STATE OF MAINE

DIRIGO HEALTH AGENCY

RE: DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE FOURTH ASSESSMENT YEAR (2009)	))))))	MAINE ASSOCIATION OF HEALTH PLANS: BRIEF

FILING COVER SHEET

TO: Board of Directors, Dirigo Health Agency
Attn: Ruth Ann Burke
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Pursuant to the Procedural Order dated May 20, 2008, the Maine Association of Health Plans ("MEAHP"), by and through its attorneys, hereby submits its Pre-Hearing Brief.

INTRODUCTION

Once again in this the fourth assessment year, the Dirigo Health Agency ("DHA") Board of Directors (the "Board") on May 27, 2008 granted MEAHP as a matter of right full party status as an intervenor. MEAHP member companies provide coverage through fully-insured and self-funded plans to approximately 680,000 Maine people. MEAHP supports the goals of the Dirigo Health Agency ("DHA"), including expanding insurance coverage and controlling the growth of healthcare costs in Maine, as well as the objectives of the Dirigo Health Act. MEAHP continues to have very serious concerns, however, about the mechanism for financing the expansion of coverage through DirigoChoice. This mechanism, of course, begins with the DHA Board's determination of aggregate measurable cost savings ("AMCS"). It is critical that the Board's determination be credible, logical, and reasonable in order for DirigoChoice to be sustainable. AMCS must not be overstated, as it becomes the basis for the Savings Offset Payment ("SOP"), which is then assessed on all Mainers covered under fully-insured and self-funded plans. If the SOP is overstated, it will cause an increase in the cost of health insurance and more Maine people to lose coverage, exactly the opposite result intended in the Dirigo Health Act. This year DHA proposes $190.2 million in AMCS from three intiatives: $147.9 million for hospital cost

per case mix adjusted discharge ("CMAD"), $35.7 million for Bad Debt and Charity Care, and $6.6 million for the so-called Medical Loss Ratio ("MLR") intiatives. As noted by the Maine State Chamber of Commerce ("Chamber") in its Pre-hearing Brief at page 2, this figure constitutes roughly 172% of the AMCS approved by the Superintendent for DHA Years 1, 2 and 3 combined.

The amount of savings determined by the Board must also be reasonably recoverable by payers from healthcare providers via lower prices paid for services (charges). If savings are overstated and cannot be reasonably recovered by payers, then those Maine people covered in fully insured plans and through self-funded plans will pay an undue burden, which will cause even more people to lose insurance coverage. This is not a sustainable way to fund Dirigo. It is imperative that the Board limit its determination to accurately calculated, recoverable AMCS, using a valid methodology.

As it did last year on the BD/CC and Provider Fees initiatives, this year the Board when reviewing all three intiatives should rely on the testimony of witnesses that the Maine State Chamber of Commerce (the "Chamber"), Anthem and MEAHP will present. MEAHP and Anthem will offer testimony from witnesses with direct knowledge of provider (hospital) contracting, hospital cost trends in Maine and elsewhere, and what factors other than Dirigo have a direct impact on the rate of hospital cost growth. The Chamber, Anthem and MEAHP will also offer testimony from three experts – Allen Dobson, Ph.D., a nationally-recognized expert in designing and conducting economic evaluation of healthcare services, Vincent Maffei, Senior Biostatistician/Health Economist in the Advanced Analytics and Innovation Department of WellPoint, Inc., and; Jack Burke, a principal and consulting actuary with Milliman, the leading provider of independent actuarial consulting services to the healthcare industry. These witnesses,

particularly the critique of srHS's calculations offered by Dr. Dobson, Mr. Maffei, and Mr. Burke, will show that DHA's methodologies for each of its three intiatives are fatally flawed, do not accurately calculate recoverable AMCS for the fourth assessment year, and therefore are not supportable and should be rejected in their entirety. Without suggesting that the new srHS model proves that any savings are due to the operation of the Dirigo law, Milliman nevertheless offers an alternative calculation of AMCS: $21.2 million in CMAD and $6.1 million for bad debt/charity care savings. These figures are based on the Superintendent's findings for Year 3; Milliman made some adjustments to reflect the Year 4 experience.

