

D. Michael Frink
dmf@curtisthaxter.com

October 24 2005

Via Hand Delivery

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Dept. of Professional & Financial Regulation
34 State House Station
Augusta, ME 04333-0034

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

Dear Superintendent Iuppa:

Enclosed please find two (2) copies of the following document:

1. Hearing Brief on Behalf of Maine Association of Health Plans.

Thank you.

Sincerely yours,



D. Michael Frink

DMF/lc
Enclosure

Cc: John Kelly (w/enc)
Thomas C. Sturtevant, Jr., Esq. (w/enc)
William H. Laubenstein, III, Esq. (w/enc)
Christopher T. Roach, Esq. (w/enc)
Rufus E. Brown, Esq. (w/enc)
Roy T. Pierce, Esq. (w/enc)
William H. Stiles, Esq. (w/enc)

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

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO HEALTH)
FOR THE FIRST ASSESSMENT YEAR))
Docket No. INS-05-700)

FILING COVER SHEET

TO: Alessandro A. Iuppa, Superintendent
ATTN: Vanessa J. Leon

Submitted by: D. Michael Frink

Date Filed: October 24, 2005

Party: Maine Association of Health Plans

Document: Hearing Brief of Maine Association Health Plans

Document Type: Motion

Confidential: No

Dated: October 24, 2005

Respectfully submitted,



D. Michael Frink (Bar No. 2637)
CURTIS THAXTER STEVENS BRODER
& MICOLEAU LLC
One Canal Plaza / P.O. Box 7320
Portland, Maine 04112-7320
(207) 774-9000

As much as any other party in this proceeding, the Association and its members have a strong interest in restraining health care costs in the State of Maine. The Association's longstanding support for the Dirigo effort has always been predicated on firm assurances that SOP assessments on Association members and other Maine payors would never exceed the aggregate measurable savings generated by DHA's operations and realized by Association members and other payors. Unfortunately, DHA's study, which purports to demonstrate over a hundred million dollars of DHA-generated savings, is simply not reasonable. Adoption of such a study would therefore destroy the credibility of the Dirigo process.

The Association therefore submits that in this proceeding, the outcome most likely to enhance the long-term integrity and success of the Dirigo initiative would be an order disapproving the DHA filing, based upon a finding that none of the cost savings presented by DHA is reasonably supported by the evidence in the record.

I. DHA's Savings Calculation Does Not Comply With The Dirigo Law.

DHA's savings calculation, to be presented in this case through the testimony of DHA witnesses Schramm, Kane and Russell, fails to meet the basic requirements established by the Maine Legislature in the Dirigo Law. As discussed below, the Kane/Mercer analysis (a) does not meet the "aggregate and measurable" test, (b) goes well beyond the savings alleged to have been generated through DHA's "operations" and the expansion of MaineCare enrollment, (c) fails to demonstrate that any of the savings allegedly generated by DHA have in fact been realized by Maine payors, and (d) is unsupported by tests of statistical validity.²

² An SOP may technically constitute a tax under Article IX of the Constitution of the State of Maine, which provides that "The Legislature shall never, in any manner, suspend or surrender the power of taxation." Irrespective of

A. **The Savings Must Be Aggregate and Measurable**

Section 6913(1) explicitly provides that the cost savings must be both “aggregate” and “measurable.” To be “measurable” (*i.e.* capable of being measured), the methodology must be based, to the extent possible, on data that is objective and verifiable. Prospective, and therefore conjectural, savings are simply not “measurable” and therefore cannot appropriately be considered in DHA’s cost savings analysis.

The Association believes that the Superintendent can and should reject DHA’s calculation on the “measurability” ground alone, given the startling admission by DHA expert Schramm that the Kane/Mercer analysis never even *attempted* to segregate DHA-generated savings from other factors known to influence the data used in the DHA study. Shiels Prefiled at 14; Shiels Exhibit 2 (attached to Shiels Prefiled); Tobin Prefiled at 5-6. Thus, as Mr. Shiels explains, DHA’s approach would demonstrate that DHA generated savings before it was chartered and millions in health care cost savings in New Hampshire, where the program clearly has no impact. Shiels Prefiled at 18.

