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August 12, 2008

Mila Kofman, Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Fourth Assessment Year, Docket No. INS-08-900

Dear Superintendent Kofman:

I am forwarding to you for filing the Decision of the Board of Directors of the Dirigo Health Agency on its determination of aggregate measurable cost savings for the fourth assessment year. I am also forwarding the record of decision.

Yours very truly

William H. Laubenstein, III
Assistant Attorney General

cc: Michael J. Colleran, AAG
Bruce C. Gerrity
William H. Stiles
Christopher T. Roach
D. Michael Frink
Joseph P.Ditre

STATE OF MAINE

DIRIGO HEALTH AGENCY

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

I. INTRODUCTION

The Board of Directors of the Dirigo Health Agency (the "Board") is required to "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). The Board's determination of aggregate measurable cost savings ("AMCS") is reviewed by the Superintendent of Insurance. 24-A M. R. S. A. § 6913 (1) (C). The determination of the Board is to be made after an opportunity for a hearing conducted in accordance with the Maine Administrative Procedure Act ("APA"). 5 M. R. S. A. §§ 9001-9064.

II. PROCEDURAL HISTORY

The Board issued a Notice of Pending Proceeding and Hearing on March 7, 2008, which set a date for commencement of the hearing, made Dirigo Health Agency ("DHA") a party to the proceedings and set the terms and conditions for intervention. The Maine Association of Health Plans ("MAHP"), the Maine State Chamber of Commerce (the "Chamber"), the Maine Automobile Dealers Association Insurance Trust (the "Trust"), Anthem Health Plans of Maine,

Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem") and Consumers for Affordable Health Care ("Consumers") filed applications to intervene.

The Board issued an Order on Intervention and Procedures on May 20, 2008, setting the date for disclosure of the DHA methodology and supporting documentation (June 2, 2008); DHA disclosure of witness (June 2, 2008); intervenors disclosure of witnesses and production of documents (June 23, 2008); DHA pre-filed testimony and exhibits (June 26, 2008)); intervenor pre-filed testimony and exhibits (July 9, 2008); pre-hearing conference (July 11, 2008); DHA pre-hearing brief (July 15, 2008); intervenor pre-hearing brief (July 18, 2008); and first session of public hearing (July 22, 2008). The Board granted the applications of the Trust and Consumers to intervene as a matter of right.

The Board appointed William H. Laubenstein, III, AAG, to serve as hearing officer. Mr. Laubenstein issued a Second Order on Intervention on May 27, 2008, granting the applications of Anthem, the Chamber and MAHP to intervene as a matter of right.

On June 24, 2008, the Hearing Officer issued a Procedural Order on Distribution of Materials, which included notice of the filings make by the parties in accordance with the Procedural Order of May 20, 200; notice that the report of Jack E. Burke, an expert witness of MAHP, had not been filed; and notice that Consumers had notified the Board on June 23, 2008, that Consumers would limit its involvement at the hearing to reviewing information and participation on an informational basis. The Hearing Officer ordered that MAHP file Mr. Burke's report on July 9, 2008; that DHA provide to the Board the schramm-raleigh Health Strategy Report and DHA's proposed witnesses on June 27, 2008; that DHA provide to the Board the proposed witnesses and documents filed by intervenors on June 27, 2008; and that the parties file a statement of issues to be presented to the Board for decision on July 10, 2008.

DHA filed a Motion for Order Requiring More Specific Disclosure of Testimony by Intervenors on June 26, 2008 and requesting that disclosures be made in accordance with Rule 26 of the Maine Rules of Civil Procedure. The Chamber, Anthem and MAHP filed responses in opposition to the motion of DHA on June 30, 2008. The Hearing Officer issued an Order on the Dirigo Health Motion for Specific Disclosure on July 1, 2008: (1) denying DHA's request for disclosures meeting the requirements of Rule 26; (2) ordering the Chamber, Anthem, the Trust and MAHP to include in pre-filed testimony sufficiently detailed information to enable DHA to analyze opinions expressed and conclusions reached; and ordering that the report of Mr. Burke be filed on July 9, 2008.

The Trust filed a motion to recuse Board Member Trish Riley and Board Member Rebecca M. Wyke on July 10, 2008. Since Ms. Riley and Ms. Wyke had already decided not to participate in the hearing, no action was taken on this motion.

