EXHIBIT A

MASSACHUSETTS HOSPITAL COSTS, 1980-92

$ MILLIONS

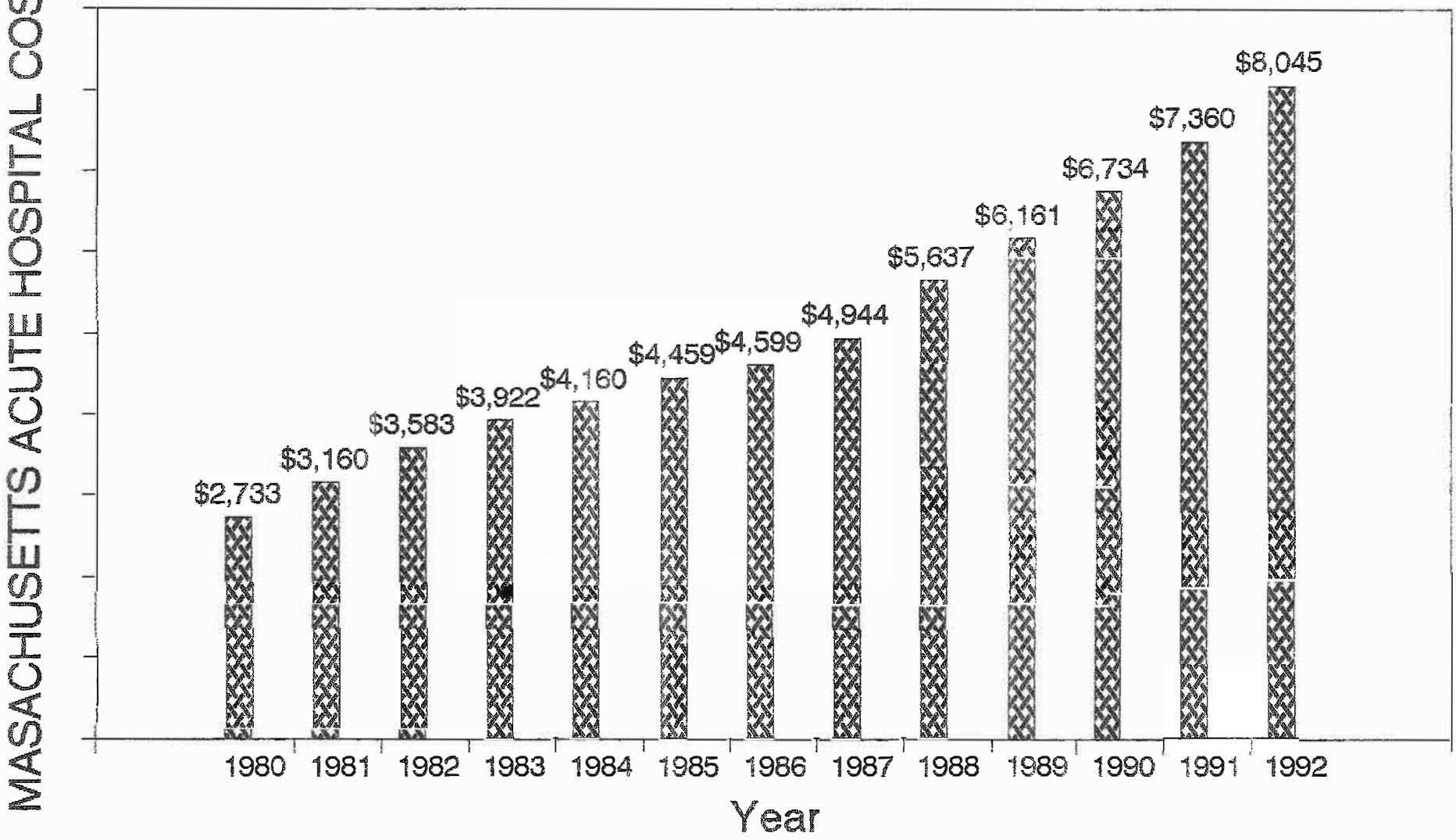


EXHIBIT B

HOSPITAL BEDS PER PERSON, 1960 - 1989

