Testimony of

Charles D. Baker

President & Chief Executive Officer

Harvard Pilgrim Health Care

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

Our largest operations are in Massachusetts, where we represent about 25 percent of the private health insurance market – or about 12 percent of the covered population, including Medicare and Medicaid. Harvard Pilgrim's clinical effectiveness and member satisfaction scores consistently rank among the very best in the United States, and we have a long history of clinical and service innovation.

I very much appreciate the opportunity to appear before you today to discuss competition and regulation in health care in the Boston marketplace. And while you may or may not have known this when you asked me to speak today, I do have some history on this issue, having served as a state official in the early and mid-1990s, prior to becoming a market participant.

As a regulator, I served as Undersecretary of the Massachusetts Executive Office of Health and Human Services from 1991 to 1992, and then as Secretary of Health of Human Services from 1992 through 1994. In this role, I oversaw a number of state agencies, including the Department of Public Health, and signed off on the Department's decision to approve the initial hospital merger between Massachusetts General Hospital (MGH) and Brigham & Women's Hospital (BWH) that created the Partners Health Care

hospital system. I had moved over to become Secretary of the Executive Office of Administration and Finance when the merger between the Beth Israel and the Deaconess Hospitals created CareGroup, and was not directly involved in that application process.

We signed off on the BWH and MGH merger in 1994, despite their obvious size and status in the Boston health care marketplace, for three reasons:

- The market appeared to be moving toward an environment in which health plans would affiliate with one or more integrated care delivery systems, and then compete with each other based on the quality, service and cost of their network – the BWH/MGH merger seemed consistent with that direction;
- MGH had just recruited several high profile physicans away from BWH, raising the real possibility of an upward cost spiral, in which each hospital, rather than sharing talent and technology in a particular marketplace, would feel obligated to build or buy their own – the BWH/MGH merger was deemed a way to avoid this "medical arms race";
- BWH was intimately aligned with Harvard Community Health Plan – the precursor to the plan I represent today – and it was hard to imagine a merger with MGH doing much to alter this existing relationship.

Partners went on to develop Partners Community Health Care, Inc. (PCHI), an extensive primary and multi-specialty care network, and also acquired several other community and specialty hospitals and community health centers. In fact, in the mid 1990s, there was significant discussion that Partners would, at

some point, seek approval from state officials to offer health insurance products, using their own network to compete with others in the marketplace.

Other provider organizations were considering similar initiatives.

Some eight to ten years later, this seems kind of quaint, given the direction in which the market has moved since that time. In between, the consumer decided that he/she did not want to be constrained by network structures that were institutional in nature, and many individual providers shared and voiced similar views. In addition, state and federal law was enacted that it made it more difficult for plans – and even some health care delivery systems – to use defined delivery systems to manage patient care. Health plans responded by dramatically expanding the size and scope of their provider networks and limiting their referral and participation rules. As a result, an industry that was expected to vertically integrate its value chain by the end of the 1990s retreated to a structure that today looks more like the 1970s.

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

Today's market is not the one that we anticipated – or that others advised us would be coming – when we made the decisions in the early and mid-1990s to approve many of these hospital mergers. This inability to accurately predict the future – and where the market will go – will inevitably limit the effectiveness of any regulatory process. But with this in mind, I do have some thoughts about how regulators could best perform their duties, and will share those at the conclusion of my presentation.

Following my public sector experience, I joined Harvard Vanguard Medical Associates, an affiliate of Harvard Pilgrim Health Care, as its President and Chief Executive in the fall of 1998. I became President of Harvard Pilgrim in June of 1999, amidst deteriorating operational and financial performance at the plan. Overall, the plan lost $227 million in 1999, and another $10 million in 2000. We generated a $35 million operating gain in 2001 and a $31 million operating gain in 2002.

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

We also raised premiums. The average premium increase in our markets has been in the 10 to 15 percent per year range for the past three years. This is consistent with the numbers displayed by Professor Altman in his presentation. This was driven by a number of factors – virtually all of which relate to the rising cost of health care. On this point, I differ with Professor Altman. There are

historic periods in which insurance carriers raise prices to catch up with "underwriting cycles," so-called. I do not believe the past three years have been about under and over-pricing. I believe the vast majority – well in excess of 90 percent – of the increase in health insurance premiums between 2000 and 2002 has been driven by rising medical costs.

In our particular case, pharmacy costs increased by 28.6% (rates by 14.6% and utilization by 12.2%), inpatient hospital costs by 18.6% (rates by 21% and utilization by –2%), physician costs by 24.2% (rates by 5% and utilization by 18%), and all other outpatient costs – including hospital outpatient costs – by 33.5% (rates by 2.5% and utilization by 30.3%). This adds up to a 26.1% increase in total health care costs (rates by 9.1% and utilization by 15.7%) for HPHC commercial plan members over a two-year period. While the projections for 2003 look a little different by category, the overall trend – 12-14% for the year – is virtually identical to the growth in medical expenses from 2000 through 2002. This trend is also virtually identical to the growth in HPHC premiums over the same period of time.