ARGUMENT

I. THE APPROPRIATE LEGAL STANDARD GOVERNING THIS PROCEEDING

As will be discussed below, DHA has the burden of proving that recommended savings in each of the three intiatives are reasonable, accurate and recoverable by purchasers of health insurance; it is has failed to meet this burden. DHA in its Pre-hearing Brief has suggested a different standard, stating that the Board is *"not determining to what extent savings are recoverable..."* and that *"the Board is only assessing and quantifying the success of the Dirigo intiatives; it is not determining the implications of that success."* DHA Pre-hearing Brief at 3 (emphasis added). Mr. Schramm explicitly states in his pre-filed testimony that he did not even attempt to determine what part of the savings is recoverable. (DHA Exhibit 2 (srHS Report) at 6).

Through these statements DHA is attempting to ignore clear precedent and re-write history. Last year the Board adopted Milliman's approach to determining a reduced amount of savings in the Uninsured /Underinsured and Payments to Physicians intiatives on the grounds that not all of the savings proposed by DHA were available to be recovered. DHA Board Third

Assessment Year Decision at 8-9. Likewise, the Superintendent last year ruled that it was appropriate to consider the extent to which proposed savings relating to the hospital cost per CMAD initiative were recoverable from hospitals with poor or negative operating margins. Superintendent's Decision and Order for the Third Assessment Year, at 10.

DHA admits that recoverability is an appropriate factor to be considered, but only at the time that the Board assesses the SOP. DHA Pre-hearing Brief at 3. The Dirigo Act, however, does not provide for any further adjudicatory hearing by DHA at the SOP phase. Moreover, the Dirigo Act does not provide for review of the DHA SOP assessment decision by the Superintendent, which is a key check and balance in the Act regarding the AMCS determination. Recoverability is not a simple element to determine and quantify, but one that requires the give-and-take of the adjudicatory hearing process and its procedural safeguards, which are described below. Thus, on its face, what the DHA proposes would violate constitutional standards of due process.[1] Even if DHA did hold a second adjudicatory hearing, it would without doubt involve

[1] In addition to the above procedural due process issue, there are also constitutional issues arising out of the vagueness of the definition of AMCS in the Dirigo Act and as applied by DHA. Clearly the Dirigo Act itself nowhere contains the phrase "assessing and quantifying the success of the Dirigo initiatives" in connection with DHA's obligation to determine AMCS. In fact, DHA's latest iteration of the applicable definition of AMCS, the sheer vastness of the proposed AMCS figure, as well as DHA's inconsistent and overlapping savings measures as pointed out in the Chamber's brief at p. 17-18, proves that the consequences of an unconstitutionally vague statute, coupled with an unconstitutional delegation of legislative authority to the executive, are even more present than ever before. As Justice Alexander stated in his dissent in *Maine Ass'n of Health Plans v. Superintendent of Ins.*, 2007 ME 69, 923 A.2d 918 ("*MEAHP*"): "the ambiguity in [the Dirigo Health Act concerning the definition of AMCS in 24-A M.R.S.A. § 6913(A)] must [not] be resolved by delegating and deferring to the administrative agency, giving the agency license to assess offset payments according to whatever definition of "cost savings" the agency deems appropriate to meet its financial needs." *MEAHP*, 2007 ME 69 at ¶ 63. Justice Alexander further pointed out that "[w]hen terminology in a statute is so vague and ambiguous that those regulated must guess at its meaning, and an agency is given license to act based on preferences or criteria so subjective that they are virtually unreviewable, we have held that such subjective license is an improper delegation of legislative authority to the executive." *MEAHP*, 2007 ME 69 at ¶ 71. MEAHP therefore preserves its objection that §6913(1)(A) of the Dirigo Health Act

many of the same issues, facts and arguments – an incredibly inefficient and costly exercise. In fact DHA has never held an adjudicatory hearing in assessing the SOP in Assessment Years 1, 2 and 3 and has never provided any of the corresponding procedural safeguards such as discovery, cross-examination of witnesses under oath, and pre-filing of testimony and reports relied upon by DHA. In fact, DHA has never inquired further into recoverability in prior years when making the SOP assessment.

