FEDERAL TRADE COMMISSION

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1 **P R O C E E D I N G S**

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3 MS. MAJORAS: Good morning, and welcome to the
4 third day of the Joint Department of Justice/FTC Health
5 Care hearings. Happy to see that we have a number of
6 hearty souls making it in through the snow this morning.
7 I think we're all probably getting used to it.
8 My name is Deborah Majoras. I am Deputy
9 Assistant Attorney General in the Antitrust Division and,
10 as such, have supervisory responsibility over Litigation
11 One, among other sections. And, of course, Litigation
12 One has our health care lawyers.
13 This morning we're going to examine in detail
14 the performance of the health care marketplace in Boston,
15 Massachusetts. Now, as you know, we had also planned to
16 examine the Little Rock, Arkansas, marketplace. And,
17 thus, with apologies to Charles Dickens, our title, A
18 Tale of Two Cities. But our friends in Little Rock,
19 unfortunately, were iced in earlier in the week and, so,
20 we're going to reschedule that session for a later time.
21 And while I doubt that today's session will be
22 as melodramatic as our eponym, I don't know that we're
23 going to start in on "The best of times and the worst of
24 times," but I believe it will provide us a useful lens
25 within which to examine the issues that we intend to

1 examine on a going-forward basis in the coming months.
2 Boston and Little Rock represent two different
3 points on the spectrum of health care marketplaces in the
4 United States. Now we selected these cities not because
5 we somehow thought that they were end points on a
6 spectrum or because we thought they were absolutely
7 typical or atypical of marketplaces in metropolitan areas
8 in the U.S. Rather, we just wanted to select a couple of
9 cities where we could provide a real-world frame of
10 reference for more narrowly targeted sessions later on in
11 the hearings.
12 Naturally a lot of our future sessions will
13 focus on close-up examinations of various sectors divided
14 by, say, providers, payers and, within providers,
15 hospitals, physicians and so forth. You've seen the
16 agenda. But today's session -- and, of course, our
17 rescheduled session -- allows us to discuss issues in all
18 of these sectors within the context of Boston today,
19 Little Rock later, permitting us to explore how these
20 various components interact and interrelate with each
21 other in actual markets.
22 Antitrust analysis, of course, is highly fact-
23 specific, and as much as we can all agree on that, we
24 have to continually remind ourselves of that, lest we get
25 hijacked by naked theory. We can't appropriately enforce

1 the Federal antitrust laws or even advocate or set sound
2 competition policy if we don't carefully examine facts
3 that are presented to us by markets. So, as we begin
4 these joint hearings, we thought this could be an
5 appropriate way to set the framework.
6 Now the panelists themselves will decide -- and
7 have decided, I'm sure -- what they think will be
8 important to discuss, but I'll just say a few words about
9 some things we can expect to hear about.
10 We're particularly interested in hearing the
11 panelists' perspectives on whether competition is working
12 or not in the particular market here today, Boston; their
13 assessments of quality and price trends in the market;
14 their views on consolidation among providers and payers
15 in the market; and what impact, if any, that has had on
16 cost, quality and price; and their thoughts on how they
17 believe enforcement of the Federal antitrust laws -- and
18 perhaps other regulatory requirements -- contributes, or
19 not, to the delivery of better quality and lower prices
20 for health care in these markets.
21 There are specific market characteristics in
22 the two cities that we anticipate discussing, and I feel
23 this need to give you a caveat now. First of all, when I
24 say market, I obviously am not defining an antitrust
25 market for any purpose in my remarks. It's just a

1 shorthand way to talk about these geographic regions, and
2 when I say something to you about this market has this or
3 that, I'm not saying that these are absolutely the facts
4 if we had a future investigation ever or an enforcement
5 action. So, I'm afraid I must say that to you.
6 So, first thinking about in Boston, the HMO
7 penetration, which, as I understand, is around 50 percent
8 and ranks among the highest in the country, although even
9 in that city there has been some shift away from HMO
10 health coverage. And HMO penetration is less in Little
11 Rock.
12 And, so, as we look at these developments it
13 may assist us in understanding the roles that HMOs,
14 traditional insurance, coverage plans, and self-insurance
15 play and how we ought to be defining health care markets
16 -- health care coverage markets.
17 Another market characteristic to think about in
18 Little Rock, later on, there have been indications that
19 the expansion of specialty hospital services may be
20 threatening the revenues of general, acute care hospitals
21 and understanding how the opening of those single-
22 specialty hospitals impacts the revenue and what the
23 general, acute hospitals are doing to respond also will
24 tell us a bit about how we should be defining markets and
25 how we should be looking at competitive effects in

1 markets.
2 Another characteristic that is of interest --
3 and this is something that may differentiate Boston and
4 Little Rock -- is that in Little Rock there's long been
5 an alliance between Arkansas Blue Cross/Blue Shield and
6 the Baptist Health System there, that has existed, like I
7 said, for many years. And in Boston, on the other hand,
8 hospitals have generally negotiated with payers without
9 an alliance.
10 Understanding the competitive impacts of these
11 alliances between multiple providers and also between
12 providers and payers helps us understand how the
13 alliances may affect the market power of the members and
14 whether they may produce any competitive results in the
15 form of higher prices or lower quality.
16 And in Boston several large hospitals have
17 consolidated, which provides us with several issues; and,
18 in particular, issues that we're going to discuss later
19 in the hearings. Parties who propose hospital mergers
20 frequently indicate that they anticipate considerable
21 efficiencies from the merger that will benefit consumers
22 and, of course, courts have, in some instances, accepted
23 those arguments.
24 And in later hearings we intend to look at some
25 consummated hospital consolidations to assess whether the

1 merged entities achieved the efficiencies. If so, why,

1 characteristics of Boston and Massachusetts in comparison
2 to the U.S.
3 I don't think it's possible to talk about
4 rising health care costs or what's going on in
5 Massachusetts without doing a little history lesson, and
6 very quickly I want to go back to the late 1980s and the
7 middle '80s, which was a decade I call Halfway
8 Competitive Markets and Ineffective Regulation.
9 Essentially, it was an environment where sort of anything
10 went.
11 We had a health care system that was growing
12 rapidly. The insurance markets, while we had a lot of
13 words called HMOs, effectively most of them were fee-for-
14 service, very little constraints. This allowed a
15 hospital system, in particular, which had substantial
16 overcapacity to continue to function quite nicely because
17 they were able to raise their rates to make up for the
18 shortfalls. And one of the ways they were able to do it,
19 even though the government, both at the Medicare/Medicaid
20 level, was putting serious constraints on what they were
21 spending, the private sector was just paying for
22 whatever, essentially, the system felt it needed.
23 And those of us who have spent time in this
24 industry -- and one of the things I did for 13 years was
25 chair the Perspective Payment Assessment Commission -- we

1 looked at these hospital payment-to-cost ratios, which
2 appear here. You'll see that the yellow and green lines,
3 which is Medicare and Medicaid, were paying, essentially,
4 either at or below what the average cost of care in the
5 hospital. It was being made up by the private sector,
6 which by 1992 was paying at 131 percent of their costs,
7 which was giving the system a nice cushion.
8 And one can draw a similar conclusion in Boston
9 and Massachusetts, although when we talk about
10 Massachusetts you'll see that the private payer cost
11 ratios were much lower than they were in the rest of the
12 country.
13 Well, the good or bad old days of the 80s came
14 to an end and by the mid-90s we had a bunch of things

1 substantially changed. Most importantly the flow of
2 dollars in inpatient care, which had been rising
3 consistently during the '80s, took a sharp drop. You can
4 see on this chart in that green checkered world,
5 inpatient spending went from plus four percent a year in
6 1993 to almost a negative over five percent by 1997.
7 Jumping ahead a little bit, you'll see that this trend
8 has changed substantially since 1997, and we're, again,
9 seeing upticks -- substantial in some cases -- upticks in
10 inpatient care.
11 When we add that to outpatient care, which had
12 grown significantly and continuously during the '90s,
13 you'll see that that continues to grow and we've had some
14 increased spending for physicians and, then, finally, we
15 had the big granddaddy, which is prescription drug
16 spending.
17 Now, along with the increase -- the reduction,
18 particularly, in use of the inpatient hospitals based on
19 serious financial pressure on them began to consolidate
20 and began to cut back their bed capacity. Overall in the
21 U.S., you saw almost 11 percent reduction between 1990
22 and 1999. The reduction in Massachusetts and in Boston
23 was substantially greater at 25 percent in Massachusetts
24 and 28 percent in Boston.
25 By the way, I will talk almost interchangeably

1 And we also saw this merger activity hit
2 Massachusetts, as well. Again, reaching a high point in
3 1996, and in this you can see that there were a whole
4 bunch of activities going on. There were closures, there
5 were mergers, there was contract affiliation. And, so,
6 Boston and Massachusetts paralleled the country. Again,
7 what's important to notice is that that activity has
8 substantially lessened since the mid-1990s.
9 So, that -- well, let's go back. We're in the
10 mid-1990s, bed capacity is being reduced, hospitals are
11 feeling a pinch and, just to show that we do recognize
12 that there are physicians in this country and we should
13 take them into account, we at the task force heard from
14 the Massachusetts Medical Society about the situation of
15 physicians.
16 And we have a -- if not a unique situation --
17 it's pretty close to being interesting -- it's clearly
18 very interesting -- on the one hand there are lots of
19 physicians practicing in Massachusetts. We have a lot of
20 very fine medical schools and many physicians don't want
21 to leave Mother Church too far away, and, so, not only do
22 they get trained in Massachusetts but they stay and
23 practice. As a matter of fact, we have more physicians
24 per capita than any other state which I'll show you in a
25 minute.

1 up a little differently. So, this includes Suffolk and
2 Middlesex.
3 There were 35 hospitals in those two counties
4 in 1993, with a total of about 9,600 beds. Of that
5 9,600, about 48 percent were teaching hospital beds and
6 the remaining were nonteaching beds. And one of the most
7 dramatic -- there were several things that happened
8 between 1993 and 2000, today, 2001. One, the number of
9 hospitals declined by 10, from 35 to 25; the number of
10 beds declined from 9,600 to 6,900 or 7,000, but there was
11 a substantial shift. While there was a 48 percent
12 decline in the number of nonteaching hospital beds, there
13 was only a five percent reduction in teaching hospitals,
14 so that the teaching hospital beds in the Boston area has
15 gone from 48 percent to 63 percent.
16 We are in love with our teaching hospitals. We
17 use them for everything, and when I say "we," I'm talking
18 about "we" as consumers. And this is -- it's just the
19 nature of Massachusetts health care, and if you are
20 looking at teaching hospitals' spending per capita in
21 1998, which our task force looked at, we spent $168 per
22 capita, where the rest of the country spent $42 per
23 capita.
24 And, so, one cannot talk, at all, about Boston,
25 Massachusetts, without talking about teaching hospitals,

1 and we have a lot of them. And, as a matter of fact, in
2 that period, we had 10 separate, full-service teaching
3 hospitals at the beginning of the decade, and through a
4 series of mergers the number was reduced to six.
5 So, six is still substantial, it's not like
6 they have one gigantic teaching hospital or teaching
7 hospital system, we have a number, and you're going to
8 hear from several of them today.
9 Now, with all this going on and with our love
10 for teaching hospitals and hospitals in general, you
11 would have thought Massachusetts hospitals were just
12 raking in the bucks. And, depending on how you look at
13 it, the answer is, well, a little bit, but in terms of
14 margins -- now, of course, in the world of not-for-
15 profits, I'm well enough to know that margins are a
16 tricky issue, and I'm not here to give you a long lecture
17 on margins, but this is what we have to look at in terms
18 of the difference between revenue and expenses.
19 And you'll see in this chart 9 that the margins
20 in the U.S., for hospitals in general, decline quite
21 substantially from fiscal 1996 through fiscal 2000, in
22 part because of managed care pressures, but more
23 importantly because of the Balanced Budget Act, which was
24 passed by the Federal Government in 1997 and began to
25 operate, and now has sort of crawled up a little bit

1 around the country to someplace between 2.4 and -- the
2 2.2 is an approximate for 2002 -- we're still sort of --
3 not we, the AHA is getting clearer data on that.
4 But what is dramatic is the difference in
5 margins between Massachusetts and the rest of the
6 country. Massachusetts has traditionally been a low
7 margin state in terms of hospital margins, and you'll see
8 here it went from a +.6 in 1996 to a -1.5 by 1998, and it
9 sort of bopped around at those negative numbers. And, by
10 the way, that was one of the reasons why the task force
11 was established in 2000. And, now, you know, has had a
12 very dramatic rise and is now at .02 percent.
13 So, yes, our hospitals are in better shape
14 today than they were in 1998, but hospitals in
15 Massachusetts are not sort of putting away large amounts
16 of money in terms of excess margins.
17 Now, what's happened to the insurance market?
18 The most dramatic impact -- and, by the way, the staff
19 asked me to look at the U.S. as well as Massachusetts --
20 is in my view a substantial shift in preferences away
21 from managed care, particularly from what we think of as
22 tightly formed managed care, which we call HMOs. PPOs
23 will tell you they do a little managed care, but I would
24 call it managed care light; some would say they would
25 call it service in drag. It depends on which side of the

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

And this is a very dramatic change. We in

1 the task force.

