made it more difficult for plans -- and even for some health care delivery systems -- to use defined delivery systems to manage patient care. Health plans responded by dramatically expanding the size and scope of their provider networks and limiting their referral and participation rules. As a result, an industry that was expected to vertically integrate its value chain by the end of the 1990s retreated to a structure that today looks a lot more like it did in the '70s.

In Massachusetts, the hospitals that made up the Partners care delivery system continued to operate on a stand-alone basis, with little clinical or systems integration. The CareGroup system did, in fact, pursue a more integrated operational approach and some of its physicians and departments actually responded to that by leaving the system. Health plans in the Massachusetts market lost many of the tools that made traditional managed care work -- either through market reforms or

outright legal prohibition -- and moved back into a model that I think Stuart referred to earlier as "indemnity in drag."

Today's market is not the one that we anticipated -- or that others advised us would be coming -- when we made the decisions in the early and mid-90s to approve many of these hospital mergers. This inability to accurately predict the future and where the market will go will inevitably limit the effectiveness of any regulatory process. But with this in mind, I do have some thoughts about how regulators could best perform their duties and will share those at the conclusion of my presentation.

After I left the public sector, I joined Harvard Vanguard Medical Associates, which was an affiliate of Harvard Pilgrim Health Care, as its President and Chief Executive in the fall of 1998. I became President of Harvard Pilgrim, as Stuart also pointed out, in the middle of 1999 in a pretty interesting meltdown. The plan ended up losing about $227 million in 1999 and another $10 million in 2000. We generated a $35 million operating gain in 2001, which is about a 1 and a half percent margin, not a big number relative to other sectors of the economy, but not bad by our standards; and a $31 million operating gain in 2002.

The gains were generated, in part, through a dramatic improvement in operating performance, geographic and product withdrawals, significant reductions in administrative spending and an over-arching commitment to strategic and operational simplicity.

We also raised prices. The average premium increase in our market has been in the 10 to 15 percent range per year for the past three years, which is also consistent with the numbers that Professor Altman displayed in his presentation. It was driven by a number of factors -- virtually all of which relate to the rising cost of health care.

On this point, I do differ a little with Professor Altman. There are certainly historic periods in which insurance carriers raised prices to catch up with "underwriting cycles." I don't believe the past three years have been about under and over-pricing. I believe the vast majority -- well in excess of 90 percent -- of the increase in health insurance premiums between 2000 and 2002 has been driven by rising medical costs.

In our particular case, pharmacy costs increased by 28.6 percent; inpatient hospital costs by 18.6 percent; physician costs by 24 percent; and all other outpatient costs -- including outpatient costs -- by 33 and a half percent. That adds up to a 26.1 percent

increase in total health care costs for Harvard Pilgrim commercial plan members over a two-year period. While the projections for 2003 look a little different by category, the overall trend -- 12 to 14 percent for the year -- is virtually identical to the growth in medical expenses from 2000 to 2002. This trend is also virtually identical to the growth in Harvard Pilgrim premiums over the same period of time.

In fact, we're so sure about this particular issue that we would welcome any audit, review, analysis or investigation the Commission might consider necessary to confirm that the rates of increase in medical expense -- in premiums for Harvard Pilgrim members have, in fact, been driven by increases in medical expenses.

Hospital costs obviously represent a significant share of the increase in spending over this time. Professor Altman's testimony concerning the increase and the use of academic medical centers for non-complex services in Massachusetts, which has undeniably contributed to the increase in health care costs here, is a pattern I believe is borne out elsewhere around the country, as well, but probably not to the same degree it has in Boston. There are a number of other factors driving up hospital costs, as well.

Reductions or very limited increases in

Medicare and Medicaid rates for the past few years have forced hospitals to seek higher rates of reimbursement from private carriers with which they do business. Labor shortages in key areas, such as nursing and some technical areas, have bid up labor costs.

Technology costs, devices and drugs, the same thing, they affect our bottom line and affect theirs. Consumer and employer preferences which have made it very difficult for health plans to discontinue relationships with any hospital or physician group in its service delivery area. And hospital and physician group consolidation, which has made it far more difficult for any health plan to drop any one hospital or physician group from its network, much less a collection of hospitals and their physician groups from its networks.

I presume debate on this final point is a large part of why we're here today. And on this issue, I would offer the following observations. First, if there were no hospital mergers and no provider consolidations, there would still be "monopoly" rates being paid to certain hospitals that are, in many cases, the only provider in their service area. This is not a Partners or CareGroup issue, per se, but a simple fact of life.

Do I believe that Harvard Pilgrim Health Care members pay more for services purchased from Partners and

CareGroup as systems than they would if each hospital in these systems continued to contract directly with Harvard Pilgrim? I believe the answer to that question is yes. What I don't know is how much more. I don't know if these institutions would have continued to engage in the kind of "arms race" type behavior we were seeking to avoid in the early '90s when the mergers were originally approved. I also don't know if the mergers generated any savings or efficiencies. I'm sure the leadership of both organizations would say the mergers have saved money, but I don't believe anyone with an independent eye has studied this issue.

I also believe the other issues I mentioned before -- public rates of payment, labor costs, technology costs, consumer demand, and the like -- would have driven up health care costs under any scenario.

Do I believe the mergers have created quality improvements? This is hard to say, and maybe too soon to tell. The tools to measure this sort of thing are just beginning to find their way into the marketplace. Nonetheless, it's difficult for any health plan, including ours, to hold large provider organizations like CareGroup or Partners accountable for quality. They're too big for us to lose as network participants, and they tell us that they face enormous obstacles in creating

single standards of care within their own organizations, due, in part, to their size and complexity.

With this in mind there are several general observations I would offer on the state of the current market that I believe regulators should consider in seeking ways to enhance market competition. First of all, it's not just market share held by any one hospital in a particular market. For example, the Mass General and the Brigham are probably the two best-known tertiary hospitals in New England and they contract together. Partners does not permit one of these hospitals to participate in any health plan product without the other -- thereby ensuring that they never compete with one another. Since each is the other's most logical market competitor, this could certainly be considered a "competitive" problem. The fact that they represent only two of many teaching hospitals in Massachusetts doesn't really matter. For certain kinds of services, they are virtually the only choice around.

Second, many hospital systems throughout Massachusetts, particularly in geographic areas where they have virtual monopolies, also control significant numbers of salaried and affiliated physicians. In most cases, no health plan can do business with any one component piece of these delivery systems without doing

business with the entire delivery system. This is, ironically, the provider equivalent of an "all products" clause, a contracting technique that has long been the object of significant animosity directed to the plans from the provider community.

Third, you don't need a lot of provider market share in today's markets to be able to "drive" the market in a particular direction. And I think Partners is a good case in point. They may represent less than 30 percent of the Massachusetts provider market, but no health plan could expect to survive without the Partners system in its network. A health plan in Massachusetts could probably compete effectively with some of the Partners system in its network, but the choice, as defined by Partners, is all or none, so that option is really no option at all.

It should be fairly obvious that this situation bids up the price of contracting with each hospital network. There is, for all intents and purposes, not a level playing field here. Some networks can literally dictate the price, and the health plans pay it. Other hospital systems then rely on those prices as "market standards" and go from there.

It also makes it much harder to structure and enforce initiatives tied to quality. If the plans need

the provider organizations in their network to meet market demand, requiring or enforcing significant patient safety or quality initiatives is very difficult. Again, the network sets the terms, not the plan.

The hospital and physician community will argue that if they don't join together to contract on a group basis with the plans they will be unable to meet the needs of their patients and cover their costs. That may or may not be true. I saw a bumper sticker the other day promoting union membership that said something like, "Together We Bargain -- Alone We Beg." From my experience, this would be reasonably applicable to the way my colleagues in the hospital and physician community view their negotiations with health plans.

Is their approach anti-competitive? Probably. Is it inflationary? Certainly. Is it a market response to the advent of managed care, the relentless hard bargaining of health plans on unit costs, and the changing preferences of consumers? Absolutely.

And it does raise questions -- for us and for the provider community -- concerning the "right" rules of engagement. For the market to work, the frame for competition established by public policy makers needs to fully understand the participants, and their relationships with one another. I commend the FTC for

engaging this discussion, and hope our observations here today can be useful to you as you consider this critical issue.

MR. KRAMER: Thank you. I'd ask Dr. Welch now to present, please.

DR. WELCH: Good morning. Thank you for giving me the opportunity to testify before you today. My name is Charles Welch, and I am a practicing psychiatrist at the Massachusetts General Hospital, where I serve as Director of the hospital's Somatic Therapies Consultation Service. I'm also an instructor in psychiatry at Harvard Medical School.

Today I'm here in my capacity as President of the Massachusetts Medical Society. I'd like to share with you some observations we have made with regard to the current physician practice environment in Massachusetts, highlighting how that environment has been shaped by economic factors and the resulting impact on physicians, physician recruitment efforts, practice patterns and ultimately access to care.

I'd like to begin by noting that the entire Commonwealth of Massachusetts is currently suffering from a declining practice environment. And we expect that the shortages in work force supply that are already apparent will only continue to worsen in the combing years.

Indeed, anecdotal reports suggest that the situation is significantly worse than the data that I will show you would indicate.

As you've heard, during the last decade there's been a significant shift in the Massachusetts healthcare market, from traditional fee-for-service insurance programs to various forms of managed care. The Boston area has been dominated by managed care. Over half of our insured residents are enrolled in managed care organizations, with three payers controlling that market. As a consequence, there has been downward pressure on reimbursement, which has caused closure of community hospitals and hospital-based services. As I will show you, declining reimbursement has also had a negative effect upon physicians' ability to provide high quality, accessible care to the people of the Commonwealth.

The Medical Society has conducted a number of studies which shed light on these issues. In 2001, the society issued its first Physician Practice Environment Index Results, the so called misery index, which confirmed that Massachusetts physician practices have been struggling in a sharply deteriorating environment since the mid 1990s. Unfortunately, I don't have the slides of this document, but it is available for all of you in hard copy.

