

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
 MEASURABLE COST SAVINGS)
 DETERMINED BY DIRIGO) FILING COVER SHEET
 HEALTH FOR THE FOURTH)
 ASSESSMENT YEAR)

DOCKET NO. INS-08-900

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NON-CONFIDENTIAL

STATE OF MAINE
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IN RE: REVIEW OF AGGREGATE)
 MEASURABLE COST SAVINGS) BRIEF OF MAINE STATE
 DETERMINED BY DIRIGO) CHAMBER OF COMMERCE
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Pursuant to the Notice of Pending Proceeding and Hearing dated July 10, 2008, and Orders on Intervention and Procedures dated August 18, 2008, Intervenor Maine State Chamber of Commerce (the “Chamber”), by and through its attorneys, hereby submits its Brief.

INTRODUCTION

On June 2, 2008, the Dirigo Health Agency (“DHA”) filed a report prepared by its consultants, schramm-raleigh Health Strategy (“srHS Report”), claiming a remarkable \$190.2 million of aggregate measurable cost savings (“AMCS”) for the Fourth Assessment Year (“Year 4”). **Administrative Record, Binder 4, Tab 64 (hereinafter “AR __, Tab __”).** The srHS Report contained only a summary description of the DHA’s proposed savings methodologies, which consisted of four categories: (1) CMAD - \$147.9 million; (2) BD/CC - \$35.7 million; (3) MLR - \$6.6 million; and (4) Overlap - \$0. Some of the documentation and calculations supporting the srHS Report were buried in two CDs, one disclosed on June 2, 2008 and the other mailed on June 3, 2008. **AR 1, Tab 10.** These CDs contained thousands of pages of articles, spreadsheets, documents and notes, many of which were duplicates or conflicting versions. Rather than identifying the exact documents used to support the srHS Report’s summary conclusions and providing a clear explanation for the various calculations, the DHA forced the intervenors to hunt through thousands of pages of documentation and “reverse engineer” the methodologies. As it turned out, the original CD and the supplemental CD did not contain all

relevant documentation and information. Indeed, the intervenors had to identify and request additional, relevant data -- including an identification of which data sets were used and a confirmation of how the calculations were made -- which the DHA did not produce until weeks after the June 2, 2008 deadline. **AR 1, Tab 10.**

The DHA Board held an adjudicatory hearing on July 22 and 23, 2008. Following its deliberations on July 24, 2008, the DHA Board adopted a proposed Year 4 AMCS of \$149.6 million, consisting of the following savings categories: (1) CMAD - \$119.4 million; (2) BD/CC - \$23.6 million; (3) MLR - \$6.6 million; and (4) Overlap - \$0. Thereafter, the DHA Board issued a written decision (“Board Decision”) which was filed with the Superintendent on August 12, 2008 along with the record of the adjudicatory hearing.¹

The Table below compares the proposed Year 4 AMCS to the amounts deemed reasonably supported by the evidence for Years 1 -3.

<u>Issue</u>	<u>Proposed Yr. 4</u>	<u>Approved Year 3</u>	<u>Approved Year 2</u>	<u>Approved Year 1</u>
CMAD	\$119.4 mm	\$ 25.0 mm	\$ 14.5 mm	\$ 33.7 mm
BD/CC	23.6 mm	6.3 mm	5.5 mm	2.7 mm
MLR	6.6 mm	n/a	n/a	n/a
Fee Initiatives	n/a	1.5 mm	14.3 mm	7.3 mm
Overlap	<u>0.0 mm</u>	<u>0.0 mm</u>	<u>n/a</u>	<u>n/a</u>
	\$149.6 mm	\$ 32.8 mm ²	\$ 34.3 mm ³	\$ 43.7 mm ⁴

Strikingly, the proposed Year 4 AMCS has grown substantially despite declining Dirigo Choice enrollment and the absence of new statutory initiatives. In fact, the proposed Year 4

¹ Despite the tight deadline for briefing in this proceeding, the DHA did not serve a copy of the Board Decision or the administrative record on the intervenors. The intervenors had to request a copy of the Board Decision from the Superintendent’s staff, and the DHA required the intervenors to pay for a copy of the administrative record, and would not permit the intervenors to pick up the record until the afternoon of Wednesday, August 13, 2008. On August 14, 2008, the Chamber received via U.S. Mail a copy of the DHA’s cover letter to the Superintendent without the Board Decision or administrative record as attachments.

² The Board originally adopted \$78.1 million of AMCS in Year 3. The Superintendent found \$32.8 million to be reasonably supported by the evidence.

³ The Board originally adopted \$41.8 million of AMCS in Year 2. The Superintendent found \$34.3 million to be reasonably supported by the evidence.

⁴ The Board originally adopted \$136.8 million of AMCS in Year 1. The Superintendent found \$43.7 million to be reasonably supported by the evidence.

AMCS (\$149.6 million) is more than four and one half (4.56) times the amount of AMCS deemed reasonably supported last year (\$32.8 million), and represents approximately 134% of the AMCS approved by the Superintendent for Years 1, 2 and 3 combined.

ARGUMENT

I. THE DHA HAS FAILED TO PROVE THAT THE \$119.4 MILLION OF CMAD SAVINGS ATTRIBUTABLE TO THE US MODEL IS REASONABLY SUPPORTED BY THE RECORD AND RECOVERABLE BY PURCHASERS OF HEALTH INSURANCE.

The DHA Board adopted \$119.4 million of CMAD savings. It found that the multi-state, multivariate regression analysis prepared by srHS was “reasonable,” but rejected the “weighting of the U.S. hospital model and Cluster 1” proposed by srHS. **Board Decision, p. 8.** The Board held that it “is not persuaded that Cluster 1 tracks Maine and find the weighting of the U.S. hospital and Cluster 1 to be arbitrary and not supported by the evidence.” **Id.** In other words, the DHA Board completely rejected the Cluster 1 Model, and chose to rely solely upon the US Model.

The Year 4 CMAD savings of \$119.4 million represents nearly five times the CMAD savings deemed reasonably supported by the evidence for Year 3. Furthermore, Year 4 CMAD savings exceeds by \$46.4 million the total CMAD savings deemed reasonably supported for Years 1, 2 and 3 combined (\$73.2 million).⁵

A. CMAD Introduction.

The basis for the proposed CMAD savings is a voluntary limit on hospital cost growth when measured on a cost per CMAD basis. **AR 4, Tab 64, p. 9.** The srHS Report explains that the “CMAD savings attributable to Dirigo is calculated by comparing the CMAD in two scenarios -- an estimate of what the CMAD would have been in the absence of Dirigo and the

⁵ Year 3 CMAD: \$25.0 million; Year 2 CMAD: \$14.5 million; Year 1 CMAD: \$33.7 million; Years 1-3 CMAD: \$73.2 million. Source: Decisions of Superintendent, Years 1, 2 and 3.

actual CMAD experienced in the presence of Dirigo.” **AR 4, Tab 64, p. 12.** At the hearing, however, DHA witnesses were forced to admit that both the “actual with Dirigo” and the “estimated without Dirigo” figures were estimates. **AR 2, Tab 60, p. 100, ln 22-25.** In other words, the “actual with Dirigo” CMAD figures did not use actual Maine CMAD data; instead these figures were estimated by summing the coefficients produced by the multivariate regression analysis.

Three different multivariate regression models were created, and each used different data and controlled for different variables. The first model used actual -- and estimated -- hospital specific CMAD data for most hospitals in the United States within the time period between 2000 and 2007 (“US Model”). The other two models were “cluster” samples that used actual (and estimated) state-level CMAD data for hospitals in selected states (“Cluster 1 Model” and “Cluster 2 Model”).

For each regression model, the “estimated actual with Dirigo” CMAD values represented the sum of the coefficient values produced by the regression model. **AR 4, Tab 85, p. 15.** The “estimated without Dirigo” CMAD figures were calculated in the same manner, except (as discussed in greater detail below) srHS “turned off” the Dirigo variable for 2007 by changing it from “1” to a “0.” **AR 2, Tab 60, p. 175, ln 2 - 7; AR 4, Tab 85, p. 6.** Because the US Hospital estimated CMAD with the Dirigo variable “on” (\$10,292.6374) was lower than the estimate with the Dirigo variable “turned off” (\$10,731.6885), the srHS Report declared the difference (\$439) to be savings “resulting from Dirigo.” **AR 4, Tab 64, p. 12.** The US Hospital total CMAD savings was then determined by multiplying the difference (\$439) by “the actual number of adjusted discharges (taking into account inpatient case-mix adjusted discharges, volume-adjusted outpatient discharges, and discharges associated with cost-based reimbursement” (272,041). **AR 4, Tab 64, p. 12 and 54.** Total CMAD savings for the Cluster 1 and Cluster 2 Models were

calculated in this manner, and then the three models were weighted by srHS for “credibility.” **Id. at p. 14, 54.** The srHS Report explained that the US Model (\$119.4 million) was awarded 75% credibility, while the Cluster 1 Model (\$233.4 million) was granted only 25% credibility due an admitted “clustering bias” concern. **Id. at p. 54; Board Decision, p. 6; AR 4, Tab 82, p. 18, ln 396 - 404.** The Cluster 2 Model was assigned 0%. **AR 4, Tab 82, p. 17, ln 391 - p. 18, ln 395.** According to the DHA’s pre-filed testimony of Mr. Schramm, the Cluster 2 Model was assigned zero credibility because “the final savings estimate, while the highest, was inconsistent with evidence presented in past AMCS proceedings.” **AR 4, Tab 82, p. 18, ln 404 - 406.**

According to the Board Decision, the Board found that the use of the multivariate regression analyses was “reasonable.” **Board Decision, p. 8.** Importantly, however, the Board specifically rejected both Cluster 1 and Cluster 2 as unreliable. In addition, the Board found the “weighting of the [US Model] and Cluster 1 to be arbitrary and not supported by the evidence.”