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

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

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

20 But I think the general conclusion is that when
21 you do the adjustments, two things happen: the gap
22 between Massachusetts and the U.S. shrinks substantially.
23 Massachusetts is still above, but it's now above in the
24 10 to 15 percent range, not the 30 percent range that is
25 suggested there. My own view is that not only does the

1 Federal Government pay for research and education but
2 that sums of money, unknown to most of us, is put into
3 the bills of Massachusetts residents.
4 And, so, the question is, do we want that? And
5 what I believe and watch, whether you like it or not, is
6 that Massachusetts residents and politicians and
7 employers, while they would not like to pay as much, are
8 filled with a tremendous amount of pride and actually see
9 a lot of economic advantage to this engine that we get
10 out of our teaching hospitals and our biomedical
11 education.
12 And, so, I don't see -- and the task force
13 grappled with this a lot -- and by the way, it was a lot
14 of people from all over the state, it included all the
15 industries, and I didn't hear a lot of testimony that
16 says, you know, we would be better off, you know, with
17 all due respect, since they're not here, if we became
18 Little Rock. There was just not a lot of talk about
19 that, and the question was, well, okay, we are what we
20 are, but can't we do it better?
21 And we did talk about whether, in fact, it made
22 sense for -- you can see, by the way, you can see us
23 using this. Look at Massachusetts outpatient hospital
24 utilization. Is that we use our hospitals and our
25 outpatient like many other parts of the country use their

1 physician offices and clinics. You can see our
2 outpatient business per thousand, first of all, is
3 significantly higher than the U.S. and is jumping. In
4 2001 I had a very sharp rise.
5 So, it's a marketplace that we use.
6 Nevertheless, the question is whether we could do a
7 better job. And the issue is going to be whether we can
8 deal with this.
9 So, on the one hand we are spending more money
10 for teaching and research. We are a high cost area in
11 general. One of the mitigating factors, though, that
12 needs to be taken into account, is the fact that our
13 payment-to-cost ratios are lower. And look at them.
14 Where in Massachusetts Medicaid paid $.75 on the $1.00;
15 Medicare is $.99 on the $1.00 and, most importantly,
16 private payers in 1999 paid less than 100 percent.
17 Now, you can't make it up in volume when
18 everybody's paying you less than your costs, so that was
19 a problem, and particularly when you're comparing
20 Massachusetts to the rest of the country -- 96 versus
21 112.
22 Again, Massachusetts' premiums, just to show
23 the other side of the coin, also are higher than the rest
24 of the country, but they're in the same ballpark as that
25 10 to 15 percent. You can see these are HMO premium

1 rates and this shows you the premiums that were paid in
2 metropolitan areas. If you compare Massachusetts to the
3 U.S. average, you will see that in comparison there is a
4 difference of about 10 percent, which -- so we have a lot
5 of convening evidence to say that Massachusetts, on a per
6 capita basis, when you make the appropriate adjustments,
7 is about 10 to 15 percent higher.
8 And, as I said, the reason is is that we do --
9 our market for a very long time has been dominated by our
10 more expensive and many of us, many of our citizens
11 believe, higher quality health system. And we also have
12 a lot of specialists. And, so, it's a different market
13 than the rest of the country.
14 In our task force, we strongly urged both the
15 state government, through Medicaid, private employers and
16 anybody who would listen to us, that we needed, where
17 possible, to shift patients into the community hospitals.
18 Our problem is the following, and I hope you've gotten a
19 flavor of it. Our community hospital system in
20 Massachusetts is in very poor shape. Financially, it's -
21 - it's -- as I showed you, the numbers are not positive.
22 The number of beds that have closed, in -- during the
23 period of time that the task force was in operation,
24 three community hospitals were on the verge of
25 bankruptcy.

1 population that is more concerned about producing, you
2 know, whatever, biomedical breakthroughs and education
3 than it is telling their employees where to go. And, so,
4 when the managed care industry tried to shift us out of
5 our teaching hospitals, they got blasted.
6 So, the bottom line here is Boston is unique in
7 a lot of ways, and I've tried to give you a flavor for
8 that. The Massachusetts health market and its consumers
9 are unique, and my sense is that the forces that are
10 pressing health care costs around the country are
11 pressing them in Massachusetts.
12 And our article goes into great detail.
13 Technology, the fact that our managed care industry has
14 seriously deteriorated, partly -- mainly because we as
15 consumers and politicians beat them up so much, they want
16 to tell their kids what they do. And, so, they finally
17 decided they were going to sort of, you know, become
decer(and6)eTtTDhpyzwaavTjcich(ar goes into great deta9want) Tj -

1 MR. KRAMER: Good morning. I'm Steve Kramer.
2 I'm a staff lawyer with the Antitrust Division,
3 representing the Department of Justice. With me is a
4 counterpart at the FTC, Mike Cowie, who is an assistant
5 branch director there, representing that organization
6 today.
7 We have a distinguished group here, and I'd
8 like to introduce them in the order in which I chose them
9 to speak, I guess violating one of the precepts that
10 generally speakers here speak in alphabetical order. I
11 thought that we'd try to interweave the perspectives a
12 little, rather than hearing from two health care planners
13 first and going upstream then to the providers.
14 First, I'd like to introduce Dr. James Mongan,
15 President and CEO of Partners Health Care in Boston.
16 Next I'd like to introduce Charles Baker, President and
17 CEO of Harvard Pilgrim Health Care Group. Third I'd like
18 to introduce Charles Welch, M.D., representing the Mass
19 Medical Society as its President. Next I'd like to
20 introduce J. Mark Waxman. Mr. Waxman is President and
21 General Counsel of CareGroup, Inc. Next I'd like to
22 introduce Dr. Harris Berman, who is CEO of Tufts Health
23 Plan. And, finally, as David mentioned, Professor Fran
24 Miller of the Boston University School of Law will offer
25 somewhat of a retrospective on some of the remarks made.

1 And then Mike and I will start up asking some
2 questions after -- I think we'll take a break before
3 Professor Miller to give her a chance to organize some of
4 her thoughts. And then after she's done, Mike and I will
5 ask some questions after we give the panelists an
6 opportunity to respond to any remarks that they might
7 like to respond to. And I would ask the panelists, in
8 the interest of time, to try not to exceed ten minutes.
9 So, with that, let me ask Dr. Mongan, please,
10 on behalf of Partners, to present his statement.
11 DR. MONGAN: Thank you, Steve. I'm Dr. Jim
12 Mongan, President of Partners Health Care. And I
13 appreciate the opportunity to appear today to give you
14 our thoughts on Boston health care and on Partners.
15 Partners is an integrated academic health care
16 system, which was formed to add value to the patient
17 care, teaching, research and community missions of our
18 founding institutions, the Brigham and Women's Hospital
19 and Massachusetts General. This morning, I'd like to
20 review what Partners has accomplished over the past nine
21 years. And then I'll address two issues: market
22 dynamics in Boston and health care costs in Boston.
23 But let me start with a brief history of the
24 formation of Partners. A decade ago, we began to see the
25 traditional academic/medical centers no longer provided

1 the best structure for care, teaching and research.
2 Services were shifting rapidly to an outpatient basis and
3 inpatient stays were growing shorter. Our hospitals
4 looked like giant intensive care units. Although among
5 the very best in the world at providing complex care,
6 these hospitals were no longer an adequate platform for
7 the range of care our patients need. They gave students
8 only a quick glimpse of the sickest patients and they
9 provided a very narrow base for important research. And
10 they were becoming less relevant to their surrounding
11 neighborhoods.
12 We believed that we needed a new model of care
13 to address these shifts. It would include not only great
14 ICUs, but also a small number of community and specialty
15 hospitals and a network of physicians. This model, which
16 we've adopted, has allowed us to protect and enhance our
17 underlying mission.
18 With regard to patient care, we are better able
19 to meet the range of our patients' needs, from acute
20 through chronic illness. We're working cooperatively to
21 improve the quality of care, and we're addressing the
22 cost of care by efficiencies of scale and by use of the
23 most appropriate settings for treatment.
24 In the cost area, by consolidating back office
25 operations, pooling our purchasing and benchmarking

1 trainees will practice in.

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

9 And finally, with regard to care of the
10 community, we forged 16 new partnerships with urban
11 health centers, and we're providing access to care to
12 200,000 patients at those centers, or three times as many
13 as when Partners was formed. Our overall commitment to
14 the under-served totals $100 million each year. Beyond
15 that, we've stabilized three failing community hospitals,
16 two of which likely would have closed without our
17 support. And in addition, we've sustained threatened
18 specialty services by adding 120 psychiatric beds while
19 others closed theirs and by shoring up fragile home
20 health and rehabilitation services.

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

1 First, let me address the market dynamics of
2 Eastern Massachusetts. We've long been a national center
3 of healthcare and, as such, are home to three medical
4 schools, 15 teaching hospitals and 31 community
5 hospitals. Almost 50 percent of our insured patients are
6 covered -- residents are covered by HMOs. Our caregivers
7 and payers are overwhelmingly not for profit. Our state
8 officials take an active role in healthcare and both the
9 current Massachusetts Attorney General and his
10 predecessor have actively enforced the public charities
11 and competition aspects of healthcare.
12 Regarding market concentration, I point to the
13 results of a Robert Wood Johnson Foundation study of
14 healthcare in 12 U.S. cities. This analysis shows that
15 in terms of hospital concentration, Boston is the least
16 concentrated city of the 12. Also, as measured in this
17 study by the Herfendahl index, Boston is the only city of
18 the 12 that is rated non concentrated in terms of
19 hospitals. Within this diverse medical environment,
20 Partners cares for 21 percent of the area's patients.
21 And, finally, I'd like to turn to the issue of
22 healthcare costs in Boston. I'll say a word about
23 hospital costs in two different contexts, and then an
24 even more important word about health insurance premiums.
25 With regards to hospital costs, I'll deal first with a

1 and a burgeoning biotech industry.
2 And even this 12.9 percent is overstated, as
3 our somewhat higher use of hospital outpatient services
4 simply shifts to another cost category in other states.
5 And whatever remains in per capita hospital cost
6 differential does not relate to hospital inefficiency.
7 In fact, Medicare data actually shows that comparing
8 costs per discharge on a wage and case mix adjusted
9 basis, Massachusetts is less costly than their national
10 counterparts. We can take pride in the fact that we
11 provide excellent care at no higher cost.
12 To pull all of this together, the proof of the
13 impact of health costs on consumers should lie in health
14 insurance premiums. As you will see attached to my
15 written testimony, we've compiled data on Massachusetts'
16 premium costs from five respective sources: three from
17 the private sector and two from the public. In raw
18 dollars, they show that our premium costs range from 7
19 percent to 13 percent above average.
20 But Stuart stopped one step too soon. When
21 adjusted for wages, our premiums range from 4 percent
22 less to 3.6 percent more than on average. And on
23 average, there is no difference at all in insurance
24 premiums in Boston compared to other cities.
25 And now one final point on market dynamics.

1 There appears to be an urban legend that our health
2 systems somehow beat up the payers in Boston and won huge
3 increases in payments. Again, attached to my testimony
4 are two charts. The first shows that private insurer
5 payments to Massachusetts hospitals in the '90s were far
6 lower than the national average. For Partners, from 1996
7 through 2000, our average annual HMO payment increase was
8 just 1.5 percent per year. Despite urban legend to the
9 contrary, the fact is that payment increases under our
10 new contracts grew an average of only 5.6 percent a year.
11 For private payers overall, we are now just about back to
12 the national average, with respect to our payment-to-cost
13 ratios.
14 So, in summary, let me simply restate my major
15 points. Partners demonstrates on a daily basis the value
16 added to its founding hospitals' mission of patient care,
17 teaching, research and community service. Provider
18 concentration in the Boston area is low, and the large
19 number of hospitals fosters a healthy level of
20 competition. Boston healthcare costs, appropriately
21 adjusted, are very close to the national average.
22 Thank you for the opportunity to appear before
23 you this morning.
24 MR. KRAMER: I now ask Charles Baker, please,
25 to present.