The MMS index measures individual indicators that represent three important factors affecting the quality of the practice environment. These being first the supply of physicians; second, practice financial conditions; and third, physicians' work environment. As a follow-up to the 2001 study, the society repeated the study in 2002 and concluded that Massachusetts continues its eight-year decline, that the index had dropped by 5.7 percent since 2001 -- in 2001.

Since 1992, the factors measured by the index have fallen by a staggering 22 percent. We also made comparisons to the rest of the nation. Massachusetts declined at a faster rate than the nation as a whole. What accounts for these results? The dominant variable demonstrating how the Massachusetts index has declined more sharply than the U.S. index since 1992 is our physicians' cost of maintaining a practice.

The cost of maintaining a practice was defined as rent, labor and medical supplies. Over the ten-year period, the cost to physicians for doing business in Massachusetts increased by 56 percent. Nationally, physicians' cost of doing business increased by only 30 percent for the same period. In addition, the drop in the overall index for Massachusetts was driven by rising malpractice premiums and the rising ratio of housing

prices to physician income.

While the cost of running a doctor's practice has soared in the last decade, payments from both private insurers and government payers have relatively declined. I would like to demonstrate these trends for you by showing you the results of a study performed by Ingenex Consulting for the Massachusetts Medical Society in 2002.

We were interested in calculating the change in reimbursement levels for 20 representative billing codes for the five-year period 1998 to the end of 2002. The particular procedures and visits were chosen because they were commonly performed and therefore representative of the mainstream of medical practice.

In the first slide, which you can see, unfortunately you can't see very well. I apologize for the scale of this, but we also can provide this for you in hard copy if the code labels on the bottom are legible. Let me talk, for example, about the first slide. In the first slide, reimbursement trends in Boston are displayed for each code studied.

For instance, on the far left, colonoscopy is shown. It is shown to have undergone a 41 percent decline in reimbursement during the study interval. Now, 41 percent is the average of all commercial payers in Massachusetts. As you can see, most of the codes studied

underwent an absolute decline in reimbursement. Those few codes which underwent an increase in reimbursement, which are displayed in green on the right side of the graph, those few codes failed to keep pace with inflation. At the top of the graph is a dotted line at plus 21 percent, which is the calculated increase in the cost of practice during the study interval. As you can see, not one of those codes studied kept pace with the increase in costs of practice.

In the second slide, the decrease in reimbursement for colonoscopy is compared with changes for colonoscopy in nine other cities during the study interval. As you can see, the decline in reimbursement in Boston was by far the greatest, almost twice the decline in the next closest city, Los Angeles. It is ironic that this large reduction in reimbursement occurred at a time when colonoscopy has the potential to reduce morbidity, mortality and the cost of care if it were performed more widely.

In the third slide, the overall average decline for Boston is compared to nine other cities. As you can clearly see, Boston had a significantly greater decline in overall average reimbursement than any of the other cities, with a 30 percent -- over a 30 percent decline in overall reimbursement to physicians.

The impact of these market forces on physicians and patients has been predictable. We are witnessing significant increases in physician practice closures and unprecedented number of practice vacancies and increased workloads for those who remain in practice. As a result of these trends, Massachusetts is experiencing physician shortages in eight critical medical specialties, a curtailment of services, significant increase in waiting times for appointments, and increasing difficulties in delivering the care that our patients need.

The Medical Society's recent physician work force study found that Massachusetts is a financially and administratively difficult environment in which to practice medicine. I also apologize for not having this study in my slides, but it is also available in hard copy, which will probably be better for all of you because it's rather rich in data.

The sentiment was expressed strongly by both practicing physicians and physicians in training. The study found that with the third highest cost of living in the country and regional physician incomes, which are the lowest in the country, Massachusetts and the Boston urban area in particular, are becoming extremely difficult places to pursue a medical career. We can continue to attract young talent from across the country and across

the world, to attend our medical schools and training programs, but we're having an extremely difficult time getting those physicians here in light of greater financial opportunity and more flexible work schedules and research support offered elsewhere.

For example, in 2002, we graduated 78 residents from our anesthesia training programs in Massachusetts. Two of them remained in Massachusetts at the end of their training. This is at a time when we already have a shortage of anesthesiologists. I am told that 36 orthopedic practices in Massachusetts are currently unable to fill vacancies in their practices.

This comprehensive work force study shows unequivocally that Massachusetts is facing a crisis situation in the number of physicians able to deliver patient care. Vacancy rates in radiology and anesthesia approach 15 percent at a time that anything over 2 percent is considered a work force shortage in any other industry. Many physician practices are already overwhelmed and unable to handle additional volume and are reducing services or adjusting their staffing patterns to cope with the labor shortage.

Over 50 percent of hospital departments surveyed reported that they have altered -- which of course means reduced services because of physician

shortages. I travel a lot around the state, and at every hospital I visit a hand goes up and someone says, "I'd just like you to know that whatever your data says, I'm the last radiologist at Milton Hospital;" or "I'm the last endocrinologist in the Merrimack Valley.

Physician shortages are already affecting patterns of care and we are very concerned that the labor shortage may already be threatening access to care. In response to your question as to the impact of the current market forces on cost, quality, and access to care, our data show that the overhead costs of practicing medicine in Boston is above the national average, that reimbursements for Boston physicians are below the national average, and that access to healthcare is deteriorating on a number of fronts, including access to physicians and timely access to necessary healthcare.

In terms of competition, I want to emphasize this. Physicians are unable to negotiate or to compete in our current environment. As a consequence, they are in an increasingly untenable position in which practice closure or relocation to another state are for some physicians the only viable alternatives.

To reverse this trend, the Medical Society has undertaken a number of collaborative endeavors with the hospitals and health plans in our area to reduce the

administrative burdens imposed upon physicians' practices. Nevertheless, despite our efforts, physician practices are struggling to survive in this environment. The reality is that individual physicians are unable to effectively negotiate in this market because the antitrust laws have created significant barriers to negotiation between the relevant parties.

Consequently, individual physicians standing alone cannot obtain increases in reimbursement to directly cover the rising costs of operating a medical practice. I question whether we can depend on the influence of competitive forces on our market when the supplier of services is unable to compete or negotiate. That being said, I want to commend both the FTC and the DOJ for analyzing the impact of current market forces, not only in terms of cost, but also and perhaps most importantly, on the quality of care that is delivered.

While much of the historic debate on competition has focused on money, physicians are even more frustrated and constrained in their ability to fight for contract terms involving the quality of patient care. Physicians continue to struggle with crushing administrative burdens and restrictions which hinder their ability to efficiently and effectively deliver the most appropriate care.

Additionally, a number of plans track and reward physician performance primarily based on overall costs and not on quality of care delivered. Clearly, this is not in the best interest of patients. The medical practice market in Boston is distinguished by one of the highest penetrations of managed care in the country, three dominant players and some of the lowest reimbursement rates in the nation.

All of this exists in a market where the cost of running a medical practice is among the highest in the nation. The impact is clear. Many physicians are unable to survive and are closing their practices to relocate elsewhere or leave medicine entirely. Of even greater concern, fewer physicians are choosing to begin practice in the Commonwealth.

While there are many reasons for the situation in which we find ourselves today, the Massachusetts Medical Society believes that the asymmetry of the bargaining relationship between payers and providers and the resultant failure of dynamic market forces is the primary reason for the current work force shortage and the impending crisis in access to care.

If dynamic market forces were functioning properly, we would not see reimbursement to physicians declining steeply at the same time that we have a severe

physician shortage. But market forces clearly are not functioning, because in our zeal to follow the gospel of antitrust, we have instead destroyed the very dynamism of market forces we all hope to foster. And instead, we have created an out-of-control machine that is in a rapid descent towards a crash.

Thank you very much for the opportunity to appear before you.

MR. KRAMER: Thank you, Dr. Welch. I'd ask Mr. Waxman to go next.

MR. WAXMAN: Thank you. I think like Charlie I'll just sit here.

Good morning. My name is Mark Waxman, and I'm with the CareGroup system. It's a Boston-area provider network consisting of some acute hospitals, principally the Beth Israel/Deaconess Medical Center, which is a strong Harvard affiliate; New England Baptist Hospital, which is a well-known orthopedic hospital; the Mount Auburn Hospital in Cambridge, a very fine community hospital, which also does some teaching; and the Associated Faculty Practice Plan at the Medical Center; the Harvard Medical Faculty Physicians; and a number of other affiliated physician groups.

As others have, I want to thank you for the opportunity to participate in the process. I've learned

a lot in just listening this morning. It gives you a lot of other thoughts as well. I want to make clear that my views are my views, and I haven't gone out and polled the affiliates and asked them what they think of everything I might say. And I'm sure I'd hear a range of thoughts.

I would also caution you that my views are of a very recent arrival to the Boston scene. I'm somewhat of an interloper here. I'm a displaced Californian, and as a result, my views are uninformed by living through the creation of CareGroup, Partners, the financial rebirth of Blue Cross, but I would also say to some extent they are unbiased by having lived through that, which we're very emotional in the marketplace. I think many of the players who were involved in that bear some of the scars of those creations, as well as the benefits, today.

Indeed among the first two issues that I faced when I came to Boston were house prices, which I am still facing. And those of you that have followed this, they just reported, they just went up 20 percent in the last year. And the almost demise of Harvard Pilgrim Health Care. Very shortly after I arrived Harvard Pilgrim went into receivership, which caused a crisis in the marketplace, which we certainly hope will not be repeated.

With that kind of introduction, let me dive

into the topic at hand and first talk a little bit about CareGroup. CareGroup was formed in October of 1996. It was the result of a merger of parent holding companies of three hospital systems, the Pathway Health Network, which was the parent corporation of the New England Deaconess Hospital and four other hospitals; the Mount Auburn Foundation; and the Beth Israel Corporation. And at the same time that the parent entities merged, two hospitals, which were literally catty-corner across the street on Longwood Avenue, Deaconess Hospital and the Beth Israel Hospital Association merged to form the now Beth Israel Deaconess Medical Center.