As a separate and independent ground for rejection, the Association would point out that DHA again and again failed to *aggregate* its data, instead selecting among the numbers available to it only those that tended to demonstrate savings. For example, DHA’s cost per case-mix-adjusted discharge (“CMAD”) analysis includes only data from hospitals that exceeded expectations, while excluding those that did not. DHA’s selective approach flatly disregards the Legislature’s requirement that any SOP be measured on an *aggregate* basis. As Mr. Shiels notes (Shiels Prefiled at 11), no reasonable economist (and, MEAHP submits, no reasonable person) could characterize DHA’s “pick and

whether the SOP aspect of the Dirigo law implicates this provision of the State’s organic law, the Association believes that Article IX, at the very least, militates against a liberal construction of the SOP aspects of the Dirigo law.

choose” approach as using “aggregate” data.³ DHA’s methodology also violates basic actuarial principles, Tobin Prefiled at 8.

B. DHA’s Savings Calculation Goes Beyond Savings Attributable to DHA

Section 6913(1)⁴ (both as originally enacted and as amended by PL 2005, ch. 400, Section A-10) provides that the aggregate measurable cost savings that constitute a ceiling on the total SOP to be levied must be generated “*as a result of the operation of Dirigo Health*” As established under Section 6902, “Dirigo Health” is “an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage”⁵ Because the law essentially defines “Dirigo Health” as a State-owned insurance carrier, its “operation” therefore, necessarily consists of the offering of subsidized insurance products. The language of Section 6913(1) bears this out by referring to reductions in “bad debt and charity care costs” as the measure of savings which can legitimately be attributed to DHA. Accordingly, only savings resulting from DHA’s insurance activities and the expansion of MaineCare are properly included in any savings determination.

Rather than following the plain language of the statute, however, DHA included in its calculation savings from initiatives that are far afield from the sale of DHA’s insurance products.⁶ In fact, Part F of the Dirigo law, which enumerates a series of

³ The Association would call the Superintendent’s attention to the fact that Mr. Shiels, a nationally recognized and respected economist in this field, considers the DHA study to be “results-biased” and “rigged,” and states that he finds it “frightening that the Mercer methodology could be found ‘reasonable.’” Shiels Prefiled at 9, 18, 36.

⁴ All statutory references herein are to Title 24-A.

⁵ Section 6902 further charges DHA with responsibility for “monitoring and improving the quality of health care in this State.” MEAHP is not aware of any claim on DHA’s part that its “monitoring and improving” functions have produced “aggregate and measurable savings” that might be taken into account in this proceeding.

⁶ During last summer’s debate on the amendment to the Dirigo law, Senator Mills pointed out that the actual savings from the sale of DHA’s insurance product were turning out to be so “minuscule” that

Legislative requests and initiatives, contains no legislative direction that any resulting savings be folded into the “aggregate measurable savings” total established in Section 6913(1), nor any legislative direction regarding how such savings are to be determined, As discussed in the testimony of several witnesses in this proceeding, the only category of savings identified in DHA’s September 19, 2005 filing that actually results from “the operations of Dirigo Health” are the “Uninsured Initiatives.” Fishbein Prefiled at 5-7; Keane Prefiled at 10. As calculated by Dirigo, these savings amount to \$5.7 Million.⁷ The other eleven categories of initiatives included in DHA’s calculation must be excluded as irrelevant to this case and beyond the scope of the plain language of the statute.

C. The Savings Must Accrue Directly to the Payors

It is clear from the language of the statute and the legislative intent that the savings-determination methodology must reflect savings accruing directly to payors, and

DHA apparently decided (without legislative sanction) that it needed to include other initiatives to increase the “savings.” Such an approach is neither supported by the legislative intent nor the plain language of the statute. Indeed, as recognized by Senator Mills, these other initiatives are “completely independent of the sale of the Dirigo product.”

