NON-CONFIDENTIAL

STATE OF MAINE

DIRIGO HEALTH AGENCY

BOARD OF DIRECTORS

IN RE:

DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE FOURTH ASSESSMENT YEAR (2009)

MEAHP EXHIBIT 3

PREFILED TESTIMONY OF DANIEL FISHBEIN, M.D.

July 9, 2008

Q. Please state your name and your position with Aetna.

A. My name is Daniel R. Fishbein. I am currently the Head of Aetna's national Health Plan Alliances business, and I am based in the company's Portland, Maine office. I attach as Fishbein Exhibit 1 a Biosketch that details my background and experience in the healthcare field. I can say that, in general, I am very familiar with our products, provider network, and customers in Maine.

Q. For whom are you testifying?

A. Aetna and the Maine Association of Health Plans ("MEAHP").

Q. What is the Maine Association of Health Plans?

A. The Maine Association of Health Plans is the trade association that represents the administrators of self-funded and fully insured health benefit plans in the State of Maine. The members of the Association are Aetna Health, Inc, Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross/Blue Shield, CIGNA HealthCare of Maine, Inc. and Harvard Pilgrim HealthCare. Collectively, health plans under the administration of MEAHP members cover approximately 680,000 Maine people.

Q. How did you prepare for your testimony?

A. I reviewed the June 2, 2008 "Report to the Dirigo Health Agency" covering Aggregate Measurable Cost Savings ("AMCS") for Year 4 prepared by schramm raleigh Health Strategy, the consultants to the Dirigo Health Agency ("DHA") (the "srHS Report"), pre-filed testimony from Steven Schramm and Dr. Kenneth Thorpe and associated pre-filed exhibits filed by DHA, and my 2005 and 2006 prefiled testimony before the Superintendant of Insurance (2005) and this

Board (2006 and 2007), as well as preliminary materials prepared by the expert witnesses for the other intervenors for Year 4: the Maine State Chamber of Commerce, Anthem and the MEAHP.

Q. Do you intend to prepare further prior to taking the stand in this case?

A. Yes. Specifically, I intend to review the prefiled testimony that will be filed by all of the parties and their experts in this case, and spend more time reviewing materials from the voluminous DHA filing, which may necessitate further examination of the Year 4 Report and the prefiled testimony and exhibits filed by DHA. I therefore plan to update this testimony when I take the witness stand. I will also try to provide additional current information regarding the cost trends that Aetna has experienced in Maine and elsewhere

Q. Does the process implemented in this case give you any concerns regarding the Board's ability to reach a sound and well-reasoned decision?

A. Yes. While the period between the delivery of this year's srHS Report and the hearings before the DHA Board is greater than the comparable period last year, the analysis in the srHS report is different from, and much more complex than that for last year, and involves significantly more data. This leaves insufficient time for experts of MEAHP, the Chamber and Anthem to fully understand and test the new methodology and its results, and for other witnesses, such as myself, to integrate sufficient other relevant information into the critique. By contrast, DHA Staff has been working on its Year 4 AMCS calculation since at least March 2008, or in other words for about four months, at a cost of $950,000. The DHA Board may therefore not have the benefit of the kind of careful review and analysis by the intervenors that is needed in this very complex area. This is especially regrettable when one considers that the DHA Staff has submitted a savings calculation which could pave the way for a multi-million-dollar increase in health insurance premiums in Maine.

Q. Please indicate the purpose of your testimony.

A. First, Aetna supports the goals of the so-called Dirigo law in attempting to reduce the number of uninsured and underinsured people in Maine. In addition, Aetna supports the State in any efforts to reduce healthcare costs to employers and individuals in Maine. However, both of these goals cannot always be achieved at the same time and with the same program. In order for this process to make sense for employers and consumers and to be a sustainable program, we need to take care to ensure that AMCS is limited to savings that are measurable and that can reasonably be recovered in the form of lower charges.

It simply is not credible that a program insuring 12,050 members (per DHA monthly numbers as of July 2, 2008) would produce savings of $190.2 million to the rest of the medical care system in Maine in a year. This inflated figure needs to be reduced to a reasonable number, but the analysis that produced it is buried in many thousands of pages of "supporting documentation." If the Dirigo program is ever to become sustainable, it must be on the basis of solid savings, calculated on a credible and reasonable methodology in which the public can be confident. The pattern of seeking to burden payers of private insurance premiums and those in self-insured plans with an unreasonably high assessment must stop.