The circumstances which led to this merger I think have received more than adequate coverage in the trade press, both in Boston and nationally, but I think there were three things that I've discerned happened. The first was that CareGroup was actually created in reaction to the creation of the Partners system. Second, there was a fear that without a system there would be an inadequate ability to respond to the changing managed care world, and I think we've heard a fair amount about that this morning, and we'll hear more. And there was a desire to take advantage of certain aspects of the financing market, which led to the issuance in 1998 of a significant debt, whose critical features were a

favorable rate, some very favorable bond covenant terms. And ultimately the glue in this system at one level, which was the joint and several liability, which clearly would tie the system together in a very important and long-lasting way.

I think it's fair to say that the track record of our merger has not been stellar. Cultures clashed; strong central leadership was not established; and over a period of several years large amounts of money were lost. Over a period of three years, the CareGroup system lost over $200 million. And we have had to dig ourselves out of that situation. This year we hope our loss will be minimal and we're optimistic we can get there, but we're only going to be able to get there with the help of a large number of people and an awful lot of work within the system itself.

As a system, therefore, we continue to be in somewhat of a turnaround situation. We think our leadership, particularly at the medical center, has now stabilized. But over time, this has led to a downsizing of the system through the divestiture of two community hospitals and some of their related physicians. We've gone through a change in governing board structure and actually the CareGroup focus has now changed from being a focus on creating a tightly coordinated system of patient

care, teaching, and research to a real focus at the parent level on financial controls, financial oversight, financial integration, and as an important role as a coordinator and facilitator of discussions through our managed care contracting network, the provider service network, or as it's known around Boston, the PSN.

The PSN has actually six hospitals. The CareGroup system is joined by the Lahey system and some 2,200 physicians. It covers approximately 300,000 managed care lives and maintains a significant managed care infrastructure.

Let me turn now as an introductory notion to the Boston market, which I think everyone would understand is unique and different. There are some aspects of it I think which are the same as other places; some which are different. First I've already mentioned, you know, I think that as Dr. Welch indicated is an increasing factor, there are certain costs to just being and living in Boston.

House prices are extremely expensive. I think the cost of living is expensive. This is going to affect and is already affecting recruiting and retention. And I agree with Dr. Welch that if this continues over time it's going to have a significant adverse effect on our ability to attract and retain high quality individuals,

both in health care and elsewhere.

Second, the cost of operating on acute hospital business in Boston are high. Some are not so unique; some are unique. Of particular note, we, like the Partners system, have been aggressively engaged in efficiency and cost-cutting, but we face nursing costs, which are, as has been reported, going up and up, and pharmacy costs, I would say you're looking at in the range of 10 percent and 15 percent, respectively. Technician shortages are real and not likely to diminish in the near future. And I think we feel that this is unlikely across the board to diminish across the system for very long.

We have high technology and capital costs of being quaternary and tertiary centers who are performing significant volumes of primary and secondary care. Yet I think everyone would admit if these centers closed, there would be significant access in the Boston market. If one looks at diversion data, for example, among our chief competitor, the Mass General and the Brigham, they are on diversion a fair amount of time. This indicates the significant access problems already exist in the market.

Another aspect of Boston that is unique that I don't think people have talked about as much as they might, is notwithstanding the competition at some levels,

there are significant and important levels of cooperation across the system. The Harvard institutions participate in a self-insured captive carrier, which results in significant savings for those who are participating in this and has worked well over time.

We all participate in the New England Health Care EDI network, across the system, which also has resulted in processing millions of pair transactions in a pair-provider cooperative, which also has significantly reduced transaction costs at that level. And, as have been noted, there are some important Boston, I would call them, abnormalities. There is a focus on academic teaching institutions, and those institutions obviously are heavily involved in physician training for the rest of the United States.

I wonder, Dr. Altman, if a statistic of physicians in this state ought to be adjusted to focus on the number of clinical FTEs actually addressing patient care. If that were the case, I think we'd see a different statistic, as many of our physicians are actually involved in research and teaching, yet their costs of malpractice insurance and other overhead costs we bear in disproportionate way. So, I would question whether that statistic is actually the right statistic for the individual receiving health care out in the

community.

Another abnormality we face is the free care or uncompensated care pool. In essence, this is a transfer tax from some health plans and hospitals to other providers in the community. I think all the teaching hospitals recognize the need for reforms in this system to make it more equitable. Whether this can occur I think is highly questionable in a state funding crisis. We are very concerned, as I think others are, that given the potential cuts in Medicaid we're going to see some changes here which lead to another disproportionality perhaps in the transfer tax. That also has effects on the competitive marketplace in Boston.

Another factor is the size of the research enterprise. This is an enterprise which is heavily dependent on government funding. It does not operate significantly to generate a profit. The question here is whether there will be a significant change in NIH funding over the near future which would have a significant effect on the research enterprise in the Boston area market.

One of the things that attracts physicians and perhaps help overcome some of the pricing problems in the Boston market is the desire to do research, both for Boston and the rest of the world. This is an important

element in the Boston dynamic. It is also a reason many people come to the academic medical centers. It also helps drive costs, because the Boston hospitals, as a result, practice a higher standard of care than many hospitals around the world. Boston hospitals are essentially required to be early adopters of new technology. That has impact and effects on the marketplace.

There has been a historical anti-for-profit view in the Boston market. This may be softening in light of difficult times for a number of hospitals. And, lastly, as has been acknowledged, and I'd be remiss without stating it again, our Medicaid rates relative to costs are quite low. This also has significant impact on the market.

Now, it has been noted the market has evolved over time, and with the exception of some potential community-based physicians, there's consolidation out in the market. And those talks are now underway. It may not change that much in the short term. We've seen the creation of the Partners system, the reactive creation of CareGroup, and the PSN, which includes Lahey and others. We do have the Keratose system, the UMass system and some other players.

It's interesting that the New England Medical

Center recently separated from its Rhode Island affiliation, and what that means to the Boston marketplace I think remains to be seen. As I mentioned, there continues to be some evolution on the physician side, whether the significant multidisciplinary medical group discussion is to create the so called G-4 group will come to pass and integrate to become a market force at this point I think is somewhat up in the air.

A few words about quality. I think the Boston market has devoted significant energy and dollars to quality. While quality at Boston-area teaching hospitals is generally presumed, I think we share with Partners and others the view that our quality is extremely high. That quality is something that is actually published and measured by a number of folks, the Tufts Health Plan measures quality, Picker surveys are published in the Boston Globe, and the MHA puts out reports on medication safety. However, we cannot tell if the payments from the payers actually differentiate in any real sense in payments based on any objectively measured quality parameter. Nor has participation in any plan that we're aware of been specifically linked to any particular quality parameter in the market. We know that the payers are beginning to experiment with incentive payments for quality. How big of a percentage of the overall dollars

those will be and whether they actually drive changes in quality performance I think is an open question.

And there have been varying degrees of integration of network providers. I think Charlie mentioned his views. I think Dr. Mongan mentioned his views. In our view, we have made a significant effort, a significant investment in systems and software development in an attempt to integrate our physicians. We have common physician credentialing; we have a referral management system; we have, I think, a very well known web reporting system with a multitude of reports on patterns of care in our network. We've had a focus on care improvement through HEDIS reporting, disease management, high risk patient management programs, universal formularies on the pharmacy side, some system-wide case management and some medical management infrastructure.

Let me now talk about the payer market. The payer market realistically consists of three plans, Harvard Pilgrim, Tufts and the Blue Cross/Blue Shield plan. Virtually all physicians and hospitals participate in each of these three plans, and the provider panels are virtually identical in all the key areas. This eliminates this factor as a potential product differentiator, so plan competition, you see, is almost

entirely based on premium and not necessarily quality or service.

Among the plans, and it's interesting that they're not here today, Blue Cross is the major plan, without which you certainly cannot be in business, particularly after you consider the HMO and indemnity business together. Without Blue Cross, you would simply not be able to function. Blue Cross, although it's a non-profit entity, is an aggressive and powerful market player. Our PSN has found it extremely challenging to have meaningful negotiations with respect to physician payments.

The reliance on a fee schedule that does not adjust for variable costs against its geographic reach is problematic, and ongoing practice issues are challenging, to say the least. We have concerns about a payment contract structure, with default provisions in the event there's not agreements on price, particularly from the physician side.

I also believe in the aggregate a serious question exists with respect to what's the balance between fee increases to providers as opposed to the desire to build reserves on behalf of the payers. We know that over time the payers have suffered in the '90s. The question is what's the balance going to be in the

future based upon the market dynamics as they now exist and are likely to change.

And lastly, although it's not a direct impact on the market, it's certainly a market irritant, and that is we continue to see payment practices collectively by the payers, notwithstanding some attempt to approve it on the state law side, which continues to delay and frustrate the providers' ability to realize on their contractually committed rates. At this point, representative of frustrating strategies, we have refusals to share payment rules prior to implementing them. There are attitudes that every error must be a provider error, almost by definition. One prominent plan can't provide premium verifications for a 2001 contract. We're still debating payments for 1999 payment rates with another. And frankly, we are concerned that constant arbitration litigators and litigation with payers will become the only viable approach to make sure that we attain payments to the rates agreed to by contract. That obviously has a very significant market cost. It has a significant human cost and it has an ongoing scarring cost for those participating in the process. We fervently hope that this particular issue can be focused on and looked at in the near term.

With respect to the provider market, we

recognize that the Partners HealthCare system is the dominant player in the market. There are very -- there are many ways, and I'll take my lawyer's hat off for the moment, that one could look at the market. We think one key element as you look at physician contracting networks, there was a very interesting article in the Boston Globe in January of 2002, which I'll say we don't accept always as having the gospel with respect to the facts, but the Boston Globe has -- went and looked at the employed and closely affiliated physicians, which are actually the ones who drive care, they're the ones that actually make admissions and make referrals. And in that the Partners system was shown as clearly the dominant group with much, much more than twice, almost three times, our size in terms of the number of affiliated physicians.

Now, as a result of payer contracts and huge capital endowment, we're concerned that Partners will become the only system with the ability to make capital investments necessary in recruitments, special services, innovative programs in market expansion that others cannot match. The big concern is that its size may end up commanding a disproportionate share of premium dollars, leading to enhanced strength and reinforcing market dominance. I'm not saying that that's an

anticompetitive practice, but it's an observation with respect to what may happen with respect to the market.