The Hearing Officer convened a conference of counsel on July 11, 2008 and issued a Report of Conference of Counsel on July 11, 2008 setting forth the order of proceedings; the extent of the examination of witnesses; the issues to be presented to the Board; the role of Consumers at the hearing; the submittal of exhibits; and directing DHA to file any supplemental material no later than July 17, 2008. Subsequently, there was an exchange of correspondence addressing the presentation of witnesses by panel. This issue was left for the hearing and to be decided by the Board. On July 17, 2008, DHA filed supplemental materials.

On July 18, 2008, Consumers filed a Disclosure stating that Board member Mary Anne Turowski was an employee of the Maine State Employees Association ("MSEA"), that the MSEA was a member of the Consumers for Affordable Health Care Coalition and that Ms.

Turowski sometimes attended Coalition Meetings. The Trust filed a letter with the Hearing Officer on July 21, 2008, requesting that this matter be addressed at the hearing.

III. ADJUDICATORY HEARING

The evidentiary portion of the adjudicatory hearing on aggregate measurable cost savings ("AMCS") for the fourth assessment year was held by the Board on July 22, 2008 and July 23, 2008. On July 24, 2008, the Board deliberated and rendered its decision. The voting members of the Board participating in the hearing were Robert McAfee, M. D., Chair, Jonathan Beal, Esq., Mary Anne Turowski, Mary E. McAleney and Edward David, M. D. Anne Head, Acting Commissioner of the Department of Professional and Financial Regulation, and David Lemoine, State Treasurer, non-voting members of the Board, participated in the hearing and deliberations.

At the commencement of the hearing, the Board members disclosed their affiliations to the extent any of such affiliations presented a conflict of interest. Ms. Turowski disclosed her employment by the MSEA. The parties were then given the opportunity to address the issue. Counsel for the Trust requested that Ms. Turowski recuse herself because of MSEA's membership in the Consumers for Affordable Health Coalition and noting that Consumers had made a substantial financial contribution to the work of persons opposed to the People's Veto petition drive relating to the funding of the Dirigo Health Program. Ms. Turowski responded that she believed she would be able to participate in the proceedings and make an impartial decision based on the evidence presented. The Hearing Officer stated that the hearing would proceed with Ms. Turowski participating. With regard to the presentation of witnesses by panel, the Hearing Officer stated that it was the desire of the Board that the parties would be able to present witnesses by panel, including experts.

DHA, MAHP, the Chamber and Anthem presented testimonial and documentary evidence at the hearing. Consumers and the Trust participated in the examination of witnesses but did not present any witnesses or offer any documentary evidence. The burden rests with DHA to demonstrate that its determination of AMCS is reasonable. All parties were given the opportunity and undertook, as appropriate, direct and cross-examination of witnesses. In addition, Board members asked questions of the witnesses.

IV. AGGREGATE MEASURABLE COST SAVINGS

DHA presented three initiatives to be included in AMCS for the fourth assessment year: Hospital Savings Initiative (Cost per Case Mix-Adjusted Discharge ("CMAD")); Uninsured/Under-Insured Savings Initiatives (Bad Debt and Charity Care ("BD/CC")); Insurer Oversight Initiatives (Medical Loss Ratio ("MLR")); and the extent of any Overlap. For CMAD, DHA's consultant, schramm-raleigh Health Strategy ("srHS"), determined savings in the amount of $147.9 million; for BD/CC $35.7 million; and for MLR $6.6 million. srHS found no overlap under the methodology used to calculate savings for Year 4. This resulted in a final determination by srHS of $190.2 million in AMCS.