In my testimony, I will discuss the specific flaws in the DHA savings determination identified by MEAHP, and I will discuss several of these flaws in detail. Another MEAHP witness, Adam Rudin of CIGNA, will submit testimony from his standpoint as an actuary working in the health insurance field regarding other specific problems with DHA's savings calculation.

I have been able to gather some preliminary information regarding medical costs incurred in Aetna's Maine health plans, medical cost trends in Maine and Aetna's network operations in Maine. As was the case last year, our data shows a slight easing of cost trend in Maine but also in the rest of New England and the country, where there is no Dirigo law in effect. Our overall

costs continue to go up, and the rate of increase in Maine is still a little higher than the rate of increase in New England as a whole. (Aetna's data is done by calendar year, so the figures we have now are not perfectly comparable to those used by DHA. We hope to have state fiscal year data by the time of oral testimony.) Based in part on this information, as well as on the reports of the experts for MEAHP, Anthem and the Chamber, I conclude that the savings generated by the Dirigo initiatives could not possibly be anywhere near the $190.2 million Year 4 figure proposed in the srHS Report.

Q. What would be the result if the Board were to establish a level of aggregate and measurable cost savings in excess of the savings that MEAHP's plan members can reasonably recover from providers?

A. First I need to point out that to the extent Aetna is able to recover savings from hospitals in the form of lower charges, those savings are reflected in the premiums charged by Aetna to its customers. The savings sought by the DHA in each of the four years of AMCS proceedings have been vastly in excess of the savings actually experienced by Aetna. As Mr. Rudin of CIGNA explains in his testimony, it is generally accepted in the health insurance industry that each increase in health insurance rates causes some percentage of the existing base of insured people to drop or lose coverage. Since any DHA-generated savings reasonably recoverable from providers have been far less than the SOPs assessed by DHA in Years One, Two and Three (and are certainly far less than the $190.2 million AMCS estimate in the srHS Report), approval of DHA's Year 4 savings calculation (even when reduced to the cap of 4% of paid claims) means that carriers operating in Maine will once again be required to increase premiums in order to reflect an unreasonable and unsupported SOP, if anything more than an amount that is reasonably recoverable from hospitals by payors is approved. This would undoubtedly result in some Maine people losing their health insurance as a result of DHA.

Q. What is MEAHP's position regarding the calculation of "aggregate measurable savings?"

A. In my prior testimony, I explained that MEAHP understood that the AMCS had to be limited to savings generated by the operations of DHA as an insurer. This was the understanding that MEAHP and its members, including Aetna, had when we agreed to support the Dirigo law four years ago. Attached to this testimony is a handout, labeled Fishbein Exhibit 2, which was distributed by the Governor's Office of Health Policy and Finance on June 11, 2003, at the time of the floor vote in the Legislature on the Dirigo law. It explains the Governor's Dirigo proposal to Maine's Legislators and the public generally. The second page of the handout contains a five-point explanation of how the subsidies built into DHA's healthcare coverage will be financed. The third and fourth points are consistent with my understanding of what DHA must show:

- "Capture realized savings ***from the reduction in bad debt and charity care*** through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. ***Insurers' payments will offset savings so payments will never exceed the savings."***
- "Use the savings offset payments to fund premium subsidies of those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum." ***(emphasis added)***

Q. Has DHA limited the scope of its savings calculation to cover only savings from the reduction in bad debt and charity care?

A. No, although DHA was sustained on this point by the Maine Supreme Court in its decision in 2007. Those of us directly involved in the discussions surrounding the enactment of the legislation, however, are aware of what we were explicitly told by the bill's sponsors regarding the scope of permissible AMCS, and you can see it in the handout. We hoped that any

expansion of scope would be restrained to other similarly measurable savings, but continue to be disappointed in the way DHA and its experts have asserted ever-increasing levels of unsupportable "savings."

Q. What is Aetna's market position in the Maine health insurance market?

A. Aetna has 325,635 members in Maine in various types of health plan products including HMO and PPO plans; of those, about 217,000 are in a plan that provides case management services only to Medicaid recipients. Most of the non-Medicaid plans are provided by employers to their employees in Maine. Aetna contracts with 39 hospitals in Maine and 2,069 Maine physicians. Aetna has an office in Maine and employs 386 Maine residents.

Q. Has Aetna observed any changes in the hospital charges it pays on behalf of its insureds?

A. During the period July 1, 2006 through June 30, 2007 (Dirigo Year 4), we saw a few hospitals temporarily lower their charges, but many raised their charges. On balance, Aetna has seen no net reduction in hospital charges either from these particular hospitals, or from Maine hospitals in general, which have gone up overall. Given that Aetna's actual cost trend experience is about the same this year as last, Aetna is shocked that DHA has proposed a six-fold increase in the hospital savings figure. This alone is a basis for the conclusion of the Year 4 Report being deemed unreasonable on its face.