With respect to other providers, as has been recognized, there is a continuing strain on metropolitan Boston area community hospitals. We dealt specifically with the Waltham situation where we found with respect to Waltham and perhaps more recently with respect to the Neshoba Hospital in Ayer, was very difficult to devote the capital dollars necessary to make the infrastructure improvements that would have been required to turn those hospitals around. It was regrettable, but we were forced to ultimately divest those hospitals.

Now, on the other side, we have seen two developments in the Eastern Mass market with respect to market entry, which are most interesting. Essent, which is a newer for-profit entity, has not entered the Boston market but has entered, I would say, the greater Boston Metropolitan market in the sense of alliances and acquired from us what was formerly the Deaconess Neshoba Hospital. This represents the first time in the very recent past that a for-profit has been active in the acute hospital market. Again, that is not the Boston area, but it will be interesting to see what effect that might have.

The second has to do with the desire of an

entity called Patient Choice, which is a plan which is essentially an insurance product, which is seeking to enter the market as well. In their view, they have experienced the true impact of market compaction on their ability to enter into the marketplace. We find a situation where payer consolidation and inadequate payments make it very difficult for the providers to discount, to invite a new entrant into the market, where at the same time, a new entrant needs a network in order to go to the employers to provide the breadth of providers necessary to be in the market.

And if you have certain networks that either will or won't participate, that may have the effect of denying the opportunity for them to get into the market. I view the patient choice desire and experiment as a very interesting aspect towards market entry in the Eastern Massachusetts area.

A couple of other comments driving costs. I think we all face the unfunded mandates and the research apparatus. I guess I'd be remiss, since you can't help but escape it, of the HIPAA costs, disaster readiness, the leapfrog initiatives, and we all face insurance costs. We have underpayment, in our view, of the true costs by the payers.

And if you look at things like prostate Brachy

therapy, neuro stimulators, and drug-eluding coronary artery stints, this is a situation where the payers simply in our view are not paying the actual costs, even though Medicare is more willing to step up to the plate. Yet in the Boston market, these things are part of everyday marketplace activity.

Issues that we think about, I think the key issues are the effects of steadily increasing market power by the dominant players. We are concerned about our own ability to find long-term capital to be a meaningful long-term competitor in the Boston health care marketplace. We are interested in what happens to the market if, in fact, the HMO penetration goes down and we see a significant shift away from all risk-based systems. We don't know the extent to which that will occur or what the effect of that might be on systems.

Over time, we're concerned about the potential effects of patients in terms of their ability to have access to the necessary physician base. We're concerned that provider payments are very low compared to the costs of making investments. I think we also specifically would have some serious questions with Dr. Altman's views that the payers are giving up power in the marketplace to the providers. In our view, when we sit down across the table, we simply don't find that to be the case,

particularly, as I indicated, on the Blue Cross side.

A comment was also made about per capita health care spending, which Dr. Mongan addressed. I have a question as to data which is based on the bills, indicating how the bills are going up without adjustments for fee schedules, capitation or DRG payments. I think it's understood that fee schedules on the physician side have not remotely kept up with the cost of actually operating a practice. And Dr. Welch's comments, I think, went directly to that point.

We also do not see on the chart the acknowledged hospitals' mandated free care contributions as part of the overall cost of doing business in our market.

With respect to the hospital education and research, I think I would echo Dr. Mongan's comments but also state specifically that when we sit down across the table from the payers to negotiate, there is a very difficult conversation with respect to actually acknowledging hospital, education, and research costs are part of the overall health care market responsibility.

In fact, in many opportunities, the payers indicate that they do not intend to fully recognize those costs as they reimburse us for the cost of doing business in our particular market.

I think that summarizes my comments. I very much appreciate the opportunity to participate.

DR. KRAMER: Thank you. Turn it over to Dr. Harris Berman.

DR. BERMAN: Good morning. I'm Dr. Harris Berman. I was especially pleased to hear from Stuart this morning that I'm kinder, gentler, and smile more than I did ten years ago. Stuart, I think being kinder and gentler has less to do with the managed care backlash than it has to do with just mellowing with age. And the smiling clearly is because after 32 years in a difficult industry I'm about to retire and move over to academia, which has kept you smiling as long as I've known you.

But in the meantime, I'm still CEO of the Tufts Health Plan, a 900,000-member, not-for-profit Massachusetts-based plan founded in 1981. I appreciate the invitation to respond to the government's questions about competition among hospitals and physicians in Eastern Massachusetts health care markets.

At the same time, I do have to own up to being a little bit uncomfortable doing this. The questions the government has raised relate primarily to the most powerful provider group in our network, Partners, and Tufts Health Plan will again enter negotiations with that powerful network in just a few months. We do recognize,

however, that the last Partners/Tufts Health Plan negotiations have become something of a national poster child for the problems that arise in the market that has experienced provider consolidation.

So, despite my discomfort, I'll do my best to describe my perceptions of the serious breakdown in competition that has occurred in Eastern Massachusetts. Healthy competition amongst providers and payers in the past helped to create a health care environment in the Boston area that includes both outstanding medical care and the nation's most highly rated health plans, including the Tufts Health Plan.

This healthy competition now stands threatened by the exercise of market dominance by Partners HealthCare and its hospital physician network known by the acronym of PCHI. Founded in 1994 with the merger of Boston's two largest and most prestigious academic medical centers, the Mass General and Brigham and Women's Hospitals. Partners and PCHI have achieved market dominance in very specific ways.

Through mergers and acquisitions over the years, the PCHI network now numbers 15 hospitals and more than 5,000 physicians in the Greater Boston area. Partners and PCHI have planned these mergers and affiliations strategically to include anchor community

hospitals and key physician groups in key geographic areas, principally north and west of the city of Boston, and to acquire monopoly or near-monopoly power in the very specialties that are most important to the consumers' choice of a health plan: internal medicine, pediatrics, and obstetrics and gynecology.

In fact, Partners owns or negotiates for virtually every hospital in the north shore suburbs of Boston. Through this aggregation of power, Partners and PCHI have literally made themselves a must-have hospital system for area employers and consumers. Partners has used this position to demand price increases above what we would expect normal healthy provider competition would otherwise produce. And the Partners system has accomplished this objective through a negotiation strategy designed to maximize their new-found leverage.

We fear that this new-found leverage will also be used in the future, not just to raise prices, but to limit consumer choice, as well. Their negotiating leverage became starkly evident in the fall of the year 2000, during the last round of contract negotiations for our commercial insurance products. We entered the negotiations with area employers encouraging us to keep premiums and costs under controls. And we fully expected to meet that goal through the normal give and take of the

negotiating process.

Partners seemed to have different ideas. It came to the table with very high demands, explicit about its plans to push up the premium and about its unique ability to do so. Then Partners drove the negotiations to their inevitable breakdown and ultimately refused to renew its contract unless we agreed to its high demands.

Partners' termination strategy was not mere posturing. It had strategically readied an orchestrated media campaign well before the negotiations terminated, designed to announce the termination to employers, subscribers and the public at large at the time of annual October/November open enrollment. The time when most employees are choosing which health plan to join for the following year.

When the negotiations broke off, immediately there were banners in hospital cafeterias, posters in hospital admissions areas and in physicians' waiting rooms on and off the hospital campuses, letters to physicians and patients and telephone messages for those calling PCHI providers, stating, in essence, that your physician will no longer be contracting with the Tufts Health Plan and you may have to switch health plans.

Our subscribers began flooding their employers with concerns over the loss of Partners from their health

plan. Employers who previously had been supportive uniformly and understandably changed their tune, telling us loudly and clearly, if you don't offer Partners, we can't offer you to our employees. Given the size and the scope of the PCHI network, Tufts Health Plan was threatened with the loss of its largest accounts. I finally concluded, in the middle of the night one night, that our very viability was at stake. And in the end, we had no choice but to acquiesce to their high demands.

In the September hearings held here on competition and health care, Cara Lesser of the Center for Studying Health System Change, cited this terminate-then-negotiate tactic as an ominous new phenomenon employed by powerful provider networks. She described this as a tactic that is threatening continuity of care for hundreds of thousands of consumers in the communities in which it is occurring, and she specifically cited that Partners/Tufts Health Plan negotiations as one of the most vivid examples.

What enables Partners to undertake such a strategy is its market dominance. For example, through its acquisition and affiliation with our Northern suburbs leading hospitals and physician groups, PCHI has obtained a monopoly in the critical areas of pediatrics and obstetrics and gynecology in the north shore market of

Boston. It enjoys monopoly or near-monopoly in other important specialties in this market: internal medicine, surgery, and pulmonary care.

Likewise in the western suburbs of Boston, PCHI enjoys market supremacy in pediatrics, pediatric psychiatry, and medical oncology. With this kind of power in such key service lines in a broad geographic area surrounding Boston, employers simply cannot offer health plans that do not have Partners and its affiliates in their network.

The exercise of this power occurs against a backdrop of a highly competitive payer field. Harvard Pilgrim, Blue Cross, Cigna, Aetna, Tufts Health Plan and a host of third-party administrators compete vigorously with each other. The absence of significant buyer power is certainly indicated by Partners' cavalier willingness to do without us.

The outcome of Partners negotiating power and market dominance have been higher prices to the consumer. This has been what Partners has been about from day one. Now Partners can raise prices because of its ability to impose its contract terms unilaterally on area payers and because the PCHI hospitals and physician groups, both those that are owned and those that are merely affiliated with PCHI, refuse or are unable to negotiate with payers

independently of PCHI.

Moreover, we have seen little evidence that the Partners hospitals have integrated major departments. As a result, when all is said and done, we ended up with contract price increases far outstripping medical inflation rates over a three-year period. We may hear that this was a market correction, but it was not. This was a market disruption leading to prices above what we would expect in a truly competitive market.

It is curious that a delivery system that trumpets in its recent “advertorials” how it has lowered the cost per patient in its hospitals by 22 percent and claims to be operating on low margins is the same system which drove what were by any account significant premium increases. Lower costs in health care are supposed to lead to lower prices. The stated rationales for the price increases, market corrections, narrow margins and the like, lose credibility when voiced by a dominant network whose then CEO during the opening of our negotiations told us explicitly that Partners doesn't care what the market will bear, that it intends to push up the premium and that it is in a unique position to move the market.

