FTC/DOJ Hearings on Health Care and Competition Law and Policy: A Tale of Two Cities

Presentation of James J. Mongan, MD
President and CEO, Partners HealthCare System
February 28, 2003

I am Dr. Jim Mongan, president of Partners HealthCare. I appreciate the opportunity to appear today to give you our thoughts on Boston healthcare and on Partners.

Partners is an integrated, academic healthcare system formed to add value to the patient care, teaching, research and community missions of our founding institutions, the Brigham and Women's Hospital and the Massachusetts General Hospital. This morning, I'd like to review what Partners has accomplished over the past nine years. Then I will address two issues:

- Market dynamics in Boston, and
- Healthcare costs in Boston

Partners' history and value-added

Let me start with a brief history of the formation of Partners.

A decade ago, we began to see that traditional academic medical centers no longer provided the best structure for care, teaching and research. Services were shifting rapidly to an outpatient basis, and inpatient stays were growing shorter. Our hospitals looked like large intensive care units. Although among the best in the world at providing complex care, these hospitals were no longer an adequate platform for the range of care our patients need. They gave students only a quick glimpse of the sickest patients; and they provided a narrow base for important research. They were becoming less relevant to surrounding neighborhoods.

We believed we needed a new model of care to address these shifts. It would include not only great ICUs, but also a small number of community and specialty hospitals and a

network of physicians. This model, which we adopted, has allowed us to protect and enhance our underlying mission.

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

  In the cost arena, by consolidating back office operations, pooling our purchasing, and benchmarking staffing and length of stay across our hospitals, we have held the increase in our cost per case to an average of just under 3% per year. Adjusted for inflation, we have actually reduced cost per case by an average 2.3% per year.

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

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

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

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

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

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

Market Dynamics

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

Regarding market concentration, I'd point to the results of a Robert Wood Johnson Foundation study of health care in 12 US cities. This analysis shows that in terms of

hospital concentration, Boston is the least concentrated city of the 12. Also, as measured in this study by the Herfindahl Index, Boston is the only city of the 12 that is rated "not concentrated" in terms of hospitals. Within this diverse medical environment, Partners cares for 21% of the area's patients.

Health Care Costs in Boston

Finally, I'd like to turn to the issue of health care costs in Boston.

I'll say a word about hospital costs in two different contexts, and then an even more important word about health insurance premiums (tables with these numbers are attached to my written testimony). With regard to hospital costs, I'll deal first with a piece of data which is widely misused – that is raw per capita hospital cost data showing Massachusetts' costs to be 40% above the national average. This raw data wildly exaggerates the burden of health care on Massachusetts employers and consumers. To accurately portray the impact, this raw number should be adjusted by four factors. First, you should subtract research costs funded by NIH, industry and national health organizations. Leaving these dollars in the per capita cost base implies that if we succeed in winning a $10 million AIDS research grant, for example, we have somehow become more of a burden to residents. That, of course, is not the case. Second, you should take out federal graduate education payments to our institutions. Third, you should take out dollars paid by out of state patients. The final adjustment is for the high wages our state pays across all industries. The bottom line? With these adjustments, our per capita hospital expenditures drop to a much more modest 12.9% above the national average – a differential arguably offset by the benefits of excellent patient care and a burgeoning biotech industry.

And finally, even this 12.9% difference is not due to hospital inefficiency, but instead to a somewhat higher use of hospital outpatient services and teaching hospitals. In fact, Medicare data actually shows that, comparing costs per discharge on a wage and case mix adjusted basis, Massachusetts hospitals are less costly than their national

counterparts. We can take pride in the fact that we provide excellent care at no higher cost.

To pull all of this together, the proof of the impact of health costs on consumers should lie in health insurance premium levels. As you will see attached to my written testimony, we have compiled data on Massachusetts premium costs from five respected sources. In raw dollars, they show that our premium costs range from 7.1% to 13.7% above average. But when adjusted for wages, our premiums range from 4.3% less to 3.6% more than average. On average, then, there is no difference at all in insurance premiums in Boston compared to other cities.

One final point on market dynamics. There appears to be an urban legend that our health system somehow "beat up" the payors in Boston and won huge increases in payments. Attached to my testimony are two charts. The first shows that private insurer payments to Massachusetts hospitals in the 90's were far lower than the national average. For Partners, from 1996 through 2000, our average annual HMO payment increase was just 1.5%. Despite urban legend to the contrary, the fact is that payment increases under our new contracts grew an average of only 5.6% a year. For private payors overall, we are now just about back to the national average with respect to our payment-to-cost ratios. (as shown in the second chart)