Moreover, data presented by MEAHP witnesses in prior AMCS proceedings demonstrated that in fact Maine's hospitals often increase their prices at a rate that substantially outstrips the cost increases they experience—a point that renders DHA's hospital-cost-based approach to determining savings invalid per se.

Q. Are there any regulatory constraints that MEAHP members have encountered in seeking favorable arrangements with Maine hospitals?

A. Yes. In Maine, the geographic access requirements of Rule 850 obligate health plans to include virtually all hospitals, doctors and other providers in their networks. This prevents an insurer from selectively contracting with providers, thereby eliminating an important source of leverage for price competition.

Q. Can you indicate whether Aetna has made progress recently in its negotiations with Maine hospitals?

A. In my two appearances in Dirigo AMCS proceedings for the first two years, I presented specific information regarding the outcome of re-negotiations with Maine hospitals during the relevant Dirigo Years. For example, in the 2005 proceeding I stated that we had "re-negotiated contracts with 15 of the 39 hospitals in Maine. In eight of these negotiations, the resulting terms were less favorable than they were in the prior agreement, in three they are better, and in four they stayed about the same." This is consistent with our experience in the past year as well; I will attempt to have more specific information on this point by the time of the hearing.

In any event, as I mentioned previously, all of these contracts give the hospitals the ability to increase at any time their underlying charges against which the negotiated discounts are applied.

Q. What were Aetna's overall medical cost trends in Maine during Dirigo Year 4?

A. As I stated earlier, our overall costs continue to go up, and the rate of increase in Maine is still a little higher than the rate of increase in New England as a whole. Aetna has experienced some slight reduction of medical cost trend in Maine for the period in question, consistent with the prior year. However, we also experienced trend reductions over the same period in other New England states (none of whom are affected by the so-called Dirigo initiatives) and in the United States as a whole. (Aetna's data is done by calendar year, so the figures we have now are not perfectly comparable to those used by DHA. We hope to have state fiscal year data by the time of oral testimony.) This appears to me to sustain the observations made in testimony from

Mr.Rudin, Mr. Dobson, Mr. Maffei and Mr. Burke to the effect that broad, national trends have a very significant impact on a state's medical cost trend.

In any event, we have not been able to determine whether any of the trend reduction experienced in Maine is attributable to Dirigo. And again, the trend reductions in other New England States are certainly not attributable to Dirigo.

Q. In DHA Exhibit 7, DHA presents information received from Elizabeth Mitchell, Senior Director of Public Policy at MaineHealth. She is reported to have said that Maine Medical Center has reduced its prices four times during the past three years to reduce its operating margin. What has Aetna observed in this regard?

A. We did see some price reductions from Maine Medical Center during the first part of Dirigo year four, followed by increases in the second half. Prior to Year 4 we did experience some price reductions for a limited period of time but not by all MaineHealth hospitals and not all hospitals across the state. In fact many hospitals continued to increase charges during this period. I will attempt to have more specific information on this point by the time of the hearing.

Q. Have the State's actions in the area of MaineCare funding in fact had any impact on savings levels?

A. Yes. In fact, the State's handling of its MaineCare program has severely aggravated the cost shift problem, overwhelming any savings that might have resulted from an expansion of MaineCare enrollment and any potential reduction of bad debt and charity care derived from DHA's operations.

Q. Could you please explain this?

A. Yes. On February 14, 2006, the Insurance and Financial Services Committee of the Maine Legislature held a hearing on L.D. 1935, the bill that would have prohibited private insurance companies doing business in Maine from including SOP charges in their insurance

rates. In the course of that hearing, the Committee heard testimony from a representative from MaineHealth, which includes Maine Medical Center and a number of other health care facilities in southern Maine, and Stephen R. Michaud, President of the Maine Hospital Association ("MHA"). I am attaching the MaineHealth and Michaud testimony and a table prepared by Maine Health, both of which were submitted to the Committee, as Fishbein Exhibits 3, 4 and 5.

Mr. Michaud's testimony stated that MHA's member hospitals have generated savings, but he explains that: "How much of these savings are attributable to Dirigo is impossible to pin down given all the factors that go into hospital budgeting and that is part of the problem with the SOP as currently constructed." Of course, here Mr. Michaud makes exactly the same point made by Mr. Shiels, Mr. Tobin and some of the Anthem witnesses in their testimony in the Dirigo Year 1 and Year 2 cases, and which Mr. McGoldrick of CIGNA made in his testimony last year.