Id.

Accordingly, the only issue before the Superintendent with respect to CMAD is whether the \$119.4 million of CMAD savings attributed to the US Model is reasonably supported by the evidence.

As explained in more detail below, the CMAD savings attributed to the US Model is not reasonably supported by the evidence. First, the projected CMAD savings result from a misinterpretation of the data in the record, the US Model data and variables, and the applicable law. Second, the data in the record shows no Dirigo related savings, as demonstrated by various reasonableness checks, recoverability measures, and proper interpretation of the companion voluntary COM limit. Third, the CMAD variable itself is a critically flawed savings measure. Finally, the US Model itself is critically flawed because it omits relevant variables and relies upon faulty data. As explained in greater detail below, the Superintendent must find that the

\$119.4 million of savings projected by the US Model is not reasonable supported by the evidence in the record.

B. The Recommended CMAD Savings Result From A Misinterpretation Of The Record, The US Model Data and Variables, And The Applicable Law.

The Chamber contends that the CMAD savings of \$119.4 million adopted by the DHA Board results from a misinterpretation of the applicable law, the US Model regression analysis and Maine hospital data. Moreover, the DHA mistakenly derives a significant amount of recommended savings from coefficients that are not related to the Dirigo Health Act. Finally, the coefficients that are driving the DHA CMAD savings are not statistically significant, and therefore cannot support a finding of Dirigo-related savings.

1. The Undisputed Evidence In The Record Demonstrates That The DHA Used the Wrong CMAD Definition, That Maine's CMAD Growth Rate Was Falling Well Before The Dirigo Health Act Was Enacted, And That The DHA Methodologies Produce Savings In A Majority Of States.

In reaching the erroneous conclusion that the Dirigo Health Act has created \$119.4 million of CMAD savings, the DHA Board ignored compelling, undisputed evidence in the record that reductions in Maine's rate of cost growth, when measured by cost per CMAD, cannot be solely attributable to the Dirigo voluntary CMAD limit. The following evidence was disregarded without explanation by the DHA Board.

- It is undisputed that the US Model's formula for determining cost per CMAD does not follow the cost per CMAD definition required by the applicable law. **AR 5, Tab 95(A), pp. 2-3 (applicable law); AR 2, Tab 60, pp. 108-120.** It is also undisputed that the failure to make the adjustments required by the applicable law in Year 4 resulted in Maine virtual hospital CMAD figures that were materially different from Years 2 and 3 (although Medicare cost report information was the source data for all three years). **AR 4, Tab 90;**

- It is undisputed that Maine’s CMAD growth rate was slowing well before the voluntary CMAD limit was enacted.⁶ Indeed, according to the DHA’s own data, Maine’s CMAD growth rate was 11.26% from 2000/2001, it fell to 9.27% from 2001/2002, and fell again to 3.11% from 2002/2003. **AR 4, Tab 90 (Chamber 7); AR 5, Tab 95(G)(Chamber 12-G, excerpted from DHA 3).** The SFY 2003 measurement period ended on June 30, 2003, only weeks after the Dirigo Health Act was first proposed in May 2003, and well before the law became effective in September 2003.

- It is undisputed that Maine’s actual cost per CMAD (expressed in dollar value) was lower than the national average in 2000, rose above the national average in 2002, and was roughly equal the national average in 2003 (all pre-Dirigo). **AR 4, Tab 64, p. 54, col. I and III; AR 4, Tab 95(G), p. 1-2; AR 4, Tab 84, p. 10, ln 1.** Since that time, however, the gap between the Maine and National actual cost per CMAD has widened. Specifically, the Maine actual cost per CMAD for 2003 (\$6,269) was just \$59 higher than the National cost per CMAD for 2003 (\$6,210). Using the DHA’s own data, Maine’s actual CMAD value for 2007 (\$7,470) is now approximately \$225 higher than the national CMAD value for 2007 (\$7,245).⁷ **AR 4, Tab 64, p. 54.** In other words, since Dirigo’s enactment, Maine’s cost per CMAD has grown more relative to the national cost per CMAD. If Maine’s CMAD value was only \$59 higher than the national average at the time of Dirigo’s enactment, but is now \$225 higher, how can there be any savings?

⁶ Governor Baldacci was elected in November 2002, took office in January 2003, and proposed the Dirigo Health Act in May 2003. The first period covered by the voluntary CMAD limit was a fiscal period beginning on or after July 1, 2003 (e.g. FYE June 30, 2004). There is simply no evidence in the record demonstrating a so-called “sentinel effect” that caused a slowing of cost growth prior to the Dirigo Health Act’s effective date.

⁷ Similarly, according to srHS data, Maine’s 2003 cost per CMAD (\$6,269) was \$734 less than the Northeast average (\$7,003). **AR 4, Tab 64, p. 54, col. II and III.** However, by 2007, Maine’s cost per CMAD (\$7,470) was \$701 less than the Northeast average (\$8,174). In other words, Maine’s cost per CMAD was increasing relative to the Northeast average.

- It is undisputed that the use of the US Model and srHS data will produce savings in a majority of states. **AR 4, Tab 88, Chamber 5.** The fact that the US Model produces savings in 29 of 50 states demonstrates that the US Model fails to control for all of the forces driving CMAD fluctuation. If the US Model confuses these forces with Dirigo in California, it clearly confuses these force with Dirigo in Maine.

- It is undisputed that the use of the DHA's conventional projection model will produce savings in a majority of states. Indeed, 39 of 50 states show Dirigo savings using the type of projection methodology used in Years 1, 2 and 3. **AR 4, Tab 87, pp. 2 - 6.** In fact, as demonstrated by **AR 4, Tab 87, p. 2,** projecting the US-Hospital Level CMAD data from page 54, Column I of the srHS Report in the same manner used in Column III will produce \$113.9 million of savings (using Maine discharge figures).⁸ Thus, not only does the methodology produce savings in 39 or 50 states, but it also produces significant savings using the US-Hospital Level CMAD data -- and, of course, the \$113.9 million of savings would increase dramatically if multiplied by the equivalent national discharge figure. These findings -- using srHS own data and methodology -- completely discredit the DHA's prior years' methodologies.

- It is undisputed that something other than Dirigo caused the other 49 states' annual growth rates to fluctuate dramatically throughout the measured time period. **AR 4, Tab 87, AR 4, Tab 87, pp. 2-6.** These same forces caused the pre-Dirigo growth rate to fall from around 11% to 9% to 3% because there was no Dirigo then. Both Mr. Schramm and Dr. Thorpe agreed that it is unlikely that 11% and 9% CMAD growth is sustainable indefinitely, and a review of the growth rates for all 50 states demonstrates that this type of growth has never been sustained long term. **AR 2, Tab 60, p. 158, ln 10 - 15; p. 165, ln 2 - 6; AR 4, Tab 87, pp. 2-6.**

⁸ On page 54 of the srHS Report, the Excel formula used to estimate 2007 savings in Columns I and II differs from Column III. Columns I and II apply the "Annual Growth Pre-Dirigo" percentages to the Maine - Hospital Level CMAD value from 2003. **Chamber 4** applied the Excel formula from Column III to Columns I and II.

Despite this concession and proof of implausibility, however, the US Model capitalizes on these anomalous, admittedly unsustainable growth rate when projecting the \$119.4 million of CMAD savings. Dr. Thorpe, implicitly admitting that the US Model is skewed by the 11% and 9% figures, simply responded “It is what it is. The numbers are the numbers. So, I mean, they grew at 11.25%. I don’t know why they grew at 11.25%.” **Tr. 1, p. 167, ln 10-18.** Admittedly, he also could not explain why they fell the next year to around 3% while still in the pre-Dirigo period. But whatever it was driving Maine costs per CMAD dramatically up and down in the pre-Dirigo period, it clearly was not Dirigo (again, because there was no Dirigo then).

- It is undisputed that the US Model mistakenly interprets as “Dirigo savings” the types of hospital cost cutting measures required to address operating losses, the loss of a key physician, uncertain regional economy, low reimbursement, budget difficulties, escalating health insurance premiums and medical malpractice trends. **AR 2, Tab 60, p. 192 ln 11 - p. 193, ln 10; AR 5, Tab 95(H).** Thus, the US Model knowingly takes credit for actions that are admittedly not related to the Dirigo Health Act or its voluntary CMAD limit.

- Finally, it is undisputed that the aggregate 2006 consolidated operating margin for the Maine “virtual” hospital was, at most, approximately \$89.5 million, or 2.6%. **AR 4, Tab 84, p. 35.** According to the data and calculations underlying the srHS Report, Maine’s “virtual” hospital operating margin was approximately .5% for 2006, and close to 0% for 2007. **AR 4, Tab 64, p. 35.** As explained in more detail below, whether one uses the DHA data or the MHA data, the current and historical COM figures simply do not support a finding that there has been \$119.4 of hospital savings.