A. CMAD. To determine savings from CMAD, srHS used a methodology that first compared the observed rate of growth in CMAD in Maine in the absence of Dirigo Health(2000 to 2003) and the observed growth rate in hospitals in the United States ("U. S. Benchmark" and in hospitals in the Northeast ("Northeast Benchmark") in the absence of Dirigo Health during the same time period. shHS then compared the observed rate of growth rate in Maine post-Dirigo (2004 to 2007) with the projected growth rate in a U. S. Benchmark and in two Clusters of selected states ("Cluster 1" and Cluster 2") during the same period of time. srHS used a traditional means projections model and a multi-state multivariate, or multi regression, modeling

approach to develop projected savings estimates for CMAD. This analysis produced savings in the range of $147.1 million to $273.0 million using traditional means projections and savings in the range of $119.4 million to $396.5 million using the multi-state multivariate model.

srHS reviewed the results of its analysis and determined that the multi-state multivariate model was the better benchmark for projecting the growth trend in the absence of Dirigo Health. srHS further determined that the savings projection for Cluster 2 savings in the amount of $396.5 million was not credible and rejected it; that the Cluster 1 savings, though credible, suffered from a bias inherent in the development of model clusters; and that, despite the lack of statistical significance of any one of the variables used in the U. S. Benchmark model, the U. S. regression model should be given weight because of the size of the model. Accordingly, srHS recommended savings in amount of $147.9 million based on a credibility weighted average of 75% applied to the U. S. regression model and 25% for the Cluster 1 regression model. The calculation of CMAD and the resulting savings from CMAD are found in Appendix G to the srHS Report to the DHA ("srHS Report").

The intervenors challenged the methodology used by srHS in a number of ways. First, the intervenors alleged that the "Dirigo" variable used by srHS is not the Dirigo Health Program, but simply a time trend. Second, the intervenors presented testimony to demonstrate that the CMAD regression analysis omitted important variables that drive hospital cost growth such as hospital competition, insurance competition, supply of physicians, economic factors and hospital operating margins. Intervenors also pointed out that srHS admitted that the U. S. Hospital model explained only 43% of the variance in cost per CMAD and that the srHS Report contains no rationale for the credibility weighting used to produce the recommended savings. It was also noted that there were unexplained material variances between Year 3 and Year 4 data being used

by srHS as well other data issues that called into question the reliability of the data underlying the CMAD regression analysis.

The intervenors further challenged the regression analysis by pointing out that only two of the coefficients—M:D and M:Y:D—has any plausible relationship to the Dirigo Health Program; that these coefficients did not achieve statistical significance; and that the analysis failed the R-squared measurement of predictive powers. With regard to the Cluster 1, which was used for the final determination of AMCS, it was pointed out that the included states did not resemble Maine in several significant aspects, such as demographics and geography. In addition, the intervenors claimed that the srHS data and methodology show that Maine's cost growth rates in the post-Dirigo period were greater than the national trend.

DHA's witnesses, Steve Schramm and Dr. Thorpe, explained that they excluded from their analysis variables that had not changed over time and that even though some variables may not have statistical significance, they did have utility in the analysis. They testified that the use of the "Dirigo" variable was standard practice in regression analysis. With regard to the data, it was explained that a conscious decision was made to limit the amount of data scrubbing and that adjustments were made to the data that varied substantially from the median. They testified that the Clusters were developed with appropriate clustering software and that Cluster 1 fairly represented Maine in the pre-Dirigo period. Schramm and Thorpe disputed the contention that the lack of statistical significance of the U. S. hospital model rendered the analysis unreliable and testified that the results of the regression analysis were consistent with the non-regressed data. Thorpe stated that in his opinion the methodology was reasonable and produced results that were a reasonable estimate of savings.

The Board carefully considered the presentations made by DHA and the intervenors as well as the responses to intervenors by DHA. The Board finds the methodology presented by DHA to be reasonable but rejects the weighting of the U. S. hospital model and Cluster 1. The Board is not persuaded that Cluster 1 tracks Maine and finds the weighting of the U. S. hospital and Cluster 1 to be arbitrary and not supported by the evidence. The Board finds further that the U. S. hospital model is the most credible and reliable indication of savings from CMAD.

The Board therefore determines savings for the Hospital Savings Initiative in the amount of $119.4 million.

B. Uninsured/Under-Insured. srHS calculated savings from BD/CC by comparing the percentage of uninsured in Maine in the absence of Dirigo Health and in the presence of the Dirigo Health , using a multi-state multivariate approach that srHS stated would reasonably calculate savings and control for non-Dirigo related changes that may have had an impact on the rate of uninsured. srHS performed multiple regressions, using the United States and the Northeast or pre-Dirigo Maine, to calculate Maine's uninsurance rate in the absence of Dirigo. The various regressions resulted in savings in the range of $17 million (1996-2006 NE model) to $49 million (U. S. trended to 2002 Maine base). This is set forth Appendix I to the srHS Report. Because of concerns that the Northeast model did not accurately reflect Maine, srHS recommended saving from BD/CC of $35.7 derived by applying credibility weights to the U. S. model of 75% and the Northeast model of 25%.