Mr. Michaud then pointed out that "in the very same year Dirigo was passed Medicaid payments to hospitals were cut by nearly $60 million. Obviously the resulting cost shift diminished any savings to premium payors."

The MaineHealth testimony makes the same point, but with a different cost shift number. MaineHealth states that, while Maine hospitals "generated over $44 million in savings, the State reduced its payments to hospitals by over $40 million. These reductions allowed the state to cover budget shortfalls. These reductions also forced hospitals to shift their costs to cover these losses. So while hospitals may have generated savings, insurers did not necessarily realize them. Savings generated by hospitals essentially went to cover the MaineCare deficit."

Q. The MHA Testimony identified a $60 Million MaineCare budget cut, while MaineHealth identified a $40 Million shortfall. Were you able to reconcile these figures?

A. Yes. We contacted the MHA to go over this and they furnished us with a very useful table, attached as Fishbein Exhibit 5, that provides the background for these numbers. This Table summarizes the MaineCare budget cuts implemented by the Maine Legislature for the

2004-05 biennium. The State of Maine is on a July 1 fiscal year basis, so the middle two columns (labeled "2003-04" and "2004-05") match up exactly with "Dirigo Year One" (July 1, 2003 through June 30 2004) and the period at issue in this case, "Dirigo Year 2" (July 1, 2004-June 30 2005). If you total up the MaineCare cuts, you find that in Dirigo Year One, the Legislature cut MaineCare by $24,503,131, and in Dirigo Year Two it cut MaineCare by $33,683,310, for a total cut during the biennium of $58,186,441. The MHA explained to us that the $40 Million number in the MaineHealth testimony consisted of the $33,683,310 MaineCare budget cut during Dirigo Year Two plus the additional hospital tax imposed by the Legislature that year, for a total of $40 Million. The "nearly $60,000,000" number in Mr. Michaud's testimony was based on the total $58 Million in cuts, rounded up to an even $60 Million.

Q. Have you been able to determine the impact of any changes in the MaineCare budget on Year 4?

A. I understand from information received from the Maine Hospital Association that these MaineCare reimbursement policies have continued into Dirigo Year 4. Even if the State made no additional cuts in Year 4, those policies continue to cause significant cost-shifting, the prior cuts continue to have a cumulative impact on hospital margins, and MaineCare continues to be very late in making payments, causing negative impacts on hospitals' cash flow. It would be improper for the Board to ignore all of these impacts in setting AMCS for Year 4, especially in light of the Superintendent's decision on this point last year.

Q. How does this relate to what is in the srHS Report for Year 4?

A. Last year the Superintendent reduced the hospital savings figure by $10 million because he concluded that these MaineCare policies did directly increase the amount of cost shifting by hospitals and thereby reduced the amount of "savings" that were reasonably recoverable by the payors. This year, the srHS Report says, at pages 14-15, "None of the data reviewed showed reductions in hospital reimbursement during the Year 4 CMAD time period or any Dirigo time

period. . . . Therefore, no adjustment to the CMAD savings figure is necessary due to MaineCare reimbursement." DHA has ignored the Superintendent's conclusion that the existing MaineCare reimbursement policies do directly impact the amount of savings reasonably recoverable by the payors and has confused overall MaineCare spending with specific policies affecting hospital reimbursement within the total spent. Fundamentally, DHA has chosen not to follow its own principle that savings must be related to reduced cost shifting. By continuing its MaineCare reimbursement policies, whether cumulative, ongoing or both, the State is causing hospitals to maintain high levels of cost-shifting; this directly affects the AMCS calculation, and it is unreasonable for DHA to ignore this fact in its Year 4 report.

Q. Didn't the expansion of MaineCare enrollment help provide additional funding to hospitals, thus addressing, at least to some degree, the cost shifting problem?

A. We understand that the expansion of MaineCare enrollment did provide some extra money for Maine hospitals. The point we are making here, however, is that the negative, cost-shifting impact of the MaineCare reimbursement policies, including the cumulative impact of prior cuts, totally overwhelms any positive effect from the Year 2 MaineCare enrollment expansion. Further, MaineCare pays only about 76% of hospital costs, and the difference is shifted to those in commercial insurance plans. In addition, the time lag in MaineCare payments to hospitals negatively impacts their cash flow. It is not reasonable, given these points and the Superintendent's ruling last year, for the DHA to ignore the tremendous impact of these policies, while including as savings some amount from the Year 2 MaineCare enrollment expansion.