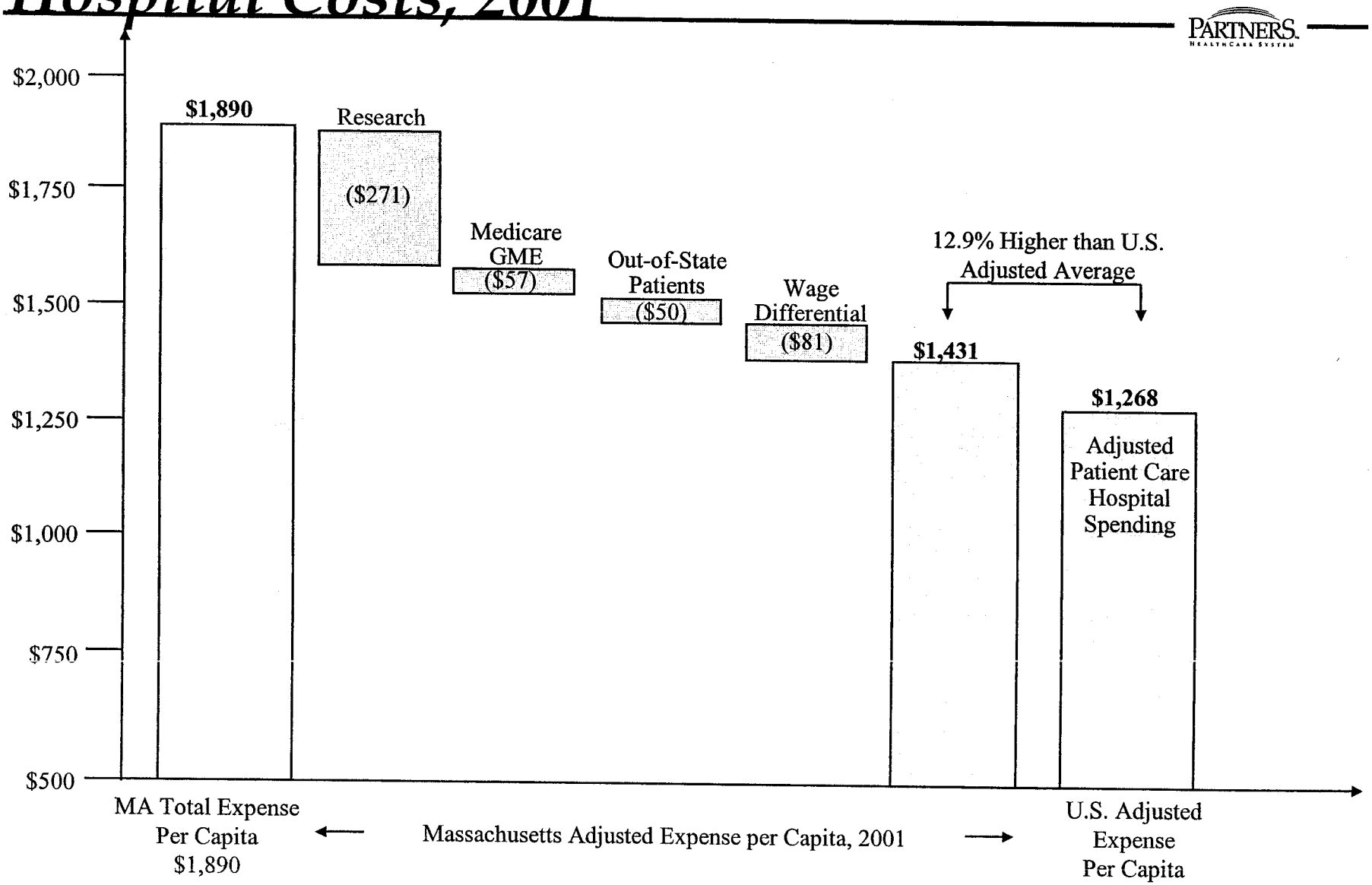
Summary

So, in summary let me simply restate my major points:

- Partners demonstrates on a daily basis the value added to its founding hospitals' mission of patient care, teaching, research and community service.
- Provider concentration in the Boston area is low, and the large number of hospitals fosters a healthy level of competition.
- Boston health care costs (appropriately adjusted) are close to the national average.

Thank you for the opportunity to appear this morning.