2. The US Model Mistakenly Interprets Non-Maine Variables as Dirigo Health Act Savings.

According to srHS, the US Model suggests \$439 of recommended savings (on a per CMAD basis). This recommended savings amount is derived from the following four variables:

(1) Dirigo -\$285.61; (2) Maine*Dirigo \$65.45; Year*Dirigo \$433.69; and Maine*Year*Dirigo \$225.53. **AR 4, Tab 84, p. 22**). However, as conceded by Mr. Schramm, the Dirigo variable does not refer to the Dirigo Health Act, but instead represents a pre-Dirigo (2000-2003) and post-Dirigo (2004-2007) time trend that applies to all hospitals in the nation.⁹ **Tr. 1, p. 176, ln 10 - 12**. That is why the “Dirigo” coefficient value is positive, and adds cost to the CMAD rather than decreasing costs. Similarly, the Year variable is not Maine-specific, but represents a seven year time trend with each year adding a specified amount of cost. Therefore, the interaction of the two variables does not describe the program effect of the Dirigo Health Act, but instead attributes a national pre-Dirigo (2000-2003) / post-Dirigo (2004-2007) time trend effect to Maine.

Stated differently, the US Model preserves the 2000 - 2003 base period so soundly criticized by the Superintendent in Years 2 and 3 as “tenuous.” Superintendent’s Year 2 Decision, p. 17-18; Superintendent’s Year 3 Decision, p. 8-9. In fact, Mr. Schramm admitted that the US Model is “driven by” the 2000 - 2003 base period. **AR 2, Tab 60, p. 243, ln 10 - 22**. Worse yet, the “tenuous” historical base period costs is now projected over four years. As the Superintendent has previously held, the passage of time both “diminishes the relevance of the available pre-Dirigo historical data and assigns an increasingly disproportionate dollar value to small variations in the trend rate chosen to project forward from 2003.” Superintendent’s Year 3 Decision, p. 9. The US Model’s projected savings of \$119.4 million, as compared to the \$25 million approved in Year 3, dramatically demonstrates the Superintendent’s concern.

The record demonstrates that hospitals across the United States, including Maine, experienced a marked slowing in the rate of cost growth during 2004 - 2007 as compared to 2000 - 2003; therefore, the Y:D interaction inappropriately credits the Dirigo Health Agency with the

⁹ A review of the underlying data shows that all US hospitals are assigned a “0” for the pre-Dirigo period (2000-2003) and a “1” for the post-Dirigo period (2004-2007). **DHA 3**.

national trend of a slowing rate of growth. In other words, since all hospitals nationally experienced a marked slowing of the rate of cost growth as a result of forces other than the Dirigo Health Act, it is improper to assume that Maine's reduction was solely attributable to the Dirigo Health Act -- if at all. Because the DHA's interpretation of the US Model includes variables that are not specific to Maine, their interpretation is flawed.

In addition, the US Model interpretation disregards the descriptive statistics (created using srHS data and methodologies) demonstrating that Maine's 4.5% annual growth rate in the post-Dirigo period (2004-2007) has actually outpaced the national trend of 3.9%. This is true notwithstanding the fact that Maine's annual growth rate for 2002/2003 (the year prior to the Dirigo Health Act) was below the national trend (3.11% v. 5.76%). **AR 4, Tab 84, p. 8, ln 1.** These descriptive statistics indicate that the Dirigo Health Act has not produced significant -- if any -- CMAD savings. Instead, the US Model produces alleged savings merely given greater weight to the "diminished relevance" of the 2000/2001 and 2001/2002 annual growth rates.

Although the US Model controls for some variables, it clearly fails to control for all non-Dirigo forces. Indeed, the US Model does not even attempt to control for several key criticisms identified in past decisions of the Superintendent, including "potential inflation of baseline cost growth due to abnormally high costs in 2002;"¹⁰ Medicaid payment cuts; effects of cost-based reimbursement (all from Superintendent's Year 2 Decision, p. 10); pre-Dirigo base period; effect of cost based reimbursement¹¹; recoverability of savings; effects of outpatient charges; and MaineCare reimbursement cuts (all from Superintendent's Year 3 Decision, pp. 8 - 14). Furthermore, the US Model admittedly did not control for known variables identified in Dr.

¹⁰ In fact, the "new" srHS CMAD methodology created another anomalous year, with the 2000/2001 annual cost growth rate somehow rising from 4.65% (Year 3) to 11.26% (Year 4). **AR 4, Tab 90.**

¹¹ Although Mr. Schramm testified that an adjustment for cost based reimbursement was made, neither the srHS Report nor Mr. Schramm's pre-filed (or direct) testimony explains how such an adjustment was made. An adjustment without explanation cannot be reasonably supported by the evidence.

Thorpe's own articles, including the use of forecasted volume versus expected volume. See AR 5, Tab 96 (Chamber 13).

At best, the DHA witnesses suggested that the US Model employed a "reasonable" selection of variables. However, it is beyond dispute that the US Model does not control for all non-Dirigo forces. If it did, the US Model would not produce savings in 29 of 50 States -- as Dr. Dobson demonstrated using the DHA's own model and data. Indeed, even Mr. Schramm admitted that if a regression analysis truly isolated the impact of the Dirigo Health Act, it would not produce savings in other states. **AR 2, Tab 60, p. 217, ln 23 - p. 218, ln 5.** (Mr. Roach: "What I mean is that if you were actually able to develop a regression analysis that truly isolated for only the effects of Dirigo, if you ran that regression in other states that did not have Dirigo, it would not produce any savings? Mr. Schramm: "In the hypothetical construct, yes.").

The US Model produces savings only because it misinterprets the underlying data, disregards prior criticisms of the Superintendent, and reintroduces the "tenuous" 2000 - 2003 base period. For these reasons alone, the Superintendent must reject the projected CMAD savings.

3. The US Model Relies Upon Coefficient Values That Are Admittedly Inconclusive With Respect To The Effect Of The Dirigo Health Act.

As explained above, it is impossible to tell from the record what part of the US Model's projected savings of \$119.4 million -- if any -- is related to the Dirigo Health Act voluntary CMAD limit (as opposed to national trends or other non-Dirigo forces). However, the type of parsing necessary to separate the Dirigo from the non-Dirigo is simply unnecessary here because the US Model is not statistically significant. Indeed, the DHA's own witnesses have conceded that the US Model is "inconclusive," **AR 4, Tab 73**, and that "the Board couldn't rely on that [the US Model] alone." **AR 2, Tab 60, p. 238, ln 14 - p. 239, ln 21.**

Of course, the DHA Board went against the opinion of all parties' experts, and relied upon the US Model alone. It now suggests that the Superintendent may overlook the undisputed evidence that the US Model is inconclusive, and the DHA witness's own expert opinion that its results cannot stand alone.

The DHA Board's suggestion must fail. The US Model seeks to prove CMAD savings solely through statistical analysis and projection, which requires adherence to the principles of mathematics. See Moultrie v. Martin, 690 F.2d 1078, 1082 (4th Cir. 1982). On the one hand, the DHA argues that its math should be conclusive while, on the other hand, it seeks to free itself from the objective process of hypothesis testing. Hypothesis testing uses well established benchmarks for statistical significance that identifies the likelihood that the regression model results are reliable. For example, a significance level of .10 means that there is only a 1 in 10 chance, or 90% confidence level, that the regression analysis results are not simply the result of random numerical variation. In many instances, a stricter standard is desired, such as the commonly used .05 or .01 standards.¹²

The DHA may quibble that courts do not always insist upon, or may loosely apply, the .10, .05, or .01 standards accepted by econometricians. However, even the DHA's wishful interpretation of these cases cannot stretch far enough to encompass the present case. For example, Mr. Schramm conceded in his pre-filed testimony that the US Model's statistical significance "means that this model is inconclusive about whether the reduction in trend is attributable to Dirigo..." **AR 4, Tab 82, p. 19, ln 418 - 424**. Indeed, even using the more favorable one-tailed test, Mr. Schramm and Dr. Thorpe both admitted that there is only a "45% chance" that the savings attributable to Dirigo are real, and that the amount is \$119.4 million.

¹² The Chamber cited numerous cases discussing the use of hypothesis testing in court cases at pp. 10-11 of its pre-hearing brief. **AR 2, Tab 55**. For brevity's sake, the Chamber will not repeat the arguments herein, but instead incorporates by this reference all arguments contained in its pre-hearing brief.

Id.; **AR 2, Tab 60, p. 203, ln 7 - 23.** In other words, according to the DHA’s own expert witnesses, there is at least a 55% chance that the alleged savings are not \$119.4 million and are not related to Dirigo Health, but instead reflect statistical random numerical variation.¹³

As discussed above, the US Model relies upon four coefficients (D, M:D, Y:D, M:Y:D) to produce the \$119.4 million of CMAD savings adopted by the DHA Board. Although Y:D reaches statistical significance at .0001, this interaction must be rejected as a savings measure because it merely introduces a national pre 2003 / post 2004 time trend series that is in no way related to the Dirigo Health Act or Maine. **AR 4, Tab 84, p. 22 - 23.** The other variables that produce savings (M:D, M:Y and M:Y:D) admittedly do not come close to achieving statistical significance (.9473, .4338, and .8916, respectively). **AR 4, Tab 73.** Therefore, the DHA’s own model conclusively proves that it is far more likely than not that the alleged savings are nothing more than random numerical variation. In fact, srHS expressly concedes that the M:Y:D intersection is not statistically significant and that “the effect of the presence of Dirigo is inconclusive on the CMAD.” **AR 4, Tab 73.** The M:D intersection is even less statistically significant than M:Y:D.