As the attached hospital testimony to the Legislature establishes, (a) the hospitals made up for the MaineCare budget cuts and policy changes by cost-shifting the additional burden over to the charges levied to their insured patients, and (b) the impact of this cost shift has a staggering effect on any savings from the Dirigo initiatives. These MaineCare reimbursement policies and practices continue to have a similar impact in Year 4.

Q. Please explain what happened to cause Aetna to pay a refund based on its Medical Loss Ratio (MLR) earlier in 2008.

A. The Dirigo legislation added subsection 2-C to 24-A M.R.S.A. §2808-B. This subsection requires health insurers to review the premium levels and related medical costs associated with their small group book of business. If total medical costs are found to be less than 78% of total premiums, the insurer must refund a percentage of the premium back to current in-force policyholders. The analysis must be done on an entity-by-entity basis.

Aetna has offered different types of plans through separate entities -- (a) HMO and POS plans through Aetna Health Inc., and (b) PPO and indemnity products through Aetna Life Insurance Company.

Due to Aetna's structure, we were not allowed to combine and report on our entire book of small group business in Maine, as other insurers have been able to do. Looked at as a whole, our complete book of small group business in Maine would have surpassed the 78% benchmark. However, when they were separated by legal entity, our HMO business, which had higher medical costs, passed the benchmark, but our PPO business, which had lower than expected medical costs, did not.

The refunds were calculated in accordance with Maine Small Group law, using a rolling 36-month timeframe, from July 1, 2004 through June 30, 2007. We reviewed medical costs and premium levels this period for both of our subsidiaries doing business in Maine. We determined that employers with small group health policies currently written by Aetna Life Insurance Company were entitled to a refund, and refunds were mailed by March 1 to about 1,000 customers. Many other Aetna policyholders were not affected by the refund. The total amount of the refund was approximately $6.5 million.

Q. How do these facts relate to whether any "savings" should be claimed by DHA for purposes of the year AMCS determination?

A. First, those Aetna-covered employers and their employees entitled to receive the refund have received the benefit of that refund. For them to pay this amount back as part as part of the AMCS/SOP assessment removes that benefit, and defeats the purpose of the medical loss ratio provision in the Dirigo legislation. If this was the purpose of the Dirigo legislation, then the law should have specified that these refunds should have been sent directly to the Dirigo Health Agency or designated specifically as constituting "savings" under that law. Second, for employers and their employees insured through Aetna's other fully insured and self-funded ASO plans, they have received no refund and yet would under DHA's methodology be assessed a portion of the AMCS/SOP. This is unreasonable as there is no "offset" of any savings to these groups whatsoever against the proposed AMCS/SOP assessment. Third, to extend this assessment to employer groups and employees covered under fully insured and self-funded plans administered by other health insurers is completely unreasonable on the same grounds. Fourth, as Mr. Burke points out in his testimony, these refunds are not available to carriers to reduce premiums and, accordingly, are not recoverable. There is simply no basis for any "savings" to be based on this theory.

Q. Does this conclude your testimony?

A. Yes, it does.

Fishbein - Exhibit 1

Biosketch of Daniel Fishbein, M.D.

Dan is Head of Aetna's national Health Plan Alliances business, and is based in the company's Portland, Maine office. Health Plan Alliances consists of various businesses that provide services to other health plans and includes HMS Healthcare of which Dan is President. HMS Healthcare provides network and medical management services in Michigan, Colorado, and several other states and includes the PPOM and Sloans Lake managed-care subsidiaries. Health Plan Alliances also includes the Aetna Signature Administrators business which provides services to large Third Party Administrators. Dan is also responsible for the company's Student Health business which provides college sponsored health plans to more than 120 colleges and universities across the country and currently serves 365,000 students. The Student Health business is operated through The Chickering Group which is the largest provider of Student Health plans in the country and is based in Cambridge, MA. Dan is the President of The Chickering Group.

Previously, Dan was also responsible for Product Development for the Key Accounts segment across the country. In 2002, Dan led the Select and Key Accounts business segment in New England and Upstate New York, with overall business responsibility for the middle market (employers from 50 to 3,000 workers) in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont and Upstate New York. Dan was also a member of Aetna's National Strategy Council, under the direction of the Office of the Chairman.