1 MR. BAKER: You know, I can just do this from
2 here. Does it matter?
3 MR. KRAMER: That's fine.
4 MR. BAKER: Good morning. For the record, my
5 name is Charles Baker. I currently serve as the
6 President and Chief Executive Officer of Harvard Pilgrim
7 Health Care, which is a Massachusetts-based non-profit
8 health plan. We and our affiliates -- Harvard Pilgrim
9 Health Care of New England and Harvard Vanguard Medical
10 Associates -- provide health insurance coverage and
11 health care services to about 900,000 people in
12 Massachusetts, New Hampshire and Maine.
13 Our largest operations are in Massachusetts,
14 where we represent about 25 percent of the private health
15 insurance market -- or about 12 percent of the covered
16 population, if you include the Medicaid and Medicare
17 population, as well. Our clinical effectiveness and
18 member satisfaction scores consistently rank among the
19 very best in the United States and we have a long history
20 of clinical and service innovation.
21 I appreciate the opportunity to be here today
22 to discuss competition and regulation in health care in
23 the Boston marketplace. And while you may or may not
24 have known this when you asked me to speak today, I do
25 have some history on this issue, having served as a state

1 official in the early 1990s, when many of these mergers
2 took place, which was prior to becoming a market
3 participant. Some would say that's the equivalent of
4 having the grenade that you throw on one end of the boat
5 roll back down and blow up on you when the boat shifts.
6 As a regulator, I served as Undersecretary of
7 the Massachusetts Executive Office of Health and Human
8 Services from 1991 to 1992, and then as Secretary of
9 Health and Human Services from '92 through '94. In this
10 role, I oversaw a number of state agencies, including the
11 Department of Public Health, and signed off on the
12 Department's decision to approve the initial hospital
13 merger and Massachusetts General Hospital and Brigham and
14 Women's Hospital that created the Partners Health Care
15 System. I was over at the Office of Administration and
16 Finance when the Beth Israel and Deaconess Hospital
17 merger that created CareGroup was consolidated and was
18 not directly involved in that decision.
19 We signed off on the Brigham and Mass General
20 merger in 1994, despite their obvious size and status in
21 the Boston health care marketplace for three reasons.
22 First, the market appeared to be moving toward an
23 environment in which health plans would affiliate with
24 one or more integrated care delivery systems, and then
25 compete with each other based on the quality, service and

1 cost of their networks. The Brigham Women/Mass General
2 merger seemed pretty consistent with that overall
3 direction.
4 Mass General had just recruited several high
5 profile physicians away from the Brigham, raising the
6 possibility of an upward cost spiral, in which each
7 hospital, rather than sharing talent and technology in a
8 particular marketplace, would feel obligated to build or
9 buy their own. The Brigham and Mass General merger was
10 deemed as a way to avoid this "medical arms race."
11 And, third, Brigham was intimately aligned with
12 Harvard Community Health Plan -- which was the precursor
13 to the plan that I represent today -- and it was hard to
14 imagine a merger with Mass General doing much to change
15 that existing relationship.
16 Partners went on to develop Partners Community
17 Health Care, Inc., PCHI so called, an extensive primary
18 care and multi-specialty care physician network, and also
19 acquired several other community and specialty hospitals
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1 Some eight to ten years later, this seems kind
2 of quaint, given the direction in which the market's
3 moved since that time. In between, the consumer decided
4 that he or she did not want to be constrained by network
5 structures that were institutional in nature, and many
6 individual providers shared and voiced similar views. In
7 addition, state and federal laws were enacted that made
8 it more difficult for plans -- and even for some health
9 care delivery systems -- to use defined delivery systems
10 to manage patient care. Health plans responded by
11 dramatically expanding the size and scope of their
12 provider networks and limiting their referral and
13 participation rules. As a result, an industry that was
14 expected to vertically integrate its value chain by the
15 end of the 1990s retreated to a structure that today
16 looks a lot more like it did in the '70s.
17 In Massachusetts, the hospitals that made up
18 the Partners care delivery system continued to operate on
19 a stand-alone basis, with little clinical or systems
20 integration. The CareGroup system did, in fact, pursue a
21 more integrated operational approach and some of its
22 physicians and departments actually responded to that by
23 leaving the system. Health plans in the Massachusetts
24 market lost many of the tools that made traditional
25 managed care work -- either through market reforms or

1 outright legal prohibition -- and moved back into a model
2 that I think Stuart referred to earlier as "indemnity in
3 drag."
4 Today's market is not the one that we
5 anticipated -- or that others advised us would be coming
6 -- when we made the decisions in the early and mid-90s to
7 approve many of these hospital mergers. This inability
8 to accurately predict the future and where the market
9 will go will inevitably limit the effectiveness of any
10 regulatory process. But with this in mind, I do have
11 some thoughts about how regulators could best perform
12 their duties and will share those at the conclusion of my
13 presentation.
14 After I left the public sector, I joined
15 Harvard Vanguard Medical Associates, which was an
16 affiliate of Harvard Pilgrim Health Care, as its
17 President and Chief Executive in the fall of 1998. I
18 became President of Harvard Pilgrim, as Stuart also
19 pointed out, in the middle of 1999 in a pretty
20 interesting meltdown. The plan ended up losing about
21 $227 million in 1999 and another $10 million in 2000. We
22 generated a $35 million operating gain in 2001, which is
23 about a 1 and a half percent margin, not a big number
24 relative to other sectors of the economy, but not bad by
25 our standards; and a $31 million operating gain in 2002.

1 The gains were generated, in part, through a
2 dramatic improvement in operating performance, geographic
3 and product withdrawals, significant reductions in
4 administrative spending and an over-arching commitment to
5 strategic and operational simplicity.
6 We also raised prices. The average premium
7 increase in our market has been in the 10 to 15 percent
8 range per year for the past three years, which is also
9 consistent with the numbers that Professor Altman
10 displayed in his presentation. It was driven by a number
11 of factors -- virtually all of which relate to the rising
12 cost of health care.
13 On this point, I do differ a little with
14 Professor Altman. There are certainly historic periods
15 in which insurance carriers raised prices to catch up
16 with "underwriting cycles." I don't believe the past
17 three years have been about under and over-pricing. I
18 believe the vast majority -- well in excess of 90 percent
19 -- of the increase in health insurance premiums between
20 2000 and 2002 has been driven by rising medical costs.
21 In our particular case, pharmacy costs
22 increased by 28.6 percent; inpatient hospital costs by
23 18.6 percent; physician costs by 24 percent; and all
24 other outpatient costs -- including outpatient costs --
25 by 33 and a half percent. That adds up to a 26.1 percent

1 increase in total health care costs for Harvard Pilgrim
2 commercial plan members over a two-year period. While
3 the projections for 2003 look a little different by
4 category, the overall trend -- 12 to 14 percent for the
5 year -- is virtually identical to the growth in medical
6 expenses from 2000 to 2002. This trend is also virtually
7 identical to the growth in Harvard Pilgrim premiums over
8 the same period of time.
9 In fact, we're so sure about this particular
10 issue that we would welcome any audit, review, analysis
11 or investigation the Commission might consider necessary
12 to confirm that the rates of increase in medical expense
13 -- in premiums for Harvard Pilgrim members have, in fact,
14 been driven by increases in medical expenses.
15 Hospital costs obviously represent a
16 significant share of the increase in spending over this
17 time. Professor Altman's testimony concerning the
18 increase and the use of academic medical centers for non-
19 complex services in Massachusetts, which has undeniably
20 contributed to the increase in health care costs here, is
21 a pattern I believe is borne out elsewhere around the
22 country, as well, but probably not to the same degree it
23 has in Boston. There are a number of other factors
24 driving up hospital costs, as well.
25 Reductions or very limited increases in

1 Medicare and Medicaid rates for the past few years have
2 forced hospitals to seek higher rates of reimbursement
3 from private carriers with which they do business. Labor
4 shortages in key areas, such as nursing and some
5 technical areas, have bid up labor costs.
6 Technology costs, devices and drugs, the same
7 thing, they affect our bottom line and affect theirs.
8 Consumer and employer preferences which have made it very
9 difficult for health plans to discontinue relationships
10 with any hospital or physician group in its service
11 delivery area. And hospital and physician group
12 consolidation, which has made it far more difficult for
13 any health plan to drop any one hospital or physician
14 group from its network, much less a collection of
15 hospitals and their physician groups from its networks.
16 I presume debate on this final point is a large
17 part of why we're here today. And on this issue, I would
18 offer the following observations. First, if there were
19 no hospital mergers and no provider consolidations, there
20 would still be "monopoly" rates being paid to certain
21 hospitals that are, in many cases, the only provider in
22 their service area. This is not a Partners or CareGroup
23 issue, per se, but a simple fact of life.
24 Do I believe that Harvard Pilgrim Health Care
25 members pay more for services purchased from Partners and

1 CareGroup as systems than they would if each hospital in
2 these systems continued to contract directly with Harvard
3 Pilgrim? I believe the answer to that question is yes.
4 What I don't know is how much more. I don't know if
5 these institutions would have continued to engage in the
6 kind of "arms race" type behavior we were seeking to
7 avoid in the early '90s when the mergers were originally
8 approved. I also don't know if the mergers generated any
9 savings or efficiencies. I'm sure the leadership of both
10 organizations would say the mergers have saved money, but
11 I don't believe anyone with an independent eye has
12 studied this issue.
13 I also believe the other issues I mentioned
14 before -- public rates of payment, labor costs,
15 technology costs, consumer demand, and the like -- would
16 have driven up health care costs under any scenario.
17 Do I believe the mergers have created quality
18 improvements? This is hard to say, and maybe too soon to
19 tell. The tools to measure this sort of thing are just
20 beginning to find their way into the marketplace.
21 Nonetheless, it's difficult for any health plan,
22 including ours, to hold large provider organizations like
23 CareGroup or Partners accountable for quality. They're
24 too big for us to lose as network participants, and they
25 tell us that they face enormous obstacles in creating

1 single standards of care within their own organizations,
2 due, in part, to their size and complexity.
3 With this in mind there are several general
4 observations I would offer on the state of the current
5 market that I believe regulators should consider in
6 seeking ways to enhance market competition. First of
7 all, it's not just market share held by any one hospital
8 in a particular market. For example, the Mass General
9 and the Brigham are probably the two best-known tertiary
10 hospitals in New England and they contract together.
11 Partners does not permit one of these hospitals to
12 participate in any health plan product without the other
13 -- thereby ensuring that they never compete with one
14 another. Since each is the other's most logical market
15 competitor, this could certainly be considered a
16 "competitive" problem. The fact that they represent only
17 two of many teaching hospitals in Massachusetts doesn't
18 really matter. For certain kinds of services, they are
19 virtually the only choice around.
20 Second, many hospital systems throughout
21 Massachusetts, particularly in geographic areas where
22 they have virtual monopolies, also control significant
23 numbers of salaried and affiliated physicians. In most
24 cases, no health plan can do business with any one
25 component piece of these delivery systems without doing

1 business with the entire delivery system. This is,
2 ironically, the provider equivalent of an "all products"
3 clause, a contracting technique that has long been the
4 object of significant animosity directed to the plans
5 from the provider community.
6 Third, you don't need a lot of provider market
7 share in today's markets to be able to "drive" the market
8 in a particular direction. And I think Partners is a
9 good case in point. They may represent less than 30
10 percent of the Massachusetts provider market, but no
11 health plan could expect to survive without the Partners
12 system in its network. A health plan in Massachusetts
13 could probably compete effectively with some of the
14 Partners system in its network, but the choice, as
15 defined by Partners, is all or none, so that option is
16 really no option at all.
17 It should be fairly obvious that this situation
18 bids up the price of contracting with each hospital
19 network. There is, for all intents and purposes, not a
20 level playing field here. Some networks can literally
21 dictate the price, and the health plans pay it. Other
22 hospital systems then rely on those prices as "market
23 standards" and go from there.
24 It also makes it much harder to structure and
25 enforce initiatives tied to quality. If the plans need

1 the provider organizations in their network to meet
2 market demand, requiring or enforcing significant patient
3 safety or quality initiatives is very difficult. Again,
4 the network sets the terms, not the plan.
5 The hospital and physician community will argue
6 that if they don't join together to contract on a group
7 basis with the plans they will be unable to meet the
8 needs of their patients and cover their costs. That may
9 or may not be true. I saw a bumper sticker the other day
10 promoting union membership that said something like,
11 "Together We Bargain -- Alone We Beg." From my
12 experience, this would be reasonably applicable to the
13 way my colleagues in the hospital and physician community
14 view their negotiations with health plans.
15 Is their approach anti-competitive? Probably.
16 Is it inflationary? Certainly. Is it a market response
17 to the advent of managed care, the relentless hard
18 bargaining of health plans on unit costs, and the
19 changing preferences of consumers? Absolutely.
20 And it does raise questions -- for us and for
21 the provider community -- concerning the "right" rules of
22 engagement. For the market to work, the frame for
23 competition established by public policy makers needs to
24 fully understand the participants, and their
25 relationships with one another. I commend the FTC for

