June 10, 2014

Christopher Barry-Smith
Deputy Attorney General
Office of the Attorney General
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Dear Deputy Attorney General Barry-Smith:

This letter is sent in follow-up to our letter dated June 10, 2014. As we stated in that letter, we continue to have grave concerns regarding your recent announcement of an "agreement in principle" with Partners HealthCare System, Inc. ("Partners"). We appreciate that the agreement has not been finalized, and we acknowledge that the only public information regarding the agreement is the press release issued by your office (the "Press Release") and an email sent by Gary Gottlieb, M.D., the chief executive officer of Partners (the "Partners Email"). Nevertheless, we think that how, and whether, such an agreement is finalized will set the course for health care spending in Massachusetts for years to come. We are, therefore, taking this opportunity to explain our concerns and questions in more detail.

The undersigned represent major providers of health care services as well as employers who bear substantial responsibility for the health care costs of our employees. We believe the proposed settlement agreement between the Attorney General and Partners (the "Settlement Agreement") raises significant concerns with respect to our ability to hold down health care costs by competing effectively with Partners and one another as providers and to control the costs we incur to cover our employees. Further, under risk contracts, all large healthcare systems are now both acting as providers *and* payors who will suffer material economic harm by the permitted expansion of the already dominant and price-advantaged Partners system. This will result in harm to patients as well, because increased leakage from competitor systems to the expanded, high-cost Partners system will impair performance under risk contracts and drain away resources that other systems desperately need to remain competitive with Partners. It will also impair the ability of other providers to provide any meaningful constraint on Partners' substantial and increased market power. Further leakage may result as these systems fail to keep pace with Partners in terms of facilities and physician recruitment and retention. This is a downward spiral which will lead to the shrinkage or loss of lower-cost alternatives to Partners, which ultimately patients will pay for through higher co-pays and deductibles and higher premiums.

As stated in our previous letter, we are troubled by the extent to which the Settlement Agreement could undermine the ongoing role for the Health Policy Commission ("HPC") prescribed by statute. We believe that the Settlement Agreement bypasses the HPC in a manner that is inconsistent with the legislative intent of Massachusetts' health care payment reform law, Chapter 224 of the Acts of 2012 ("Chapter 224"). As you know, Chapter 224 charges the HPC with holding public hearings on health care cost growth (in which your office participates), setting the annual cost growth benchmark, and revisiting the cost growth benchmark annually (with stakeholder input) beginning in 2017. In so doing, the legislature selected the HPC as the regulatory body responsible for examining and setting limits on health care expenditures. The

legislature's intent was for your office to act in conjunction with, and not instead of, the HPC, as memorialized in the legislature's rejection of language in Section 13 of Senate Bill 2270 (2012) (creating Section 11N(b) of Chapter 12 of the M.G.L.) and the adoption of Section 18 of Chapter 224.[1] By negotiating the Settlement Agreement prior to the completion of the HPC process with respect to Hallmark Health, the role of the HPC has been diminished in a manner inconsistent with Chapter 224.

Bearing this in mind, our focus in the remainder of this letter is on the many unanswered and material questions with respect to implementation of certain aspects of the Settlement Agreement.

Cost Control Measures

The Press Release states that: "Partners cannot raise costs across its network more than the rate of general inflation, which over the last several years has averaged between one to two percent and has stayed well below the medical market's average." As you know, health care costs and prices are exceedingly difficult to quantify and compare in a meaningful manner. It is not clear to us what particular reimbursement, spending, and/or prices would be capped under this proposal. Our comments and questions about this aspect of the Settlement Agreement include the following:

- As stated above, we request clarification on what "costs" would be capped (e.g., total patient care revenues, weighted-average fee-for-service prices or reimbursement, etc.). To the extent that the cap is on anything other than total revenues, we request an opportunity to further examine how such a cap would, or would not, be likely to result in reduced increases in total health care spending.

- It is not clear what is intended by "general inflation." We assume it is a measure such as Consumer Price Index ("CPI"). If so, it is a different measure from Gross State Product, which has been established by the Massachusetts legislature as an appropriate benchmark for health care spending growth. CPI, by contrast, is highly variable and is likely to grow, in the natural course, as the economy continues to recover. Such growth could substantially weaken any possible protections for consumers from this portion of the Settlement Agreement.