From 1998 to 2001, Dan was General Manager and had overall responsibility for business in Maine. This included over 100,000 health plan members. During 2001, Dan was part of a six-person team that developed the strategy for the "New Aetna". From 1995 to 1998, Dan was president and CEO of NYLCare Health Plans of Maine, and the regional executive responsible for NYLCare's New England region. NYLCare of Maine was a start-up health plan that grew rapidly from inception to 60,000 members and was a part of New York Life's NYLCare Health Plans subsidiary. Aetna purchased NYLCare in 1998.

From 1990 to 1995, Dan was Vice President and an executive officer of New York Life, responsible for the Product Development and Managed Care divisions of Group Benefits. From 1985 to 1990, Dan was with the Massachusetts Mutual Life Insurance Company in Springfield, MA where he held several positions, including Second Vice President, healthcare product development and managed care.

Dan received his B.A. degree magna cum laude and his M.D. from Boston University.

6/11/2003

Dirigo Health

Dirigo Health will make quality, affordable health care available to every Maine citizen and initiate new and important processes for cost containment and quality improvement.

Access

- Dirigo Health offers Dirigo Health Insurance through private insurance carriers to individuals, small business (<50 employees) and the self-employed – enrollees benefit from lower and more stable rates provided by participation in a larger group
- Universal access to affordable and quality health care is achieved in 5 years
  - MaineCare is expanded to cover more low income citizens: to 125% FPL for individuals and 200% FPL for adults with MaineCare eligible children
  - Individuals, families, small business employees and the self-employed with incomes below 300% FPL are eligible for subsidies to help pay Dirigo Health Insurance premium costs on a sliding scale based on ability to pay – up to $27,000 in income for an individual and $55,000 for a family of 4 (see attachment for Access narrative)

Quality Improvement

- Maine Quality Forum is established – a quality watchdog for Maine providing more public information about costs and quality of health care
  - MQF will collect and disseminate research, adopt quality and performance measurers, issue quality reports, promote evidence based medicine and best practices, encourage adoption of electronic technology, make recommendations to the State Health Plan

Cost Containment

- Commission to Study Maine's Hospitals
  - Examine hospital costs and expenditures, impact on local economies, opportunities for hospital coordination in health care delivery and efficiency, improve planning for capital improvements, etc.

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- Biennial State Health Plan to assess need and available resources, set statewide goals for health care access and establish a budget for planning statewide expenditures
- One year voluntary caps on cost and operating margin of insurers, hospitals and providers to inform State Health Plan
- Capital Investment Fund is created to place capital expenditures on a budget – ensures wise and appropriate allocation of resources but ends the medical arms race
    - One year CON moratorium (from May 5, 2003) to inform Capital Investment Fund planning
    - Expand CON to ambulatory surgery centers and doctors offices for investments in new technologies costing over $1.2 million and capital expenditures over $2.4 million
- Require small group health plans to submit rate filings to the Superintendent of Insurance for review and approval and strengthened oversight of the large group market

Financing

- Drawdown additional federal Medicaid dollars by expanding Medicaid eligibility
- Use the employers' share of Dirigo health insurance premiums for Medicaid eligible individuals to pay state share of Medicaid expansion
- Capture realized savings from the reduction in bad debt and charity care through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings
- Use the savings offset payments to fund premium subsidies of those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum
- Use about $52 million one time federal fiscal relief monies to fund the first year premium subsidies and about $1 million to fund the Maine Quality Forum

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Fishbein - Exhibit 3

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Testimony of MaineHealth

In opposition to

LD 1935, 'An Act to Protect Health Insurance Consumers'

February 14, 2006

Good afternoon Senator Sullivan, Representative Perry and members of the Insurance and Financial Services Committee, I am here today on behalf of MaineHealth. MaineHealth is a non-profit health care system serving Southern, Central and Western Maine. As Maine's largest health care system, we are committed to the improvement of health care and the health of our communities.

I am here today to testify in opposition to LD 1935, 'An Act to Protect Health Insurance Consumers'. As the debate over the future of Dirigo Health becomes increasingly polarized, it is increasingly difficult to offer constructive criticism. The message from Dirigo proponents and this Administration seems to be all or nothing: you either support every aspect of the Dirigo program or you are opposed to helping people get needed medical care. This message is neither accurate nor helpful. Whether or not there is room in this debate for constructive change will largely be up to this committee and the Legislature. We sincerely hope that this is possible. Because there are aspects of this program that do require reconsideration but that also need broad support, this all or nothing message may, in fact, leave us with nothing.