1 engaging this discussion, and hope our observations here
2 today can be useful to you as you consider this critical
3 issue.
4 MR. KRAMER: Thank you. I'd ask Dr. Welch now
5 to present, please.
6 DR. WELCH: Good morning. Thank you for giving
7 me the opportunity to testify before you today. My name
8 is Charles Welch, and I am a practicing psychiatrist at
9 the Massachusetts General Hospital, where I serve as

1 Indeed, anecdotal reports suggest that the situation is
2 significantly worse than the data that I will show you
3 would indicate.
4 As you've heard, during the last decade there's
5 been a significant shift in the Massachusetts healthcare
6 market, from traditional fee-for-service insurance
7 programs to various forms of managed care. The Boston
8 area has been dominated by managed care. Over half of
9 our insured residents are enrolled in managed care
10 organizations, with three payers controlling that market.
11 As a consequence, there has been downward pressure on
12 reimbursement, which has caused closure of community
13 hospitals and hospital-based services. As I will show
14 you, declining reimbursement has also had a negative
15 effect upon physicians' ability to provide high quality,
16 accessible care to the people of the Commonwealth.
17 The Medical Society has conducted a number of
18 studies which shed light on these issues. In 2001, the
19 society issued its first Physician Practice Environment
20 Index Results, the so called misery index, which
21 confirmed that Massachusetts physician practices have
22 been struggling in a sharply deteriorating environment

1 The MMS index measures individual indicators
2 that represent three important factors affecting the
3 quality of the practice environment. These being first
4 the supply of physicians; second, practice financial
5 conditions; and third, physicians' work environment. As
6 a follow-up to the 2001 study, the society repeated the
7 study in 2002 and concluded that Massachusetts continues
8 its eight-year decline, that the index had dropped by 5.7
9 percent since 2001 -- in 2001.
10 Since 1992, the factors measured by the index
11 have fallen by a staggering 22 percent. We also made
12 comparisons to the rest of the nation. Massachusetts
13 declined at a faster rate than the nation as a whole.
14 What accounts for these results? The dominant variable
15 demonstrating how the Massachusetts index has declined
16 more sharply than the U.S. index since 1992 is our
17 physicians' cost of maintaining a practice.
18 The cost of maintaining a practice was defined
19 as rent, labor and medical supplies. Over the ten-year
20 period, the cost to physicians for doing business in
21 Massachusetts increased by 56 percent. Nationally,
22 physicians' cost of doing business increased by only 30
23 percent for the same period. In addition, the drop in
24 the overall index for Massachusetts was driven by rising
25 malpractice premiums and the rising ratio of housing

1 underwent an absolute decline in reimbursement. Those
2 few codes which underwent an increase in reimbursement,
3 which are displayed in green on the right side of the
4 graph, those few codes failed to keep pace with
5 inflation. At the top of the graph is a dotted line at
6 plus 21 percent, which is the calculated increase in the
7 cost of practice during the study interval. As you can
8 see, not one of those codes studied kept pace with the
9 increase in costs of practice.
10 In the second slide, the decrease in
11 reimbursement for colonoscopy is compared with changes
12 for colonoscopy in nine other cities during the study
13 interval. As you can see, the decline in reimbursement
14 in Boston was by far the greatest, almost twice the
15 decline in the next closest city, Los Angeles. It is
16 ironic that this large reduction in reimbursement
17 occurred at a time when colonoscopy has the potential to
18 reduce morbidity, mortality and the cost of care if it
19 were performed more widely.
20 In the third slide, the overall average decline
21 for Boston is compared to nine other cities. As you can
22 clearly see, Boston had a significantly greater decline
23 in overall average reimbursement than any of the other
24 cities, with a 30 percent -- over a 30 percent decline in
25 overall reimbursement to physicians.

1 the world, to attend our medical schools and training
2 programs, but we're having an extremely difficult time
3 getting those physicians here in light of greater
4 financial opportunity and more flexible work schedules
5 and research support offered elsewhere.
6 For example, in 2002, we graduated 78 residents
7 from our anesthesia training programs in Massachusetts.
8 Two of them remained in Massachusetts at the end of their
9 training. This is at a time when we already have a
10 shortage of anesthesiologists. I am told that 36
11 orthopedic practices in Massachusetts are currently
12 unable to fill vacancies in their practices.
13 This comprehensive work force study shows
14 unequivocally that Massachusetts is facing a crisis
15 situation in the number of physicians able to deliver
16 patient care. Vacancy rates in radiology and anesthesia
17 approach 15 percent at a time that anything over 2
18 percent is considered a work force shortage in any other
19 industry. Many physician practices are already
20 overwhelmed and unable to handle additional volume and
21 are reducing services or adjusting their staffing
22 patterns to cope with the labor shortage.
23 Over 50 percent of hospital departments
24 surveyed reported that they have altered -- which of
25 course means reduced services because of physician

1 shortages. I travel a lot around the state, and at every
2 hospital I visit a hand goes up and someone says, "I'd
3 just like you to know that whatever your data says, I'm
4 the last radiologist at Milton Hospital;" or "I'm the
5 last endocrinologist in the Merrimack Valley.
6 Physician shortages are already affecting
7 patterns of care and we are very concerned that the labor
8 shortage may already be threatening access to care. In
9 response to your question as to the impact of the current
10 market forces on cost, quality, and access to care, our
11 data show that the overhead costs of practicing medicine
12 in Boston is above the national average, that
13 reimbursements for Boston physicians are below the
14 national average, and that access to healthcare is
15 deteriorating on a number of fronts, including access to
16 physicians and timely access to necessary healthcare.
17 In terms of competition, I want to emphasize
18 this. Physicians are unable to negotiate or to compete
19 in our current environment. As a consequence, they are

1 administrative burdens imposed upon physicians'
2 practices. Nevertheless, despite our efforts, physician
3 practices are struggling to survive in this environment.
4 The reality is that individual physicians are unable to
5 effectively negotiate in this market because the
6 antitrust laws have created significant barriers to
7 negotiation between the relevant parties.
8 Consequently, individual physicians standing
9 alone cannot obtain increases in reimbursement to
10 directly cover the rising costs of operating a medical
11 practice. I question whether we can depend on the
12 influence of competitive forces on our market when the
13 supplier of services is unable to compete or negotiate.
14 That being said, I want to commend both the FTC and the
15 DOJ for analyzing the impact of current market forces,
16 not only in terms of cost, but also and perhaps most
17 importantly, on the quality of care that is delivered.
18 While much of the historic debate on
19 competition has focused on money, physicians are even
20 more frustrated and constrained in their ability to fight
21 for contract terms involving the quality of patient care.
22 Physicians continue to struggle with crushing
23 administrative burdens and restrictions which hinder
24 their ability to efficiently and effectively deliver the
25 most appropriate care.

1 Additionally, a number of plans track and
2 reward physician performance primarily based on overall
3 costs and not on quality of care delivered. Clearly,
4 this is not in the best interest of patients. The
5 medical practice market in Boston is distinguished by one
6 of the highest penetrations of managed care in the
7 country, three dominant players and some of the lowest
8 reimbursement rates in the nation.
9 All of this exists in a market where the cost
10 of running a medical practice is among the highest in the
11 nation. The impact is clear. Many physicians are unable
12 to survive and are closing their practices to relocate
13 elsewhere or leave medicine entirely. Of even greater
14 concern, fewer physicians are choosing to begin practice
15 in the Commonwealth.
16 While there are many reasons for the situation
17 in which we find ourselves today, the Massachusetts
18 Medical Society believes that the asymmetry of the
19 bargaining relationship between payers and providers and
20 the resultant failure of dynamic market forces is the
21 primary reason for the current work force shortage and
22 the impending crisis in access to care.
23 If dynamic market forces were functioning
24 properly, we would not see reimbursement to physicians
25 declining steeply at the same time that we have a severe

1 physician shortage. But market forces clearly are not
2 functioning, because in our zeal to follow the gospel of
3 antitrust, we have instead destroyed the very dynamism of
4 market forces we all hope to foster. And instead, we
5 have created an out-of-control machine that is in a rapid
6 descent towards a crash.
7 Thank you very much for the opportunity to
8 appear before you.
9 MR. KRAMER: Thank you, Dr. Welch. I'd ask Mr.
10 Waxman to go next.
11 MR. WAXMAN: Thank you. I think like Charlie
12 I'll just sit here.
13 Good morning. My name is Mark Waxman, and I'm
14 with the CareGroup system. It's a Boston-area provider
15 network consisting of some acute hospitals, principally
16 the Beth Israel/Deaconess Medical Center, which is a
17 strong Harvard affiliate; New England Baptist Hospital,
18 which is a well-known orthopedic hospital; the Mount
19 Auburn Hospital in Cambridge, a very fine community
20 hospital, which also does some teaching; and the
21 Associated Faculty Practice Plan at the Medical Center;
22 the Harvard Medical Faculty Physicians; and a number of
23 other affiliated physician groups.
24 As others have, I want to thank you for the
25 opportunity to participate in the process. I've learned

1 a lot in just listening this morning. It gives you a lot
2 of other thoughts as well. I want to make clear that my
2

1 favorable rate, some very favorable bond covenant terms.
2 And ultimately the glue in this system at one level,
3 which was the joint and several liability, which clearly
4 would tie the system together in a very important and
5 long-lasting way.
6 I think it's fair to say that the track record
7 of our merger has not been stellar. Cultures clashed;
8 strong central leadership was not established; and over a
9 period of several years large amounts of money were lost.
10 Over a period of three years, the CareGroup system lost
11 over $200 million. And we have had to dig ourselves out
12 of that situation. This year we hope our loss will be
13 minimal and we're optimistic we can get there, but we're
14 only going to be able to get there with the help of a
15 large number of people and an awful lot of work within
16 the system itself.
17 As a system, therefore, we continue to be in
18 somewhat of a turnaround situation. We think our
19 leadership, particularly at the medical center, has now
20 stabilized. But over time, this has led to a downsizing
21 of the system through the divestiture of two community
22 hospitals and some of their related physicians. We've
23 gone through a change in governing board structure and
24 actually the CareGroup focus has now changed from being a
25 focus on creating a tightly coordinated system of patient

1 both in health care and elsewhere.
2 Second, the cost of operating on acute hospital
3 business in Boston are high. Some are not so unique;
4 some are unique. Of particular note, we, like the
5 Partners system, have been aggressively engaged in
6 efficiency and cost-cutting, but we face nursing costs,
7 which are, as has been reported, going up and up, and
8 pharmacy costs, I would say you're looking at in the
9 range of 10 percent and 15 percent, respectively.
10 Technician shortages are real and not likely to diminish
11 in the near future. And I think we feel that this is
12 unlikely across the board to diminish across the system
13 for very long.
14 We have high technology and capital costs of
15 being quaternary and tertiary centers who are performing
16 significant volumes of primary and secondary care. Yet I
17 think everyone would admit if these centers closed, there
18 would be significant access in the Boston market. If one
19 looks at diversion data, for example, among our chief
20 competitor, the Mass General and the Brigham, they are on
21 diversion a fair amount of time. This indicates the
22 significant access problems already exist in the market.
23 Another aspect of Boston that is unique that I
24 don't think people have talked about as much as they
25 might, is notwithstanding the competition at some levels,

1 community.