We are so sure about this particular issue that we would welcome any audit, review, analysis or investigation the Commission might consider necessary to confirm these rates of increase in medical expense for Harvard Pilgrim members.

As you can see, hospital cost increases represent a significant share of the increase in health care spending over this period of time. Professor Altman's testimony concerning the increase in the use of Academic Medical Centers for

non-complex services in Massachusetts, which has undeniably contributed to the increase in health care costs here, is a pattern that I believe is borne out elsewhere around the country, but probably not to the same degree it has been in Boston. There are a number of other factors driving up hospital costs for private health plans, which I offer in no particular order:

- Reductions or very limited increases in Medicare and Medicaid rates for the past few years have forced hospitals to seek higher rates of reimbursement from the private carriers with which they do business;
- Labor shortages in some key areas, such as nursing services and some technical areas, have bid up labor costs;
- Technology costs, specifically devices and drugs, affect hospital bottom lines the same way they affect ours;
- Consumer and employer preferences, which have made it very difficult for health plans to discontinue its relationship with any hospital or physician group in its service delivery area, and;
- Hospital and physician group consolidation, which has made it far more difficult for any health plan to drop any one hospital or physician group from its network, much less a collection of hospitals and their physician groups from its network.

I presume debate on this final point is a large part of why we are gathered here today. On this issue, I would offer the following observations. First, if there were no hospital mergers and no provider consolidations, there would still be "monopoly" rates being paid to certain hospitals that are, in many cases, the only

provider in their service area. This is not a Partners or CareGroup issue, per se, but a simple fact of life.

Do I believe that Harvard Pilgrim Health Care members pay more today for services purchased from Partners and CareGroup as systems than they would pay if each hospital in these systems had continued to contract with HPHC directly? I believe the answer to that question is, "Yes." What I don't know is how much more. I don't know if these institutions would have continued to engage in the kind of "arms race" type behavior we were seeking to avoid in the early 1990s when these mergers were originally approved. I also don't know if the mergers generated any savings or efficiencies. I'm sure the leadership at both organizations would say the mergers have saved money, but I don't believe anyone with an independent eye has studied this issue.

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

Do I believe the mergers have created quality improvements? This is hard to say, and maybe too soon to tell. The tools to measure this sort of thing are just beginning to find their way into the market place. Nonetheless, it is difficult for any health plan, including ours, to hold large provider organizations like CareGroup or Partners accountable for quality. They are generally too big for us to lose as network participants, and they tell us they face enormous obstacles in creating single standards of care within their own organizations, due, in part to their size and complexity.

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

Second, many hospital systems throughout Massachusetts, particularly in geographic areas where they have virtual monopolies, also control significant numbers of salaried or affiliated physicians. In most cases, no health plan can do business with any one component piece of these delivery systems without doing business with the entire delivery system. This is, ironically, the provider equivalent of an "all products" clause, a contracting technique that has long been the object of significant animosity directed to the plans from the provider community.

Third, you don't need a lot of provider market share in today's markets to be able to "drive" the market in a particular direction. Partners is a case in point. They may represent less than 30 percent of the Massachusetts provider market,

but no health plan could expect to survive without the Partners system in its network. A health plan in Massachusetts could probably compete effectively with some of the Partners system in its provider network, but the choice, as defined by Partners, is all or none, so that option is really no option at all.

It should be fairly obvious that this situation bids up the price of contracting with each hospital network. There is, for all intents and purposes, no level playing field here. Some networks can literally dictate the price, and the health plans pay it. The others rely on these prices as "market standards," and go from there.

It also makes it much harder to structure and enforce initiatives tied to quality. If the plans need the provider organizations in their network to meet market demand, requiring and/or enforcing significant patient safety or quality initiatives is very difficult. Again, the network sets the terms, not the plan.

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

Is their approach anti-competitive? Probably. Is it inflationary? Certainly. Is it a market response to the advent of managed care, the relentless

hard bargaining of health plans on unit costs, and the changing preferences of consumers? Absolutely.

And it does raise questions – for us and for the provider community – concerning the "right" rules of engagement. For the market to work, the frame for competition established by public policy makers needs to fully understand the participants, and their relationships with one another. I commend the FTC for engaging this discussion, and hope our observations here today can be useful to you as you consider this critical issue.

Thanks again for the opportunity to testify today. I look forward to engaging these issues further during the open discussion period.