Aggregated Per Capita Massachusetts Adjusted Hospital Costs, 2001



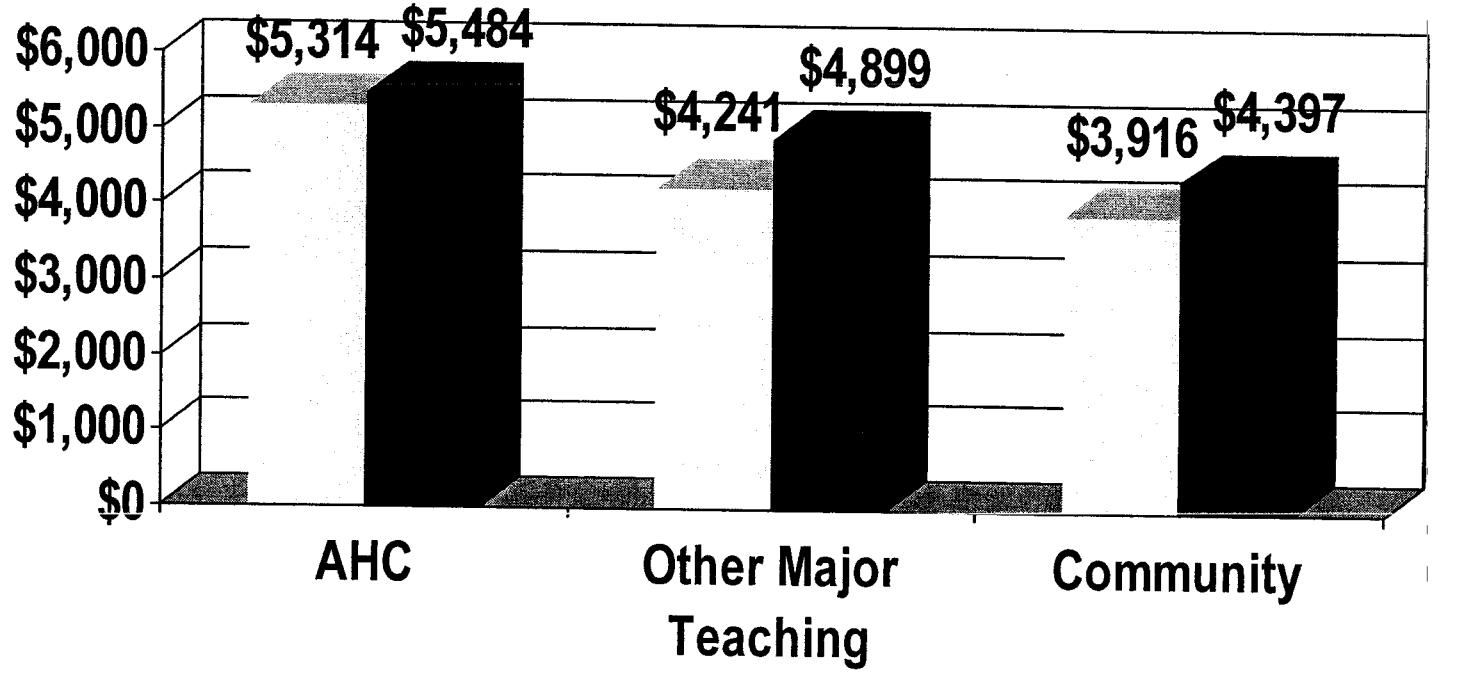
Notes: Research reflects difference between reported total expense and net patient revenues.

Source: Calculations based on 2001 AHA survey and 2001 HCFA File.

Massachusetts Hospitals Are More Efficient Measured on an "Apples to Apples" Basis

PARTNERS HEALTHCARE SYSTEM

1999 Case Mix and Wage Adjusted Medicare Inpatient Cost per Case
Urban Hospitals With 100+ Beds



Source: Analysis of PPS-16 Medicare cost reports.

* **Adjustments based on Medicare geographic wage index and Medicare case-mix index. AHCs designated by AAMC. Major teaching hospitals have resident to bed ratio > 0.25.**

Many Recent Surveys Show Massachusetts Premiums Close to US Averages

PARTNERS HEALTHCARE SYSTEM

	Unadjusted	Wage Adj. [6]
Hewitt 2002 [1]	**+7.4%**	**0.0%**
Mercer 2002 [2]	**+7.1%**	**0.0%**
AHRQ 2000 [3]	**+8.4%**	**+1.6%**
AHRQ 2000 [4]	**+2.3%**	**-4.3%**
M&R 2002 [5]	**+13.7%**	**+3.6%**

Sources:

[1] Hewitt Associates 2002 Survey of Large Employers in Selected Cities: Total Per-Employee Health Benefit Cost

[2] Mercer/Foster Higgins 2002 Employer Survey: Total Per-Employee Health Benefit Cost

[3] Agency for Health Care Research and Quality Medical Expenditure Survey (Family Premium)

[4] AHRQ/MEPS (Single Premium)