Intervenors questioned the usefulness and validity of the multi-state multivariate methodology since there was actual data available to calculate savings from BD/CC, an approach approved by the Board and the Superintendent in Year 3. They noted the substantial discrepancy for savings from prior years. For example, the Year 4 savings recommend by srHS is five times

the amount of savings approved for Year 3. srHS responded that for Year 4 a global approach was taken that took into account more than enrollment in DirigoChoice and MaineCare. With regard to intervenors' contention that the srHS methodology failed to recognize that the rate of uninsured was declining prior to the enactment of Dirigo as a result of the MaineCare expansion in 2003, Thorpe testified that the methodology took into account MaineCare eligibility requirements.

The MAHP offered Jack Burke as a witness on BD/CC. Mr. Burke presented an alternative approach to calculating savings. This alternative was the methodology adopted by the Board and approved by the Superintendent for Year 3, updated with current data. Under this alternative savings were calculated at $6.1 million.

The Board carefully considered the alternative methodologies, the testimony on the issues addressed and the testimony on other issues raised by intervenors. The Board concluded that the evidence supports a finding of savings from BD/CC care in the amount of $23.6 million set forth in Table 3 of Appendix I to the srHS Report. The Board rejected the weighting of the U. S. model and the NE model as arbitrary and not supported by the evidence.

The Board therefore determines savings for the Uninsured/Underinsured Initiative in the amount of $23.6 million.

C. Medical Loss Recovery. The third initiative presented by DHA was savings from MLR. The savings are the amount derived from a comparison of the ratio of medical expenditures over premiums to MLR targets established by the Legislature. These savings equal the amount returned to policy holders by insurers. The amount claimed for Year 4 is $6.6 million. This is the amount DHA calculated based on Aetna's report of Guaranteed Minimum Loss Ratio.

Intervenors objected to the characterization of MLR as savings and requested the Board not include the $6.6 million in AMCS because the money was paid directly to policy holders. Thus, there are no "savings" that the insurers can pass as AMCS.

The Board finds that MLR is appropriately included in AMCS as savings from the Dirigo Health Program. The Board therefore determines savings for MLR in the amount of $6.6 million.

D. Overlap. srHS did an analysis of possible overlap in the savings calculations and concluded there was no overlap between CMAD and BD/CC and that there was no data available to determine whether there was overlap between CMAD and MLR or between BD/CC and MLR.

Intervenors contended that the global approach espoused by srHS for BD/CC shows that this initiative "swallows" CMAD and MLR and that the total savings for Year 4, if any, are no more than the $35.7 million calculated for BD/CC. They further contend that the BD/CC is incorporated in the regression analysis for CMAD and therefore $36 million should be deducted from AMCS.

The Board finds that there is no overlap and therefore makes no deduction.

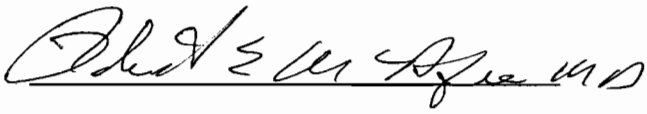
V. CONCLUSION

Based upon the evidence presented, the Board has determined that it is reasonable to include in AMCS savings the three initiatives submitted by DHA: Hospital Savings Initiative ("CMAD"), Uninsured/Underinsured Initiatives ("BD/CC") and Medical Loss Recovery ("MLR").

Based upon the evidence, the Board finds AMCS in the amount of $149.6 million for the 4th assessment year. This amount is comprised of: CMAD--$119.4 million;

Uninsured/Underinsured--$23.6; and Medical Loss Recovery --$6.6 million. The Board makes no reduction for overlap.

Dated: August 11, 2008



Robert E. McAfee, M. D.

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Jonathan S. R. Beal, Esq.

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Edward David, M. D.

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Mary Anne Turowski

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Mary E. McAleney

Uninsured/Underinsured--$23.6; and Medical Loss Recovery --$6.6 million. The Board makes no reduction for overlap.

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8/11/08

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