

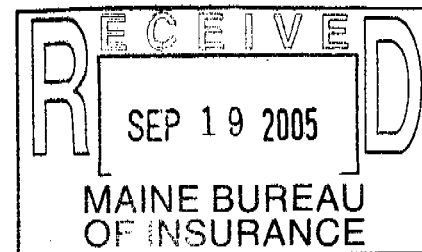
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JOHN ELIAS BALDACCI  
GOVERNOR

STATE OF MAINE  
**DIRIGO HEALTH AGENCY**  
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AUGUSTA, MAINE 04333-0053



KARYNLEE HARRINGTON  
EXECUTIVE DIRECTOR

September 19, 2005

Alessandro A. Iuppa, Superintendent  
Bureau of Insurance  
Department of Professional and Financial Regulation  
34 State House Station  
Augusta, Maine 04333-0034

Re: Review of Aggregate Measurable Cost Savings  
Determined by Dirigo Health for the First  
Assessment Year, Docket No. INS-05-700

Dear Superintendent Iuppa:

The Board of Directors of Dirigo Health hereby submits to you its determination of aggregate measurable cost savings for the first year of savings offset payments as required by P.L. 2005, ch. 400, Section B-2. The submittal includes this letter of transmittal and attached documents.

#### Introduction

The Dirigo Health Act, P.L. 2003, ch. 469, § A-8, as amended by P.L. 2005, ch. 400, § B-2, (the "Act"), established the framework for a comprehensive approach to improve the quality, access and cost of health care in Maine. A major goal of the Act was to control the rate of growth of costs for health care and health coverage in Maine. The Act tasked the Board of Directors of Dirigo Health ("Board") with annually determining the aggregate measurable cost savings as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility. 24-A M.R.S.A. § 6913 (1). For the first year determination, the Legislature put into place a process that included establishment of a working group to make recommendations no later than September 20, 2005, on the methodology for calculating aggregate measurable cost savings. P.L. 2005, ch. 400, § B-1. The working group reported to the Board on August 29, 2005 that it could not reach consensus and presented two methodologies for consideration, one by the Payor Group (composed of members

appointed to represent the interests of payors) and one by the Dirigo Group (composed of members appointed to represent Dirigo Health). After consideration of the methodologies presented, and recognizing that considerable adjustments had been made to the original Dirigo Group proposal to address concerns of the Payor Group, the Board, working from the methodology presented by the Dirigo Group, determined aggregate measurable cost savings for the first assessment year to be \$136.8 million.

### **Statutory Framework**

The Act established Dirigo Health as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to small employers and individuals. 24-A M.R.S.A. § 6902. The Act also established a Board of Directors that oversees the work of Dirigo Health. 24-A M.R.S.A. § 6904. An essential component of the Dirigo Health Program is the provision of subsidies for the purchase of Dirigo Health Insurance by low income individuals and employees. 24-A M.R.S.A. § 6912. These subsidies are funded by savings offset payments made by health insurance carriers, employee excess benefit insurance carriers and third-party administrators. 24-A M.R.S.A. § 6913(2). In turn, health insurance carriers, third party administrators and employers are to take steps to recover savings offset payments through negotiation of reimbursement rates with health care providers. 24-A M.R.S.A. § 6913(7).

The amount of savings offset payments is not unlimited. For health insurance carriers, the Legislature has set a maximum payment of 4.0% of annual paid claims for health care on policies issued in Maine for Maine residents. For third-party administrators the maximum payment is 4.0 % of annual paid claims for health care for residents of Maine. The maximum payment for employee benefit excess insurance carriers is 4% of annual paid claims on employee benefit excess insurance policies issued in Maine for Maine residents. 24-A M.R.S.A. § 6913 (3) (B). In addition, the savings offset amount is to reflect and not exceed aggregate measurable cost savings. 24-A M.R.S.A. § 6913 (2) (C).

The first step in establishing the savings offset amount to be paid by the health insurance carriers, employee benefit excess insurance carriers and third-party administrators is the determination of aggregate measurable cost savings pursuant to 24-A M.R.S.A. § 6913. This determination is made by the Board and reviewed by the Superintendent of Insurance. 24-A M.R.S.A. § 6913. The Board is to determine annually "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).