Nevertheless, the DHA Board will ask the Superintendent to ignore the results of this well accepted and important test, and instead look to the R-squared measure “as an indicator of the model’s predictive powers.” However, this argument too must fail. Indeed, srHS admits that its model only “explains 43% of the variance in cost per CMAD” and conversely leaves 57% of the variance unexplained. **AR 4, Tab 73; AR 2, Tab 60, p. 196 ln 13 - 21.** Although srHS suggests that this low threshold should be enough to satisfy the Board, the Chamber contends that a more conclusive finding is required in the context of a proceeding that will ultimately determine a substantial health insurance tax. This is especially true where, as here, the variables

¹³ Using the two-tailed test, there is only an 11% chance that the CMAD savings are real, and an 89% chance that it is only a random numerical variation. **AR 2, Tab 60, p. 195, ln 13 - 21.**

that drive the recommended savings do not contribute to the R-squared so-called predictive powers. Indeed, if the US Model is re-run without these variables, the R-squared result remains exactly the same out to three decimals -- .428. **AR 4, Tab 84, p. 25 - 27.** In other words, the variables that drive the savings cannot possibly influence the R-squared result. Therefore, these variables cannot contribute to the model's alleged predictive power. **AR 4, Tab 84, p. 26.**

Furthermore, using the US Model and srHS's own data, Dr. Dobson ran the exact same US Model regression analysis for all 50 states. The results were astonishing: a majority of states (29 of 50) showed a Dirigo variable "saving" effect, and 15 states showed a per-CMAD "savings" figure that was similar or greater than Maine's.¹⁴ **AR 4, Tab 84, p. 28-29; AR 4, Tab 88.** Certainly, the "savings" identified by the US Model in other states cannot be attributable to the Dirigo Health Act. And if the US Model accurately controlled for all non-Dirigo variables, of course there should be no savings in other states.¹⁵

The simple fact is that, in a majority of States, the US Model produces an estimated "actual with Dirigo" CMAD value that is lower than the "estimated without Dirigo" CMAD value. This is proof that the US Model does not take into account significant drivers of rates of cost growth, but instead confuses them with "savings" attributable to the Dirigo Health Act. Because the statistical significance of the US Model, as applied in Maine, suggests that the alleged savings is more likely than not to be the product of random numerical variation -- and

¹⁴ A similar result was found when Dr. Dobson replicated for all 50 states the Column III analysis set forth on page 54 of the srHS Report. This analysis is similar to the Years 1, 2 and 3 comparison of projected historical growth rates to actual CMAD. 39 of 50 states showed "savings," and 20 states (including Maine) has "savings" of \$150 million or more. This is additional evidence of a general nationwide slowing of the rates of cost growth that is unrelated to the Dirigo Health Act. As demonstrated by Dr. Dobson (again using srHS data and methods), the rate of cost growth began slowing in Maine long before the Dirigo Health Act was proposed and enacted. **AR 4, Tab 84, p. 8.**

¹⁵ Dr. Thorpe's explanation for why the US Model produces savings in 29 of 50 states is at best unconvincing. First, he argued that "that's not what we've done." **AR 2, Tab 60, p. 168 ln 24-25.** Then he suggested that the US Model was simply "a national average..." and that one would naturally find "25 states lower and 25 states higher." **Id. at p. 169, ln 1-13.** However, if the US Model is simply an average, and there will always be 25 states below the average, the fact that Maine was below this average does nothing to explain or support Dirigo-related savings.

because the US Model produces savings in a majority of states -- the Superintendent must reject the DHA's CMAD savings. Indeed, there is no proof that Maine's alleged Dirigo savings of \$439 per CMAD is any more real than California's \$762.

Stated differently, if a 95% confidence level is required simply to publish an article, this same level of confidence should be the minimum required for consideration of an estimate used to assess a tax. Indeed, courts frequently apply this minimum even in cases addressing alleged discrimination, something that the law prohibits and aims to discourage. Since the US Model produces -- at best -- a 45% confidence level, the \$119.4 million of CMAD savings must be deemed not supported by the evidence in the record.

C. The Evidence in the Record Demonstrates Zero Dirigo Health Act Savings.

In addition to the faulty interpretations and lack of statistical significance identified above, the record contains additional evidence that demonstrates the DHA's CMAD savings estimates lack of credibility.

1. Reasonableness Checks Discredit the Claimed CMAD Savings.

In light of the significant savings recommended by srHS Report, the Chamber performed several "reasonableness checks" to determine whether the recommended savings reflected reality. First, the Chamber replicated the US Model for all 50 states using srHS's data and methodology. As explained above, the fact that the 29 of 50 states show savings completely discredits the US Model. **AR 4, Tab 88.**

Second, the Chamber replicated the Column III savings projection for all 50 states, the US and the Northeast. **AR 4, Tab 87.** Again, 39 of 50 states, the US and the Northeast all show savings, further discrediting the DHA interpretation that there has been significant CMAD savings.

Finally, the Chamber incorporated the srHS data and regressions into an efficiency model. As Dr. Dobson explained, “one would expect a model that shows such dramatic savings would likewise show increased efficiency.” **AR 4, Tab 84, p. 34.** However, the efficiency model proved just the opposite. Instead of increased efficiency (as compared to all other states), the efficiency model showed that Maine has not controlled costs as well as other states. **Id.** This finding further supports the Chamber arguments above (based upon srHS’ raw data) that there can not be significant CMAD savings because Maine’s CMAD growth rate -- both in annual growth percentages and actual dollar value -- has outpaced the nation in the post-Dirigo period. **AR 4, Tab 84, p. 8, 10; AR 5, Tab 95(G).** Taken together, this evidence indicates that the Dirigo Health Act has not produced any savings. Indeed, if Maine is losing ground *vis a vis* all other states with respect to post-Dirigo CMAD costs, how can it be said that Maine has experienced Dirigo savings?

2. The COM Data In The Record Discredits The Claimed CMAD Savings.

The Chamber tested the CMAD savings projected by the US Model against the COM evidence in the record. There are two separate sources of operating margin data in the record. First, the DHA included Maine “virtual” hospital operating margin data based upon the raw data received from the AHD. **AR 4, Tab 64, p. 35.** According to the DHA’s own data and calculations -- the same data underlying the US Model -- the Maine “virtual” hospital maintained an operating margin of approximately .5% in 2006 and around 0% in 2007. **Id.** Second, the Chamber presented aggregated hospital consolidated operating margin data from the Year 1, 2 and 3 proceedings, as well as information from the Maine Hospital Association. **AR 4, Tab 92.** Both sets of data prove that the amount of savings projected by the US Model cannot be accurate.

Year	COM	Percent	Source
2001	\$ 30,298,000	1.44%	DHA Yr. 1
2002	\$ 2,011,000	.009%	DHA Yr. 1
2003	\$ 13,729,000	0.53%	DHA Yr. 1
2004	\$ 52,291,000	1.84%	DHA Yr. 1
2005	\$ 92,369,164	2.90%	MHA
2006	\$ 89,562,692	2.60%	MHA

Source: DHA Yr. 1 Calculation by Dr. Kane (2001-2004) and MHA Data. Individual hospital data grouped by calendar year in which hospital fiscal year ended. **AR 4, Tab 92.**

As demonstrated by the table above, the DHA Board's CMAD savings of \$119.4 million substantially exceeds the consolidated operating margin for all Maine hospitals for 2006 as determined by the MHA (\$89.6 million). Moreover, this one year of alleged savings represents approximately 43% of six years worth of consolidated operating margin. Using the DHA's own data, the projected CMAD savings is even more implausible.

Whether the Superintendent uses the Chamber's data or the DHA's data, one thing is certain: there is simply not enough recent or historical operating margin to entertain an inference that there has been \$119.4 million of CMAD savings. Indeed, even using the MHA data, one would have to assume that operating margins would have been \$209 million for 2007 (\$119.4 million + \$89.6 million) in the absence of Dirigo. This alone proves that the adopted CMAD savings is not reasonable, as total COM for 2000 - 2006 is approximately \$280 million.

Prior decisions of the Superintendent have properly considered whether or not the savings estimated by the DHA Board is recoverable by the entities subject to the SOP. For example, the Superintendent has reduced AMCS for, among other items, the failure to address the impact of (1) cost based reimbursement from governmental payors; (2) Medicaid rate cuts; and (3) hospital operating margins. Although Mr. Schramm testified at the hearing that 2007 discharges were

reduced to take into account cost based reimbursement,¹⁶ he specifically admitted that no adjustments were made to address the Superintendent's concerns regarding Medicaid rate cuts or hospital operating margins. **AR 2, Tab 60, p. 181, ln 22 - 23; p.**

Neither the srHS Report nor the DHA argue that commercial payers or self-insured businesses (the entities that are assessed the SOP) have directly realized the proposed CMAD savings. **AR 4, Tab 64.** Instead, the srHS Report simply theorized that “[l]ower CMAD trends over time result in lower charges or lower premiums paid by the consumers, resulting in savings to the Maine health care system.” **Id. at p. 12.** However, US Model does not control for or analyze changes in hospital charges, and Mr. Schramm admitted that he did not analyze whether or not hospitals could actually pass along the alleged savings to payors subject to the SOP. In fact, Mr. Schramm specifically stated that srHS did not attempt to address the concept of recoverability of the projected savings, and specifically conceded that srHS “made no analysis of whether it’s even conceivable that the hospitals could pass along [the] savings [srHS has] projected to insurance carriers.” **AR 2, Tab 60, p. 146, ln 6 - 10.** A review of the Board Decision and the underlying deliberations prove that the DHA Board likewise failed to consider recoverability. **AR 3, Tab 62.**

In the Year 3 Decision, the Superintendent held that “[i]t is reasonable to assume that hospitals with margins below 1% could not be expected to generate recoverable savings.” Superintendent’s Year 3 Decision, p. 11 Thus, using the DHA’s own data, the projected CMAD savings fails the Superintendent’s recoverability test. Indeed, the exact same AHD source data underlying the US Model demonstrates that the Maine “virtual” hospital operating margin was below 1% for both 2006 and 2007. Accordingly, the same Maine virtual hospital cannot be deemed to have created recoverable AMCS.