DHA's attempt to remove the issue of reasonable recoverability from this AMCS proceeding confirms the worst fears of many who are critical of this financing mechanism: DHA wants the Board to make a $190 million decision in a vacuum without regard to the consequences for hundreds of thousands of Maine people who pay for health insurance and the SOP assessment, and who are at risk of losing such coverage as premiums rise to absorb the SOP.

II. DHA HAS FAILED TO PROVE THAT THE RECOMMENDED CMAD SAVINGS ARE REASONABLE, ACCURATE AND REASONABLY RECOVERABLE BY PURCHASERS OF HEALTH INSURANCE

Last year the Superintendent directed DHA to develop a multivariate model to identify the extent to which any reductions in the rate of hospital cost growth per CMAD was due to Dirigo versus a variety of other factors. This year DHA's expert, srHS, has developed a model, but it is fatally flawed for a host of reasons. The evidence will show that the new cost per CMAD methodology is many times more complex than the prior methodology, and many times more flawed. In addition, DHA still has failed to show that any reduction in the trend in hospital costs in Maine for the measuring year (7/1/06-6/30/07) is due to Dirigo versus normal fluctuation in

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as applied by DHA, constitutes an improper delegation of legislative authority, and also contains a lack of any reasonable standards or criteria for determining aggregate measurable cost savings, which renders it unconstitutionally vague.

trend and other factors. Under the new methodology DHA is asking the Board to approve $147.9 million in CMAD savings – almost six times what the Superintendent approved last year ($25 million), when the actual hospital cost per CMAD growth in Maine exceeded the US average. In short, DHA has failed to show that its new methodology and the related calculations are reasonably supported, and the Board should therefore reject this methodology.

To understand DHA's approach, one can start with its witness list – two outside experts. DHA has listed no witnesses to testify as to their experience in Maine in the last year. Nor is there any indication in the srHS report that its authors conducted interviews in Maine or made any real attempt to find out what Maine health care professionals thought was affecting Maine medical costs. DHA has submitted one exhibit giving evidence of some price reductions, and moderating cost increases, in one hospital system (DHA Exhibit 7); nothing more. A regression analysis tests a hypothesis, and needs to control for the other factors affecting the outcome. If it does not properly control for such factors, then it will over-attribute, in this case to a factor, deemed the Dirigo factor, that in fact does not measure savings due to Dirigo activity, but rather some macro changes from pre-July 1, 2003 to post-June 30, 2003.

Maine's rate of growth in medical costs was greater than the national average in the measuring year, as noted by a lay witness for the intervenors (MEAHP Exhibit 3 (Fishbein) at 7) as well as its experts; srHS itself shows annual post-Dirigo CMAD growth in Maine of 4.5%, versus 3.9% for the U.S. (DHA Exhibit 2 (srHS Report) at 54). Faster growth in costs means lower savings. This fact alone should have cautioned DHA against anything concluding that there was six (6) times the amount of savings in Year 4 as were found for Year 3.