As indicated above, a major goal of the Act was to control the rate of growth of costs for health care and health coverage in Maine, a goal to which the Legislature asked health care practitioners, hospitals and health insurance carries to contribute. Health care practitioners were asked to limit for a one year period (July 1, 2003 to June 30, 2004) the growth of net revenue of the practitioner's practice to 3%; hospitals were asked to hold

for that period consolidated operating margins to no more than 3% and to restrain cost increases to no more than 3.5% as measured by expenses per case mix adjusted discharge (“CMAD”); health insurance carriers were asked to limit for that period the pricing of products sold in Maine to a level that supported no more than a 3% underwriting gain less federal taxes. P.L. 2003, ch. 469, § F-1.

The Act also addressed the impact of capital expenditures on health care costs and established the capital investment fund as a limit on resources allocated annually under the certificate of need program. 2 M. R. S. A. § 102.

It is within this statutory framework that the Board undertook to determine aggregate measurable cost savings.

### **Procedural Framework**

In P.L. 2005, ch. 400, §§ B-1 and B-2, the Legislature established the procedural steps to be followed in determining aggregate measurable cost savings in the first year of savings offset payments. In Section B-1, the Superintendent of Insurance was directed to convene a working group to advise the Board on a number of issues. The working group was to include 5 members “representing the interests of insurers, self-insured entities and third-party administrators [the ‘Payor Group’] and 5 members representing the interests of Dirigo Health [the ‘Dirigo Group’]”. With regard to the savings offset payment, the working group was commissioned to make a recommendation on the definition of paid claims and a recommendation on the methodology for calculating aggregate measurable cost savings. This latter recommendation was to be made no later than September 20, 2005. The Bureau of Insurance provided technical assistance to the working group and a facilitator was retained by the Superintendent of Insurance to moderate the meetings of the working group. P.L. 2005, ch. 400, § B-1 (1), (2), (3) and (4).

Section B-2 of Chapter 400 directed the Board to file with the Superintendent of Insurance its determination as to the “aggregate measurable cost savings in this State, including any reduction or avoidance of bad debt and charity care cost to health care providers 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” no later than the effective date of Chapter 400, which was September 17, 2005.<sup>1</sup> The Board is required to include with its filing supporting documentation for its determination. P.L. 2005, ch. 400, § B-2 (2) (A).

Within six weeks of the effective date of Chapter 400, and following a public hearing in accordance with the Maine Administrative Procedure Act, the Superintendent of Insurance is to issue an order approving, in whole or in part, or disapproving the filing made by the Board with regard to aggregate measurable cost savings. The filing is to be approved if the Superintendent determines that the aggregate measurable cost savings filed by the Board are reasonably supported by the evidence in the record. P.L. 2005, ch. 400, § B-2 (2) (B).

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<sup>1</sup> This filing is being made on September 19, 2005, the first working day following the effective date.

The working group met 13 times between June 30, 2005 and August 26, 2005. It heard presentations from the Maine Health Data Organization and Mercer Government Human Services Consulting (“Mercer”), a consultant retained by Dirigo Health to develop a methodology for measuring cost savings that was consistent, reasonable and made use of readily available data sources. The working group reached consensus on the definition of paid claims, except on one issue, but did not reach consensus on the methodology for calculating aggregate measurable cost savings. *See* Interim Report to the Dirigo Health Agency Board of Directors by the Savings Offset Payment Working Group dated August 29, 2005 (“WG Interim Report”). **Attachment 1.**

At a public meeting on August 29, 2005, the working group submitted the WG Interim Report to the Board. Karynlee Harrington, Executive Director, Dirigo Health Agency, distributed materials and made a presentation to the Board on the methodology recommended by the Dirigo Group. Daniel Roet, Director of Human Resource Services, Bath Iron Works, and Frank McGinty, Executive Vice President and Treasurer, MaineHealth, distributed materials and made a presentation to the Board on the methodology recommended by the Payor Group. *See* Dirigo Health Agency Board of Directors Minutes of Meeting-August 29, 2005. **Attachments 2 (Minutes), 3 (Dirigo Group), and 4 (Payor Group) .**