¹⁶ The srHS Report does not explain how the reduction in discharges was calculated, and does not refer to a specific spreadsheet which explains the calculation.

3. **The Proposed CMAD Savings Are Not Recoverable Because The Dirigo Voluntary COM Limit Entitles Hospitals To Maintain A 3.0% Operating Margin.**

Apart from the reasonableness check explained above, the Chamber argues that evidence of a reduction in the rate of CMAD cost growth (even assuming that it is properly calculation) is insufficient to prove AMCS. Indeed, the voluntary CMAD limit has a companion COM limit of 3%. **AR 5, Tab 95(A), p. 2.** These limits are subsets of the same statutory provision (Section 4(1)(A) and (B), and therefore must be interpreted together consistently. Taken together, the voluntary CMAD limit encourages hospitals to restrain cost growth, and if they are successful, the companion COM limit encourages the hospitals to pass along any savings, but only to the extent that the reduced cost growth would cause the hospitals to exceed the voluntary 3% COM limit.¹⁷

Therefore, even assuming (for sake of argument) that the CMAD savings were properly calculated (which they were not), the fact that savings exceeds COM proves that the alleged savings is not recoverable. Indeed, passing the projected savings along to private insurers would force the “virtual” hospital into insolvency. Significantly, even using the data most favorable to the DHA, the consolidated operating margin for the “virtual hospital” has increased from .53% in 2003 (the year prior to Dirigo) to 2.6% in 2006, but has at all times remained below the voluntary 3.0% COM limit created by the Dirigo Health Act.

The Chamber contends that the DHA must demonstrate that the alleged CMAD savings is recoverable by the insurance companies and TPAs that ultimately pay the SOP. At a minimum, the Chamber asserts that the DHA must prove that the alleged cost reductions are attributable to Dirigo and would force the virtual hospital to exceed the 3.0% COM limit (and

¹⁷ On the other hand, the DHA’s implicit interpretation is that any reduction in the trend rate, whether related to Dirigo or not, is AMCS. In other words, if a hospital institutes cost cutting measure in order to avoid a negative operating margin, the hospital must turn over to insurance carriers each dollar it did not spend (thus ensuring the negative operating margin that the hospital hoped to avoid).

thus require a reduction of hospital charges) before any reductions in per CMAD cost growth may be considered “savings.” One without the other does not represent savings to the Maine health care system. Indeed, a hospital cannot be expected to turn over each and every dollar it chooses not to spend. And because the law clearly contemplates hospitals maintaining a 3.0% COM, the law does not require them to do so.

D. The CMAD Variable Itself is Critically Flawed from a Savings Perspective.

The Chamber has consistently argued that the voluntary CMAD limit was never intended as a measure of “savings,” and at the very least must be read in tandem with the voluntary COM limit to have real meaning. As explained by Dr. Dobson, the CMAD variable itself is critically flawed as a measure of savings because it merely represents a per unit cost of hospital services, and does not take into account total expenditures, which is the product of price and quantity. This is important because a per unit cost may be influenced by a relative increase in volume. Although the per unit price may be lower, more units are purchased leading to similar or greater total expenditures. Therefore, volume increases generally mean higher expenditures from the payer’s perspective. However, according to the US Model, as the volume increases, CMAD savings increase, because the differential is multiplied by the total number of discharges (and outpatient discharge equivalents). Thus, the US Model is plainly inconsistent with the traditional health care industry approach of focusing on total expenditures, rather than the misleading per unit cost that disregards the impact of volume.

Collapsing all Maine hospitals into a “virtual” hospital only serves to exacerbate this problem. In the virtual hospital methodology, all hospitals’ discharges are used to determine savings. However, if the calculations were made on an individual hospital basis, not all discharges would produce savings. Indeed, some hospitals’ discharges would produce “negative” savings, and this negative savings would be offset against the “positive.” In other

words, the discharges associated with the hospitals that had “negative” savings would not be used to inflate CMAD savings, as they do in the virtual hospital model.¹⁸

E. The US Model Itself Is Flawed.

Even assuming that cost per CMAD is an appropriate savings measure and that the DHA interpreted the US Model correctly (which the Chamber contests), the US Model must be rejected because it is fatally flawed. First, it does not control for several important variables that drive hospital cost growth, and therefore the model is mis-specified. Second, the data set used to perform the analyses is riddled with numerous known errors and admittedly implausible values. Taken together, these flaws render the US Model unreliable.

1. The srHS CMAD Regression Analysis Fails to Control for Important Variables that Drive Hospital Cost Growth.

The Chamber contends that the US Model produces very misleading savings projections. Rather than incorporating important, well-known variables that drive hospital cost growth, the US Model instead relies upon the “Dirigo” variable. However, the “Dirigo” variable used by DHA to derive its inflated savings figure does not refer to the Dirigo Health Act or the Dirigo Health Agency. Instead, as Mr. Schramm conceded at the hearing, the Dirigo variable is merely a binary variable that introduces a 2000-2003 versus 2004-2007 national time trend. **AR 2, Tab 60, p. 176, ln 10 - 12.** In other words, the Dirigo variable reintroduces the exact same concept -- a 2000 - 2003 pre-Dirigo comparison period -- that the Superintendent found to be unreasonable in his Year 3 Decision.

As explained more fully in the pre-filed Testimony of Dr. Dobson, the US Model fails to control for hospital competition, insurance competition, supply of physicians, CON and other types of regulations, hospital owner status, economic and employment variables, and hospital

¹⁸ Furthermore, a health insurer subject to the SOP cannot possibly negotiate lower charges with a virtual hospital that does not exist. Thus, there is no meaningful way for health insurers to recover the alleged savings.

operating margins. **AR 4, Tab 84, p. 15.** Dr. Thorpe’s own peer reviewed article stated that there is a “consensus” regarding variables that includes “case mix, input prices, market structure, staffing patterns, teaching affiliation, location, and bed size...” **AR 5, Tab 96(B), p. 4.** In addition, Dr. Thorpe’s article argued that two additional variables should be added to the consensus: (1) source of hospital admission (physician scheduled versus emergency room) and (2) the impact of market structure and demand uncertainty on costs. **Id.** In fact, Dr. Thorpe stated that “Failure to include forecasted arrivals in hospital cost function analysis leads to specification error.” **Id., p. 5.** This article also discusses the importance of hospital competition (Herfindahl index) and labor costs (hospital specific salary per FTE). **Id.**

As Dr. Dobson explained (and Dr. Thorpe has conceded) the failure to include the correct variables in a regression analysis may cause the Dirigo coefficient to reflect the impact of the omitted variables. **AR 4, Tab 84, p. 16; AR 2, Tab 60, p. 202, ln 5 - 10.** The US Model includes only the following control variables: (1) total beds; (2) ratio of interns to beds; (3) rural / urban indicator; (4) uninsured percentage; (5) Medicare wage index. **AR 4, Tab 73.** Thus, the US Model does not include several of the variables Dr. Thorpe identified as “consensus,” including input prices, market structure, and staffing pattern. In fact, the US Model did not even use all of the variables specified by Dr. Thorpe in his own pre-filed testimony. **AR 4, 83, p. 3; AR 2, Tab 60, p. 107, ln 8 - 10.** Moreover, the US Model at best distinguishes only between Maine and other states, and therefore fails to control for geographical location. Furthermore, while the US Model uses the case mix index to determine volume, it does not control for variations in case mix during the measured time period. Therefore, according to Dr. Thorpe’s own writings, there are a significant number of “consensus” variables omitted from the US

Model.¹⁹ This appears to have been the case here, as the DHA admits that the variables in US Model explain only “43% of the variance in cost per CMAD.” **AR 4, Tab 73.** Furthermore, Mr. Schramm candidly admitted that the US Model would interpret as Dirigo “savings” the types of cost saving measures employed by Mayo Regional Hospital, Inland Hospital, and MaineGeneral Health to address difficult economic circumstances. **AR 5, Tab 95(H); AR 2, Tab 60, p. 193, ln 6-10.** Finally, the US Model fails to incorporate the concept of forecasted arrivals or determine the impact of year to year fluctuations in volume.