- To the extent that the Settlement Agreement would include a cap on fee-for-service reimbursement to Partners, it fails to take into account that the market is shifting rapidly

[1] Section 13 of Senate Bill 2270 (2012) proposed inserting the following language as Section 11N(b) of Chapter 12 of the M.G.L.: "The attorney general shall, in consultation with the institute of health care finance and policy, take appropriate action within existing statutory authority to: (i) prevent excess consolidation or collusion of provider organizations and to remedy these or other related anticontracting competitive dynamics in the health care market; (ii) prevent unreasonable increases in health care rates, charges, medical expenses or prices; and (iii) prevent or mitigate adverse effects on patient access and quality in the health care market." Section 18 of Chapter 224 adopted the following language instead: "the attorney general may investigate any provider organization referred to the attorney general by the health policy commission under section 13 of chapter 6D to determine whether the provider organization engaged in unfair methods of competition or anticompetitive behavior in violation of chapter 93A or any other law, and, if appropriate, take action under chapter 93A or any other law to protect consumers in the health care market."

to one dominated by risk contracting and other payment mechanisms that make fee-for-service reimbursement less relevant to total health care spending. According to the 2013 Annual Report on the Massachusetts Health Care Market issued by the Center for Health Information and Analysis, in 2012 alone, the most recent year for which data is available, 35% of enrollees in commercial insurance products were enrolled in risk products, which represent 39% of all spending under commercial contracts.[2] For this reason, controlling fee-for-service pricing is a poor, and wholly inadequate, mechanism for controlling total health care spending, which should be the goal of any settlement (which was the legislature's primary goal in enacting Chapter 224).

- The Partners Email suggests that the agreement to limit cost increases is, as we speculated in the previous bullet, a limit only on fee-for-service prices, because it states that Partners' "increase in total medical expense (TME) for [its] HMO contracts will not be greater than the growth cap set by the Health Policy Commission." The cost growth benchmark set by the HPC through 2017 is 3.6%. This suggests that utilization under HMO contracts may increase and/or such utilization could shift to higher-cost settings (i.e., from lower-cost non-Partners providers to higher-cost Partners providers), because these are the two changes that could result in TME increases that are greater, on a percentage basis, than the increases in fee-for-service reimbursement.

- The Partners Email also implies that there is no cap on TME growth for non-HMO products. As you know, PPO is a very large, and growing, portion of the market. (The Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D, § 8 published by your office in 2013 reported that commercial PPO membership, insured and self-insured, represented 28.5% of the commercial market in 2012, up from 24.1% in 2011.[3]) If this is the case, it underscores the fact that caps on fee-for-service prices are inadequate and inappropriate tools for attempting to reduce total health care spending, which should be the goal of any government intervention related to costs.

- While fee-for-service reimbursement for Partners has historically increased at a rate higher than inflation (which means that the Settlement Agreement would result in lower rates of increase), the Settlement Agreement needs to be examined in a context in which fee-for-service reimbursement for providers other than Partners is already growing at a rate lower than inflation, because providers other than Partners do not have the market clout to exact better terms from the payors. Therefore, under the Settlement Agreement, Partners rates, which are already much higher than those of its competitors, are likely to continue growing at faster rate than those of its competitors. This will exacerbate the current, severe distortions in the market to which your office has drawn attention in your influential cost-driver reports.

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[2] Center for Health Care Information and Analysis, Annual Report on the Massachusetts Health Care Market (August 2013), 19, available at: http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf.

[3] These figures are derived from combining the Fully-Insured PPO and Self-Insured PPO percent commercial membership figures as set forth in the table on page 15, "Percent Commercial Membership by Product and Insured Status for the Major Health Plans," (April 24, 2013) available at: http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf.

- Moreover, to the extent that there is value in the price caps under the Settlement Agreement, such value is compelling evidence of Partners' market power. Organizations that do not have market power must accept the prices established in the free market. Agreement to a price cap, conversely, means that – absent the cap – an organization like Partners has the ability to charge higher prices. While the Settlement Agreement may impose temporary price caps, it also allows Partners to grow in size and, therefore, increase its market power, which it can: (a) leverage in the short-term, subject to the terms of the Settlement Agreement (e.g., leverage in non-economic ways, such as refusing to contract with particular insurance plans or insuring that Partners, unlike its competitors, will always get the highest permitted increases); and (b) leverage in the long-term free from the time-limited restrictions imposed by the Settlement Agreement.