On September 6, 2005, at a public meeting, the Board gave the Dirigo Group and the Payor Group the opportunity to elaborate on their respective methodologies. Steven Schramm of Mercer and Nancy Kane, DBA, Harvard School of Public Health, made a presentation and distributed materials in support of the Dirigo Group methodology. **Attachments 5 (Mercer) and 6 (Kane).** Dr. Kane had been retained by Dirigo Health to develop a methodology to measure savings from the statutory limitation on consolidated operating margins and expenses per case mixed adjusted discharge. Mr. Schramm and Dr. Kane also answered questions from the Board and attendees, including members of the Payor Group. The Payor Group did not make a presentation. The Board expressed a strong interest in having a presentation by the Payor Group and scheduled a meeting for September 13 in order to give the Payor Group that opportunity. The Board indicated that it would meet on September 13 in order to give the Payor Group and interested persons the opportunity to present their positions on the recommended methodologies. A subsequent Board meeting was scheduled for September 14 to receive data from the Dirigo Group and the Payor Group that each proposed for use in the respective methodologies to calculate aggregate measurable cost savings and to engage in deliberations.

The Payor Group made a presentation in support of its methodology and distributed materials on September 13, 2005. The presentation was made by John Sheils and Grady Catterall, FSA, of the Lewin Group. Mr. Sheils and Mr. Catterall answered questions from the Board and from members of the Dirigo Group. The Lewin Group was retained by the Maine Chamber of Commerce, with participation of other groups that supported the Payor Group’s position. The presentation included a critique of the methodology proposed by the Dirigo Group. **Attachment 7.**

On September 14, Mr. Scheils, on behalf of the Payor Group, and Mr. Schramm, on behalf of the Dirigo Group, made presentations and submitted data to be used to calculate aggregate measurable cost savings. During the course of his presentation, Mr. Scheils made clear that the Lewin Group did not develop the Payor Group methodology and that it had been retained primarily to critique the Dirigo Group methodology. **Attachment 8** (Summary of Savings Initiatives—Savings amounts/Mercer), **Attachment 9** (Draft Final: Dirigo Health Savings Offset Payments (SOP): Methodology and Calculations/Mercer and **Attachment 10** (Estimated Hospital Savings in First Year of Dirigo Program Under Alternative Formulas/Lewin Group).

After the presentations by Mercer and Lewin, the Board went into deliberative session. After consideration and discussion of the presentations and the written submissions, the Board made its determination of aggregate measurable cost savings.

### **Dirigo Group Methodology**

The Dirigo Group methodology undertakes to determine aggregate measurable cost saving by calculating savings on 13 initiatives. These initiatives closely track the Act and use data that is readily available, verifiable and relied upon by the health care industry. The methodology is set forth in **Attachment 11**, Final Report: Dirigo Health Savings Offset Payment (SOP): Methodology and Calculations prepared by Mercer; **Attachment 12A**, Calculation of SOP Related to Limit on Growth in Cost Per CMAD prepared by Dr. Kane; and **Attachment 12B**, Final Report to DHA SOP: Voluntary Operating Profit Limit prepared by Dr. Kane. Additionally, the Cost Per Case-Mix Adjusted Discharge Formula Proposed by the Maine Hospital Association is included as **Attachment 13**.

### **Hospital Initiatives.**

1. The Act asked hospitals to hold consolidated operating margins ("COM") to no more than 3% for the period July 1, 2003 to June 30, 2004, P.L. 2003, ch. 469, § F-1 (1) (B). Operating margin is defined as operating revenue minus operating expense expressed as a percentage of operating revenue. This definition is derived from "Proposal for Maine Hospital Association Report on Charges, Cost Efficiency, and Consolidated Operating Margins", February 24, 2004. For the purpose of the calculation of savings, the entity examined is a hospital and its subsidiary (ies). Because hospitals may have fiscal years that do not correspond with the statutory period, appropriate weighting was applied to the year of analysis. In addition, reported operating margins are standardized to eliminate investment income from operating income. In response to comments made by the Payor Group, calculations for this initiative include only those hospitals where the baseline margin is above 3%.

The savings from this initiative are calculated by comparing 2004 actual operating margins to a baseline average operating margin, which is the average 2001-2003 operating margin. If the baseline average operating margin is above 3% and the

2004 actual operating margin is less than the baseline, then there is a savings to be included in aggregate measurable savings.

For the first assessment year these savings were \$8.8 million.