In addition to omitting key variables, the US Model is unreliable because it fails to address or control for key concerns identified by past Superintendent Decisions. For example, in the Year 2 Decision, the Superintendent identified the following concerns with the DHA methodology: (1) “potential inflation to baseline cost growth due to abnormally high cost in 2002”; (2) “the failure to consider potential Medicaid payment cuts”; and (3) “the degree to which cost reductions produce some offsetting reductions in payments received via cost-based reimbursement...”. Superintendent’s Year 3 Decision, p. 10. The Superintendent also criticized the continued reliance upon the pre-Dirigo time period of 2000-2003, which, as explained above, is preserved through the US Model’s “Dirigo” time trend variable. He further explained that the DHA methodology did not consider: (1) potential effect of hospital operating margins; (2) MaineCare cuts; and (3) rising outpatient prices. *Id.* at p. 14. Because the US Model admittedly doesn’t control for the Superintendent’s long repeated concerns, it must be rejected.

2. The srHS CMAD Data Lacks Credibility.

In the prior years’ proceedings, the DHA provided paper copies of the relevant Medicare cost report worksheets as support for their calculations. This important step created an audit trail

¹⁹ Mr. Schramm testified that Dr. Thorpe recommended variables. **AR 4, Tab 82, p. 11, ln 243.** Dr. Thorpe testified that he recommended the use of “teaching intensity, case mix, wage index, number of hospital beds, urban / rural location, mix between types of payors, and demographic information related to the poverty level and level of uninsurance in the State.” **AR 4, Tab 83, p. 3, ln 61-66.** Interestingly, the US Model failed to include all of the recommended variables, and in fact each of the three srHS Models used a different set of variables.

that could be reviewed to confirm the accuracy of the data underlying the calculations, as Mr. Mercier did when identifying tens of millions of dollars of errors in past proceedings. In contrast, the DHA failed to provide an audit trail for this year's proceeding. Instead, srHS purchased raw text file data from the American Hospital Directory ("AHD"), "condensed" the data to include only certain fields, imported the data into a Microsoft Access database, and then adjusted the data, including the replacement of individual hospital names with a random numeric identifier (not the provider number used by CMS). **AR 4, Tab 64, pp. 43-44.** There is no paper trail. There is not even a Microsoft Access database or Excel spreadsheet that contains the unadjusted AHD data. **AR 2, Tab 60, p. 128, ln 4-6.** As explained by Mr. Schramm, "[t]here are a series of tables and queries that an individual could work backwards to use to develop the unadjusted data". **Id.**

Although srHS suggests that this information should be relied upon without any means of independent verification, the Chamber believes that the US Model's results must be rejected unless verifiable, auditable source data is provided. Indeed, in the Year 3 Report, srHS stated that one of its "guiding principles" was to "use readily available, verifiable, and auditable data sources," and "make AMCS calculations transparent by presenting all data used in the calculation, the formulas used in the calculation, and the documentation relied on as best as possible in this report." See Year 3 Report, p. 6. Auditable documentation and transparent calculations are important because the AMCS determined at this proceeding will ultimately be translated into a tax on health insurance which will increase the costs to the Maine health care system and the ultimate purchasers of health insurance (Maine businesses, employers, employees and individuals).

Auditable documentation and transparent calculations are also important because there is compelling evidence that the US Model data is inaccurate. First, the table below demonstrates that the “virtual hospital” costs per CMAD have materially changed from Year 3 to Year 4:

<u>SFY</u> <u>Year</u>	<u>CMAD</u> <u>Year 2</u>	<u>CMAD</u> <u>Year 3</u>	<u>CMAD</u> <u>Year 4</u>	<u>DHA</u> <u>DS-18</u>
2000	4868	4882	5001	5151
2001	5097	5109	5564	5747
2002	5613	5571	6080	6315
2003	5800	5739	6269	6511
2004	5912	5922	6588	6872
2005	6316*	6160	7011	7234
2006	--	6407*	7233	7492
2007	--	--	7470*	7757*

*srHS estimates based upon an incomplete data set.

Source: DHA Year 2 Report, Appendix; DHA Year 3 Report, p. 39; srHS Year 4 Report, p. 54; dha dataset_18.

AR 4, Tab 89.

Although there is a modest differential between the Year 2 and Year 3 CMAD figures, this differential was verified by auditable documentation as the effect of audit findings by the Medicare fiscal intermediary, correction of prior DHA errors, or the replacement of srHS estimates with actual cost report data. However, the DHA has not provided a satisfying explanation for the material variances between the Year 3 and Year 4 CMAD data. Indeed, Mr. Schramm conceded at the hearing that the cost data underlying the CMAD values should not change materially. **AR 2, Tab 60, p. 153, ln 20 - p. 154, ln 5.** Since the cost data underlying the CMAD values is still the Medicare cost reports, and there admittedly should be no material change in this data, the use of AHD data cannot explain the material differences identified in the table above. This is strong evidence that there is something materially wrong with the DHA’s multiple manipulations of the AHD data, the same manipulations that (as described below) produced anomalous CMAD values, hospitals with more than 100% Medicare days, and other implausible values.

Mr. Schramm attempted to explain the admittedly material difference by a change in “methodology,” that is, that srHS did not, as in the past three years, “go through and do all the adjustments to the data that we have done in the past removing certain line items through the Medicare Cost Report.” **AR 2, Tab 60, p. 157, ln 20 - p. 158, ln 4.** He further conceded that srHS did not make adjustments required by the law which contains the voluntary CMAD limit, as it did in past years. For example, the “new” methodology did not remove, as required by the law, bad debt, hospital tax, home health agencies, swing beds, hospital owned physician practices. **Id. at p. 125, ln 13 - p. 126, ln 8.** However, if the material change in CMAD values is the result of a new methodology, and that new methodology disregards the clear statutory definition of cost per CMAD, then the US Model must be rejected.

Whether the result of faulty data or an inappropriate change in methodology, the material variance in cost per CMAD between Year 3 and Year 4 has a material impact on Maine’s pre-Dirigo CMAD growth rate. As explained above, the rate of cost growth between 2000/2001, which was 4.65% in Year 3, has more than doubled to 11.26% for Year 4. This one change has the effect of raising the average cost growth in the pre-Dirigo period (2000-2003) from 5.54% (based upon the Year 3 audited figures) to 7.82% (based upon Year 4 un-audited figures). As Dr. Dobson has explained in his pre-filed testimony, the differential in average growth rates between the pre-Dirigo period (2000-2003) and the post-Dirigo period (2004-2007) figures prominently in the US Model and its recommended savings. Indeed, Mr. Schramm conceded that the pre-Dirigo period is “driving” the CMAD analysis. **AR 2, Tab 60, p. 243, ln 10 - 14.** Furthermore, Dr. Thorpe’s justification for his opinion that the US Model is reasonable was based upon going “back to the basics,” examining the raw data, and seeing that Maine’s pre-Dirigo cost per CMAD “grew at about 2.4 percentage points faster, and the cost per case mix adjusted discharge in Maine post-Dirigo grew at about .6 percentage points faster than the

national average.” **AR 2, Tab 60, p. 38, ln 16 - p. 40, ln 1.** It is clear, however, that Dr. Thorpe’s rationale holds true only if one uses the questionable inflated Year 4 CMAD values, as use of the audited Year 3 values would produce a Maine pre-Dirigo growth rate that was very similar to the national average.

Although the DHA contends that the change in CMAD values from Year 3 to Year 4 is the result of a new methodology, there is additional evidence faulty data is to blame. Even a brief review of the data underlying the US Model demonstrates that there are significant additional problems with the data itself. **AR 4, Tab 89.** Some examples include:

- An implausible range of CMAD values from a low of 0.41513060 to 19,982.66541, and the hospitals at the higher end do not appear to be teaching hospitals.
- There were 740 observations of hospitals with the same CMAD value when expressed out to the 11th decimal (e.g. 7 hospitals had the exact value of 5403.28606406227). Given the number of variable that are contained in the CMAD formula used by srHS, it is highly unlikely that exact duplication is plausible.
- There were 21 observations of hospital beds exceeding the largest number of beds (1660 according to CMS data), including a bed size of 44491.82665 and 16299.17355;
- % Days Medicare included hospitals with percentages of 106.1728% and 4744.8276%.

These examples demonstrate significant problems with the srHS data cleaning process, and calls into question the reliability of the data underlying the srHS CMAD regression analysis. As explained by Dr. Dobson, this results in “garbage in, garbage out.” **AR 4, Tab 84, p. 19, ln 21-22.**

Interestingly, although the DHA “truncated” CMAD values deemed too high (exceeding \$20,000), it retained the implausibly low CMAD values (such as \$0.415). **AR 2, Tab 60, p. 149, ln 9 - 16.** Since each of these implausibly high and low CMAD values were found outside of Maine, the removal of high values coupled with the retention of implausibly low values acted to

depress the national average. Because the US Model compares changes in Maine CMAD relative to the rest of the United States, this has the effect of improperly increasing projected savings.

Furthermore, following the receipt of Dr. Dobson's testimony, the DHA revised some, but not all, of the criticized data values. However, the DHA did not determine the source of the problem or attempt to identify the correct value; instead, it merely truncated the data to the highest known value (e.g. 1660 hospital beds, 100% Medicare days). **AR 2, Tab 60, p. 138, ln 7 - 20.** At the hearing, Mr. Schramm admitted that srHS made a conscious decision to limit data cleaning, although some adjustments were made to adjust outlier data (such as CMAD values greater than \$20,000). **Board Decision, p. 7.** Mr. Schramm also conceded that srHS -- not AHD -- calculated the CMAD figures, percent Medicare / Medicaid days, SFY adjusted values, and other figures used in the CMAD regression analysis. **AR 2, Tab 60, p. 148, ln 7 - 23.** He admitted that after srHS converted, manipulated and used the AHD data to make necessary calculations, srHS neglected to review the converted data for outliers or errors. **AR 2, Tab 60, p. 136, ln 8 - 21.** More importantly, once errors were identified by Dr. Dobson, srHS did not go back and analyze their data and calculations. **AR 2, Tab 60, p. 137, ln 7 - 16.** Instead, srHS ignored many of the problems (duplicated CMAD values, implausibly low CMAD values, etc.). If a "correction" was made at all, srHS merely replaced the clearly wrong data with the highest possible value (total beds, 100% Medicare days, etc.). **AR, Tab 60, p. 138, ln 7 - 20.** Indeed, srHS made no attempt to verify the cause of the data error (e.g. incorrect data base formula) or determine what the proper value should be.