Component Contracting

The Press Release states that under the Settlement Agreement terms, Partners will agree to contract with payors on a component basis. This raises a host of questions and concerns, including the following:

- Segregating community hospital contracting from academic medical center ("AMC") contracting, into so-called "component contracting," has no material difference from the approach Partners has taken to hospital contracting historically. Even if Partners creates separate teams to contract on behalf of the separate component parts (and it is not at all clear that such an approach would be required or that, if required, is feasible), those teams would report to, and be accountable to, Partners leadership. Moreover, component contracting may be rejected by payors because it introduces administrative inefficiencies for the payors themselves. In short, there is no documented basis for concluding that component contracting (where all components are subject to common governance control and executive oversight) will change the negotiating dynamics that have historically characterized this market. Its likely impact on cost restraint is, at best, purely speculative. It is just as likely, if not more likely, that payors will conclude that component contracting is more complicated than contracting with Partners as a system with no offsetting gain in leverage from the payors' perspective.

- The Press Release states that one component, for purposes of component contracting, will be "community hospitals and physicians." There is no reference to "physicians" as being included in any other component. Does this mean that all physicians, many of whom provide services strictly in the AMC setting (e.g., Massachusetts General Physicians Organization and Brigham and Women's Physicians Organization) will be in the "component" that includes community hospitals? If so, the component structure seems largely illusory, because it would be entirely impracticable to have a payor contract with an AMC that did not include the physicians who provide services at that AMC. In addition, the component contracting provision does not appear to address contracting on behalf of Partners' non-hospital facilities.

- To the extent component contracting will actually result in health plan products that include some, but not all, Partners facilities and providers (and, as stated above, we think there is good reason to question that conclusion), such an outcome could present

significant risks to Partners competitors. As stated earlier, health care providers (especially the larger systems) are increasingly compensated under risk contracts, under which the provider (not the payor) bears the primary insurance risk associated with services provided to certain members under the health plan. Under such a health plan, the provider is at risk for (and is essentially the payor with respect to) services rendered out-of-network (i.e., rendered by providers other than the contracting health system). This presents especially challenging issues with respect to urgent and emergent services, which are often necessarily provided out-of-network. When they are provided out-of-network, they become covered services that must be reimbursed at the provider's full charges. If Partners facilities are out-of-network for certain health plan products for which other providers bear financial risk, this could put the other providers in the dangerous economic situation of having to pay Partners for urgent or emergent care delivered to their patients at Partners' full charges, which are much higher than its top-of-the-market negotiated rates. Because Partners is the largest provider in eastern Massachusetts, and under the Settlement Agreement authorized to become even larger, this could happen frequently. Any settlement should take steps to ensure that this potential adverse consequence of component contracting is mitigated or eliminated.

Prohibition on Joint Contracting

The Press Release states that Partners must "cease joint contracting on behalf of non-owned physician group affiliates outside its own physician hospital organizations." It is unclear to us what this aspect of the Settlement Agreement prohibits that current law would otherwise permit. We assume this provision prohibits joint contracting through Partners Community Healthcare, Inc. ("PCHI"). Is that correct? If so, does this element of the Settlement Agreement prohibit any other current contracting activities? In addition, we have the following questions:

- Are there any limits on bringing new PHOs into Partners?

- Under the Settlement Agreement, for how many physicians will Partners cease contracting?