MaineHealth continues to support Dirigo Health. But we are here again to express our concerns about this particular legislation, while still maintaining our support for Dirigo and its goals. We understand the pressing need to find a way to provide care to the uninsured – we face this on a daily basis. We also understand the need to reduce the

growth of health care costs. We understand this so well, in fact, that we proposed voluntary limits on hospital margins before Dirigo ever existed. We also fully understand the need to find a sustainable funding source if the Dirigo program is going to continue. We are happy to contribute to that solution. Unfortunately, we do not believe this bill represents that solution.

You may wonder why we are even here today, why a hospital system would weigh in on something that 'isn't our fight' since this really impacts insurers. We are here in part because we believe there must be a collaborative – not divisive – approach to solving these complex public policy issues. But, put most simply, this bill is bad public policy and we oppose it as such.

Our reasons for opposing this bill are as follows:

1. This bill presumes that there are savings in the system that insurers are not 'passing on' to employers. It is our belief that any savings that Anthem and other payors did experience have been incorporated into their rates. The Superintendent of Insurance, in his recent ruling on Anthem's rate filing, ruled that Anthem had already included all savings in their proposed rates. The ruling reads, 'The Superintendent concludes that Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives. Therefore, Anthem may include a charge in its rates for the actual savings offset payment'.[1] We have no reason to believe that Anthem or any other insurer has experienced savings that are not included in their rate projections.

2. This bill fails to acknowledge the impact of MaineCare cuts on hospital charges. What this committee may not realize is that at the same time hospitals reduced

[1] State of Maine, Department of Professional and Financial Regulation, Bureau of Insurance. 'Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for Healthchoice and Healthchoice Standard and Basic Products: Decision and Order', Docket No. INS-05-820

their expense increases and generated over $33 million in savings, the State reduced its payments to hospitals by over $40 million. These reductions allowed the state to cover budget shortfalls. These reductions also forced hospitals to shift their costs to cover these losses. So while hospitals may have generated savings, insurers did not necessarily realize them. Savings generated by hospitals essentially went to cover the MaineCare deficit.

3. There is little meaningful difference between how Anthem and other insurers determine their rates and how self insured companies like MaineHealth calculate their own. To the extent that there were savings in the market – through voluntary limits and reduced operating margins – our health plan experienced those benefits in 2004 and 2005 through claims expenses that were lower than they would have been without the voluntary limits in place. Our projections for 2006 include this history of lower claims, but must also include the assessment for the Savings Offset Payment. In order to cover the full costs of our health insurance plan, we must be able to include these new costs regardless of their source. Insurers, like self-insured employers, must be able to include new costs in their rates in order to accurately project costs of coverage.

4. We are concerned that not allowing insurers to include the assessment in their rates will result in a further reduction in the number of insurers in Maine's insurance market. This will further decrease competition which could potentially result in higher rates for insurance coverage. We think that this should be a concern for everyone.

It is our view that the Savings Offset Payment is a fatally flawed funding mechanism. What were good ideas – capturing bad debt and charity care costs and limiting rates of increase – have proven inadequate as a funding mechanism for the entire Dirigo Health program. It is not unusual for an ambitious new program to require adjustments and corrections as it is implemented. There were no guarantees that this plan would work. But now that things aren't working out as hoped, the response is not one of coming back to

Fishbein - Exhibit 4

MEMORANDUM

TO: Senator Nancy Sullivan, Chair
Representative Anne Perry, Chair
Members of the Insurance & Financial Services Committee

FROM: Steven R. Michaud, President

DATE: February 14, 2006

RE: Testimony in Opposition to LD 1935 - An Act to Protect Health Insurance Consumers

Good afternoon, my name is Steven Michaud and I am the President of the Maine Hospital Association. The Maine Hospital Association represents 39 acute care and specialty hospitals and their affiliates. Our acute care hospitals are nonprofit, community-governed organizations with more than 800 volunteer community leaders serving on their boards of trustees. Maine is one of only a handful of states in which all of its acute care hospitals are nonprofit. In addition to acute care hospital facilities, our hospitals own 19 home health agencies, 19 skilled nursing facilities, 17 nursing facilities, 8 residential care facilities, and 50 physician practices. Our membership also includes the state's two private psychiatric hospitals and a free-standing rehabilitation hospital.

With more than 25,000 full and part-time employees, hospitals are vital to our economy, and as a whole, one of the very largest employers in Maine. Hospitals are most often the largest employer in their communities.

Given that hospitals are such large employers, providers of health insurance for their employees, and thus a significant payor of the Savings Offset Payment (SOP)--$5-6 million, one may wonder why MHA would oppose a bill that would in theory save us millions of dollars. We do not do so lightly.