2 Another abnormality we face is the free care or uncompensated care pool. In essence, this is a transfer

1 element in the Boston dynamic. It is also a reason many
2 people come to the academic medical centers. It also
3 helps drive costs, because the Boston hospitals, as a
4 result, practice a higher standard of care than many
5 hospitals around the world. Boston hospitals are
6 essentially required to be early adopters of new
7 technology. That has impact and effects on the
8 marketplace.
9 There has been a historical anti-for-profit
10 view in the Boston market. This may be softening in
11 light of difficult times for a number of hospitals. And,
12 lastly, as has been acknowledged, and I'd be remiss
13 without stating it again, our Medicaid rates relative to
14 costs are quite low. This also has significant impact on
15 the market.
16 Now, it has been noted the market has evolved
17 over time, and with the exception of some potential
18 community-based physicians, there's consolidation out in
19 the market. And those talks are now underway. It may
20 not change that much in the short term. We've seen the
21 creation of the Partners system, the reactive creation of
22 CareGroup, and the PSN, which includes Lahey and others.
23 We do have the Keratose system, the UMass system and some
24 other players.
25 It's interesting that the New England Medical

1 Center recently separated from its Rhode Island
2 affiliation, and what that means to the Boston
3 marketplace I think remains to be seen. As I mentioned,
4 there continues to be some evolution on the physician
5 side, whether the significant multidisciplinary medical
6 group discussion is to create the so called G-4 group
7 will come to pass and integrate to become a market force
8 at this point I think is somewhat up in the air.
9 A few words about quality. I think the Boston
10 market has devoted significant energy and dollars to
11 quality. While quality at Boston-area teaching hospitals
12 is generally presumed, I think we share with Partners and
13 others the view that our quality is extremely high. That
14 quality is something that is actually published and
15 measured by a number of folks, the Tufts Health Plan
16 measures quality, Picker surveys are published in the
17 Boston Globe, and the MHA puts out reports on medication
18 safety. However, we cannot tell if the payments from the
19 payers actually differentiate in any real sense in
20 payments based on any objectively measured quality
21 parameter. Nor has participation in any plan that we're
22 aware of been specifically linked to any particular
23 quality parameter in the market. We know that the payers
24 are beginning to experiment with incentive payments for
25 quality. How big of a percentage of the overall dollars

1 those will be and whether they actually drive changes in
2 quality performance I think is an open question.
3 And there have been varying degrees of
4 integration of network providers. I think Charlie
5 mentioned his views. I think Dr. Mongan mentioned his
6 views. In our view, we have made a significant effort, a
7 significant investment in systems and software
8 development in an attempt to integrate our physicians.
9 We have common physician credentialing; we have a
10 referral management system; we have, I think, a very well
11 known web reporting system with a multitude of reports on
12 patterns of care in our network. We've had a focus on
13 care improvement through HEDIS reporting, disease
14 management, high risk patient management programs,
15 universal formularies on the pharmacy side, some system-
16 wide case management and some medical management
17 infrastructure.
18 Let me now talk about the payer market. The
19 payer market realistically consists of three plans,
20 Harvard Pilgrim, Tufts and the Blue Cross/Blue Shield
21 plan. Virtually all physicians and hospitals participate
22 in each of these three plans, and the provider panels are
23 virtually identical in all the key areas. This
24 eliminates this factor as a potential product
25 differentiator, so plan competition, you see, is almost

1 entirely based on premium and not necessarily quality or
2 service.
3 Among the plans, and it's interesting that
4 they're not here today, Blue Cross is the major plan,
5 without which you certainly cannot be in business,
6 particularly after you consider the HMO and indemnity
7 business together. Without Blue Cross, you would simply
8 not be able to function. Blue Cross, although it's a
9 non-profit entity, is an aggressive and powerful market
10 player. Our PSN has found it extremely challenging to
11 have meaningful negotiations with respect to physician
12 payments.
13 The reliance on a fee schedule that does not

1 future based upon the market dynamics as they now exist
2 and are likely to change.
3 And lastly, although it's not a direct impact
4 on the market, it's certainly a market irritant, and that
5 is we continue to see payment practices collectively by
6 the payers, notwithstanding some attempt to approve it on
7 the state law side, which continues to delay and
8 frustrate the providers' ability to realize on their
9 contractually committed rates. At this point,
10 representative of frustrating strategies, we have
11 refusals to share payment rules prior to implementing
12 them. There are attitudes that every error must be a
13 provider error, almost by definition. One prominent plan
14 can't provide premium verifications for a 2001 contract.
15 We're still debating payments for 1999 payment rates with
16 another. And frankly, we are concerned that constant
17 arbitration litigators and litigation with payers will

1 recognize that the Partners HealthCare system is the
2 dominant player in the market. There are very -- there
3 are many ways, and I'll take my lawyer's hat off for the
4 moment, that one could look at the market. We think one
5 key element as you look at physician contracting
6 networks, there was a very interesting article in the
7 Boston Globe in January of 2002, which I'll say we don't
8 accept always as having the gospel with respect to the
9 facts, but the Boston Globe has -- went and looked at the
10 employed and closely affiliated physicians, which are
11 actually the ones who drive care, they're the ones that
12 actually make admissions and make referrals. And in that
13 the Partners system was shown as clearly the dominant
14 group with much, much more than twice, almost three
15 times, our size in terms of the number of affiliated
16 physicians.
17 Now, as a result of payer contracts and huge
18 capital endowment, we're concerned that Partners will
19 become the only system with the ability to make capital
20 investments necessary in recruitments, special services,
21 innovative programs in market expansion that others
22 cannot match. The big concern is that its size may end
23 up commanding a disproportionate share of premium
24 dollars, leading to enhanced strength and reinforcing
25 market dominance. I'm not saying that that's an

1 entity called Patient Choice, which is a plan which is
2 essentially an insurance product, which is seeking to
3 enter the market as well. In their view, they have
4 experienced the true impact of market compaction on their
5 ability to enter into the marketplace. We find a
6 situation where payer consolidation and inadequate
7 payments make it very difficult for the providers to
8 discount, to invite a new entrant into the market, where
9 at the same time, a new entrant needs a network in order
10 to go to the employers to provide the breadth of
11 providers necessary to be in the market.
12 And if you have certain networks that either
13 will or won't participate, that may have the effect of
14 denying the opportunity for them to get into the market.
15 I view the patient choice desire and experiment as a very
16 interesting aspect towards market entry in the Eastern
17 Massachusetts area.
18 A couple of other comments driving costs. I
19 think we all face the unfunded mandates and the research
20 apparatus. I guess I'd be remiss, since you can't help
21 but escape it, of the HIPAA costs, disaster readiness,
22 the leapfrog initiatives, and we all face insurance
23 costs. We have underpayment, in our view, of the true
24 costs by the payers.
25 And if you look at things like prostate Brachy

1 therapy, neuro stimulators, and drug-eluding coronary
2 artery stints, this is a situation where the payers
3 simply in our view are not paying the actual costs, even
4 though Medicare is more willing to step up to the plate.
5 Yet in the Boston market, these things are part of
6 everyday marketplace activity.
7 Issues that we think about, I think the key
8 issues are the effects of steadily increasing market
9 power by the dominant players. We are concerned about
10 our own ability to find long-term capital to be a
11 meaningful long-term competitor in the Boston health care
12 marketplace. We are interested in what happens to the
13 market if, in fact, the HMO penetration goes down and we
14 see a significant shift away from all risk-based systems.
15 We don't know the extent to which that will occur or what
16 the effect of that might be on systems.
17 Over time, we're concerned about the potential
18 effects of patients in terms of their ability to have
19 access to the necessary physician base. We're concerned
20 that provider payments are very low compared to the costs
21 of making investments. I think we also specifically
22 would have some serious questions with Dr. Altman's views
23 that the payers are giving up power in the marketplace to
24 the providers. In our view, when we sit down across the
25 table, we simply don't find that to be the case,

1 particularly, as I indicated, on the Blue Cross side.
2 A comment was also made about per capita health
3 care spending, which Dr. Mongan addressed. I have a
4 question as to data which is based on the bills,
5 indicating how the bills are going up without adjustments
6 for fee schedules, capitation or DRG payments. I think
7 it's understood that fee schedules on the physician side
8 have not remotely kept up with the cost of actually
9 operating a practice. And Dr. Welch's comments, I think,
10 went directly to that point.
11 We also do not see on the chart the
12 acknowledged hospitals' mandated free care contributions
13 as part of the overall cost of doing business in our
14 market.
15 With respect to the hospital education and
16 research, I think I would echo Dr. Mongan's comments but
17 also state specifically that when we sit down across the

1 I think that summarizes my comments. I very
2 much appreciate the opportunity to participate.
3 DR. KRAMER: Thank you. Turn it over to Dr.
4 Harris Berman.
5 DR. BERMAN: Good morning. I'm Dr. Harris
6 Berman. I was especially pleased to hear from Stuart
7 this morning that I'm kinder, gentler, and smile more
8 than I did ten years ago. Stuart, I think being kinder
9 and gentler has less to do with the managed care backlash
10 than it has to do with just mellowing with age. And the
11 smiling clearly is because after 32 years in a difficult
12 industry I'm about to retire and move over to academia,
13 which has kept you smiling as long as I've known you.
14 But in the meantime, I'm still CEO of the Tufts
15 Health Plan, a 900,000-member, not-for-profit
16 Massachusetts-based plan founded in 1981. I appreciate
17 the invitation to respond to the government's questions
18 about competition among hospitals and physicians in
19 Eastern Massachusetts health care markets.
20 At the same time, I do have to own up to being
21 a little bit uncomfortable doing this. The questions the
22 government has raised relate primarily to the most
23 powerful provider group in our network, Partners, and
24 Tufts Health Plan will again enter negotiations with that
25 powerful network in just a few months. We do recognize,

1 however, that the last Partners/Tufts Health Plan
2 negotiations have become something of a national poster
3 child for the problems that arise in the market that has
4 experienced provider consolidation.
5 So, despite my discomfort, I'll do my best to
6 describe my perceptions of the serious breakdown in
7 competition that has occurred in Eastern Massachusetts.
8 Healthy competition amongst providers and payers in the
9 past helped to create a health care environment in the
10 Boston area that includes both outstanding medical care
11 and the nation's most highly rated health plans,
12 including the Tufts Health Plan.
13 This healthy competition now stands threatened
14 by the exercise of market dominance by Partners
15 HealthCare and its hospital physician network known by
16 the acronym of PCHI. Founded in 1994 with the merger of
17 Boston's two largest and most prestigious academic
18 medical centers, the Mass General and Brigham and Women's
19 Hospitals. Partners and PCHI have achieved market
20 dominance in very specific ways.
21 Through mergers and acquisitions over the
22 years, the PCHI network now numbers 15 hospitals and more
23 than 5,000 physicians in the Greater Boston area.
24 Partners and PCHI have planned these mergers and
25 affiliations strategically to include anchor community

1 hospitals and key physician groups in key geographic
2 areas, principally north and west of the city of Boston,
3 and to acquire monopoly or near-monopoly power in the
4 very specialties that are most important to the
5 consumers' choice of a health plan: internal medicine,
6 pediatrics, and obstetrics and gynecology.
7 In fact, Partners owns or negotiates for
8 virtually every hospital in the north shore suburbs of
9 Boston. Through this aggregation of power, Partners and
10 PCHI have literally made themselves a must-have hospital
11 system for area employers and consumers. Partners has
12 used this position to demand price increases above what
13 we would expect normal healthy provider competition would
14 otherwise produce. And the Partners system has
15 accomplished this objective through a negotiation
16 strategy designed to maximize their new-found leverage.
17 We fear that this new-found leverage will also
18 be used in the future, not just to raise prices, but to
19 limit consumer choice, as well. Their negotiating
20 leverage became starkly evident in the fall of the year
21 2000, during the last round of contract negotiations for
22 our commercial insurance products. We entered the
23 negotiations with area employers encouraging us to keep
24 premiums and costs under controls. And we fully expected
25 to meet that goal through the normal give and take of the

1 negotiating process.