2. The Act asked hospitals to restrain cost increases to no more than 3.5% as measured by expenses per case mix adjusted discharge ("CMAD") for the period July 1, 2003 to June 30, 2004. P.L. 2003, ch. 469, § F-1 (1) (B). CMAD is defined as the sum of inpatient discharges adjusted by the Centers for Medicare and Medicaid Services ("CMS") case mix weights applied to all discharges plus an outpatient adjustment. Again, this definition is from the Maine Hospital Association. As portrayed in the COM, appropriate weighting is applied to account for disparate hospital fiscal years. In response to comments made by the Payor Group, this initiative used a CMS market basket index to adjust for inflation and was compounded annually to determine inflation-adjusted trend.

The savings from this initiative are calculated by comparing two projected 2004 CMAD amounts. One is determined by applying the base line average rate of growth to the 2003 CMAD. The base line average rate of growth is the rate above the hospital market basket inflationary index. The other projection is calculated by applying the difference between the target rate and the inflation rate to the 2003 CMAD. If the first projection was greater than the second projection, savings were calculated by taking the difference between the two amounts and multiplying by the number of 2004 case-mix adjusted and outpatient-adjusted discharges. Savings were summed across hospitals and included in aggregate measurable savings.

For the first assessment year these savings were \$75.0 million.

#### **Health Care Practitioner Initiatives**

The Act asked health care practitioners for one year to limit the growth of net revenue of their practice to 3%. P.L. 2003, ch. 469, § F-1 (1) (A). Because there is no data available at this time, no attempt has been made for the first assessment period to calculate savings associated with this legislative request.

#### **Carrier Initiatives.**

3. The Act asked health insurance carriers to limit the pricing of products sold in Maine to a level that supported no more than a 3% underwriting gain less federal taxes for the period (carrier fiscal year starting) July 1, 2003 to June 30, 2004. P.L. 2003, ch. 469, § F-1 (1) (C).

The methodology for this initiative first calculates the 2000 to 2003 average underwriting gain as a percentage of premium. This average is then multiplied by each carrier's 2004 total premium to arrive at the underwriting gain estimate for 2004. The difference between the projected and actual 2004 underwriting is the savings. These

amounts were taken from audited, calendar year insurance filings. This initiative incorporates comments made by the Payor Group that only carriers that voluntarily agreed to participate are to be included and that only plans whose historical gains were 3% or higher are included.

For the first assessment year these savings were \$11.2 million.

**Uninsured/Under-Insured Initiatives.**

4. The Act states that aggregate measurable cost savings are to include any reduction or avoidance of bad debt and charity care costs as a result of the operation of Dirigo Health. 24-A M.R.S.A. § 6913 (1) (A). The calculation for this initiative begins with the identification of the portion of Bad Debt/Charity Care related to all uninsured. This is then converted to a member per month ("PMPM") figure for previously uninsured Dirigo members based on "incurred member months ("MMs"). This figure is adjusted for higher-than-average Bad Debt/Charity Care costs for Dirigo enrollees. A calculation is then made to obtain the actual MMs for previously uninsured. The risk adjusted Bad Debt/Charity Care PMPM for uninsured is then multiplied by incurred MMs for total savings. In response to comments from the Payor Group, an adjustment was made to the cost per uninsured to reflect the risk profile of the uninsured that use Bad Debt/Charity Care.

For the first assessment year these savings were \$1.6 million.

5. The under-insured also incurred Bad Debt/Charity Care. This calculation is similar to that used for the uninsured. It begins, however, with a definition of "under-insured", a definition that was developed in response to concerns of the Payor Group. This calculation, too, reflects an adjustment to the cost per under-insured to reflect the risk profile of the under-insured that use Bad Debt/Charity Care.

For the first assessment year these savings were \$1.1 million.

6. The savings identified in 5 and 6 above reflect the savings in Bad Debt/Charity Care resulting from enrollees in Dirigo. It is also possible to calculate Bad Debt/Charity Care savings from enrollment in MaineCare as a result of the operation of Dirigo Health. This is called "Woodwork Enrollment." Calculations similar to that described above for Bad Debt/Charity Care are made and include a calculation of the net change in MaineCare and State Children's Health Insurance Program (CubCare) ("SCHIP"). To meet concerns of the Payor Group, the calculation of savings uses only net MaineCare and SCHIP enrollees between SFY2004 and SFY2005 and does not include Bad Debt/Charity Care savings calculations due to increased reimbursement for Dirigo MaineCare enrollees.