As demonstrated by **AR 5, Tab 95(D)**, the srHS "corrections" cannot be accurate. For example, the data base underlying the US Model has 21,776 hospitals with Medicaid days (but no Medicaid revenue); 326 hospitals with 0 Medicaid days (but Medicaid revenue); 59 hospitals

with 0 Medicare days (but Medicare revenue); 26 hospital with 100% Medicare days (but Medicaid revenue or only modest Medicare revenue); 10 hospitals with 100% Medicaid days but no Medicaid revenue (but Medicare revenue). Not only would it be anomalous for a hospital to have 100% Medicare days, many of the hospitals that the DHA identified as having 100% Medicare days also showed Medicaid revenue (which is conclusive proof of Medicaid patients).

More importantly, the small number of “corrections” that were made had a material impact on the amount of savings identified by the US Model and Cluster 1 Model. **AR 2, Tab 60, p. 139, ln 14 - 21.** If 692 minor adjustments (out of approximately 40,000) can result in an approximately \$3 million swing in CMAD savings, it is clear that the regression models are highly sensitive to small changes. **AR 2, Tab 60, p. 151, ln 7-10.** This fact makes it all the more important that the data underlying the models is accurate.

Because srHS failed to adhere to the statutory definition of CMAD, and because the data underlying its calculations are clearly erroneous, the Superintendent must reject the proposed CMAD savings.

CMAD Conclusion

For the reasons set forth above, and for the reasons identified in the briefs of Anthem, the MeAHP, and the Trusts (incorporated herein by this reference), the Superintendent must find that the CMAD savings are not reasonably supported by the evidence in the record.

II. THE DHA HAS FAILED TO PROVE THAT THE \$23.6 MILLION OF BD/CC SAVINGS ATTRIBUTABLE TO THE MAINE MODEL ARE REASONABLY SUPPORTED BY THE EVIDENCE IN THE RECORD AND RECOVERABLE BY PURCHASERS OF HEALTH INSURANCE.

A. BD/CC Background.

For Year 4, the DHA proposed yet another new methodology to measure BD/CC savings. Rather than take a “direct” approach of identifying newly insured Dirigo Choice and/or Dirigo MaineCare expansion members, the DHA employed an “indirect” methodology. This

methodology compared the uninsurance rate in two scenarios: (1) in the “absence” of Dirigo; and (2) in the “presence of Dirigo.” **AR 4, Tab 64, p. 16.** The “presence” of Dirigo was estimated by projecting 1999 to 2006 actual Maine rates of uninsurance to 2008. **Id. at p. 16 and 70.** The “absence” of Dirigo was estimated using various methodologies, including a multivariate regression analysis incorporating data from the US (US Model), the Northeast (NE Model) and Maine (Maine Model). **Id.** The models’ estimated uninsurance rates in the “absence” of Dirigo were then compared to the projected uninsurance rate in the “presence” of Dirigo, and the difference was deemed to be attributable to the Dirigo Health Act. **Id.** This percentage difference was then multiplied by a population figure to determine the “additional people insured directly attributable to Dirigo.” **Id.** These additional people were then multiplied by “the average amount of BD/C they would have contributed if they had stayed uninsured.” **Id.** This amount, as calculated by Dr. Thorpe, was \$893.

Similar to the CMAD methodology, the srHS weighted the various models, assigning 75% credibility to the US Model, 25% credibility to the NE Model, and 0% credibility to the Maine Model. **Id.** As a result, the srHS Report recommended BD/CC savings of \$35.7 million. **Id.**

The recommended savings admittedly represented more than a five-fold increase over the approved BD/CC savings from Year 3. The srHS Report explained that the substantial increase from Year 3 to Year 4 reflected the new methodology’s “global” approach which “incorporates all of the impacts that Dirigo has had on the marketplace in Maine ...” **AR 4, Tab 82, p. 21, ln 470 - 479.** Therefore, the new BD/CC methodology attempts to measure the impact of all of the Dirigo initiatives, including the initiative identified in Section 2 and Appendices B through D of the srHS Report. **Id.** These initiative include, among other items, the voluntary CMAD limit and the MLR.

The DHA Board rejected the srHS Report recommendation of \$35.7 million based upon the US Model and the NE Model. The Board Decision specifically states that “[t]he Board rejected the weighting of the U.S. Model and the NE Model as arbitrary and not supported by the evidence.” Board Decision, p. 9. In fact, the DHA Board rejected the US Model and the NE Model altogether. The Board Decision explained that the Board “concluded that the evidence supports a finding of savings from BD/CC care [sic] in the amount of \$23.6 million set forth in Table 3 of Appendix I to the srHS Report.” Board Decision, p. 9. However, the Board Decision does not explain why it adopted a figure that was given zero credibility by the DHA’s own experts.

B. The Year 4 BD/CC Savings Is Inconsistent with the Year 3 Approved Savings.

At the hearing, the Chamber demonstrated that the new srHS BD/CC methodology should be rejected because the methodology produces nearly four times the savings determined to be reasonable by the Superintendent in the Year 3 proceeding. As the Superintendent explained in the Year 3 Decision, “[o]ne final test of the overall reasonableness of this result is that it is not inconsistent with the \$5.5 million found reasonably supporting in Year Two, when adjusted for growth in enrollment during the intervening year and for the addition of a new category of savings within this initiative.” Year 3 Decision, p. 18. Mr. Schramm has indicated agreement with this type of analysis, noting in his pre-filed testimony that he afforded the CMAD Cluster 2 zero credibility “because the final savings estimate, while the highest, was inconsistent with evidence presented in past AMCS proceedings.” **AR 4, Tab 82, p. 18, ln 404-406.**

Like Year 3, srHS has now proposed a whole new methodology for determining BD/CC savings. Unlike Year 3, however, enrollment in Dirigo Choice for the current year has substantially declined when compared to the prior year. Yet, srHS suggests that the Board

should increase savings nearly four fold. The Chamber suggests this fact alone requires rejection of the recommended BD/CC savings.

C. The Maine Model Assumes A Newly Insured Population That Is Not Supported By The Evidence In the Record.

The adopted BD/CC savings of \$23.6 million implicitly assumes that approximately 26,443 previously uninsured Maine residents now have insurance as a result of the Dirigo Health Act initiatives (\$23.6 million / \$893 = 26,443). This figure simply does not match up with Maine’s historical and actual experience. The table below, which appeared as Table 11 in Dr. Dobson’s pre-filed testimony, incorporates the calendar year percent uninsured and population figures from p. 70 of the srHS Report:

Year	Percent Uninsured	Maine Population	# of Uninsured	Increase (Decrease)	Change
1999	13.25%	1,103,652	146,220		
2000	12.40%	1,126,144	139,670	(6,549)	0.955208
2001	12.07%	1,081,270	130,501	(9,169)	0.934351
2002	13.04%	1,067,611	139,250	8,749	1.067039
2003	11.79%	1,073,084	126,538	(12,712)	0.908714
2004	11.64%	1,087,397	126,536	(2)	0.999981
2005	11.67%	1,114,873	130,133	3,598	1.028431
2006	10.67%	1,146,038	122,296	(7,837)	0.939774
2007	10.15%	1,131,955	114,881	(7,414)	0.939373
2008	9.65%	1,135,544	109,605	(5,276)	0.954075

Source: srHS Report, Appendix I, Table 1, p. 70

There are two problems with the Maine Model’s assumptions. First, the Maine Model assumes that the percent uninsured will continue to decrease after 2006 (the last available actual figures). However, this assumption is not supported by the evidence in the record, as the decreases in the uninsured rates between 2002 and 2006 are largely explained by three occurrences: (a) the MaineCare non-categorical waiver (October 2002²⁰); (b) Dirigo Choice

²⁰ Because the MaineCare non-categorical waiver was created and authorized before the Dirigo Health Act was enacted, any savings associated with it may not be attributable to the Dirigo Health Act. Furthermore, any savings associated with this waiver cannot be attributable to “any increased enrollment due to an expansion in MaineCare eligibility occurring on or after June 30, 2004” as required by the applicable statute. 24-A M.R.S.A. § 6913(1)(A).

enrollees who were previously uninsured (January 2005); and (c) the Dirigo Health Act MaineCare parent's expansion (July 2005). Indeed, the MaineCare non-categorical waiver had 0 members in SFY 2002, 13,445 members in SFY 2003, and 25,978 members in SFY 2004. **AR 4, Tab 64, p. 60.** Since additional enrollment is limited by Maine's federal Medicaid DSH cap, and this limit provides no significant room for additional enrollees, it is not appropriate to assume that the substantial decline in the uninsured rate associated with this program will continue.