Massachusetts as percent of U.S. total

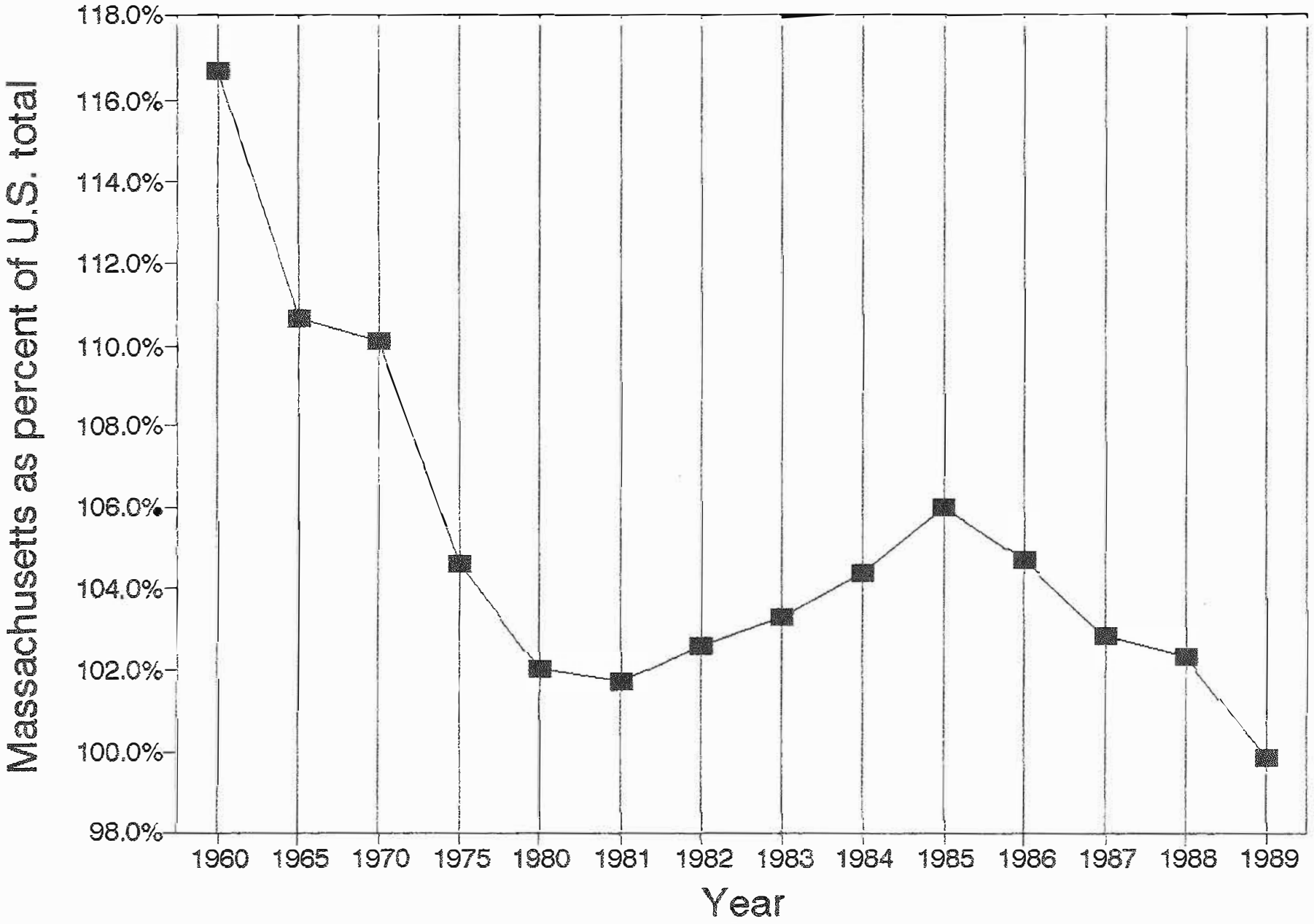


EXHIBIT C

HOSPITAL OCCUPANCY RATES, 1960 - 1989

Massachusetts and United States