Other Questions and Concerns

- In the original letter we estimated that, with the contemplated acquisitions, Partners' net patient service revenues would increase by 14%, from $6.8 billion to $7.8 billion, roughly four times the size of the next largest Massachusetts system. A more complete breakout of this information is included below:

Provider	FY 2013 Net Patient Service Revenue
Existing Partners providers (includes all providers)	$6.8 billion[4]
Brigham and Women's Hospital	$1.78 billion[5]
Massachusetts General Hospital	$2.3 billion[6]
Faulkner Hospital	$181 million[7]
Martha's Vineyard Hospital	$59 million[8]
McLean Hospital	$122 million[9]
Nantucket Cottage Hospital	$31 million[10]
Newton-Wellesley Hospital	$398.6 million[11]
North Shore Medical Center	$402 million[12]
Subtotal (does not include non-hospital providers)	*$5.2 billion*
Cooley Dickinson (joined Partners in July 2013)	$156 million[13]
South Shore Hospital	$445 million[14]
Hallmark Healthcare	$224 million[15]
Emerson Hospital	$182 million[16]
Subtotal	*$1 billion*
TOTAL	**$7.8 billion**

[4] Partners HealthCare System, Inc. and Affiliates Consolidated Financial Statements for FY 2013, available at: http://www.partners.org/Assets/Documents/Medical-Research/PCRO/A-133%20Audits/Partners_HealthCare_System_Inc_%20A-133_FY13.pdf. To the extent that NPSR for Cooley Dickinson Hospital was included, this number would include revenue only from the date Cooley joined Partners (July 1, 2013) until the end of the fiscal year (September 30, 2013). Unlike the information from the CHIA Fact Sheets, this number includes all of the Partners providers.

[5] CHIA Fact Sheet for Brigham and Women's Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/brig-and-wom.pdf.

[6] CHIA Fact Sheet for MGH, available at: http://www.mass.gov/chia/docs/r/qtr/2013-09-30/2014-04-29/mass-gen.pdf.

[7] CHIA Fact Sheet for Faulkner Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-09-30/2014-04-29/faulkner.pdf.

[8] CHIA Fact Sheet for Martha's Vineyard Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/marthavin.pdf.

[9] McLean Hospital 2013 Annual Report, available at: http://mclean.harvard.edu/pdf/about/ar-13/mclean-ar-13.pdf.

[10] CHIA Fact Sheet for Nantucket Cottage Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/nantucke.pdf.

[11] CHIA Fact Sheet for Newton-Wellesley Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/newt-wel.pdf.

[12] CHIA Fact Sheet for North Shore Medical Center, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/no-shore.pdf.

[13] CHIA Fact Sheet for Cooley Dickinson Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/cooleyd.pdf.

[14] CHIA Fact Sheet for South Shore Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/so-shore.pdf.

[15] CHIA Fact Sheet for Hallmark Health, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/hallmark.pdf.

[16] CHIA Fact Sheet for Emerson Hospital, available at: http://www.mass.gov/chia/docs/r/qtr/2013-12-31/2014-04-29/emerson.pdf.

These figures do not include any increase in net patient service revenue associated with the growth in the Partners physician network. If Partners' network of physicians increased by approximately 590 physicians, as the Partners Email states is permitted under the Settlement Agreement, this could be expected to result in a significant increase in the net patient service revenue derived from the professional services of employed physicians. In addition, if these new physicians increased their referrals to Partners hospitals and other facilities, as would be expected, then the net patient service revenues of these facilities would increase. The impact of the growth of the Partners physician network on the overall Partners system should be carefully analyzed before any Settlement Agreement is finalized.

- The Press Release states that there are growth restrictions on Partners network community physicians. Are there any limits on growth with respect to non-community (e.g., AMC) physicians? Are "community physicians" defined by geographic criteria alone? The Press Release states that "[a]ll AMC physicians practicing outside metro Boston will be counted" toward the community physician growth restrictions. How will the "metro Boston" area be defined? A broad definition of "metro Boston" could encompass a significant area and, therefore, exempt all AMC physicians practicing within that area from the growth caps referenced in the Settlement Agreement. (A broad definition would, however, increase the number of markets subject to any restrictions in place within metro Boston—although no such restrictions are identified in the Press Release.) By contrast, a narrower definition of "metro Boston" would subject more physicians to the caps summarized in the Press Release. For example, if Weymouth and surrounding South Shore communities are outside of metro Boston, we assume a significant portion of the network growth cap would be consumed by Harbor Medical Associates and the South Shore Physician Hospital Organization. The implications of these critical terms should be fully and carefully considered before inclusion in the final Settlement Agreement.