There is no doubt that price increases translate into higher premiums. At the same time,

contrary to Partners' assertions, our recent premium increases are, in fact, not to our profit, not to reserves, not to administrative costs, but directly to medical cost increases. In fact, as a percentage of premium revenues, our administrative costs for 2002 stayed flat and our profits for 2002 actually declined compared to 2001. That is, the claims paid actually increased faster than the premiums did from 2001 to 2002.

Partners dominance has played out in other troublesome ways. The chiefs of cardiac surgery of both Partners teaching hospitals jointly refused to participate in a Tufts Health Plan quality management program involving outcomes data. Their refusal essentially gutted our initiative to provide objective data to our members on the quality of care available from the 11 different hospitals in our network which provide coronary bypass surgery.

Partners has already killed an innovative and heavily promoted product offered by one of our competitors, Blue Cross/Blue Shield, a product called Access Blue, by refusing to participate. We fear that a similar refusal by Partners to participate in new consumer choice products that our plan is developing could effectively prevent consumers in Massachusetts from the opportunity to choose between higher-end and lower-

cost products.

We are concerned about the impact of their approach to product innovation. Innovation and consumer choice are critical and long overdue in our market, where our patient population, as you have heard, is excessively dependent on care and costly tertiary facilities. Our new consumer choice products are clearly pro-competitive in that they permit consumers to make clearer choices about the cost of their health care services. These programs hold real promise for controlling health care costs, something that Professor Altman told us is badly needed.

Many of these issues will come to a head as we face our next round of contract negotiations with Partners in the next few months. We welcome your attention to the critical issues of these competitive issues -- critical importance of these competitive issues in the interest of stemming price increases and enhancing quality and consumer choice in the great Boston health care market.

I thank you for your time.

MR. KRAMER: Thank you. At this point, I'd like to break until 11:25 and we'll pick up with Professor Miller and then go on with some questions from there, to the extent that we have time.

(Whereupon, a brief recess was taken.)

MR. KRAMER: At this point, I ask Professor Fran Miller to give us a bit of a retrospective on what we heard, as well as her perceptions of the health care marketplace up in the Boston area. Fran is a long-time Boston-area resident.

PROF. MILLER: Thanks, Steve. Okay, I might add that Steve's assignment to me was to, you know, have a few things to say on your own -- could I borrow somebody's water -- say a few things on my own, and then also react primarily to what's been said this morning. And I realize that if you want to break at 12:15 I better be --

MR. KRAMER: Actually, it turns out I misspoke, it's 12:30.

PROF. MILLER: Okay.

MR. KRAMER: As we just heard.

PROF. MILLER: Well, I don't want to keep the rest of you from digging in, as well. I want -- there are a lot of things that were said this morning that were part of the things that I wanted to touch on anyway, so I think it will meld together. I hope it comes forward in a relatively organized way as I do so.

My name is Fran Miller. I am Professor of Law at Boston University School of Law. I'm going to give

you just a little bit of background on me so you know where I'm coming from as I make these remarks. I have indeed been watching the Boston health care market for at least 35 years, and watching it quite closely. I'm also a Professor of Health Care Management at the Boston University School of Management and also a Professor of Public Health at Boston University School of Public Health.

So, I come at all of these things from three different perspectives, but the common theme is, if you want to put it baldly, money, economic, and management, School of Public Health and Law School. My focus has always been on the economic aspects of health care delivery.

You may also find it relevant to my comments to know that for a brief period of time in the 1970s I was a Commissioner of the Massachusetts Rate Setting Commission. That means I have a healthy skepticism for what anyone says costs are. When we started investigating what we were being asked to reimburse, we started finding things like a gross of gold golf balls that were given out as souvenirs to house staff graduating from some of our teaching hospitals. We decided that wasn't a cost that we wanted to cover in our reimbursement.

But anyway, I have a healthy skepticism about the concept of cost. And for roughly the past two decades, I have chaired the Health Facilities Appeals Commission in Massachusetts, which is the certificate of need appeals agency for the Commonwealth. So, I have a good fix on who's doing what in terms of substantial changes in service and substantial capital expansions.

And for the record, you should also know that I am a trustee of the Joslin Diabetes Center, which is not an inpatient facility. And I also serve on the Partners -- one of the Partners institutional review boards, so I see the research operation at that level, or at least part of it, as it occurs within the Partners system.

Professor Altman framed this morning's discussions by outlining trends in the national Massachusetts and Boston health care markets as they have evolved over the past decade or so, with particular focus on hospitals and MCOs in Middlesex and Suffolk Counties, which are the Boston-Cambridge Metropolitan areas.

His comments, in conjunction with the detailed task force report accompanying his remarks give an overview of health care economics, particularly in the Commonwealth. They provide an excellent frame of reference within which to consider and evaluate the more focused perspectives in these stakeholders in the Boston

hospital market in particular and insurance markets whose presentations we've just heard.

My objective in making these concluding remarks is somewhat different from those who have preceded me here. I'm a lawyer; I've been teaching courses about antitrust in the health sector for more than 20 years. I've written on the subject. I have taken a keen interest in the Boston hospital market and insurance markets for some time, but I don't believe I have a vested interest in either, per se, other than, as I say, you know, a health insurance subscriber and certainly a consumer of, quote, the best medicine in the world, which I truly think we have in the Boston area.

My comments should primarily be considered as those of an academic observer, and I've always examined competition in the Boston hospital market, primarily from that perspective. If I were giving this particular presentation 10, 12 years ago, I would have been focusing very closely on Blue Cross/Blue Shield and what was happening in the insurance market. If I'd been giving it three or four years ago, I might have been focusing on Harvard Pilgrim and its problems.

It happens that where we are in the world today I'm going to focus a lot on Partners, but I want you to know that I am an equal opportunity, perhaps, I don't

want to say dart-thrower, but that's just where we are right now in this market in Boston, and I am certainly someone who understands the cyclical nature of markets and knowing that things change.

So, I do want to focus a little bit on Partners, because to understand where Boston is right now, you just have to. You cannot ignore it. And the original movement to consolidate the renowned Harvard teaching hospitals in the 1990s, the early 1990s, was stimulated primarily by financial concerns. I don't think there's any doubt about that, although the consolidation movement was also concerned with improving the quality of the services to meet the needs of the 20th century.

Now, this information has come to me from several participants in the discussion -- the original discussions among Brigham and Women's, Mass General, Children's, Beth Israel and the Deaconess Hospitals. They are Harvard's five flagship teaching hospitals in the Boston area, and they met together in the early '90s to start talking about what they could do. And those five hospitals were, quite frankly, seeking ways to counter the market power of the Commonwealth's then quite dominant managed care insurers, all of them. We have a robust competitive situation among health insurers, but

they're very powerful buyers of provider services.

Those MCOs were engaged in increasingly aggressive bargaining over rates and hospital costs containment measures. And the Harvard teaching hospitals in that group envisioned that their teaching budgets, among other areas, clinical care, would be increasingly stressed if the trend continued. The five of them engaged in these talks for some period of time and could not agree on a plan among them. In fact the plans never really got very far. My understanding is Bob Locke was advising them and, of course, cautioning them of the obvious for antitrust violations that for the five of them to combine would cause or would raise.

Finally, when nothing was going anywhere particularly, there was the famous parking lot conversation between Dr. Buchanan, who headed Mass General, and Dr. Nesin, who headed Brigham and Women's. And they basically said well, if we can't do it with five, let's see if we can do it with two. And I can quote Sam Thier's statement, which he may regret having made, it was in the Boston Globe two years ago, but it says, "By Samuel O. Thier's own admission, Partners is trying to reset the prices in this marketplace. We wanted to be able to climb out of the hole and get a little extra for inflation. To the extent that pushes

up premiums, that should help out other providers, as well."

So, that's a frank admission that this was a cost-driven, a financially driven, merger, at least at the outset. Of course, there are all the wonderful and admirable clinical improvements that Dr. Mongan has mentioned this morning. And Partners has done a wonderful job with very many of its programs that certainly qualify as clinical improvements over time. But the primary motivation was indeed financial.

And this merger went forward pretty much under the regulatory radar screen. Yes, the Massachusetts Attorney General did look at it. To my knowledge, no conditions were attached to it. I can be mistaken on that, but to my knowledge, none did. Okay, no conditions, they were simply permitted to do it. And when the announcement was made -- it was a stealth merger. And when the announcement was made, the other three people with whom -- the other three teaching hospitals with whom they'd been negotiating were, to put it mildly, displeased with the fact that the rug had been pulled out from under them.

So, you know, that's the situation in 1994 when this merger took place. No one knew about it. And to underline that point, the same law firm represented both

Mass General and the Brigham and the Beth Israel Hospital. And within the firm, the lawyers were not told -- the two sets of lawyers who dealt with these institutions didn't know it. They were not pleased either, let me tell you.

So, anyway, that's how quietly this was done. It came in under the radar screen, as I said, and with respect to regulatory oversight or antitrust agency oversight, there was virtually -- it was -- I won't call it a rubber stamp, but there was not the kind of searching inquiry that I think one ought to have had at that time.

Now, as an antitrust lawyer, we know how we look at market share. We all say, "Well, what's your geographic market? What's your product market?" And when you take a look at the geographic market and product market definition that are possible with respect to analyzing Partners' market share, yes, I understand that under some product and geographic markets the market share can look pretty small. But I also know that one can look at it through different lenses in terms of both geographic and product market and who just -- oh, Dr. Berman was just talking about the monopoly in the North Shore enjoyed by Partners. Now in terms of -- if you're going to take a market -- if you're going to take issue,

geographic market, the North Shore area of Boston, you're going to get quite different market share numbers than if you take the inside Route 128, inside -- or 95, all of Massachusetts, et cetera, we all know how to play these games as antitrust lawyers.