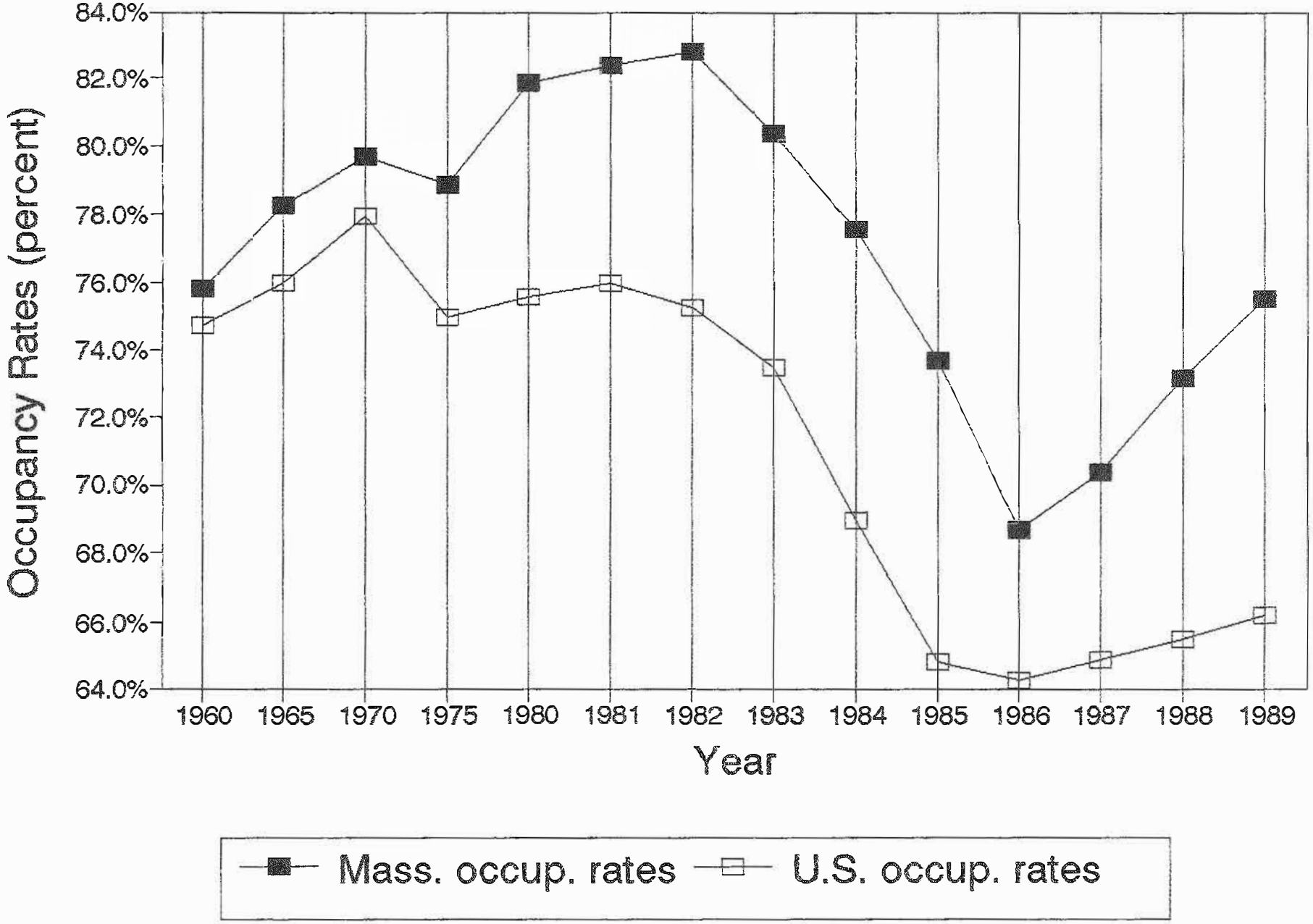


EXHIBIT D

NUMBER OF MASSACHUSETTS HOSPITALS

1960 -1991

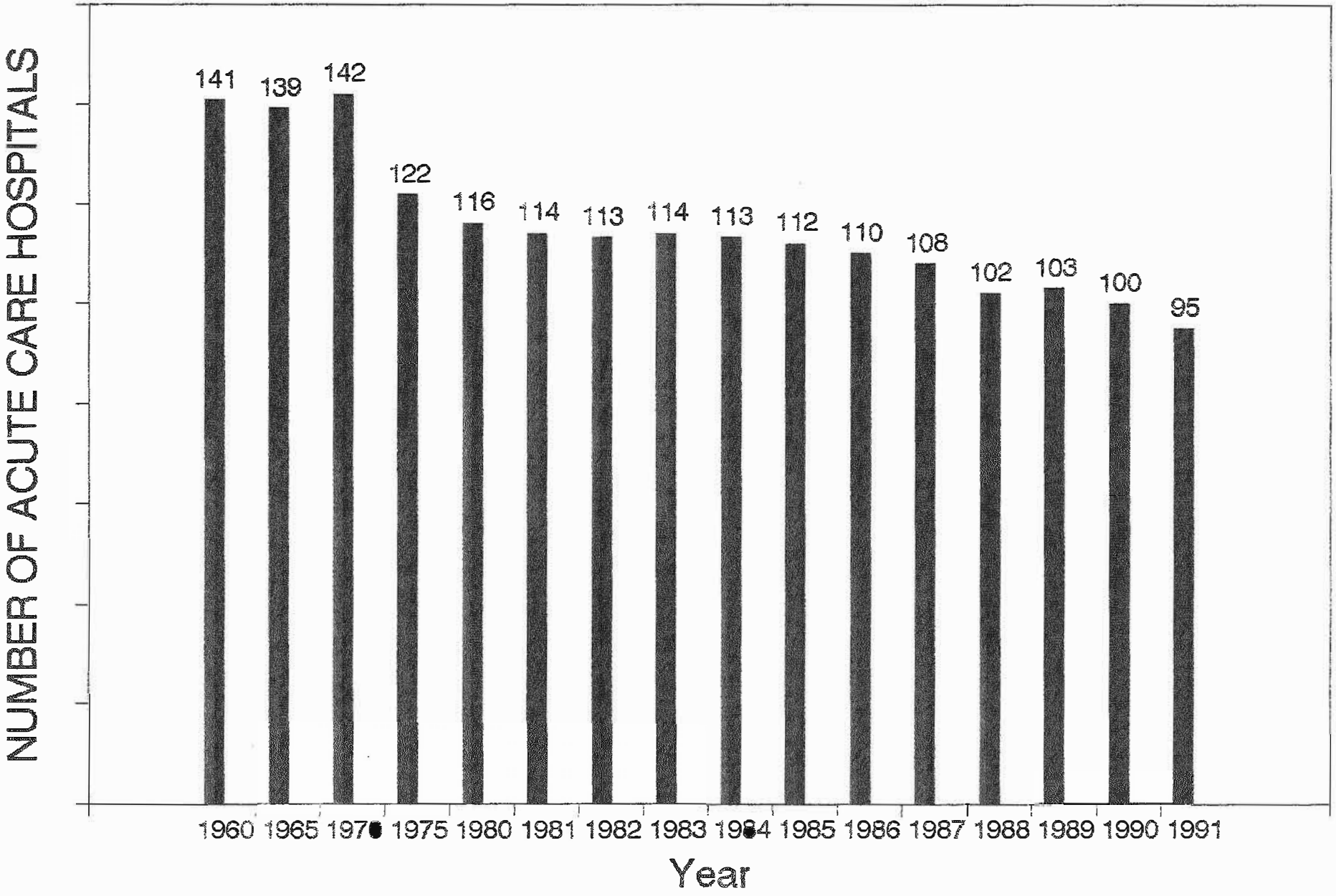