[5] Milliman and Robertson, 2002 HMO Rate Survey

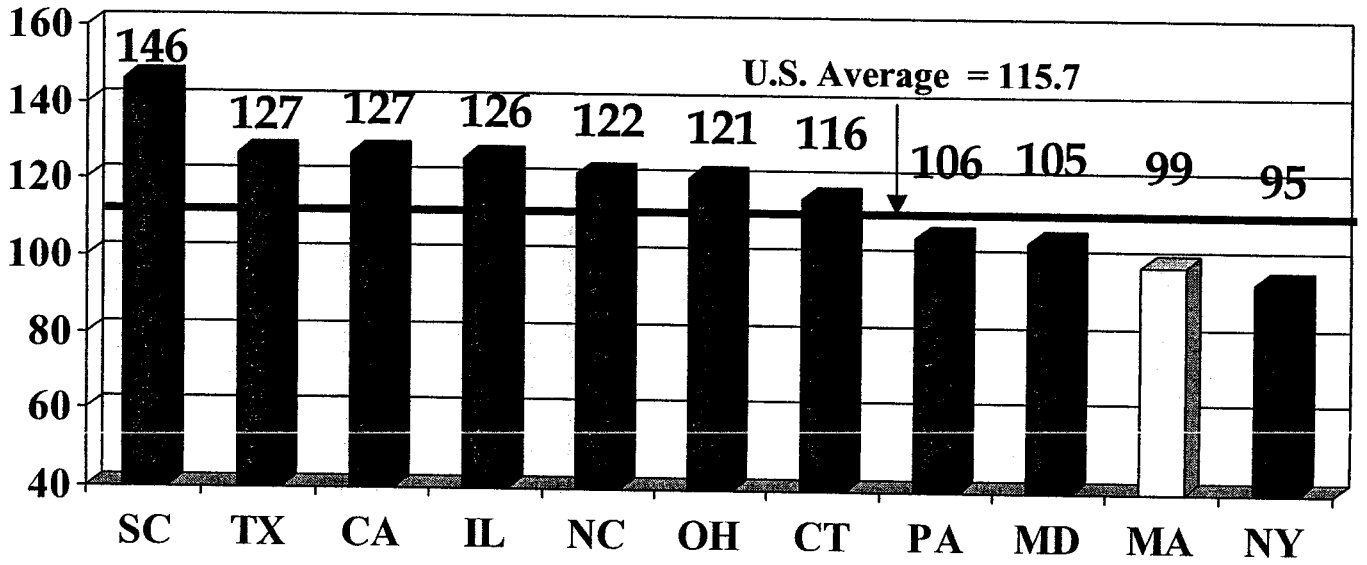
[6] Wage adjusted using BLS ES-202 2001 Wage data

* Data in Hewitt and M&R are for Boston only. Data in other surveys reflect Massachusetts.

Massachusetts Health Plans Negotiated Aggressive Discounts Through 2000

PARTNERS HEALTHCARE SYSTEM

2000 Hospital Private Payment-To-Cost Ratio

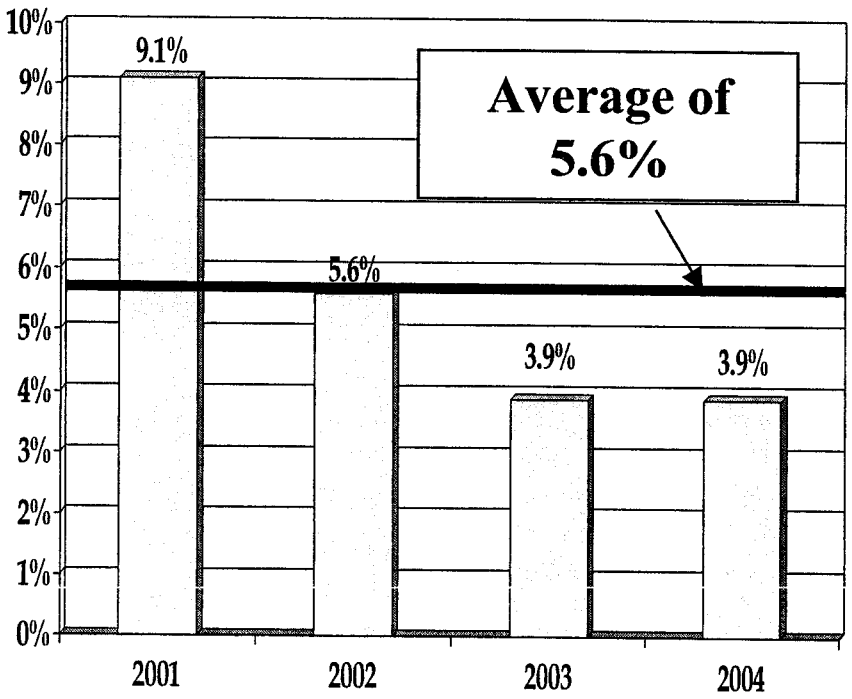


Source: American Hospital Association.

The last round of negotiations improved the PHS hospital rates but payment to cost ratios are still below other cities.

PARTNERS HEALTHCARE SYSTEM

Annual price lift for PHS hospitals in the last round of negotiations with the Big 3 HMOs



Hospital payment to cost ratios for the Big 3 are well below industry norms