We support the goals of Dirigo Health and have long supported efforts to expand affordable health care coverage to Maine citizens. We have also worked diligently and successfully to meet our voluntary targets for cost containment as well as quality improvement efforts. In fact, hospitals were responsible for almost all the savings related to the SOP as determined by the Superintendent of Insurance.

Our opposition to LD 1935 is in no way opposition to the goals of Dirigo nor health care reform in general. We do believe however that Dirigo is in need of urgent reform itself and LD 1935 points us in the opposite direction from that reform.

We also believe there have been savings related to Dirigo, while the amount of those savings is not exactly clear. We know it is no where near the more than $200 million originally claimed during the SOP proceedings last fall, but we believe there have been health care cost savings in the tens of millions of dollars. How much of these savings are attributable to Dirigo is impossible to pin down given all the factors that go into hospital budgeting and that is part of the problem with the SOP as currently constructed. However, there were savings at some amount and they have been passed on by the hospital community to the insurance carriers and self-insured businesses and individuals. It is also important to remember, however, that the very same year Dirigo was passed Medicaid payments to hospitals were cut by nearly $60 million. Obviously the resulting cost shift diminished any savings to premium payors.

Our opposition to LD 1935 is based on the following:

- Any savings that have been reflected in the slowing of the rate of growth in hospital costs and charges have been passed on to the payors and in turn reflected in the lowering of the increase in insurance premiums at the time of renewal.
- To now prohibit a premium tax later assessed from being passed on to premium payors amounts to double taxation. This increases health care costs, it doesn't lower them.
- The original agreement among all parties, and passed on a bipartisan basis, clearly allowed the payors to pass the premium tax on to premium payors. It was clear in the negotiation and is clear in documents from those discussions. This bill is a reversal and a breach of faith to the spirit and the letter of that agreement.
- Passing this bill is not the answer to Dirigo's ills. Passing the bill is worse than putting a band-aid on a patient's gaping wound. It is more like using a band-aid when the patient is suffering from internal bleeding.
- Passing this bill hinders and does not help to fix what is needed if Dirigo or any health care reform is to be successful.
- If Dirigo and health care reform in Maine is to be successful in substantially decreasing the numbers of uninsured by providing coverage and affordable care we must do the following:

  o Acknowledge Dirigo's strengths and weaknesses;
  o Be honest and realistic about Maine's ability to cover all its citizens with health insurance;
  o Be open and honest in budgeting;
  o Reform the health insurance product and its financing;
  o Right size the Medicaid program. Maine is struggling and failing to afford its Medicaid program-a program that is funded 2/3rds by the federal government. How are we to believe that we can afford a large scale effort to provide universal coverage in light of that fact?

As Dana Connors has said, we have established a working group with the Chamber and the payors to make recommendations on restructuring Dirigo and fixing the flawed financing mechanism. We take this effort seriously and are committed to making health care reform work for Maine through that process in partnership with the Legislature and the Governor.

Thank you

Hospital Reductions in 04-05
Biennial Budget – Public Law 20

January 14, 2004

	2003-04	2004-05	Biennium Totals
COLA/Inpatient Cuts/No PIP, page 242			
Provides for the reduction of funds resulting from eliminating the Cost of Living Adjustment (COLA) for hospitals. Establishes price per discharge system based upon rebased amount. Rebased amount will be discounted by $8.5 million (state and federal).			
GENERAL FUND	(2,724,246)	(5,302,997)	
FEDERAL EXPENDITURES FUND	(5,472,623)	(10,628,062)	
TOTAL	(8,196,869)	(15,931,059)	(24,127,928)
Outpatient Cuts, page 244			
Provides for the reduction of funds resulting from changing the way that some hospital outpatient services are reimbursed. Limits the percentage of hospital outpatient charges to 75% of charges.			
GENERAL FUND	(3,500,000)	(4,000,000)	
FEDERAL EXPENDITURES FUND	(6,813,076)	(7,768,167)	
TOTAL	(10,313,076)	(11,768,167)	(22,081,243)
Bonus Payments, page 244-245			
Provides for the reduction of funds resulting from eliminating the bonus payment that presently allows a hospital to receive an additional payment when their actual costs are below or significantly above its per discharge payment.			
GENERAL FUND	(2,000,000)	(2,000,000)	
FEDERAL EXPENDITURES FUND	(3,893,186)	(3,884,084)	
TOTAL	(5,893,186)	(5,884,084)	(11,777,270)
Licensure Fee Revisions, page 318			
Hospital Licensing Fees will increase from $10 per bed to $40 per bed.	(100,000)	(100,000)	(200,000)
			(58,186,441)

Prepared by Maine Hospital Association