EXHIBIT E

HOSPITAL COSTS PER PERSON, 1960 - 1989

Massachusetts as percent of U.S. total

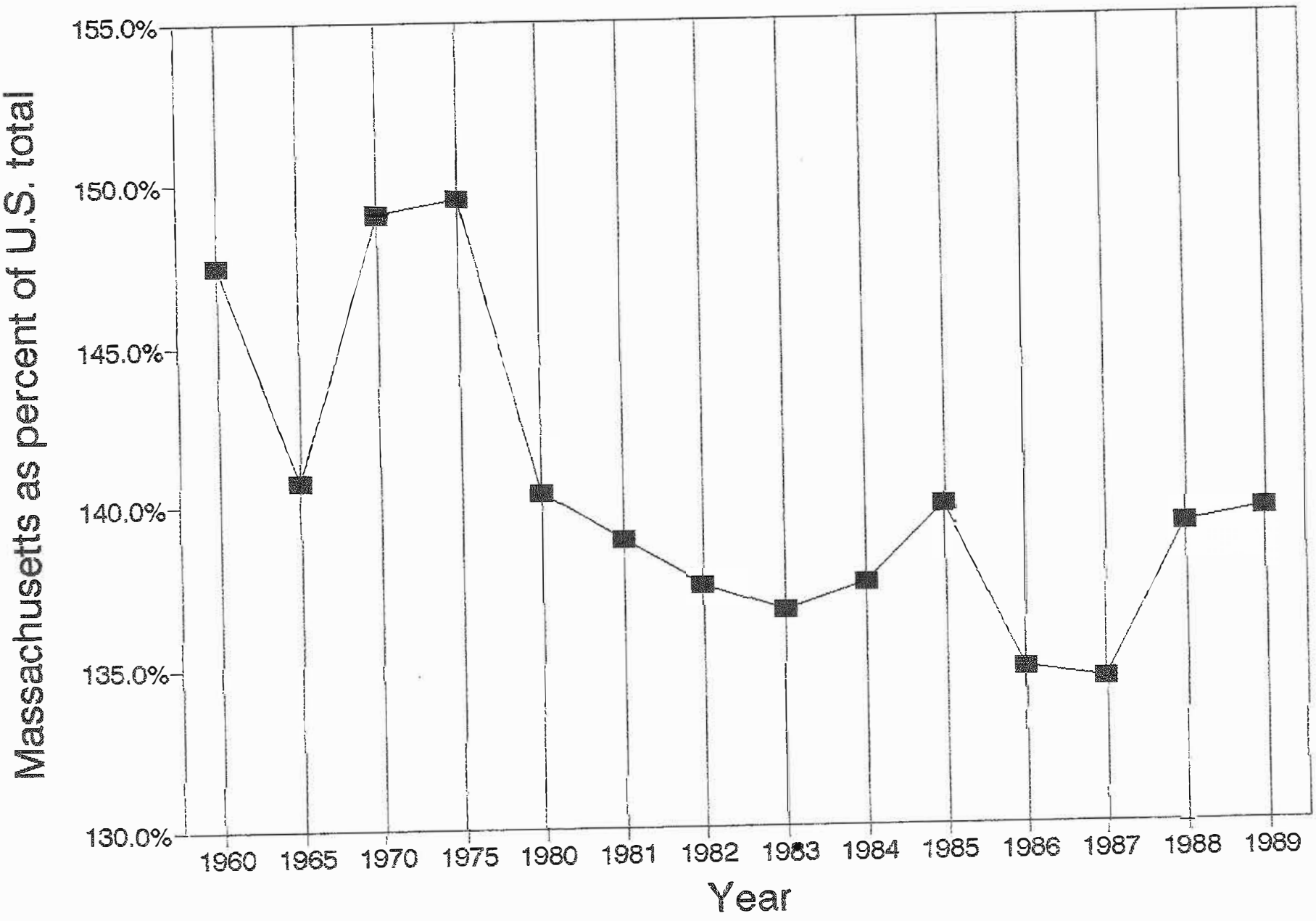


EXHIBIT F-1