For the first assessment year these savings were \$3.0 million.

7. The analysis in 6 above was also used to identify "Woodwork Enrollment" for the previously uninsured who purchased private insurance as a result of the operation of Dirigo. This enrollment was triggered from heightened awareness of the availability of health insurance following the enactment of Dirigo and market efforts of Dirigo Health and Anthem. This calculation captures the reduction in the un-insurance rate since the enactment of Dirigo. Due to insufficient data at this time, no calculation of savings was made for this first assessment period.

**Certificate of Need ("CON")/Capital Investment Fund ("CIF") Initiatives.**

8. Hospitals. The Act established the Capital Investment Fund ("CIF") as a limit on the resources allocated annually under the certificate of need program. 2 M. R. S. A. § 102. In furtherance of this limitation, the Bureau of Medical Services, Department of Health and Human Services, adopted Chapter 501, Maine Certificate of Need Act Limitation, which established a moratorium on the issuance of certificates of need. **Attachment 14.**

In order to determine savings resulting from the moratorium and implementation of the CIF, a calculation was made of the historical 3 year average CON hospital spending using submitted first through third year operating costs. Spending amounts grandfathered during the moratorium were included in the analysis. A review was undertaken of the multiple year operating costs for applicability to CON spending trend and a projection of historical CON spending as the CMS market basket index was made. Savings were determined by comparing the projected CON spending to what was actually spent. To meet the concerns of the Payor Group, savings were counted only in the years expenditures were avoided.

For the first assessment year these savings were \$4.1 million.

9. Non-hospitals. Since the moratorium and CIF applied also to non-hospital spending, a calculation similar to that made for hospitals was made.

For the first assessment year these savings were \$5.7 million.

10. The Legislature found that unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services. 22 M.R.S.A. § 327 (1). The Commissioner of the Department of Health and Human Services was then directed "to approve an application for a certificate of need if the commissioner determines that the project can be funded with the capital investment fund". 22 M.R.S.A. § 335 (1) (E).

A determination of savings from this limitation on capital investment was made using the formula for CON set forth in 8 above. In addition, an adjustment was made for spending allowable under the Hospital Capital Investment Fund ("HCIF").

Savings once again were only counted for the years expenditures were avoided as suggested by the Payor Group.

For the first assessment year these savings are included in 8 above.

11. Using the formula set forth in 10 above, a determination was made also for savings from a limitation on non-hospital spending on capital improvements.

For the first assessment year these savings are included in 10 above.

**Budget Initiatives.**

12. A significant piece of P.L. 2003, ch. 469 was the establishment of the Commission to Study Maine's Community Hospitals (the "Commission"). P.L. 2003, ch. 469, § F-3 (1). The Legislature asked the Commission: "To study funding mechanisms and levels, methods of reimbursement, the role of insurance and 3<sup>rd</sup>-party payors and the effect of unreimbursed care..." and to report to the Legislature no later than November 1, 2004. P.L. 2003, ch. 469, §§ F-3 (1) (C) and (5).

In its report, **Attachment 15**, the Commission recommended that the Legislature "budget and pay past obligations to hospitals in a timely manner and revise future Periodic Interim Payment (PIP) estimates to include realistic forecast of Medicaid utilization increases."

In response to the Report, at the urging of the Board and with the support of the Legislature, the Department of Health and Human Services entered into a settlement agreements with hospitals of claims for past un-reimbursed Medicaid costs. In addition, the Legislature included in the budget for SFY 05 and SFY 06, Medicaid settlement amounts for SFY 03 through SFY 05 and Periodic Interim Payments ("PIP") increases for SFY 06 and one-half of SFY 07.

The following table summarizes the types of hospital settlements included in the analysis, hospital payment amounts, those amounts which are considered "new money" (i.e., the hospitals were not planning on receiving any of this money), those amounts that the hospitals will be receiving earlier than planned, the estimated number of months early, and the time value of that money (i.e., due to hospitals receiving this money earlier than expected, they could invest the amount now and at 3% interest, could earn this much additional money).