Likewise, enrollment in the Dirigo Choice product and the Dirigo Health Act MaineCare parents expansion explains the reduction in the uninsured rate for calendar year 2006. However, because Dirigo Choice enrollment has actually declined from 2007 to 2008, and there has been no substantial increase in Dirigo MaineCare parents expansion, it is improper to assume that the reduction in the uninsured rate experienced from 1999 to 2006 will continue. Accordingly, the DHA Board's adoption of the estimated 2008 uninsured rate in the "presence" of Dirigo is not reasonably supported by the evidence in the record.

Second, the projected number of uninsured in the "absence" of Dirigo finds no support in the record. Again, \$23.6 million of savings implicitly assumes that 26,443 previously uninsured Maine residents now have insurance as a result of the Dirigo Health Act initiatives ($\$23.6 \text{ million} / \$893 = 26,443$). However, according to the DHA's own data, the total number of uninsured persons decreased by only 16,933 from 2003 (before Dirigo) to 2008. Furthermore, correction of the estimated 2008 uninsured rate (as explained above) would shrink this number. As a result, the 26,443 of projected newly insured people is not supported by the evidence in the record.

Third, there is simply no evidence in the record (apart from the table on p. 70 of the srHS Report) that provides any explanation or support for the Maine Model. The DHA's experts gave zero credibility to the Maine Model, offered no documentation or testimonial support for the

Maine Model, and therefore the model must be considered waived. To find otherwise would impinge on the Chambers right to due process.²¹

Of greater concern is the fact that the srHS BD/CC regression models lacks transparency. As Dr. Dobson explained, “[s]tatistical programs were written that included instructions to delete interim datasets that were key to the analysis, output needed to evaluate results from the regression analysis was missing, and the process used to ‘un-log’ regression results were not detailed.” **AR 4, Tab 84, p. 40, ln 13-17.** Interestingly, Mr. Schramm and Dr. Thorpe spend a significant amount of time explaining the statistical significance of the CMAD regression analysis output, and the DHA pre-hearing brief suggests that the “DHA uses the same sort of multivariate multi-state methodology” for BD/CC. **AR 2, Tab 50, p. 9.** However, neither Mr. Schramm nor Dr. Thorpe (or the DHA Brief) bothers to discuss the statistical significance any of the BD/CC models -- or even provide the regression analysis output for review by the parties or the DHA Board. Without these significance measures, there are no means to evaluate the degree to which BD/CC models’ savings projections occurred by chance, nor are there means to assess if any of the calculated BD/CC “savings” are attributable to the Dirigo Health Act. In other words, there is nothing in the record to support any of the BD/CC models. We only know that the DHA’s own experts assigned the Maine Model zero credibility.

Finally, the Maine Model apparently assumes that everyone who is newly insured in the period 2003 - 2008 owes their insurance to the Dirigo Health Act. This assumption is plainly contrary to the plain language of 24-A M.R.S.A. § 6913(1)(A).²² Furthermore, it is contrary to Maine’s actual pre-Dirigo uninsured rate data which shows that the rate of uninsured fell from 13.25% in 1999 to 11.79% in 2003 -- before Dirigo was enacted. **AR 4, Tab 64, p. 70.**

²¹ In past Decision, the Superintendent has declined to address legal arguments raised by the parties. For this reason, the Chamber hereby preserves this legal issue, including waiver, failure of due process, and the DHA’s failure to exhaust its administrative remedies.

²² The applicable law specifies that bad debt and charity care savings must be related to the operation of Dirigo Health or the Dirigo-related MaineCare expansions occurring after June 30, 2004.

However, in order to improperly inflate BD/CC savings, the DHA now asks the Superintendent to assume that whatever factors caused this decrease magically disappeared upon the enactment of the Dirigo Health Act. This assumption, which defies common sense, is not supported by the evidence in the record.

BD/CC Conclusion

For the reasons set forth above, and for the reasons identified in the briefs of Anthem, the MeAHP, and the Trusts (incorporated herein by this reference), the Superintendent must find that the BD/CC savings are not reasonably supported by the evidence in the record.

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

Throughout the srHS report and the DHA pre-filed testimony, AMCS is referred to as “savings to the Maine health care system.” The basis for this savings initiative, however, is a refund made by Aetna to certain policyholders as a result of the medical loss ratio (“MLR”) imposed by the Dirigo Health Act. Because this refund represents savings to individual policyholders, it cannot credibly be considered savings to the Maine health care system. Therefore, it cannot be considered AMCS. Indeed, the DHA admits in its pre-hearing brief that this savings of \$6.6 million is “obviously not recoverable by Aetna.” As such, it is certainly not recoverable by other health insurance carriers or third party administrators who must pay the SOP.

Notwithstanding its concession, the DHA urges the Superintendent to include this amount in AMCS, suggesting that this hearing is meant to take place in a vacuum, and the sole purpose of this hearing is to measure any savings that may have inured to anyone in the State of Maine, without regard for whether the particular “savings” has -- or even can -- inure to the benefit of the Maine health care system. The MLR has not, and cannot, inure to the benefit of the Maine

health care system. The refunds are paid to certain existing policy holders of Aetna, not spread out generally to make future policies more affordable for all. Since Aetna will have already issued the refunds, including this amount in the SOP will result in Aetna paying out some portion of the \$6.6 million twice -- with the rest paid by other health insurance carriers and third party administrators subject to the SOP. Because the sole purpose of determining AMCS is to set a ceiling on the SOP, the consideration of any savings initiative that cannot possibly form the basis of the SOP is illogical.

For the reasons set forth above, and for the reasons identified in the briefs of Anthem, the MeAHP, and the Trusts (incorporated herein by this reference), the Superintendent must find that the MLR savings are not reasonably supported by the evidence in the record.

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

In his pre-filed testimony, Mr. Schramm attempts to explain the six fold increase in BD/CC savings as follows: “We are taking a much more global view in Year 4 by incorporating all of the impacts that Dirigo has had on the marketplace in Maine, since Dirigo has driven down the rate of cost growth of health care expenditures in Maine.” **AR 4, Tab 82, p. 21.** He explains that the rate of cost growth has been driven down by the various initiatives detailed in Section 2 and Appendix B through D of the srHS Report. **Id.** According to the cited sections of the srHS Report, the scope of the new “global approach” admittedly swallows the CMAD and MLR initiatives. This is demonstrated by the fact that the original \$35.7 million of recommended savings to the “Maine health care marketplace” is consistent with the Superintendent’s total approved savings of \$43.7 million, \$34.3 million and \$32.8 million for Years 1, 2 and 3, respectively.

According to the srHS Report, “the Year 4 analysis for BD/CC includes only those costs, charges and discharges that would have existed in the absence of Dirigo as well as in the presence of Dirigo.” **AR 4, Tab 64, p. 20.** The Maine Model apparently assumes 26,443 newly insured ($\$23.6 \text{ million} / \$893 = 26,443$). Since the costs, charges and discharges associated with this significant number of people is admittedly incorporated in the CMAD regression analyses, there was significant overlap between the CMAD and BD/CC savings calculations. Again, srHS specifically cites the voluntary limits as one of the Dirigo initiatives that has made health insurance more affordable. Likewise, srHS appears to be attempting to capture the MLR a second time -- once individually and again in the BD/CC savings because the MLR is specified as one of the contributing factors for more affordable health insurance. Although there is clearly overlap between the three savings initiatives, the DHA urges the Superintendent to ignore it.

V. THE DHA’S INCONSISTENT AND OVERLAPPING SAVINGS MEASURES PROVE THAT THE STATUTE IS UNCONSTITUTIONALLY VAGUE AND AMBIGUOUS AND RESULTS IN AN IMPROPER DELEGATION OF LEGISLATIVE AUTHORITY TO THE EXECUTIVE.

The concern expressed by Justice Alexander in his dissenting opinion has materialized. Maine Ass’n of Health Plans v. Superintendent of Ins., 2007 ME 69, 923 A.2d 918, 935 - 938 (“MEAHP”)(Justice Alexander Dissenting). In Year 4, the DHA struggles to define AMCS consistently. Sometimes it is defined as refunds to select individual citizens (MLR refunds). At other times, it is defined as savings to the Maine health care system as a whole (BD/CC / more affordable insurance premiums for all). And yet other times, it is defined as a subset of the Maine health care marketplace (hospital CMAD) without regard to whether a projected reduction in the rate of CMAD cost growth by a mythical “virtual” hospital was -- or even could be -- passed on to the purchasers of health insurance policies (thereby justifying the imposition of an SOP on health insurance carriers). The DHA’s shifting and inconsistent definition of the term AMCS has led to an increase in the cost of health insurance for most Mainers. MEAHP, 2007

ME 69 at ¶ 68. Indeed, if an SOP is assessed which has not been -- and cannot reasonably be -- recovered by the payers of health care services, the SOP is merely an added cost to the system.

For the reasons specified by Justice Alexander in his dissent (and acknowledged without opinion by the majority), the Chamber contends that 24-A M.R.S.A. § 6913 is void for vagueness and therefore the Legislature has unconstitutionally delegated its taxing and spending authority. MEAHP, 2007 ME 69 at ¶ 58, fn 14, ¶¶ 61 - 75.

Dated: August 26, 2008.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, William H. Stiles, hereby certify that a copy of the Maine State Chamber of Commerce's Brief was served on each of the persons listed below via hand delivery and electronic mail in the manner described in the Superintendent's Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures dated August 18, 2008:

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