HOSPITAL ADMISSION RATES, 1960 - 1989

Massachusetts and United States

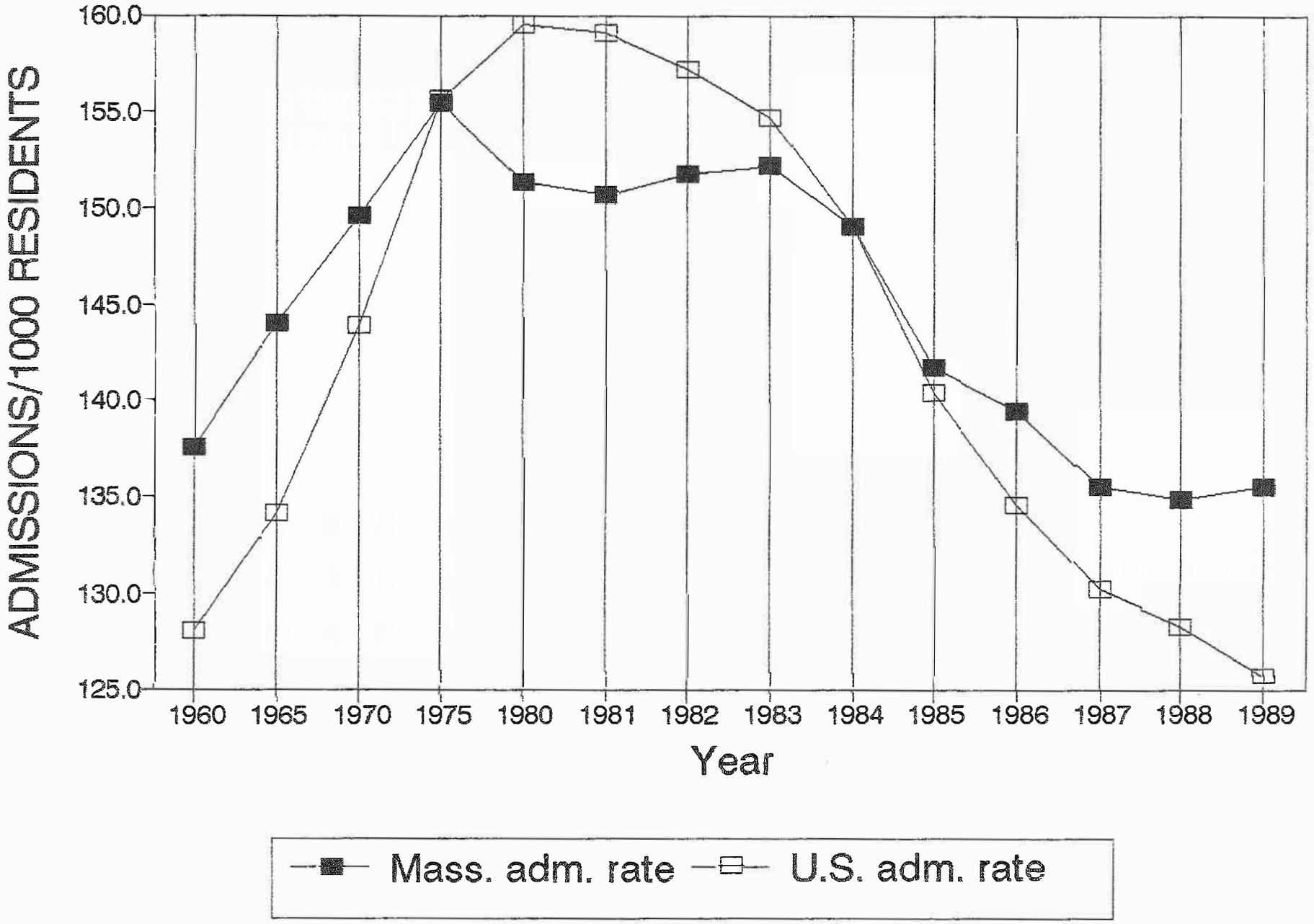


EXHIBIT F-2

OUTPATIENT VISITS, 1975-89 (000s)