But given -- Stuart -- has Stuart left? Oh, Stuart, what did you say you thought the number of hospitals in Massachusetts was? In the neighborhood of 65, something like that. Something like 65 or 70 hospitals in the State of Massachusetts. Well, nine hospitals are owned by Partners HealthCare system, and six more are affiliated with them. So that's not -- that's 20 -- nine and six is -- I'm really good with numbers on my feet -- all right. That's a healthy slug of a number of hospitals in the Commonwealth that all get negotiated together when it comes to contract negotiations. My understanding is that they do get negotiated together.

So, again, I think you have to be careful how you look at all these numbers, what you really think you're talking about. Now, if we're talking about -- well, I just made a little comment about geographic market, let's talk a little bit about product market. It's one thing if you think your product market is acute inpatient beds, hospital beds. And I certainly am

perfectly willing to accept that that number, depending on what you really think your geographic market ought to be, it sort of ranges in the 20 percent area for Partners.

But if you talk about your product market as being the flagship Harvard teaching hospitals, without which an insurance company cannot offer a product, you get a whole different story. This isn't just any two hospitals that have banded together. It's what many in Massachusetts would call the two best hospitals. It is a very specialized and unique product. And it's one that Massachusetts' patients/consumers/subscribers want. And as was -- as Dr. Berman pointed out, there was a pretty big backlash against Tufts' plan when it became clear that it might have to be offered without those two hospitals in particular in it, let alone all the affiliated ones that came with it.

So, I have a little trouble with the definition of product market here as being acute hospital inpatient beds in Massachusetts, or even in Southeast -- you know, the Eastern third of Massachusetts. It's really -- when you understand the market in Boston, it's really something else. We are very highly educated and sophisticated consumers of medical services in the Boston area market, and I certainly number myself among

them. They're fine, fine hospitals, and I wouldn't want not to have that option either. So, they've got a lot of clout.

So, the next question is -- and I might add you could do the same thing with sub-product markets. We had talk here about cardiac surgery. My understanding is that of the open heart procedures done in the sort of metropolitan area are a little larger than that. Brigham and Women's does 21 percent of them; Mass General does another 20 percent or so. You're moving way up in these sub-markets when you look at them that way. And, you know, we could all tick off all kinds of other areas.

So, the question any antitrust lawyer asks afterwards is, "Hmm, a lot of power here, did this on balance -- is it on balance? More pro-competitive than not? Did it enhance consumer welfare?" And, you know, there's a “yes” and a "Hmm, I wonder" answer to that kind of a question. And one of the obvious things that faces you when you look at the Massachusetts market, and Stuart and others have done a good job pulling apart the many reasons why this is the case, nonetheless, the health care costs in Massachusetts are just about the highest on the planet, are among the very highest on the planet. They are very, very high. And of course the fact that we have a lot of wonderful teaching hospitals in this market

is part of the reason, so is the reason -- so is the fact that we are very technology-intensive for lots of other subsidiary reasons having to do with the biotech market in the area. And sophisticated consumers. They're also all part of it.

So, we're faced on the one hand with "Well, we haven't seen costs going down, in fact, we've seen quite the opposite. We don't see cost savings that you would think you might see in the context of a merger that's that large." Yes, there have been undoubted administrative efficiencies, and they're across the board in many areas in the Partners system. But I don't see them quite the same way in terms of clinical efficiencies.

And, in fact, most people in Boston thought well, with this merger that means Mass General won't open an OB department, which it hadn't had. Brigham and Women's had the biggest, and still does have the biggest, and most comprehensive fine OB unit in the state, and yet very shortly thereafter Mass General went right ahead and opened its own. And everybody's going, "Wait a minute, we thought there were going to be clinical efficiencies out of this merger." There certainly weren't -- you know, right away from the get-go, that was going forward, quote, no matter what.

Now, I understand all the subsidiary reasons why it made sense to open it, at least from Mass General's point of view. The question I want to ask is how much was that rethought. Or did the plans that were already in progress just steamroller forward without really thinking about this.

You don't see, at least to the outside eye, you don't see an awful lot of clinical integration. You don't see a lot of it between those two institutions in particular and among the PCHI system in general. I mean, this is, you know, not a fair shot, but this is PCHI's newsletter from last year, and they were talking -- and Ellen Zane's writing about clinical integration and she writes, you know, "Clinical integration is the platform from which we can show the improvements in patient care that the fact that we have a system makes possible, but we're not there yet. We need to do better, we haven't done this, we haven't done this, we haven't done this."

Now, I realize she's exhorting her physicians to cooperate in integrating clinically, but I'm just saying that you get acknowledgments throughout the system that it sure hasn't happened -- and this is ten years later, in a way that you might want to think it should have. Now, clinical integration, to my naive mind, would have been the first -- one of the first things one would

think of in doing.

Now, I understand all the problems, the culture clashes and, you know, for better or for worse, CareGroup is an example of one that it was -- you had culture clash there of a very high magnitude and it was very destructive to the CareGroup system for a long time. I think you're coming out of it, but it was a terrible. Those who talk about it, who know about it, talk about it as having been jamming two cultures together too fast. And I understand that you can't do that. But it's a long time now since this happened. And yet we're not seeing a lot of movement within the system. Yes, I understand Brigham and Women's now has a lot of the things it used to do done at Faulkner, but beyond some obvious things like that, you don't see a lot of re-organization within the system, in terms of clinical integration.

A side note, because I had the certificate of need appeals agency, I see what goes on in the certificate of need process below. I have here a printout of determination of need projects that have been completed over -- as of January of 2000 -- but when you look at what the projects have, they're not a lot compared to what there used to be. Just for the heck of it, I went and looked through as to what Brigham and Women's and Partners had in general, but North Shore

Medical Center, et cetera, and I'm looking, a lot of MRI units, PET scanners, three MRI units, two hybrid PET/CT scanners, et cetera.

I look at all this, and I also know with my other hat a question I raised with respect to a research proposal that came through the IRB within the past year or so, and the question I raised, it was one that was a retrospective cardiac surgery -- cardiac study. I haven't a clue what it was even about, but it had to do with cardiac care, and they wanted to do -- I think it was either an MRI or it was a CT scan, but for this purpose, it doesn't matter which -- on 2000 patients, just to see whether X or Y had happened since then. And, you know, everybody's saying, “Well, this is great, great research; we'll find out this; we'll find out that." And I said, "Do we have that kind of spare capacity, that we can do that?" And people said, "Well, what do you mean?" And I said, "Well, 2000 scans, I mean I'm guessing a scan is half-hour, 45 minutes apiece, you do the numbers, multiply that out. Do we have that much excess capacity that we can just do that?"

I was outvoted on it, because -- and I voted against it, just because I don't think that's the way our scanners ought to be used without a lot of thought -- without a lot of addressing that question up front. But

then I go back and look at the certificate of need approvals and see all this stuff and well, who's paying for that?

It's not that I don't want that research to be done. Who knows, it might have saved my life. I do want that research to be done, but I want you to -- I want people to think hard and justify why they're using that much time on that much expensive technology. And this wasn't, you know, a phase one, two, three trial; it was something like, you know, a retrospective -- I'm not even sure it was a phase four trial, but it was someone doing -- taking a look-see. It wasn't part of clinical care, that's for sure. So, again, it's not that I don't want that done; I sure do want that done, but I want people to think about doing it.

Now, with respect to Dr. Berman's comments about their upcoming negotiations. Again, how can you not notice this? It's designed to be noticed. I've got two here, there are four. For the last four Wednesdays, on page 3 of the Metro section in the Boston Globe, these have been running. And this one is -- and they're very good. They're excellent; they're factual; they're full of stuff. This is on how we can improve health care costs; this one's on the pressures on health care premiums; but my favorite one was the first one in which

they repeat the market share of 21 percent, you know, that Partners has 21 percent of the market, just a little piece of it, and so forth and so on.

And I look at them and I say, why now? Why these? And, so, just for the heck of it I ran back and through my sources, I don't know if I have the right numbers, but I found out how much those ads cost. The first one was $19,999.37; the second one, $15,262.41; third one, $13,981.17; and I assume the fourth one was cheaper, some kind of bulk rate. But, okay, that's a cost of health care in the Commonwealth of Massachusetts. I realize it's chump change. It's nothing.

And maybe it's doing a lot of good. I don't know. But what am I thinking when I see these, this timing? Why now? Was there some emergency, this had to be out there? I don't know, but I'm sure I'm going to find out. So, anyway, that kind of thing is out there.

As for costs, et al., I will also point to the Globe as of -- and, again, I just share this skepticism about what appears in the Globe, but here's a story from the December 21st Boston Globe, and the headline is "Partners Post the Best Results Ever in its History." And it said, Partners HealthCare reported its best financial results since forming the network in 1994, including a turnaround of several once-struggling

community hospitals, et cetera, et cetera.

But, again, my rate setter mentality goes back to, you know, I know about accounting. I know how one can move things from here to there to the other, but if that comes out, that tells me that maybe the premium increases that I sometimes hear are being asked for maybe aren't as necessary as they might be.

Now, just a couple more comments and then I'll let you go at it. And I realize that I do not want to end up being hospitalized in a Partners hospital any time soon after this.

(Laughter).

PROF. MILLER: But, you know, I'm just sitting here telling you what I see from what I know and what I've been around, because I've been around here for a long time and I've been watching it. And, again, I'd be doing this to whoever else the dominant player was if we were doing this ten years ago or whatever. It's just fun. It's interesting to do. And if I could find the rest of my thing about where the rest of my questions are, I did want to ask Dr. Welch a question. I know where it is, it's on the back. There we go.

You were talking about the physicians' inability to negotiate, you know, one-on-one with these providers. And you said we can't compete in this market.

The antitrust lawyer listens to that and reads it differently from the way you listen to that, because competitors, to an antitrust lawyer, competitors -- competing is with your horizontal competitors. And I think you meant we can't bargain with insurers. They're your vertical relationship people rather than your competitors in the physician sense. But my question to you, which you can address later if you want to or now if you want to, don't a lot of physicians in Massachusetts negotiate through PCHI or through other network providers? And it's not that they're all alone; they've got a big system bargaining for them for their rates. I realize that docs who aren't affiliated in one of those are in just the position you meant. But it's not like all doctors in Massachusetts are. It's some.