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

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

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

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

1 plan. Employers who previously had been supportive
2 uniformly and understandably changed their tune, telling
3 us loudly and clearly, if you don't offer Partners, we
4 can't offer you to our employees. Given the size and the
5 scope of the PCHI network, Tufts Health Plan was
6 threatened with the loss of its largest accounts. I
7 finally concluded, in the middle of the night one night,
8 that our very viability was at stake. And in the end, we
9 had no choice but to acquiesce to their high demands.
10 In the September hearings held here on
11 competition and health care, Cara Lesser of the Center
12 for Studying Health System Change, cited this terminate-
13 then-negotiate tactic as an ominous new phenomenon
14 employed by powerful provider networks. She described
15 this as a tactic that is threatening continuity of care
16 for hundreds of thousands of consumers in the communities
17 in which it is occurring, and she specifically cited that

1 Boston. It enjoys monopoly or near-monopoly in other
2 important specialties in this market: internal medicine,
3 surgery, and pulmonary care.
4 Likewise in the western suburbs of Boston, PCHI
5 enjoys market supremacy in pediatrics, pediatric
6 psychiatry, and medical oncology. With this kind of
7 power in such key service lines in a broad geographic
8 area surrounding Boston, employers simply cannot offer
9 health plans that do not have Partners and its affiliates
10 in their network.
11 The exercise of this power occurs against a
12 backdrop of a highly competitive payer field. Harvard
13 Pilgrim, Blue Cross, Cigna, Aetna, Tufts Health Plan and
14 a host of third-party administrators compete vigorously
15 with each other. The absence of significant buyer power
16 is certainly indicated by Partners' cavalier willingness
17 to do without us.
18 The outcome of Partners negotiating power and
19 market dominance have been higher prices to the consumer.
20 This has been what Partners has been about from day one.
21 Now Partners can raise prices because of its ability to
22 impose its contract terms unilaterally on area payers and
23 because the PCHI hospitals and physician groups, both
24 those that are owned and those that are merely affiliated
25 with PCHI, refuse or are unable to negotiate with payers

1 independently of PCHI.
2 Moreover, we have seen little evidence that the
3 Partners hospitals have integrated major departments. As
4 a result, when all is said and done, we ended up with
5 contract price increases far outstripping medical
6 inflation rates over a three-year period. We may hear
7 that this was a market correction, but it was not. This
8 was a market disruption leading to prices above what we
9 would expect in a truly competitive market.
10 It is curious that a delivery system that
11 trumpets in its recent “advertorials” how it has lowered
12 the cost per patient in its hospitals by 22 percent and
13 claims to be operating on low margins is the same system
14 which drove what were by any account significant premium
15 increases. Lower costs in health care are supposed to
16 lead to lower prices. The stated rationales for the
17 price increases, market corrections, narrow margins and
18 the like, lose credibility when voiced by a dominant
19 network whose then CEO during the opening of our
20 negotiations told us explicitly that Partners doesn't
21 care what the market will bear, that it intends to push
22 up the premium and that it is in a unique position to
23 move the market.
24 There is no doubt that price increases
25 translate into higher premiums. At the same time,

1 contrary to Partners' assertions, our recent premium
2 increases are, in fact, not to our profit, not to
3 reserves, not to administrative costs, but directly to
4 medical cost increases. In fact, as a percentage of
5 premium revenues, our administrative costs for 2002
6 stayed flat and our profits for 2002 actually declined
7 compared to 2001. That is, the claims paid actually
8 increased faster than the premiums did from 2001 to 2002.
9 Partners dominance has played out in other
10 troublesome ways. The chiefs of cardiac surgery of both
11 Partners teaching hospitals jointly refused to
12 participate in a Tufts Health Plan quality management
13 program involving outcomes data. Their refusal
14 essentially gutted our initiative to provide objective
15 data to our members on the quality of care available from
16 the 11 different hospitals in our network which provide
17 coronary bypass surgery.
18 Partners has already killed an innovative and
19 heavily promoted product offered by one of our
20 competitors, Blue Cross/Blue Shield, a product called
21 Access Blue, by refusing to participate. We fear that a
22 similar refusal by Partners to participate in new
23 consumer choice products that our plan is developing
24 could effectively prevent consumers in Massachusetts from
25 the opportunity to choose between higher-end and lower-

1 cost products.

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

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

21 I thank you for your time.

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

1 **(Whereupon, a brief recess was taken.)**
2 MR. KRAMER: At this point, I ask Professor
3 Fran Miller to give us a bit of a retrospective on what
4 we heard, as well as her perceptions of the health care
5 marketplace up in the Boston area. Fran is a long-time
6 Boston-area resident.
7 PROF. MILLER: Thanks, Steve. Okay, I might
8 add that Steve's assignment to me was to, you know, have
9 a few things to say on your own -- could I borrow
10 somebody's water -- say a few things on my own, and then
11 also react primarily to what's been said this morning.
12 And I realize that if you want to break at 12:15 I better
13 be --
14 MR. KRAMER: Actually, it turns out I misspoke,
15 it's 12:30.
16 PROF. MILLER: Okay.
17 MR. KRAMER: As we just heard.
18 PROF. MILLER: Well, I don't want to keep the
19 rest of you from digging in, as well. I want -- there
20 are a lot of things that were said this morning that were
21 part of the things that I wanted to touch on anyway, so I
22 think it will meld together. I hope it comes forward in
23 a relatively organized way as I do so.
24 My name is Fran Miller. I am Professor of Law
25 at Boston University School of Law. I'm going to give

1 you just a little bit of background on me so you know
2 where I'm coming from as I make these remarks. I have
3 indeed been watching the Boston health care market for at
4 least 35 years, and watching it quite closely. I'm also
5 a Professor of Health Care Management at the Boston
6 University School of Management and also a Professor of
7 Public Health at Boston University School of Public
8 Health.
9 So, I come at all of these things from three
10 different perspectives, but the common theme is, if you
11 want to put it baldly, money, economic, and management,
12 School of Public Health and Law School. My focus has
13 always been on the economic aspects of health care
14 delivery.
15 You may also find it relevant to my comments to
16 know that for a brief period of time in the 1970s I was a
17 Commissioner of the Massachusetts Rate Setting
18 Commission. That means I have a healthy skepticism for
19 what anyone says costs are. When we started
20 investigating what we were being asked to reimburse, we
21 started finding things like a gross of gold golf balls
22 that were given out as souvenirs to house staff
23 graduating from some of our teaching hospitals. We
24 decided that wasn't a cost that we wanted to cover in our
25 reimbursement.

1 But anyway, I have a healthy skepticism about
2 the concept of cost. And for roughly the past two
3 decades, I have chaired the Health Facilities Appeals
4 Commission in Massachusetts, which is the certificate of
5 need appeals agency for the Commonwealth. So, I have a
6 good fix on who's doing what in terms of substantial
7 changes in service and substantial capital expansions.
8 And for the record, you should also know that I
9 am a trustee of the Joslin Diabetes Center, which is not
10 an inpatient facility. And I also serve on the Partners
11 -- one of the Partners institutional review boards, so I
12 see the research operation at that level, or at least
13 part of it, as it occurs within the Partners system.
14 Professor Altman framed this morning's
15 discussions by outlining trends in the national
16 Massachusetts and Boston health care markets as they have
17 evolved over the past decade or so, with particular focus
18 on hospitals and MCOs in Middlesex and Suffolk Counties,
19 which are the Boston-Cambridge Metropolitan areas.
20 His comments, in conjunction with the detailed
21 task force report accompanying his remarks give an
22 overview of health care economics, particularly in the
23 Commonwealth. They provide an excellent frame of
24 reference within which to consider and evaluate the more
25 focused perspectives in these stakeholders in the Boston

1 hospital market in particular and insurance markets whose
2 presentations we've just heard.
3 My objective in making these concluding remarks
4 is somewhat different from those who have preceded me
5 here. I'm a lawyer; I've been teaching courses about
6 antitrust in the health sector for more than 20 years.
7 I've written on the subject. I have taken a keen
8 interest in the Boston hospital market and insurance
9 markets for some time, but I don't believe I have a
10 vested interest in either, per se, other than, as I say,
11 you know, a health insurance subscriber and certainly a
12 consumer of, quote, the best medicine in the world, which
13 I truly think we have in the Boston area.
14 My comments should primarily be considered as
15 those of an academic observer, and I've always examined
16 competition in the Boston hospital market, primarily from
17 that perspective. If I were giving this particular
18 presentation 10, 12 years ago, I would have been focusing
19 very closely on Blue Cross/Blue Shield and what was
20 happening in the insurance market. If I'd been giving it
21 three or four years ago, I might have been focusing on
22 Harvard Pilgrim and its problems.
23 It happens that where we are in the world today
24 I'm going to focus a lot on Partners, but I want you to
25 know that I am an equal opportunity, perhaps, I don't

1 want to say dart-thrower, but that's just where we are
2 right now in this market in Boston, and I am certainly
3 someone who understands the cyclical nature of markets
4 and knowing that things change.
5 So, I do want to focus a little bit on
6 Partners, because to understand where Boston is right
7 now, you just have to. You cannot ignore it. And the
8 original movement to consolidate the renowned Harvard
9 teaching hospitals in the 1990s, the early 1990s, was
10 stimulated primarily by financial concerns. I don't
11 think there's any doubt about that, although the
consolidation movement was also concerned with improving

1 they're very powerful buyers of provider services.
2 Those MCOs were engaged in increasingly
3 aggressive bargaining over rates and hospital costs
4 containment measures. And the Harvard teaching hospitals
5 in that group envisioned that their teaching budgets,
6 among other areas, clinical care, would be increasingly
7 stressed if the trend continued. The five of them
8 engaged in these talks for some period of time and could
9 not agree on a plan among them. In fact the plans never
10 really got very far. My understanding is Bob Locke was
11 advising them and, of course, cautioning them of the
12 obvious for antitrust violations that for the five of
13 them to combine would cause or would raise.
14 Finally, when nothing was going anywhere
15 particularly, there was the famous parking lot
16 conversation between Dr. Buchanan, who headed Mass
17 General, and Dr. Nesin, who headed Brigham and Women's.
18 And they basically said well, if we can't do it with
19 five, let's see if we can do it with two. And I can
20 quote Sam Thier's statement, which he may regret having
21 made, it was in the Boston Globe two years ago, but it
22 says, "By Samuel O. Thier's own admission, Partners is
23 trying to reset the prices in this marketplace. We
24 wanted to be able to climb out of the hole and get a
25 little extra for inflation. To the extent that pushes

1 up premiums, that should help out other providers, as
2 well."
3 So, that's a frank admission that this was a
4 cost-driven, a financially driven, merger, at least at
5 the outset. Of course, there are all the wonderful and
6 admirable clinical improvements that Dr. Mongan has
7 mentioned this morning. And Partners has done a
8 wonderful job with very many of its programs that
9 certainly qualify as clinical improvements over time.
10 But the primary motivation was indeed financial.
11 And this merger went forward pretty much under
12 the regulatory radar screen. Yes, the Massachusetts
13 Attorney General did look at it. To my knowledge, no
14 conditions were attached to it. I can be mistaken on
15 that, but to my knowledge, none did. Okay, no
16 conditions, they were simply permitted to do it. And
17 when the announcement was made -- it was a stealth
18 merger. And when the announcement was made, the other
19 three people with whom -- the other three teaching
20 hospitals with whom they'd been negotiating were, to put
21 it mildly, displeased with the fact that the rug had been
22 pulled out from under them.
23 So, you know, that's the situation in 1994 when
24 this merger took place. No one knew about it. And to
25 underline that point, the same law firm represented both

1 Mass General and the Brigham and the Beth Israel
2 Hospital. And within the firm, the lawyers were not told
3 -- the two sets of lawyers who dealt with these
4 institutions didn't know it. They were not pleased
5 either, let me tell you.
6 So, anyway, that's how quietly this was done.
7 It came in under the radar screen, as I said, and with
8 respect to regulatory oversight or antitrust agency
9 oversight, there was virtually -- it was -- I won't call
10 it a rubber stamp, but there was not the kind of
11 searching inquiry that I think one ought to have had at
12 that time.
13 Now, as an antitrust lawyer, we know how we
14 look at markets. We all say, "Well, what's your

1 geographic market, the North Shore area of Boston, you're
2 going to get quite different market share numbers than if
3 you take the inside Route 128, inside -- or 95, all of
4 Massachusetts, et cetera, we all know how to play these
5 games as antitrust lawyers.
6 But given -- Stuart -- has Stuart left? Oh,
7 Stuart, what did you say you thought the number of
8 hospitals in Massachusetts was? In the neighborhood of
9 65, something like that. Something like 65 or 70
10 hospitals in the State of Massachusetts. Well, nine
11 hospitals are owned by Partners HealthCare system, and
12 six more are affiliated with them. So that's not --
13 that's 20 -- nine and six is -- I'm really good with
14 numbers on my feet -- all right. That's a healthy slug
15 of a number of hospitals in the Commonwealth that all get
16 negotiated together when it comes to contract
17 negotiations. My understanding is that they do get
18 negotiated together.
19 So, again, I think you have to be careful how
20 you look at all these numbers, what you really think
21 you're talking about. Now, if we're talking about --
22 well, I just made a little comment about geographic
23 market, let's talk a little bit about product market.
24 It's one thing if you think your product market is acute
25 inpatient beds, hospital beds. And I certainly am

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

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

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

1 them. They're fine, fine hospitals, and I wouldn't want
2 not to have that option either. So, they've got a lot of
3 clout.
4 So, the next question is -- and I might add you
5 could do the same thing with sub-product markets. We had
6 talk here about cardiac surgery. My understanding is
7 that of the open heart procedures done in the sort of
8 metropolitan area are a little larger than that. Brigham
9 and Women's does 21 percent of them; Mass General does
10 another 20 percent or so. You're moving way up in these
11 sub-markets when you look at them that way. And, you
12 know, we could all tick off all kinds of other areas.
13 So, the question any antitrust lawyer asks
14 afterwards is, "Hmm, a lot of power here, did this on
15 balance -- is it on balance? More pro-competitive than
16 not? Did it enhance consumer welfare?" And, you know,
17 there's a “yes” and a "Hmm, I wonder" answer to that kind
18 of a question. And one of the obvious things that faces
19 you when you look at the Massachusetts market, and Stuart
20 and others have done a good job pulling apart the many
21 reasons why this is the case, nonetheless, the health
22 care costs in Massachusetts are just about the highest on
23 the planet, are among the very highest on the planet.
24 They are very, very high. And of course the fact that we
25 have a lot of wonderful teaching hospitals in this market

1 is part of the reason, so is the reason -- so is the fact
2 that we are very technology-intensive for lots of other
3 subsidiary reasons having to do with the biotech market
4 in the area. And sophisticated consumers. They're also
5 all part of it.
6 So, we're faced on the one hand with "Well, we
7 haven't seen costs going down, in fact, we've seen quite
8 the opposite. We don't see cost savings that you would
9 think you might see in the context of a merger that's
10 that large." Yes, there have been undoubted
11 administrative efficiencies, and they're across the board
12 in many areas in the Partners system. But I don't see
13 them quite the same way in terms of clinical
14 efficiencies.
15 And, in fact, most people in Boston thought
16 well, with this merger that means Mass General won't open
17 an OB department, which it hadn't had. Brigham and
18 Women's had the biggest, and still does have the biggest,
19 and most comprehensive fine OB unit in the state, and yet
20 very shortly thereafter Mass General went right ahead and
21 opened its own. And everybody's going, "Wait a minute,
22 we thought there were going to be clinical efficiencies
23 out of this merger." There certainly weren't -- you
24 know, right away from the get-go, that was going forward,
25 quote, no matter what.