Massachusetts, Non-Emergency Only

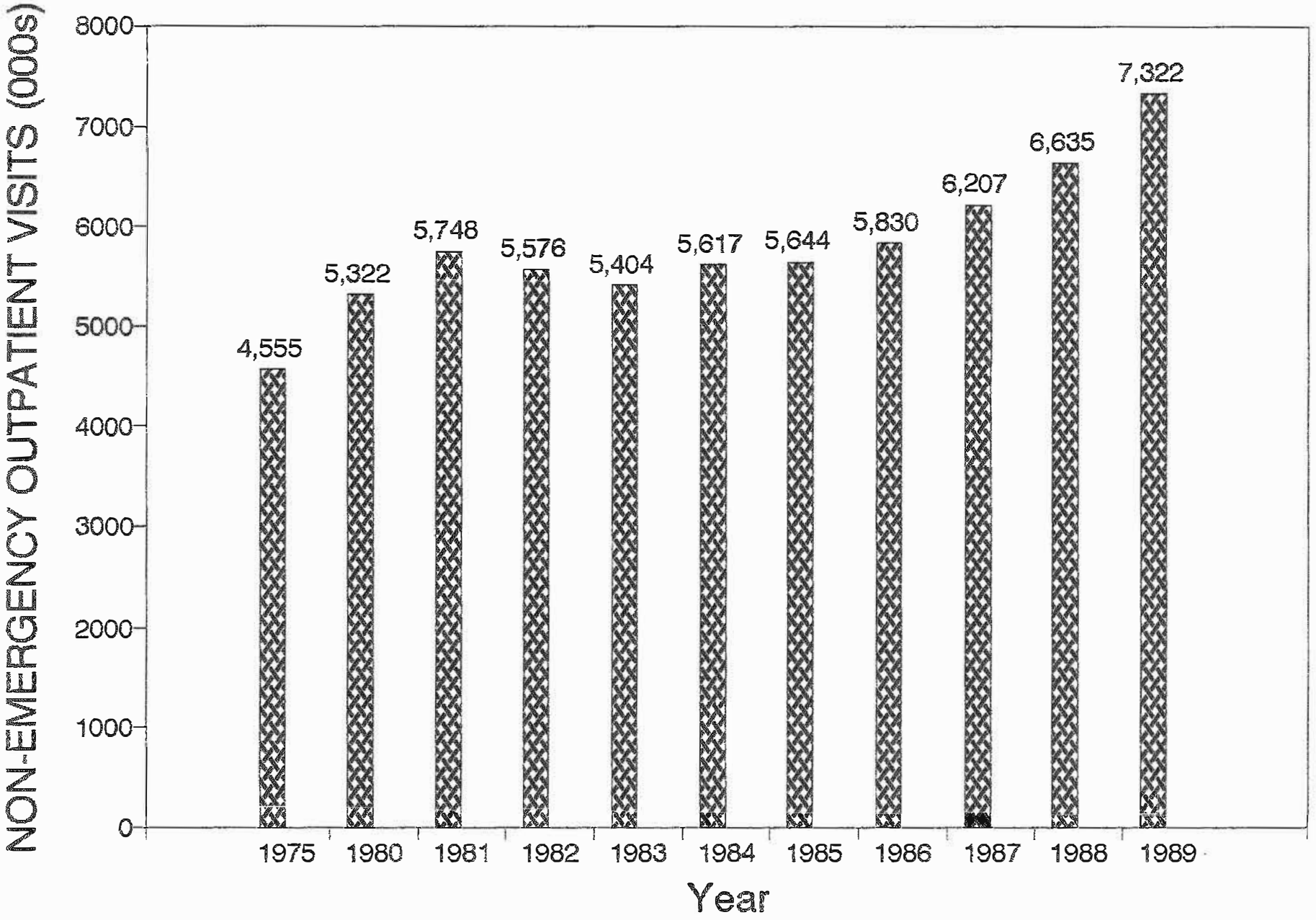


EXHIBIT G

HMO MARKET SHARE AND HOSPITAL COSTS