<b>Hospital Payments</b>	<b>Amount</b>	<b>Amount (new money)</b>	<b>Amount (available for time value of money)</b>	<b>Number of Months Early</b>	<b>Amount (time value of money)</b>
Historical Settlements SFY99-SFY02	\$96.4 million	\$96.4 million	\$96.4 million	36 months	\$8.2 million

<b>Hospital Payments</b>	<b>Amount</b>	<b>Amount (new money)</b>	<b>Amount (available for time value of money)</b>	<b>Number of Months Early</b>	<b>Amount (time value of money)</b>
Current Settlements SFY03-SFY05	\$35 million (SFY06 payments plus half of SFY07 payments)			N/A — current	
PIP Increases SFY06 and second half of CY06	\$68.5 million (SFY06 payments plus half of SFY07 payments)		\$68.5 million	36 months	\$5.8 million
<b>Total</b>		\$96.4 million			\$14.0 million

For the first assessment year these savings were \$110.4 million.

### 13. **Physician Reimbursement**

The Legislature asked the Commission: “To study funding mechanisms and levels, methods of reimbursement, the role of insurance and 3<sup>rd</sup>-party payors and the effect of un-reimbursed care...” and to report to the Legislature no later than November 1, 2004. P.L. 2003, ch. 469, §§ F-3 (1) (C) and (5).

In its report, the Commission recommended that the State “increase Medicaid payment to physicians as soon as possible and to hospitals over the next few years to cover their costs.”

Similar to hospital PIP amounts, fee increases for physicians were built into the budget for payments made by 12/31/06. There was \$8.2 million allocated for both SFY 06 and SFY 07. The entire amount of SFY 06 amount would be paid (\$8.2 million) and half of the SFY 07 amount would be paid (\$4.1 million).

For the first assessment year these savings were \$12.3 million.

### **Payor Group Methodology**

The Payor Group recommended a methodology that measures changes in a hospital’s case-mix adjusted charges over time. This methodology first calculates a hospital’s average charge increase over the period 2000 to 2003, projects it forward to 2004 and then compares it to the actual increase in 2004. If there has been a reduction in

the rate of increase, then there would be a savings that could be attributed to Dirigo Health. This methodology includes a formula for the calculation of a hospital's charges per adjusted discharge ("CHGD"): CHGD equals the sum of inpatient charges plus outpatient charges divided by adjusted discharges. This methodology replaces the COM and CMAD and the bad debt and charity measures set forth in the Act. The methodology addresses only hospital savings and does not include any savings for CON, budget initiatives or underwriting gains. The Payor Group acknowledges that there may be savings from CON but does not believe there are any measurable savings from underwriting gains. The Payor Group does not believe that the budget initiatives can be attributed to the operation of Dirigo Health.

The Payor Group believes that its methodology captures many of the components in the Dirigo Group methodology and establishes a "clear line of sight" between Dirigo initiatives and prices paid by health care consumers and payors.

The Payor Group believes that the calculation of aggregate measurable cost savings must take into account the difficulty in isolating the impact of Dirigo Health on health care costs and that any savings identified must be shared with employers and employees who are buying and paying for health insurance. The Payor Group feels strongly that there must be a system wide analysis of health care costs and that any savings from Dirigo Health must be netted against increased costs in the system, whether or not the costs can be attributed to Dirigo Health.

Using its methodology, the Payor Group estimated savings for the first assessment year of \$35.7 million. The Payor Group made clear, however, that only 50% of these savings should be included in aggregate measurable cost savings attributable to Dirigo and then reduced another 50% to ensure savings are shared with the payor community. In presenting these savings, the Payor Group indicated that it did not have data from all hospitals and that it did not believe that one year's data was sufficient to accurately measure savings from the operation of Dirigo Health.

### **Discussion**

The Dirigo Group proposes a methodology that tracks the initiatives identified by the Legislature in the Act. The Payor Group proposes a methodology that departs from these Legislative initiatives and establishes, in its view, a "direct line of sight" from Dirigo initiatives to cost savings. While the Board appreciates the apparent simplicity of the Payor Group methodology and understands the goal of savings being passed on to employers and consumers, it believes that the Dirigo Group methodology offers a more accurate approach to the measurement of cost savings and a more transparent response to the initiatives identified in the Act. In particular, the Payor Group methodology measures only rate reductions to payors while the Dirigo Group methodology incorporates multiple measures of savings to providers, as envisioned by the Legislature. Furthermore, the Dirigo Group made clear that it took a conservative approach to measuring savings and

that it had made several adjustments to its methodology in response to comments of the Payor Group.