DR. WELCH: First of all, with regards to bargaining through PCHI, Dr. Mongan, I think, should speak to that issue, because he has a better overview of that.

PROF. MILLER: Okay.

DR. WELCH: In terms of competition, yes, we can't negotiate competitively in relation to the plans, but we're also limited in competing with each other to provide better service at a lower cost, because we are boxed in by the stipulations of the insurers as to how

we're going to practice medicine. It is -- the current environment, as if we had frozen our profession in ice. It's like Sleeping Beauty where, you know, the whole castle went to sleep for 20 years, the dogs and the horses, as well.

We are -- because we don't have incentivization of innovation, we can't move on to the next generation of health care. We've got to get out of this stasis where the incentives are all in a sense going in the wrong direction. So, I actually meant competition in both ways, and I'm sorry it was not clear.

PROF. MILLER: Well, you know, lawyers speak a weird kind of language.

DR. WELCH: Well, I also think that I should perhaps criticize myself first, but all of us as well, for tending to get into assertions that have rather spindly legs of data under them and that were dealing with issues which are so highly charged. I really, given the tone this morning, I think that I, as well as all of us, should think twice when we say something like there are more physicians per population in Massachusetts than in the rest of the country; or the incentives are wrong, because, you know, we really need data on all of these assertions. I'm glad we can talk about that freely, but I would just want to stress that almost all the

assertions we as panelists have made this morning need to be looked at in -- with a question mark in the back of our minds.

PROF. MILLER: Sure.

DR. WELCH: Do we have good data to support what we're saying.

PROF. MILLER: And you lead into just what I wanted to say for my concluding remarks. First of all, I haven't a clue what the answer is. Academics are very good at picking things apart, because they know how to look at them and find inconsistencies, et cetera. I haven't a clue how I would structure just the terrific optimal situation for Massachusetts.

But for better or for worse, we've sort of adopted competition as the mold to structure our health care delivery system in Massachusetts. Sure, it's regulated at the margins, but competition is basically the thing that organizes our health care system. And if markets are the structural drivers here, as we say it is, why aren't we seeing more evidence of slowing costs? And, again, I understand the technology imperative, I understand the teaching hospital thing. And it's not for a second that I would want it to not to be that way in my state -- I do.

But I guess I want to end up with what Stuart

said before, we are what we are, and we are at the moment in time where we are, but can't we do it a little better? Okay, that's what I have to say.

MR. KRAMER: Thank you. I would like to give the panelists -- particularly the panelists that went early, starting with Dr. Mongan, and we'll do it in order, a chance to respond very briefly to any statements that have been made today. And when I say briefly, I'm talking at this point 90 seconds, so that we'll have at least some time to pose a few questions. And I'll ask you to stop at 90 seconds. So, with that, please go ahead, Dr. Mongan.

DR. MONGAN: Thank you, Steve. I've just learned a new definition of a framing presentation this morning that I will keep in mind. I think any fair-minded person in the room could understand that I could take the whole time responding to Dr. Miller's animated and colorful history and analysis of Partners, starting from gold golf balls and going forward. I will only go back to the broad and full rationale that I laid out in my statement regarding the formation of Partners. We were formed to add value to our underlying missions of patient care, research, teaching and community benefits, and we have done that.

As to the highest costs on the planet, I would

refer you back to the data set out by Stuart and myself. Our costs, our premiums, are not different than the rest of the country. And just a word as far as the payer testimony, it's hard for me to recognize the portrait painted by the payers. If we are such dominant players able to set our own prices, why did we get extremely minimal increases for years and then after the much ballyhooed negotiations still end up with only modest increases and still below the national average. And secondly, with regard to the so-called showdown negotiations, I've never understood why it is that when employers fail to reach agreement with their existing health plans and drop coverage in favor of better priced options, it's considered a solid business decision; yet when hospitals seek improved rates it's considered a showdown. Consumers are routinely inconvenienced when employers switch plans and when health plans drop providers, and these things occur much, much more frequently than showdowns.

Thank you.

MR. KRAMER: Thank you. Mr. Baker, please proceed if you'd like.

MR. BAKER: I don't know where the role of the misuse, overuse, and underuse of technology fits into all of this, but clearly, if you were to ask me what's really

driving a big piece of the cost quality equation, in our market and in others, it's the fact that we don't have a good way of organizing anybody's thinking around the right use and the most practical application of both new and existing technologies. And this is obviously especially profound in a market like ours which has so much heavy emphasis on research and teaching.

But I guess I think absent, you know -- the other stuff is all debatable, and everybody's got a point of view, but I really do believe that absent any attempt to try to create a more cohesive approach to managing technology developments over the course of the next five, ten, 15 years, whatever number you want to pick, I think a lot of us are going to be banging away on the margin on what's really driving spending and what's driving quality.

MR. KRAMER: Thank you. Dr. Welch, please proceed.

DR. WELCH: I think that the issue of cost is clearly the most burning one. From our perspective, it's driven by three drivers. The first is a growing administrative overhead. It is now consuming between 35 and 40 percent of the health care dollar and it is a garden of opportunities for recapturing funds to plow back into clinical care.

The second is antiquated systems of delivery, which make it very difficult for clinicians to deliver care that is optimally effective and optimally efficient. And that's no -- and I'm not pointing the finger at anybody. It's the system of health care that we've inherited from our fathers and the incentives have not been adequate for us to move on to deliver better, cheaper, safer and easier health care along the vision of the Institute of Medicine model.

Third, I would agree with Charlie that our use of technology is irrational and that we desperately need an evidence-based, scientifically-based system for selecting which technologies we're going to adopt and which ones we're not going to adopt and how we're going to use the ones we do.

And I think that what we really need is not so much a regulatory shift -- although I do think that regulation plays into this. I think what we really need is for a constructive, ongoing process between insurers, providers, patient representatives, and the government to reinvent this whole system.

MR. KRAMER: Thank you.

DR. WELCH: And, finally, I would say that as someone who works in the Partners system, I am very proud of what this organization has done by improving the

quality of care throughout the Boston area and saving some hospitals that were on the way out from extinction, and I really am overjoyed to be able to work in a system that is so committed to that mission.

MR. KRAMER: Mr. Waxman.

MR. WAXMAN: Among the data sets that we really did not examine is whether the entire system is under-funded itself to accomplish what it is people would like. Without knowing that, I think it makes the analysis harder. We, of course, are concerned that the larger players, whether it's on the payers' side or the providers' side, will end up getting hurt the least in a system that doesn't have enough money to deliver the goods.

Second, I think as the market continues to evolve we all look to your two agencies to spend more time and have deeper analysis of the relationship between integration and risk-sharing as the managed care penetration goes down. As you know there are various questions that come up as to what the relationship between those two are and would invite further clarification from your agencies of the antitrust statements in that regard.

MR. KRAMER: Thank you. And, finally, Dr. Berman.

DR. BERMAN: Professor Miller's redefinition of what market dominance means triggered a memory which actually had a profound effect on my thinking in that week or ten-day period when we and the public knew that we had no contract with Partners.

I received a phone call from a member whose name I don't even remember now, telling me that she's been a long-term member of the Tufts Health Plan and satisfied with the Tufts Health Plan and she was very disturbed at the idea that we weren't able to reach an agreement with Partners. She told me she's been healthy and she had never walked in the door of the Mass General Hospital, but she said she would not be comfortable having a health plan where if she got sick that she would not know that she could go there if she needed to. And she was going to have to change health plans. To me, that's market dominance in a way that I didn't understand before and that affected my decision that we had to come back to the table and basically acquiesce.

MR. KRAMER: Thank you. And, finally, I want to give Dr. Altman the same opportunity, given that he has been the recipient of some comments.

DR. ALTMAN: Well, I think I've just been just perfect. When you get shot at from both sides and then you have a professor who also shoots at you, I think I

just played it right.

(Laughter).

DR. ALTMAN: And, so, a couple of comments I can't resist. First, having been a relative newcomer to Massachusetts, as I said, 25 years, you're still not -- you still don't have your pinstripes, and there is a parochialism, and I think we saw that in spades with Professor Miller, about sort of -- you know, little inside baseball stories.

And I do think it's very important, and I know ultimately the Federal Trade Commission and the Justice Department will do this, is to say well, really, when all gets said and done, how different is life in Boston with what's going on in the rest of the country. And not let's get away from all these little stories, because then you have to say to yourself, what is it about our health system that dominates. And it think what Charlie Baker said is the one that resonated the best with me. And that is that, you know, we are driven very much by technology. We do have a very litigious system.

And, so, I think it's very important that we cannot lose sight of comparing ultimately the Boston, Massachusetts area with the Federal Government. A and B, I strongly agree that we should be based on facts. In spite of your statement about the contrary, every which

way you switch the physician population, you can modify it and reduce it. We are blessed with very high quality physicians and a lot of them.

But I'm also very concerned about the income of physicians. It's not so that A -- I never use the Boston Globe. I would flunk a student who used the Boston Globe as their centerpiece for statistics. But nevertheless, be that as it may, I do think that we could ultimately pull back from the inside baseball and compare us to the rest of the country, and when you do that, you find the statistics that I think I tried to show you.

We are more expensive. We're not outlandishly more expensive. There is this business about the cost of living, and certainly, you know, I mean, I'm a professor, my salary at Brandeis is not adjusted by the cost of living. There are legitimate places to use cost of living, and then there are questionable ones. So, I used it sometimes and I didn't use it other times.

But I think we need to put ourselves in the context of the rest of the country. And, yes, we have certain unique characteristics in Massachusetts. But when all is said and done, I hate to tell it for my friends from Massachusetts, we look a lot like a lot of other parts of the country. And I know that comes as a deep hurt.

(Laughter).

MR. KRAMER: Thank you. I can't resist the pinstripe thought, relating that to Boston, coming from New York originally.

(Laughter).

MR. KRAMER: At any rate, with that, we outdo --

DR. ALTMAN: I'm a New Yorker, too.

MR. KRAMER: That's what I mean.

(Laughter).

MR. KRAMER: As you may know, I'm from Middleboro, Massachusetts originally.