1980 - 1990

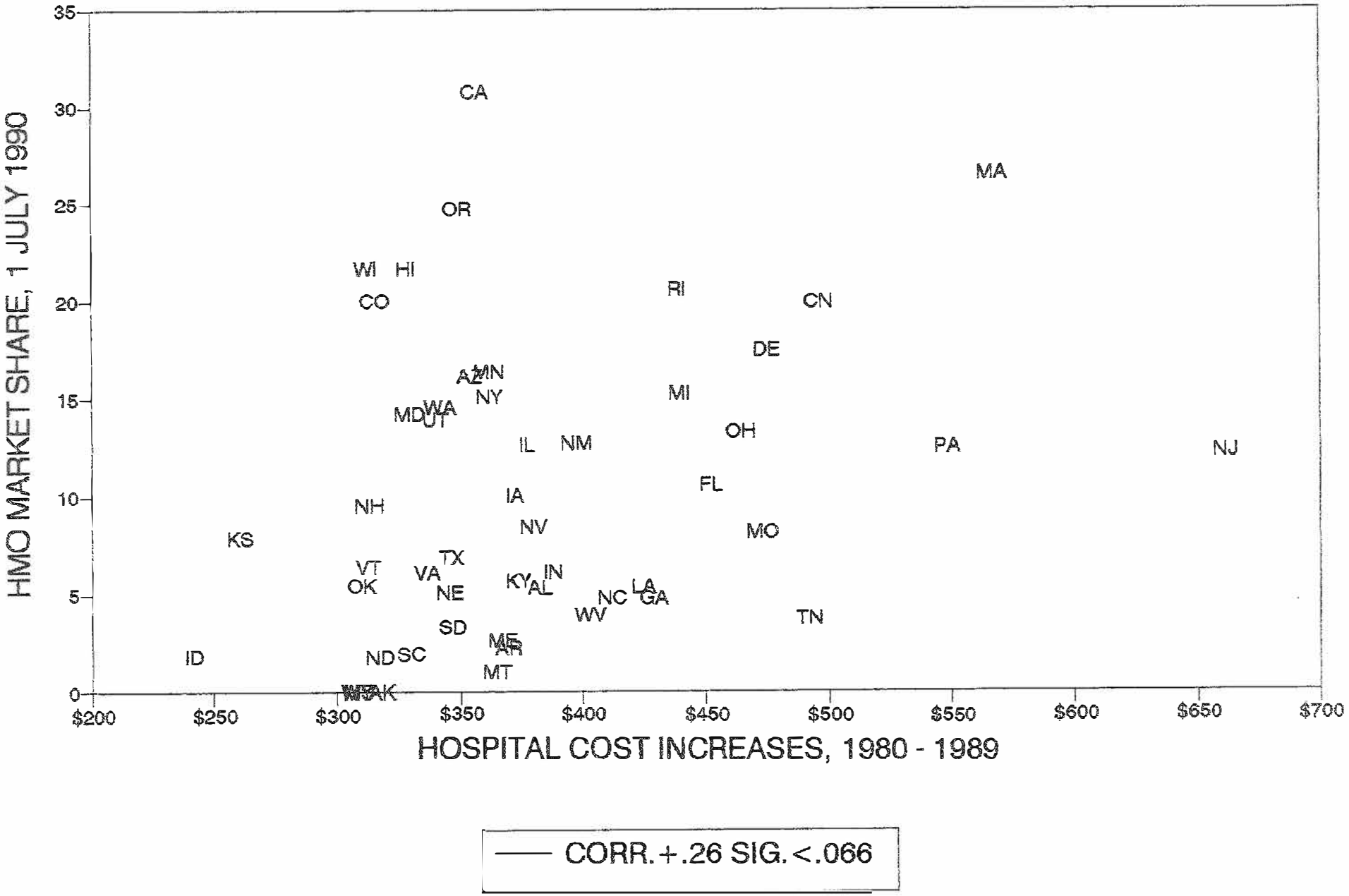
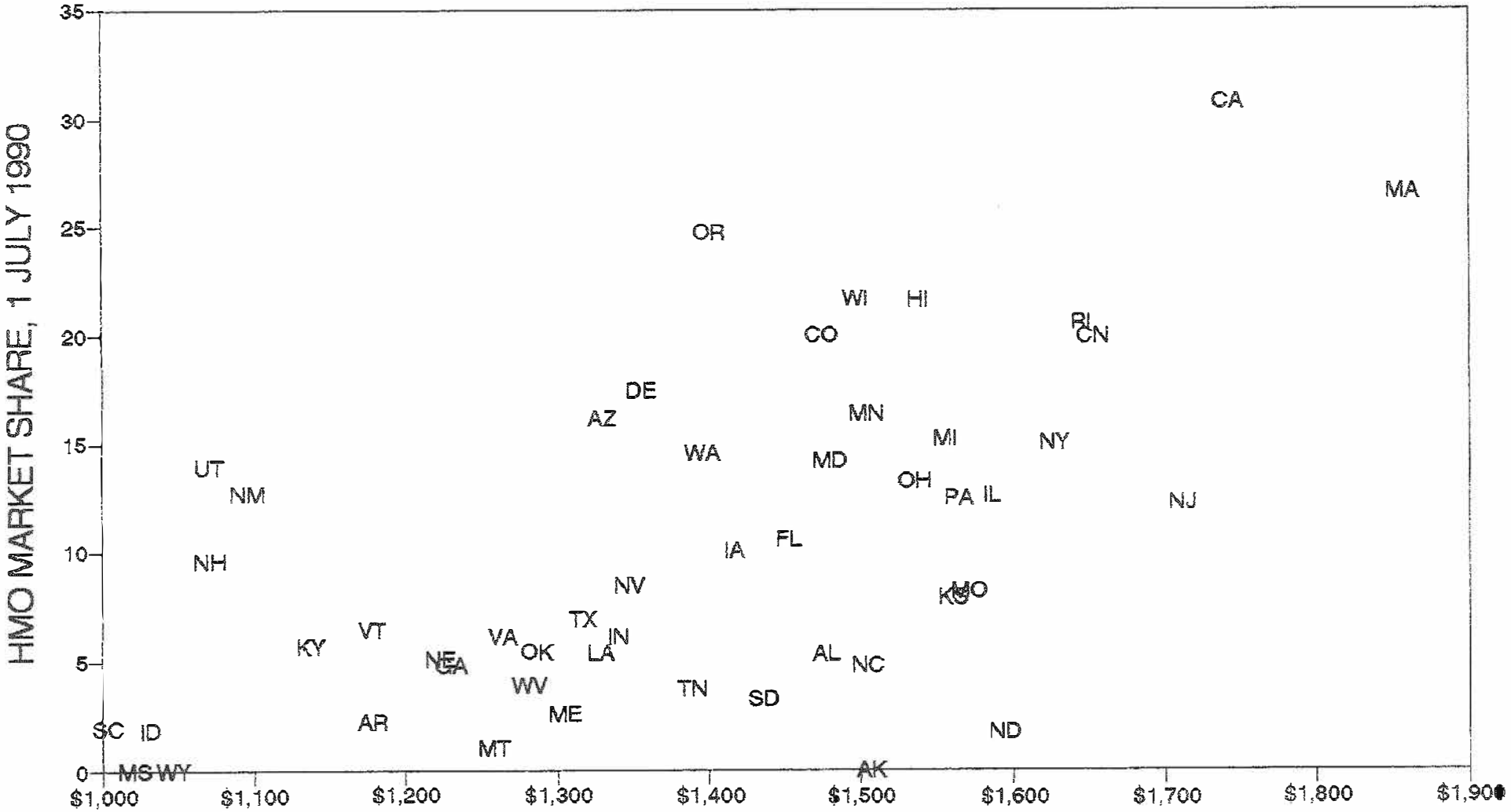