Looking at the litany of major flaws in the DHA model highlighted by payor intervenors' experts, some of which are listed below, one can only conclude that DHA's model was a blatant attempt to inflate the savings figure. The flaws include the following:

1. Opportunistic choice of cluster for comparison. The srHS model compared Maine cost trends against two sample groups – (a) the US as a whole (weighted 75%), and (b) a cluster of six states (weighted 25%) – Colorado, Louisiana, Maine, Minnesota, New Mexico, and Utah. srHS found that the cluster came out with a much higher rate of CMAD growth during the period than Maine, resulting in Maine showing $233.4 million in "savings," as contrasted with the $119.4 million in "savings" when compared with national figures (DHA Exhibit 2 (srHS Report) at 52). But the other cluster states had characteristics that made them very different from Maine and that were not controlled for. The most blatant example is Louisiana, which had a major event during this period (Hurricane Katrina) which had a huge impact on the profile of medical care provided and employment growth. The model also did not control for factors such as age distribution of population, which make Maine very different from most of the cluster states and which affect medical costs. There are no other Northeastern states, yet there are three Southwestern states (out of 6 total), despite the very different sociological and economic environments of the two regions (Anthem Exhibit 3 (Maffei) at 20-21).

2. The "Dirigo variable" merely tests for before and after a date near the passage of the Dirigo Act (rather than substantive Dirigo activity), and produces "Dirigo savings" in many states. As noted in Milliman's report (MEAHP Exhibit 1, Burke Exhibit 2 (Report) at 2-4), the same numeric variable could be used to attribute the same amount of cost "savings" to the fact that the Red Sox won the World Series in 2004, and that the Yankees have not won the Series since then, using the srHS methodology, and similarly ignoring the same problems with the

model. And 29 of 50 states show "Dirigo savings" using the same variable, including 15 with similar or greater "savings" than Maine. (Chamber Exhibit 1 (Dobson) at 28). This shows that the Dirigo variable is not that at all, since it is not responsible for activity in states such as California. Instead, it's measuring other things. As Dr. Dobson points out, one explanation is that there are strong national forces pushing down CMAD cost growth in the post-6/30/2003 time period. (Chamber Exhibit 1(Dobson at 29). In fact, this model produces a national "Dirigo savings" of $110 per CMAD in the period, which is illogical and is likely driving up the Dirigo savings found for Maine (Dobson at 30).

3. The srHS model fails standard statistical tests for reliability. Dr. Dobson and Mr. Maffei both tested the variables used in the srHS model, and found that "all of the Maine and Maine / Dirigo related variables have no statistical significance, and therefore, there is no statistically significant Dirigo Health Act impact for Maine." (Dobson at 26-27; similar finding at (Anthem Exhibit 3 (Maffei) at 11-16). This renders the model invalid for purposes of determining AMCS (Anthem Exhibit 3 (Maffei) at 16). Dr. Dobson also found that the only coefficients that drive the savings estimates for the Cluster 1 comparison are statistically insignificant (Dobson at 32). In its Pre-Hearing Brief DHA argues that because a single interaction term in the Cluster 1 analysis (M*D*Y) is nearly statistically significant, this fact conclusively establishes that the projected savings are attributable to the Dirigo Health Act. DHA Pre-hearing Brief at 7-8; *see also* DHA Exhibit 2 (srHS Report) at 19. MEAHP agrees with Anthem's response in its brief that DHA has confused its burden of proof with the standard for a reliable statistical regression, which is no more legitimate than its attempt to cure the flaws in each of its models by blending the results of its invalid U.S. regression with the invalid and biased results of the Cluster 1 regression. *See* Anthem Brief at 10-11. This single interaction

term rests upon a mis-specified model and numerous statistically insignificant variables, and as explained above in point 1 and by Mr. Maffei, Cluster 1 is an invalid and flawed sample. (Anthem Exhibit 3 (Maffei) at 23). This is not a valid basis for the Board to conclude that DHA has met its burden of proof.

4. The srHS model fails to control for factors that the Bureau of Insurance found important in making substantial cuts to the savings number found by srHS for Year 3. All are still factors in Year 4. These include (a) cost-shifting as a result of MaineCare reimbursement policies and cuts in reimbursement rates (MEAHP Exhibit 3 (Fishbein) at 8-11), (b) recoverability, including the effects of low operating margins on the ability of hospitals to pass on savings (Anthem Exhibit 1 (Roberts) at 3-4), and (c) the effects on CMAD when outpatient utilization and charges grow faster than the inpatient cost per case, thereby deflating the average CMAD growth (MEAHP Exhibit 1, Burke Exhibit 2 (Report) at 5).