1 Now, I understand all the subsidiary reasons
2 why it made sense to open it, at least from Mass
3 General's point of view. The question I want to ask is
4 how much was that rethought. Or did the plans that were
5 already in progress just steamroller forward without
6 really thinking about this.
7 You don't see, at least to the outside eye, you
8 don't see an awful lot of clinical integration. You
9 don't see a lot of it between those two institutions in
10 particular and among the PCHI system in general. I mean,
11 this is, you know, not a fair shot, but this is PCHI's
12 newsletter from last year, and they were talking -- and
13 Ellen Zane's writing about clinical integration and she
14 writes, you know, "Clinical integration is the platform
15 from which we can show the improvements in patient care
16 that the fact that we have a system makes possible, but
17 we're not there yet. We need to do better, we haven't
18 done this, we haven't done this, we haven't done this."
19 Now, I realize she's exhorting her physicians
20 to cooperate in integrating clinically, but I'm just
21 saying that you get acknowledgments throughout the system
22 that it sure hasn't happened -- and this is ten years
23 later, in a way that you might want to think it should
24 have. Now, clinical integration, to my naive mind, would
25 have been the first -- one of the first things one would

1 think of in doing.
2 Now, I understand all the problems, the culture
3 clashes and, you know, for better or for worse, CareGroup
4 is an example of one that it was -- you had culture clash
5 there of a very high magnitude and it was very
6 destructive to the CareGroup system for a long time. I
7 think you're coming out of it, but it was a terrible.
8 Those who talk about it, who know about it, talk about it
9 as having been jamming two cultures together too fast.
10 And I understand that you can't do that. But it's a long
11 time now since this happened. And yet we're not seeing a
12 lot of movement within the system. Yes, I understand
13 Brigham and Women's now has a lot of the things it used
14 to do done at Faulkner, but beyond some obvious things
15 like that, you don't see a lot of re-organization within
16 the system, in terms of clinical integration.
17 A side note, because I had the certificate of
18 need appeals agency, I see what goes on in the
19 certificate of need process below. I have here a
20 printout of determination of need projects that have been
21 completed over -- as of January of 2000 -- but when you
22 look at what the projects have, they're not a lot
23 compared to what there used to be. Just for the heck of
24 it, I went and looked through as to what Brigham and
25 Women's and Partners had in general, but North Shore

1 then I go back and look at the certificate of need
2 approvals and see all this stuff and well, who's paying
3 for that?
4 It's not that I don't want that research to be
5 done. Who knows, it might have saved my life. I do want
6 that research to be done, but I want you to -- I want
7 people to think hard and justify why they're using that
8 much time on that much expensive technology. And this

1 they repeat the market share of 21 percent, you know,
2 that Partners has 21 percent of the market, just a little
3 piece of it, and so forth and so on.
4 And I look at them and I say, why now? Why
5 these? And, so, just for the heck of it I ran back and
6 through my sources, I don't know if I have the right
7 numbers, but I found out how much those ads cost. The
8 first one was $19,999.37; the second one, $15,262.41;
9 third one, $13,981.17; and I assume the fourth one was
10 cheaper, some kind of bulk rate. But, okay, that's a
11 cost of health care in the Commonwealth of Massachusetts.
12 I realize it's chump change. It's nothing.
13 And maybe it's doing a lot of good. I don't
14 know. But what am I thinking when I see these, this
15 timing? Why now? Was there some emergency, this had to
16 be out there? I don't know, but I'm sure I'm going to
17 find out. So, anyway, that kind of thing is out there.
18 As for costs, et al., I will also point to the
19 Globe as of -- and, again, I just share this skepticism
20 about what appears in the Globe, but here's a story from
21 the December 21st Boston Globe, and the headline is
22 "Partners Post the Best Results Ever in its History."
23 And it said, Partners HealthCare reported its best
24 financial results since forming the network in 1994,
25 including a turnaround of several once-struggling

1 community hospitals, et cetera, et cetera.
2 But, again, my rate setter mentality goes back
3 to, you know, I know about accounting. I know how one
4 can move things from here to there to the other, but if
5 that comes out, that tells me that maybe the premium
6 increases that I sometimes hear are being asked for maybe
7 aren't as necessary as they might be.
8 Now, just a couple more comments and then I'll
9 let you go at it. And I realize that I do not want to
10 end up being hospitalized in a Partners hospital any time
11 soon after this.
12 (Laughter).
13 PROF. MILLER: But, you know, I'm just sitting
14 here telling you what I see from what I know and what
15 I've been around, because I've been around here for a
16 long time and I've been watching it. And, again, I'd be
17 doing this to whoever else the dominant player was if we
18 were doing this ten years ago or whatever. It's just
19 fun. It's interesting to do. And if I could find the
20 rest of my thing about where the rest of my questions
21 are, I did want to ask Dr. Welch a question. I know
22 where it is, it's on the back. There we go.
23 You were talking about the physicians'
24 inability to negotiate, you know, one-on-one with these
25 providers. And you said we can't compete in this market.

1 The antitrust lawyer listens to that and reads it
2 differently from the way you listen to that, because
3 competitors, to an antitrust lawyer, competitors --
4 competing is with your horizontal competitors. And I
5 think you meant we can't bargain with insurers. They're
6 your vertical relationship people rather than your
7 competitors in the physician sense. But my question to
8 you, which you can address later if you want to or now if
9 you want to, don't a lot of physicians in Massachusetts
10 negotiate through PCHI or through other network
11 providers? And it's not that they're all alone; they've
12 got a big system bargaining for them for their rates. I
13 realize that docs who aren't affiliated in one of those
14 are in just the position you meant. But it's not like
15 all doctors in Massachusetts are. It's some.
16 DR. WELCH: First of all, with regards to
17 bargaining through PCHI, Dr. Mongan, I think, should
18 speak to that issue, because he has a better overview of
19 that.
20 PROF. MILLER: Okay.
21 DR. WELCH: In terms of competition, yes, we

1 we're going to practice medicine. It is -- the current
2 environment, as if we had frozen our profession in ice.
3 It's like Sleeping Beauty where, you know, the whole
4 castle went to sleep for 20 years, the dogs and the
5 horses, as well.
6 We are -- because we don't have incentivization
7 of innovation, we can't move on to the next generation of
8 health care. We've got to get out of this stasis where
9 the incentives are all in a sense going in the wrong
10 direction. So, I actually meant competition in both
11 ways, and I'm sorry it was not clear.
12 PROF. MILLER: Well, you know, lawyers speak a
13 weird kind of language.
14 DR. WELCH: Well, I also think that I should
15 perhaps criticize myself first, but all of us as well,
16 for tending to get into assertions that have rather
17 spindly legs of data under them and that were dealing
18 with issues which are so highly charged. I really, given
19 the tone this morning, I think that I, as well as all of
20 us, should think twice when we say something like there
21 are more physicians per population in Massachusetts than
22 in the rest of the country; or the incentives are wrong,
23 because, you know, we really need data on all of these
24 assertions. I'm glad we can talk about that freely, but
25 I would just want to stress that almost all the

1 assertions we as panelists have made this morning need to
2 be looked at in -- with a question mark in the back of
3 our minds.
4 PROF. MILLER: Sure.
5 DR. WELCH: Do we have good data to support
6 what we're saying.
7 PROF. MILLER: And you lead into just what I
8 wanted to say for my concluding remarks. First of all, I
9 haven't a clue what the answer is. Academics are very
10 good at picking things apart, because they know how to
11 look at them and find inconsistencies, et cetera. I
12 haven't a clue how I would structure just the terrific
13 optimal situation for Massachusetts.
14 But for better or for worse, we've sort of
15 adopted competition as the mold to structure our health
16 care delivery system in Massachusetts. Sure, it's
17 regulated at the margins, but competition is basically
18 the thing that organizes our health care system. And if
19 markets are the structural drivers here, as we say it is,
20 why aren't we seeing more evidence of slowing costs?
21 And, again, I understand the technology imperative, I
22 understand the teaching hospital thing. And it's not for
23 a second that I would want it to not to be that way in my
24 state -- I do.
25 But I guess I want to end up with what Stuart

1 said before, we are what we are, and we are at the moment
2 in time where we are, but can't we do it a little better?
3 Okay, that's what I have to say.
4 MR. KRAMER: Thank you. I would like to give
4 the panelists -- particularly the panelists that went

1 refer you back to the data set out by Stuart and myself.
2 Our costs, our premiums, are not different than the rest
3 of the country. And just a word as far as the payer
4 testimony, it's hard for me to recognize the portrait
5 painted by the payers. If we are such dominant players
6 able to set our own prices, why did we get extremely
7 minimal increases for years and then after the much
8 ballyhooed negotiations still end up with only modest
9 increases and still below the national average. And
10 secondly, with regard to the so-called showdown
11 negotiations, I've never understood why it is that when
12 employers fail to reach agreement with their existing
13 health plans and drop coverage in favor of better priced
14 options, it's considered a solid business decision; yet
15 when hospitals seek improved rates it's considered a
16 showdown. Consumers are routinely inconvenienced when
17 employers switch plans and when health plans drop
18 providers, and these things occur much, much more
19 frequently than showdowns.
20 Thank you.
21 MR. KRAMER: Thank you. Mr. Baker, please
22 proceed if you'd like.
23 MR. BAKER: I don't know where the role of the
24 misuse, overuse, and underuse of technology fits into all
25 of this, but clearly, if you were to ask me what's really

1 driving a big piece of the cost quality equation, in our
2 market and in others, it's the fact that we don't have a
3 good way of organizing anybody's thinking around the
4 right use and the most practical application of both new
5 and existing technologies. And this is obviously
6 especially profound in a market like ours which has so
7 much heavy emphasis on research and teaching.
8 But I guess I think absent, you know -- the
9 other stuff is all debatable, and everybody's got a point
10 of view, but I really do believe that absent any attempt
11 to try to create a more cohesive approach to managing
12 technology developments over the course of the next five,
13 ten, 15 years, whatever number you want to pick, I think
14 a lot of us are going to be banging away on the margin on
15 what's really driving spending and what's driving
16 quality.
17 MR. KRAMER: Thank you. Dr. Welch, please
18 proceed.
19 DR. WELCH: I think that the issue of cost is
20 clearly the most burning one. From our perspective, it's
21 driven by three drivers. The first is a growing
22 administrative overhead. It is now consuming between 35
23 and 40 percent of the health care dollar and it is a
24 garden of opportunities for recapturing funds to plow
25 back into clinical care.