EXHIBIT H

HMO % OF POP. VS. HEALTH COST RISE
1980 - 1990



CORR=+.55 SIG<.000

EXHIBIT I

MARYLAND and MASSACHUSETTS: The Experience with Regulation

The differences between hospital payment rules in Maryland and Massachusetts in the past decade demonstrate that strong and simple regulations save money and protect hospitals. High Massachusetts hospital costs long antedated regulation. Our regulatory efforts to constrain volume and costs made progress in the mid-1980s, as the gap between our hospital costs per capita and the nation's shrank in 1987 to the smallest in decades. But those hospital payment rules were complex and inequitable, inviting contention.

Then in 1988, chapter 23 unleashed our costs, combining competitive incentives that encouraged volume growth with generous regulatory increases in hospitals' rates. It proposed to rely on hospital closures and managed care to save money. From 1987 to 1989, hospital costs per capita rose from 34.5 to 39.7 percent above the U.S. average.

In contrast, consistent and simple regulations over 15 years brought Maryland's hospital costs below the U.S. average, without closing hospitals or compromising quality. Comparing the two states reveals the kinds of regulations that work to contain costs, improve inter-hospital and inter-payor equity, and keep open all needed hospitals.

Maryland's hospital payment method:	Massachusetts' hospital payment method:
1) uses a fair base on which to build future revenue increases and holds all hospitals to fair standards	1) has used 1981 costs as a base since 1983, disadvantaging hospitals that were efficient in 1981
2) -- gives hospitals' predictable, guaranteed revenues, enough for efficient hospitals to stay open -- gives a motive to economize because hospitals keep the money they save -- focuses hospitals on efficiency and quality, not marketing, lobbying, litigating or corporate empire-building -- prohibits cost-shifts and discounts, ensuring that all payors both pay their shares and benefit from cost control	2) -- set caps on allowable revenues, rather than guaranteeing revenues -- closed hospitals as a central cost control technique, leaving them even more insecure and, since 1988, anxious to raise volume; the number of Mass. hospitals has dropped by a third since 1970, while Maryland gained six -- undermined efforts to limit cost-shifts by allowing discounts for HMOs
3) was designed in collaboration with hospitals, so they trusted its rules	3) invited contention, as it was complex, inequitable, and allowed exceptions
4) pays revenue equal to incremental costs only, for volume increases, and subtracts an equivalent amount when volume declines	4) -- adjusted for volume changes using incremental cost, from 1983 to 1987 -- but, to encourage competition, used full average cost since 1988, thus rewarding hospitals that add patients, by paying more than their added costs
5) pays most hospitals' actual cash needs (principal and interest) for capital	5) rewards capital-rich hospitals with unwarrented cash gifts
6) has effectively contained costs -- in ways acceptable to hospitals, doctors, and payors -- for 15 years	6) contained costs for a time, but raised them under chapter 23, while needed hospitals face financial distress