The srHS model fails to control for other important factors. This includes important variables for any medical cost regression: "(1) hospital competition; (2) insurance competition; (3) supply of physicians; (4) certificate of need and other types of regulations; (5) hospital owner status; 6) employment. (Dobson at 15). It also includes factors pointed out by the lay witnesses, such as the governmental reimbursement levels, effect of the cost cycle, effects of insurer programs such as wellness initiatives and consumer-driven plans, etc. (MEAHP Exhibit 2 (Rudin) at 5-10); MEAHP Exhibit 3 (Fishbein) at 7-10). There are numerous other factors described by the expert and lay witnesses, showing further flaws in the srHS analysis. For example, Dr. Dobson points out that srHS used a 7-year compounding factor, when Dirigo has only been in effect 4 years. This alone would reduce the "savings" by 65%, from a $439 factor to $157. (Dobson at 21-22). The deeper one looks at the srHS model and analysis, the more

flaws one finds. This, on top of the fact that its entire savings premise relies on unsupportable, insignificant variables, leads to the conclusion that it must be rejected in its entirety.

The payor intervenors' witnesses have confirmed that there has been a moderating in the rate of cost increases in Year 4, and presented testimony that such moderation (a) can be seen as a natural part of a cost cycle after the steep increases experienced in the first years of the decade, and (b) reflect national trends as well (MEAHP Exhibit 1, Burke Exhibit 2 (Report) at 4-6; MEAHP Exhibit 2 (Rudin) at 5-7; MEAHP Exhibit 3 (Fishbein) at 7-8). Thus, DHA has not separated out the effects of the Dirigo law versus other factors including declining national cost growth trends.

Simply put, DHA has failed to prove any measurable cost savings. Rejecting the srHS findings causes a need to develop an alterative measure of CMAD savings. The obligation to measure savings is on DHA, and not on any intervenor. Nevertheless, without suggesting that the new srHS model proves that any savings are due to the operation of the Dirigo law, MEAHP expert Milliman estimates $21,187,761 in CMAD savings, with the calculations shown on Attachment I to its report. Milliman started from the Superintendent's findings for Year 3 of $25 million in CMAD savings, and made adjustments for (a) the impact of Maine CMAD growing about .3% faster than national CMAD, and (b) the change in adjusted discharges used in each year's srHS report.

MEAHP urges the Board to adopt a number no greater than Milliman's figure.

III. DHA HAS FAILED TO PROVE THAT THE RECOMMENDED UNINSURED/UNDERINSURED SAVINGS ARE REASONABLE, ACCURATE AND REASONABLY RECOVERABLE BY PURCHASERS OF HEALTH INSURANCE

Last year the DHA Board itself accepted as reasonably supported the methodology put forth by DHA and its experts, srHS, subject to several adjustments proposed by MEAHP's

expert, Milliman. This approach was approved by the Superintendent as being reasonably supported and did not direct DHA to develop new methodology, especially since there is reported data on how many previously uninsured people enrolled in Dirigo Choice and how many previously unenrolled people are enrolled in the expanded MaineCare program in the measuring year (2008).

Nonetheless, srHS, on behalf of DHA, and without any direction to do so by the Superintendent, has developed a new BD/CC methodology which includes a complex multivariate regression, using a series of flawed underlying assumptions, in claiming that Dirigo has caused a reduction in "uninsurance" rates in all markets in Maine, thereby seeking $35.7 million, another six-fold multiple of last year's approved amount ($6.3 million). Again, this methodology and the related calculations are fatally flawed, and the Board should reject them as not reasonably supported.