1 The second is antiquated systems of delivery,
2 which make it very difficult for clinicians to deliver
3 care that is optimally effective and optimally efficient.
4 And that's no -- and I'm not pointing the finger at
5 anybody. It's the system of health care that we've
6 inherited from our fathers and the incentives have not
7 been adequate for us to move on to deliver better,
8 cheaper, safer and easier health care along the vision of
9 the Institute of Medicine model.
10 Third, I would agree with Charlie that our use
11 of technology is irrational and that we desperately need
12 an evidence-based, scientifically-based system for
13 selecting which technologies we're going to adopt and
14 which ones we're not going to adopt and how we're going
15 to use the ones we do.
16 And I think that what we really need is not so
17 much a regulatory shift -- although I do think that
18 regulation plays into this. I think what we really need
19 is for a constructive, ongoing process between insurers,
20 providers, patient representatives, and the government to
21 reinvent this whole system.
22 MR. KRAMER: Thank you.
23 DR. WELCH: And, finally, I would say that as
24 someone who works in the Partners system, I am very proud
25 of what this organization has done by improving the

1 DR. BERMAN: Professor Miller's redefinition of
2 what market dominance means triggered a memory which
3 actually had a profound effect on my thinking in that
4 week or ten-day period when we and the public knew that
5 we had no contract with Partners.
6 I received a phone call from a member whose
7 name I don't even remember now, telling me that she's
8 been a long-term member of the Tufts Health Plan and
9 satisfied with the Tufts Health Plan and she was very
10 disturbed at the idea that we weren't able to reach an
11 agreement with Partners. She told me she's been healthy
12 and she had never walked in the door of the Mass General
13 Hospital, but she said she would not be comfortable
14 having a health plan where if she got sick that she would
15 not know that she could go there if she needed to. And
16 she was going to have to change health plans. To me,
17 that's market dominance in a way that I didn't understand
18 before and that affected my decision that we had to come
19 back to the table and basically acquiesce.
20 MR. KRAMER: Thank you. And, finally, I want
21 to give Dr. Altman the same opportunity, given that he
22 has been the recipient of some comments.
23 DR. ALTMAN: Well, I think I've just been just
24 perfect. When you get shot at from both sides and then
25 you have a professor who also shoots at you, I think I

1 just played it right.

2 (Laughter).

3 DR. ALTMAN: And, so, a couple of comments I

4 can’t resist. First, having been a relative newcomer to

5 Massachusetts, as I said, 25 years, you're still not --

6 you still don't have your pinstripes, and there is a

7 parochialism, and I think we saw that in spades with

8 Professor Miller, about sort of -- you know, little

9 inside baseball stories.

10 And I do think it's very important, and I know

11 ultimately the Federal Trade Commission and the Justice

12 Department will do this, is to say well, really, when all

13 gets said and done, how different is life in Boston with

14 what's going on in the rest of the country. And not

15 let's get away from all these little stories, because

16 then you have to say to yourself, what is it about our

17 health system that dominates. And it think what Charlie

18 Baker said is the one that resonated the best with me.

19 And that is that, you know, we are driven very much by

20 technology. We do have a very litigious system.

21 And, so, I think it's very important that we

22 cannot lose sight of comparing ultimately the Boston,

23 Massachusetts area with the Federal Government. A and B,

24 I strongly agree that we should be based on facts. In

25 spite of your statement about the contrary, every which

1 way you switch the physician population, you can modify
2 it and reduce it. We are blessed with very high quality
3 physicians and a lot of them.
4 But I'm also very concerned about the income of
5 physicians. It's not so that A -- I never use the Boston
6 Globe. I would flunk a student who used the Boston Globe
7 as their centerpiece for statistics. But nevertheless,
8 be that as it may, I do think that we could ultimately
9 pull back from the inside baseball and compare us to the
10 rest of the country, and when you do that, you find the
11 statistics that I think I tried to show you.
12 We are more expensive. We're not outlandishly
13 more expensive. There is this business about the cost of
14 living, and certainly, you know, I mean, I'm a professor,
15 my salary at Brandeis is not adjusted by the cost of
16 living. There are legitimate places to use cost of
17 living, and then there are questionable ones. So, I used
18 it sometimes and I didn't use it other times.
19 But I think we need to put ourselves in the
20 context of the rest of the country. And, yes, we have
21 certain unique characteristics in Massachusetts. But
22 when all is said and done, I hate to tell it for my
23 friends from Massachusetts, we look a lot like a lot of
24 other parts of the country. And I know that comes as a
25 deep hurt.

1 that have occurred as a result of the merger, in other
2 words, that could not have been achieved independently by
3 the institutions?
4 DR. MONGAN: Thank you. I'd be happy to. I
5 guess there's always a little room for judgment there,
6 but let me flag two of the, I think, commonly accepted
7 indicators by the business community, which has invested
8 a great deal in the leapfrog initiative. And I think if
9 you look on their website you'll see that there are seven
10 hospitals around the country that have met all of the
11 leapfrog criteria and the Brigham and Mass General are
12 two of them.
13 And I think in one of those key areas, it is an
14 example, the order entry systems for drug administration,
15 which are one of the key leapfrog elements, was far ahead
16 at the Brigham than what the Mass General had. And I
17 think it's clear to every observer that without the
18 integration we would not have been able to expand the
1210 10's e ohowserverproc bus Tksf them.

1 MR. KRAMER: Any of the other panelists have a
2 follow-up. Okay.
3 MR. COWIE: Charles Baker of Harvard Pilgrim
4 mentioned the presence of all products clauses, in other
5 words, take me, you've got to take my brother. I was
6 wondering if either you or Dr. Berman of Tufts could
7 describe what you've seen in the marketplace in terms of
8 all product clauses.
9 MR. BERMAN: Well, the reason I picked all
10 product clauses is because it was obviously something
11 that people have an issue with when the plans do it. And
12 actually the plans do less of that in Massachusetts than
13 they do in some other markets. But I think generally
14 speaking, I'm guessing now, but if you took the top four
15 care delivery systems in Massachusetts, you'd probably be
16 talking about somewhere in the vicinity of 50 percent of
17 most of the admission activity and probably at least that
18 much of the physician activity overall.
19 And I think generally speaking, you know, they
20 bargain as groups, negotiate as entities and
21 organizations. And does that have an impact on their
22 leverage in the context of those discussions?
23 Absolutely. I don't know how it can't. And I'm actually
24 surprised that people don't just acknowledge that and get
25 over it and get on it.

1 But it seems to me that the -- again, given all
2 the other dynamics that have been at work in the
3 marketplace over the last few years, if you asked me to
4 put a number on it, I'd be very hard-pressed to do that.
5 And if someday they actually translate into organizations
6 that can bring significant improvements and enhancements
7 into the way people make decisions about the use and
8 application of technology and the administrative
9 information that's available to support the way they use
10 technology in managed care, that would be a big benefit.
11 But I certainly haven't seen that yet.
12 MR. KRAMER: To follow up on that point, the
13 point's been made that there are some substantial
14 physician affiliations with some of the large hospital
15 systems, and the point has also been made that physicians
16 are unable in individual practices to exhort any
17 negotiating countervailing response to health care plans.
18 And I'm wondering if there is differentiation in payments
19 with the physicians that are in the affiliated systems as
20 opposed to the ones who are essentially solo
21 practitioners.
22 DR. WELCH: I can't give you data on this, but
23 certainly I am seeing no difference in the rates that I'm
24 paid compared with the rates that my colleagues in
25 private practice are paid. I don't think that being in

1 an IDN gets a physician much of anything in the way of
2 extra reimbursement. I think the incentive for being in
3 an IDN is that the system that supports care is better.
4 You can deliver better care if you have that kind of a
5 system behind you. Electronic system and all of the
6 other elements of care are easier to assemble.
7 I hope that where we get to in a few years is
8 that every physician in Massachusetts, if not the
9 country, will be in a sense functioning in the context of
10 some sort of integrated system. I think medicine is just
11 too complex for a solo practitioner to be doing it out
12 there by themselves in an office. There's too much going
13 on, and it's almost impossible for an individual, no
14 matter how bright and capable, to wrap their arms around
15 all of this.
16 MR. KRAMER: Any other responses on that?
17 MR. BAKER: The complexity of trying to manage
18 it any other way is overwhelming. And, yeah, for the
19 most part, the structure is -- I mean, we do mostly
20 business with groups. I mean, that's sort of the fun to
21 me. Almost all of our contracting is with groups of
22 physicians. We only use individual contracting when we
23 have issues with regard to access or geographic coverage.
24 And we typically use the same set of fee schedules across
25 all of that, because, frankly, doing anything other than

1 that gets really hard to administer, really hard.
2 MR. COWIE: I have a question for either of the
3 payer representatives. We've heard some statements that
4 Partners may have market power or have acquired leverage
5 that makes them indispensable. To what extent are you
6 able to design products that steer patients away from
7 Partners or other large payers -- other large providers?
8 In other words, are you able to use tiering or other
9 mechanisms to deal with large providers?
10 DR. BERMAN: We do have a product, which we
11 call Choice Copay, which members who are part of this
12 product, and it's a small number of our members so far,
13 can choose to have a lower copay if they go to community
14 hospitals than if they get the same services at tertiary
15 care hospitals. So, we've introduced products like that
16 into the market.
17 MR. COWIE: Is that a solution to mergers that
18 appear to create market power? I mean, are you -- have
19 you -- are you able to steer patients away from, say,
20 Partners?
21 DR. BERMAN: Well, we don't steer. This was
22 putting the choice in the consumer's hands, that they
23 have to make a choice, would they rather pay $500 and get
24 their hernia fixed at a teaching hospital or have no
25 copay and get it done at a community hospital. So, we're

1 not steering; we're hoping the incentive will steer.
2 MR. BAKER: I think the market is going to
3 develop a lot of the -- plans aren't going to steer
4 people, but financial arrangements are going to be
5 developed that are designed to provide them with an
6 incentive. And I think the $64,000 question is how big
7 an incentive do you need to create for it actually to
8 matter to somebody.
9 And then the second question is does creating
10 that incentive in the first place create, under certain
11 circumstances, access issues for people. And I think the
12 -- I don't think people know the answer to that one yet.
13 DR. ALTMAN: The issue there -- we've been
14 studying the drug -- use of prescription drugs with
15 tiering, and at one level tiering is working quite well.
16 But I think this market is going to be much tougher,
17 because there you're dealing with a product where the
18 quality is perceived and has been viewed as being roughly
19 equal. The generic drug industry which had its problems
20 with quality is now sort of coming out of that.
21 But if the perception is that the hospital A,
22 the teaching hospital, is perceived higher quality, in
23 the nature of the beast, Charlie's question is a very
24 good one. Is $500 enough for me to take a chance?
25 Nevertheless, I strongly support that kind of product and

1 I think what's surprising to me is how small the number
2 is, the number of employers that have taken up on it.
3 Again, I would go back to the nature of our employer
4 market as an important part of the Massachusetts story
5 that needs to be here. And it's a very different
6 employer market than I see in other parts of the country.
7 MR. WAXMAN: Just a comment, and I suspect that
8 one of the issues that you highlighted is, you know, am I
9 prepared to take a chance. And the question is what's
10 the investment that we all are going to make to determine
11 whether there's a chance or not in the sense of how much
12 investment are we prepared to make to determine quality.
13 And at this point, to me, that's an open question that
14 remains up in the air.
15 MR. KRAMER: We heard yesterday about a
16 consolidation of health insurers in many markets.
17 Massachusetts, I believe, is unusual, since the cartel
18 case was litigated about 20 years ago, when Blue Cross
19 was found to be a monopolist. The market has
20 deconcentrated. I'm wondering if anyone has observations
21 on the trend in the market to a deconcentration,
22 particularly when you consider that there are some not-
23 too-small players, such as Cigna, United and Aetna, that
24 don't appear to be significant players in the market but
25 certainly are poised for entry if the opportunity

1 presented itself.

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

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

25 So you have to make a real commitment to be in

1 the market. And I think for some of the national
2 carriers they look around and they say, Where am I best
3 and most likely to be able to make an investment in a
4 market and get where I want to go with a limited amount
5 of, you know, new ways of doing business, new business
6 processes, products we've never seen or managed before.
7 And I think they say, you know what, maybe Massachusetts
8 isn't such a hot place to go.
9 And the second issue is, you know, the three
10 plans all put out the year-end numbers today. We
11 reported between us an average of a 1 point -- I think we
12 made it over 1, I think it's about a 1.1 percent margin
13 for the three plans. You can't sell a lot of stock if
14 you're -- and most people think we all had decent years.
15 So, I mean, I just don't think you can sell a lot of
16 equity making the argument to the outside world that
17 you're going to deliver a 1 percent return on an annual
18 basis. So . . .
19 MR. KRAMER: All right. Mike points out to me
20 it's 12:30, so I will attempt to keep to the schedule
21 here. Thank you very much for your attendance and
22 interest.
23 (Applause).
24 **(Whereupon, the discussion concluded at 12:30**
25 **p.m.)**

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

2

3 DOCKET/FILE NUMBER: P022106

4 CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

5 DATE: FEBRUARY 28, 2003

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12 DATED: MARCH 7, 2003

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15 _ SONIA GONZALEZ

16

17 **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**

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20 accuracy in spelling, hyphenation, punctuation and

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25