The Board expressed concern that the Payor Group methodology was not a credible response to P. L. 2003, ch. 469 and strayed too far from the legislative history of the Act. The Board noted that the Payor Group analysis was incomplete: it did not include CON or underwriting gains and did not fully explain how it captured the Legislative savings initiatives. It was pointed out, too, that very few pay established charges; most payors pay discounted charges, which are unknown to the public; and, that using rates as a touchstone placed too much control over the allocation of savings in the hands of the hospitals. In addition, the Payor Group only briefly explained how it made its calculations of savings.

The Board is not persuaded that the Act requires a netting of savings and cost increases system wide. Rather, the Board interprets the Act to require that any savings as a result of the operation of Dirigo Health be netted against any increased costs as a result of the operation of Dirigo Health. Neither the Dirigo Group nor the Payor Group has identified any increase in costs as a result of the operation of Dirigo Health. It is well known that rates will continue to rise with or without Dirigo Health. Furthermore, there is no justification for netting savings from Dirigo Health against cost increases attributed to factors unrelated to Dirigo Health.

The Board agrees with the Payor Group that savings should be passed on to employers and employees. It does not agree that the savings are to be passed on through a cap (such as the Payor Group proposed 50% shared savings) on the savings available for assessment by the Board. The Legislature specifically addressed the issue of a limitation on the amount of savings to be assessed by (1) limiting payments to be made by insurance carriers, third-party administrators and employee benefit excess insurance carriers and (2) capping the offset payment amount to total aggregate measurable cost savings. In addition, the Board, in the exercise of its discretion, can further limit the payments to be made. The Legislature also made it clear that health insurance carriers have a responsibility to pass savings on to employers and employees through negotiation with health care providers of reimbursement rates. The negotiation of lower reimbursement rates based on savings identified through the Dirigo Group methodology, which are then passed on to employers and employees, provides the "clear line of sight" advocated by the Payor Group.

The Board carefully considered the Payor Group's objection to the inclusion of the Budget Initiatives included in the Dirigo Group's methodology, and, after extended debate, decided not to include the settlement amounts for past un-reimbursed Medicaid costs, the settlement amounts for current Medicaid payments, and the periodic interim payments in aggregate measurable cost savings. Nevertheless, the Board does believe, and the Payor Group apparently agrees, that there are savings as a result of the early payment of the settlements and the PIP (time value of money) and that these savings should be included in aggregate measurable cost savings. The Board is satisfied that the physician reimbursements are attributable to Dirigo Health and should be included.

During the course of its deliberations, one member of the Board made it clear that he supported the adoption of the methodology proposed by the Payor Group. He believed strongly that there were some positive aspects and strengths to the Payor Group methodology and that the methodology addressed concerns raised by all parties. He stated that the Board should not dismiss the market side of the argument of how to measure savings and that he was concerned that even though the Dirigo Group proposal had some positive aspects, it would create expectations of savings that may not be realized.

As pointed out above, however, the other members of the Board had serious concerns about the Payor Group methodology. In particular, the Board noted that the Payor Group methodology strayed too far from the clear statutory language. The methodology did not include several of the legislative initiatives; was not adequately documented; and, notably ignored the role that the legislature assigned to the Payor Group in passing savings on to employers and consumers.

#### **Determination of Aggregate Measurable Cost Savings**

After careful consideration of the two proposed methodologies and the supporting documentation and arguments, the Board, by a vote of 3-1, agreed to determine aggregate measurable cost savings using the Dirigo Group methodology as adjusted to meet concerns of the Payor Group, with the following modifications: the Budget Initiatives are not to include historical and current settlement amounts or periodic interim payments except for the time value of money related to these initiatives.

For the first year of assessment, the Board has determined that aggregate measurable cost savings are \$136.8 million.

Sincerely,



Robert McAfee, MD  
Chair  
Dirigo Health Agency  
Board of Directors