DR. ALTMAN: No pinstripes.

MR. KRAMER: At any rate, I want to give Mike Cowie an opportunity to ask the first question. And I'll try to follow up with that.

MR. COWIE: For Dr. Mongan of Partners, in evaluating mergers the FTC and Justice Department obviously look at rate or price effects, but we also want to make sure we take into account improvements in quality of care. In the brief time you had, you listed some advances that have occurred since the 1994 merger. You mentioned genetic research; you mentioned additional psych beds. You mentioned improved home health services. Can you elaborate on the significant quality improvements

that have occurred as a result of the merger, in other words, that could not have been achieved independently by the institutions?

DR. MONGAN: Thank you. I'd be happy to. I guess there's always a little room for judgment there, but let me flag two of the, I think, commonly accepted indicators by the business community, which has invested a great deal in the leapfrog initiative. And I think if you look on their website you'll see that there are seven hospitals around the country that have met all of the leapfrog criteria and the Brigham and Mass General are two of them.

And I think in one of those key areas, it is an example, the order entry systems for drug administration, which are one of the key leapfrog elements, was far ahead at the Brigham than what the Mass General had. And I think it's clear to every observer that without the integration we would not have been able to expand the order entry system to the Mass General in the fashion in which it was expanded and with the speed in which it was expanded. So, I think that will just serve as one striking exemplar of how that process works.

MR. KRAMER: Boston is unusual in the sense that both the large insurers operate in the market, as well as the hospitals, are all not-for-profit. There may

be some other states, but certainly Boston, Massachusetts sticks out with the mention of the Arrow being the subject of a recent purchase.

And my question to the panelists is is there any significance to the not-for-profit form of organization in Boston as opposed to having a for-profit form of organization of any of these large players. We heard yesterday a suggestion that the for-profit motive of for profits affects the market, and I'm wondering if the not-for-profit form has a salutary effect.

DR. ALTMAN: Steve, I have looked at that quite, and, yes, there are some differences between the two, but, again, if you take a picture about the important components, really, when all gets said and done, it doesn't matter. Each has its advantages and disadvantages, but in terms of the basic quality of care, prices, for-profits tend to be more aggressive on pricing, but probably may in places reduce costs so that they -- reduce their costs, then they push up the prices so that they try to make the margins.

I really don't believe the for-profit/not-for-profit distinguishes Massachusetts at all. I think it has much more to do with the unique characteristics of the institutions, particularly the dominance of teaching, because of the history of the area.

MR. KRAMER: Any of the other panelists have a follow-up. Okay.

MR. COWIE: Charles Baker of Harvard Pilgrim mentioned the presence of all products clauses, in other words, take me, you've got to take my brother. I was wondering if either you or Dr. Berman of Tufts could describe what you've seen in the marketplace in terms of all product clauses.

MR. BERMAN: Well, the reason I picked all product clauses is because it was obviously something that people have an issue with when the plans do it. And actually the plans do less of that in Massachusetts than they do in some other markets. But I think generally speaking, I'm guessing now, but if you took the top four care delivery systems in Massachusetts, you'd probably be talking about somewhere in the vicinity of 50 percent of most of the admission activity and probably at least that much of the physician activity overall.

And I think generally speaking, you know, they bargain as groups, negotiate as entities and organizations. And does that have an impact on their leverage in the context of those discussions? Absolutely. I don't know how it can't. And I'm actually surprised that people don't just acknowledge that and get over it and get on it.

But it seems to me that the -- again, given all the other dynamics that have been at work in the marketplace over the last few years, if you asked me to put a number on it, I'd be very hard-pressed to do that. And if someday they actually translate into organizations that can bring significant improvements and enhancements into the way people make decisions about the use and application of technology and the administrative information that's available to support the way they use technology in managed care, that would be a big benefit. But I certainly haven't seen that yet.

MR. KRAMER: To follow up on that point, the point's been made that there are some substantial physician affiliations with some of the large hospital systems, and the point has also been made that physicians are unable in individual practices to exhort any negotiating countervailing response to health care plans. And I'm wondering if there is differentiation in payments with the physicians that are in the affiliated systems as opposed to the ones who are essentially solo practitioners.

DR. WELCH: I can't give you data on this, but certainly I am seeing no difference in the rates that I'm paid compared with the rates that my colleagues in private practice are paid. I don't think that being in

an IDN gets a physician much of anything in the way of extra reimbursement. I think the incentive for being in an IDN is that the system that supports care is better. You can deliver better care if you have that kind of a system behind you. Electronic system and all of the other elements of care are easier to assemble.

I hope that where we get to in a few years is that every physician in Massachusetts, if not the country, will be in a sense functioning in the context of some sort of integrated system. I think medicine is just too complex for a solo practitioner to be doing it out there by themselves in an office. There's too much going on, and it's almost impossible for an individual, no matter how bright and capable, to wrap their arms around all of this.

MR. KRAMER: Any other responses on that?

MR. BAKER: The complexity of trying to manage it any other way is overwhelming. And, yeah, for the most part, the structure is -- I mean, we do mostly business with groups. I mean, that's sort of the fun to me. Almost all of our contracting is with groups of physicians. We only use individual contracting when we have issues with regard to access or geographic coverage. And we typically use the same set of fee schedules across all of that, because, frankly, doing anything other than

that gets really hard to administer, really hard.

MR. COWIE: I have a question for either of the payer representatives. We've heard some statements that Partners may have market power or have acquired leverage that makes them indispensable. To what extent are you able to design products that steer patients away from Partners or other large payers -- other large providers? In other words, are you able to use tiering or other mechanisms to deal with large providers?

DR. BERMAN: We do have a product, which we call Choice Copay, which members who are part of this product, and it's a small number of our members so far, can choose to have a lower copay if they go to community hospitals than if they get the same services at tertiary care hospitals. So, we've introduced products like that into the market.

MR. COWIE: Is that a solution to mergers that appear to create market power? I mean, are you -- have you -- are you able to steer patients away from, say, Partners?

DR. BERMAN: Well, we don't steer. This was putting the choice in the consumer's hands, that they have to make a choice, would they rather pay $500 and get their hernia fixed at a teaching hospital or have no copay and get it done at a community hospital. So, we're

not steering; we're hoping the incentive will steer.

MR. BAKER: I think the market is going to develop a lot of the -- plans aren't going to steer people, but financial arrangements are going to be developed that are designed to provide them with an incentive. And I think the $64,000 question is how big an incentive do you need to create for it actually to matter to somebody.

And then the second question is does creating that incentive in the first place create, under certain circumstances, access issues for people. And I think the -- I don't think people know the answer to that one yet.

DR. ALTMAN: The issue there -- we've been studying the drug -- use of prescription drugs with tiering, and at one level tiering is working quite well. But I think this market is going to be much tougher, because there you're dealing with a product where the quality is perceived and has been viewed as being roughly equal. The generic drug industry which had its problems with quality is now sort of coming out of that.

But if the perception is that the hospital A, the teaching hospital, is perceived higher quality, in the nature of the beast, Charlie's question is a very good one. Is $500 enough for me to take a chance? Nevertheless, I strongly support that kind of product and

I think what's surprising to me is how small the number is, the number of employers that have taken up on it. Again, I would go back to the nature of our employer market as an important part of the Massachusetts story that needs to be here. And it's a very different employer market than I see in other parts of the country.

MR. WAXMAN: Just a comment, and I suspect that one of the issues that you highlighted is, you know, am I prepared to take a chance. And the question is what's the investment that we all are going to make to determine whether there's a chance or not in the sense of how much investment are we prepared to make to determine quality. And at this point, to me, that's an open question that remains up in the air.

MR. KRAMER: We heard yesterday about a consolidation of health insurers in many markets. Massachusetts, I believe, is unusual, since the cartel case was litigated about 20 years ago, when Blue Cross was found to be a monopolist. The market has deconcentrated. I'm wondering if anyone has observations on the trend in the market to a deconcentration, particularly when you consider that there are some not-too-small players, such as Cigna, United and Aetna, that don't appear to be significant players in the market but certainly are poised for entry if the opportunity

presented itself.

MR. BAKER: This is pure speculation on my part. I have no evidence to support this at all, although we obviously talked to a bunch of the for-profit plans back when we had our headaches in '99 and 2000. Massachusetts, in particular, is a pretty heavily regulated environment. And I think to some extent it's more regulated than many other markets. And I think -- and it's not just regulated on the corporate side; it's also regulated for a health plan or insurance company; it's also regulated on the product side and it's regulated in a lot of ways that are unusual on the product side. And I think to some extent that regulatory activity makes it more difficult for somebody who's not organic to the market to deal with the regulatory requirements associated with it.

It's very hard to just sort of say I'm going to put an operating structure and a way of doing business in Massachusetts that looks like the one I have in Illinois and Maryland and California and make it work because a lot of the ways things need to be done, a lot of the way products get structured, a lot of the way reporting is done, a lot of the way you offer stuff, and all the rest is just different than it is in other places.

So you have to make a real commitment to be in

the market. And I think for some of the national carriers they look around and they say, Where am I best and most likely to be able to make an investment in a market and get where I want to go with a limited amount of, you know, new ways of doing business, new business processes, products we've never seen or managed before. And I think they say, you know what, maybe Massachusetts isn't such a hot place to go.

And the second issue is, you know, the three plans all put out the year-end numbers today. We reported between us an average of a 1 point -- I think we made it over 1, I think it's about a 1.1 percent margin for the three plans. You can't sell a lot of stock if you're -- and most people think we all had decent years. So, I mean, I just don't think you can sell a lot of equity making the argument to the outside world that you're going to deliver a 1 percent return on an annual basis. So . . .

MR. KRAMER: All right. Mike points out to me it's 12:30, so I will attempt to keep to the schedule here. Thank you very much for your attendance and interest.

(Applause).

(Whereupon, the discussion concluded at 12:30 p.m.)

C E R T I F I C A T I O N O F R E P O R T E R

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DATE: FEBRUARY 28, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the tapes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: MARCH 7, 2003

SONIA GONZALEZ

C E R T I F I C A T I O N O F P R O O F R E A D E R

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

SARA J. VANCE