The most flagrant flaw, which is also the one with the biggest impact, is including 2003 in the "post-Dirigo" period for purposes of the calculation. This enables DHA to take credit for a significant MaineCare expansion, effective October 2002, to cover the non-categorical adults, which contributed to an increase in MaineCare enrollees from July 1, 2002 to July 1, 2003 of 36,347 persons. Milliman finds that if 2003 were shifted to pre-Dirigo in the srHS calculation, it would reduce the BD/CC savings about 75%, to $7.2 million. (MEAHP Exhibit 2 (Report) at 8).

There is no reason to include 2003 in the post-Dirigo period, other than to grossly inflate the BD/CC number. The statute calls for calculation of:

> "aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6913.1.A (emphasis added)

Clearly the 2002 expansion of MaineCare eligibility is outside the scope of this provision of the Dirigo Health Reform Act. And, given that DHA did not begin issuing DirigoChoice medical insurance coverage until 2005, there is no honest argument that Dirigo affected bad debt and charity care in 2003 (Dobson at 38-39).

Another flaw is that the uninsurance rates used by srHS for 2007 and 2008 are projections of the trend from the 2003-2006 period, without any demonstration that such trend in fact continued (Dobson at 40-41). As reported by Milliman (Report at 8-9), there were reductions in the number of uninsured persons during the 2003-2006 period that were more than 100% attributable to three specific events: (1) the 2002 MaineCare expansion described above, (2) the DirigoChoice program, which added about 12,000 enrollees, of whom 35% reported being previously uninsured, and (3) the 2005 expansion of MaineCare to Parents of Children, which was part of the Dirigo legislation. The srHS figures that Milliman cites show that, after going down in 2003 (the first full year after the 2002 event), the number of uninsured increased in the 2004-2005 period, so it is not at all clear that the number would have further decreased in the two years after the 2005 event. Dr. Dobson finds further flaws in the srHS methodology for projecting amounts for 2007 and 2008 (Chamber Exhibit 1 (Dobson at 40-43). He also notes that the datasets used in the BD/CC regression, received in discovery from DHA, had deletions and other problems that made it impossible to evaluate the results from the regression analysis. (Dobson at 40).

Even with the above two flaws corrected, it is not clear that the srHS model controls for the non-Dirigo factors that could influence the outcome of the regression. Thus, without suggesting that the new srHS model proves that any savings are due to the operation of the Dirigo law, MEAHP and its expert, Milliman, suggest a return to the more direct method

approved by the DHA Board and the Bureau of Insurance last year. This results in a $6.1 million BD/CC figure, down from $6.3 million last year, as a result of a decline in the DirigoChoice enrollment from 14,185 to 12,050, more than offsetting the MaineCare expansion increase in enrollment from 5,100 to 5,597 (MEAHP Exhibit 1, Burke Exhibit 2 (Report) Attachment II).

IV. DHA HAS FAILED TO PROVE THAT THE RECOMMENDED MLR SAVINGS ARE REASONABLE, ACCURATE AND REASONABLY RECOVERABLE BY PURCHASERS OF HEALTH INSURANCE

In Year 4, for the first time, DHA asserts $6.6 million in "cost savings" due to the fact that Aetna Life Insurance Company ("Aetna Life") paid a refund of $6,563,907 to certain policyholders as a result of the operation of the Medical Loss Ratio ("MLR") provisions of the Dirigo legislation. MEAHP will offer testimony to show that Aetna offers health insurance in Maine through two subsidiaries, and that these refunds are not recoverable by Aetna from those insured by its other subsidiary, nor are any of these refunds recoverable by other payors and self-funded plans and their subscribers. DHA flatly admits in its brief that these refunds are "obviously not recoverable," yet still claims them as "savings." DHA Brief at 10. It is totally unfounded to consider these refunds as savings for purposes of determining AMCS.

Such savings are calculated pursuant to the following provision in the Dirigo Health Act:

> "[T]he board shall determine annually not later than August 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6913.1.A (emphasis added)

It is impossible to conceive of how payment of a refund results, in and of itself, in any savings to anybody who does not actually receive the refund. Nowhere in the law is there any connection between the MLR refund provisions and the savings provisions. If any was intended, then the law should have specified that these refunds should have been sent directly to the Dirigo

Health Agency or retained by the carrier and designated specifically as constituting "savings" under that law.