- In the prior section, we stated that we assumed that, based on the Press Release, the Settlement Agreement would prohibit joint contract for non-owned/leased physicians through PCHI. If that is the case, we would expect such PCHI groups to become employed or leased by PCHI or leave PCHI. The Press Release states that "Partners network community physicians shall not exceed the Partners 2012 baseline physician leave for three years." Are existing PCHI affiliates counted in the baseline? If this is the case (as we assume it is), does that mean that Partners will be able to replace all existing PCHI affiliates with employed/leased physicians? If so, because of the greater control that can be exercised over employed and leased physicians, might not these provisions of the Settlement Agreement work together to increase (not reduce) the dominance of the Partners physician network?[17]

[17] For example, approximately 50 physicians from Pentucket Medical Associates are anticipated to become Partners employees this summer. Since those physicians are in the 2012 baseline, we assume this will not have a net impact on Partners under the Settlement Agreement, despite the fact that the result will be to replace a large group of affiliated physicians with a large group of employed (more tightly controlled) physicians.

- Any limit on the aggregate number of new network community physicians should also factor in the distribution of these physicians across markets and the anti-competitive effects of market concentration in specific markets. Without such market-specific restrictions, Partners, with all of its resources, will be able to achieve dominance in specific markets that will drive existing providers out of those markets or out of business altogether, thus driving up the cost of health care for all patients and restricting access to needed services for the most vulnerable patients. Given the announced plans of Partners and Hallmark to add primary care physicians in a newly formulated network, the outcome of the Settlement Agreement in certain North Shore communities is especially problematic. If the Hallmark transaction is consummated, and before Partners and/or Hallmark add any new physicians, Partners will control 69% of the primary care physician full-time-equivalents,[18] and more than one-half of all inpatient discharges,[19] in the communities of Malden, Chelsea, Revere, Everett, and Winthrop.

- In addition to its dominant position as a provider, Partners also owns a licensed health maintenance organization, Neighborhood Health Plan ("NHP"). As reported, the Settlement Agreement does not address NHP and what Partners might do with it in the future. While NHP's activities have not changed significantly since it was acquired by Partners, we believe it is important to ensure that protections are in place to ensure that Partners does not cross-leverage its payor and provider roles in a manner that increases total health care spending. For example, NHP could refuse to contract with (or contract only on non-preferred terms with) non-Partners providers. Aside from NHP, the Settlement Agreement appears not to address Partners' actions in the insurance market other than with respect to pricing terms. For example, Partners could use it market power to refuse to contract with certain insurers, or to refuse to provide services under certain plans. Such actions could significantly undermine payor efforts to control costs, if such efforts were, for example, targeted at payors attempting to develop attractively-priced tiered or limited network plans that discouraged use of Partners' substantially higher-priced providers. (Such actions could include, for example, refusing to participate in such plans, possibly making such plans non-viable in the market because of the absence of Partners "can't do without" flagship hospitals.) Such actions could also undermine efforts to care for the most vulnerable segments of the population if, for example, they were targeted at Medicaid plans (e.g., if Partners' providers withdrew from Participation in Medicaid plans other than those offered by NHP). We recommend that any Settlement Agreement address the insurance/payor side of the health care market in a careful and thoughtful manner.

- Because these are such complicated and highly interdependent issues, it is imperative that any final Settlement Agreement incorporates robust monitoring and enforcement provisions. Such provisions will be, in certain respects, as important as the substantive terms of the Settlement Agreement. Consistent with common practice in this area, we would expect such monitoring to include an independent monitor, selected at the

[18] Study performed by Barlow/McCarthy Hospital and Physician Solutions, June 2013.
[19] Massachusetts Health Data Consortium Inpatient Discharge Database, available at: http://www.mahealthdata.org/data/inpatient

discretion of the Attorney General and funded by Partners, who issues periodic public reports.

We take this opportunity to reiterate our request for an opportunity for providers, payors, employers and consumers to provide meaningful input with respect to the proposed Settlement Agreement. As described to date, the proposed Settlement Agreement would be likely to have profound and negative effects on the cost of health care services in the Commonwealth.

We continue to have the utmost respect for the commitment of your office to bring greater transparency to the growing problem of health care costs in the Commonwealth and the efforts it has made to craft creative solutions to this problem. Given the high stakes in this case, however, we believe additional steps are absolutely necessary to protect the interests of the citizens of Massachusetts in having access to cost-effective, high quality health care services.

Sincerely,

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