Further, costs are measured at the provider level. A provider never directly sees a refund paid to a policyholder, either as income or cost. It is invisible to the provider. Thus the amount of the MLR refund is not includable as such in AMCS as a matter of law.

The DHA in its filing and testimony do not demonstrate any AMCS as a result of the Aetna Life refund. The report simply annexes the Aetna Life letter and calculation, and does not do any independent calculation. As noted above, no AMCS resulted directly from the refund described in the Aetna Life letter.

There were, in fact, no savings for the following reasons. 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. Second, for employers and their employees insured through employer groups and employees covered under any other fully insured and self-funded plans (including plans offered by another Aetna entity), 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. Fourth, as Milliman points out in its 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.

VI. DHA SIGNIFICANTLY OVERSTATES SAVINGS BY IGNORING CLEAR OVERLAP BETWEEN THE CMAD, BD/CC AND MLR SAVINGS INITIATIVES

MEAHP and other intervenors will offer testimony and exhibits to show that if any hospital savings figure is approved using the DHA methodology, it must be reduced due to the overlap with the expanded DHA methodology for calculating BD/CC savings. srHS found no overlap between any of its elements of "savings." That is not realistic or accurate. The BD/CC savings accrue to all providers, but srHS has already estimated global cost savings to hospitals in the CMAD regression. "Any reduction in bad debt at the hospital would in theory reduce the pressure on the cost per case for the remaining, paying customers, and would thus be reflected in the CMAD calculation." (MEAHP Exhibit 1, Burke Exhibit 2 (Report) at 10). Milliman, relying on the Hadley/Holleran sources used by srHS, finds that 66% of uncompensated care is for hospitals (the remainder being for physicians (14%) and community health clinics (20%)), and accordingly recommends that if any savings figure is derived from the srHS analysis, the total SOP be reduced by 66% of the amount of the final BD/CC savings. If Milliman's recommendations for both CMAD and BD/CC are followed, there is no need for an overlap adjustment, since it is built into Milliman's calculation (MEAHP Exhibit 1, Burke Exhibit 2 (Report) at 10).

While DHA did not prove any savings from the MLR initiative, DHA claims that if there were any savings from such initiative, they would make insurance coverage more affordable, allowing more people to buy insurance and reducing the amount of bad debt and charity care. As such, any MLR savings overlap with and should be picked up in the BD/CC calculation.

VII. CONCLUSION

The regression models upon which DHA has based its hospital cost per CMAD and Uninsured/Underinsured savings calculations are fatally flawed and do not provide an accurate measure of AMCS. The MLR initiative is based upon an erroneous interpretation of the Dirigo Act and totally groundless assumptions. Based on the evidence produced by DHA, the Board should reject in their entirety DHA's proposed AMCS methodologies and the supporting calculations for all three intiatives.

If the Board is to approve any AMCS calculation for year four, it should be limited to no more than the alternative calculations and underlying assumptions on the CMAD and Uninsured/Underinsured initiatives presented by Milliman, in the amounts of $21,187,761 and $6,100,000, respectively.

Dated: July 18, 2008

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CERTIFICATE OF SERVICE

I certify that on July 18, 2008, pursuant to the paragraph 3(a) of the Order on Intervention and Procedures, I caused to be filed electronically the foregoing document by emailing a true copy to:

Board of Directors, Dirigo Health Agency at Ruth.A.Burke@maine.gov

I further certify that on July 18, 2008, pursuant to paragraph 3(b) of the Order on Intervention and Procedures, I caused to be served by sending an identical electronic copy of the foregoing document to:

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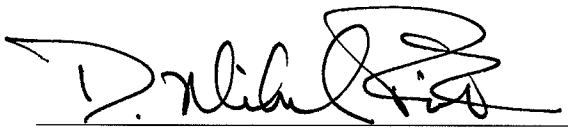

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