The original theory of the Dirigo product was that by taking people off the uninsured list and giving them insurance that this would save on bad debt and charity care. I have no doubt that there will be some small measure of savings arising from the sale of this product to people who are uninsured. Because it is miniscule, I understand that the directors of Dirigo plan to take credit for, and maybe they should, other initiatives of the Dirigo program in a broader context. One of the awkward things in our discussion is that the Dirigo label is used not just for the health product, which is one initiative, but also for a whole set of government initiatives in the field of healthcare; the new controls over certificate of need, the efforts to gain control over hospital costs, and to gain voluntary compliance to limits on the growth in healthcare expenses. All of those things are initiatives of government that could have taken place, and indeed have taken place, in a fashion that is completed independent of the sale of the Dirigo Health product.

Remarks of Sen. Mills, Legislative Record, June 10, 2005 (emphasis supplied). *See also* Fishbein Exhibit 2, Handout of Governor’s Office of Health Policy and Finance, June 11, 2003 (financing of DHA limited to savings “realized . . . from the reduction in bad debt and charity care through savings offset payments Payments will be made only after savings are shown. Insurers’ payments will offset savings, so payments will never exceed savings.”

⁷ As discussed below, the Association contends that this figure has no basis in fact.

ultimately to end purchasers in the system – consumers and employers. The support of the employers and insurers in the State for this program depends on some plausible and reasonable connection between the savings found in this proceeding and the extent to which these savings have been realized by payors, employers and consumers. Indeed, from the very beginning, the justification for having carriers pay a “Savings Offset Payment” to DHA was that DHA would generate *actual savings* for providers, which the providers would then pass along to carriers in the form of lower charges. See remarks of Rep. Glynn, Legislative Record, June 12, 2003⁸; see also remarks of Sen. Mayo, Sagadahoc, Legislative Record, June 10, 2005. As Mr. Shiels succinctly states: “It can’t be a savings unless it’s passed back to the consumer.” Shiels Prefiled at 12.

Subsection 9 of Section 6913 offers further substantiation for this position. This provision requires that filings with the Superintendent in support of health insurance rates or rating formulas reflect, as part of the claims experience, “known changes in payments by the carrier to health care providers in this State, including any reduction for bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health” and any post-June 30, 2004 expansion in MaineCare enrollment “as determined by the board [of DHA] consistent with subsection 1.” Here, the bad debt and charity care savings generated by DHA’s operations pursuant to subsection 1 have come full circle, and need to be folded into any health insurance rate filing to be submitted to, and considered by, the Superintendent.

8

Those savings are expected to be in a large amount of money. Those savings are expected to be reflected in reductions and rates at hospitals and at doctor’s offices. It is then expected that because the savings are reduced in doctor’s offices and hospitals that savings in turn is going to be passed onto insurance carriers, which, in turn, will ultimately be passed on to businesses and also passed onto the consumer.

Legislative Record, House, June 12, 2003 (remarks of Rep. Glynn, S. Portland explaining savings offset payments).

The voluntary hospital targets in Part F of the Dirigo law are quite specific – 3.0% for the consolidated operating margin and 3.5% for CMAD. MEAHP submits that if the Legislature had actually intended to credit DHA with savings from these efforts, as DHA contends, then certainly the Legislature would have inserted a particular reference to these targets in the Section 6913(1) and the other sections of the law that govern the calculation of DHA-generated savings.

Despite the obvious intent of the Legislature, DHA's calculations focus solely on the provider's costs, stopping well short of the Legislature's target of reducing costs to payors. For example, merely showing that certain hospitals have reduced their cost per case mix adjusted discharge, or have voluntarily reduced their consolidated operating margins, does not establish that any payor's spending on health care has been reduced.

Prefiled testimony submitted by the Association establishes that for the time period at issue in this proceeding, at least two of Maine's payors – Aetna and CIGNA - have not experienced any reduction in their overall growth of spending for health care as a result of DHA, whether as a result of a decrease in the number of uninsured or underinsured, an expansion in the number of MaineCare enrollees, or, for that matter, as a result of any of the other factors contained in Dirigo's determination. Fishbein Prefiled at 10-11 (Aetna experience); Tobin Prefiled at 8-9. Moreover, Anthem witness Keane (Prefiled at 6 et seq.) and MEAHP witness Tobin (Prefiled at 10) each point out that hospital revenues and hospital costs are by no means correlated. In Mr. Tobin's view, this fundamental problem "render[s] DHA's hospital-based cost-per-CMAD calculation meaningless for the purpose of determining whether carriers have seen any savings (whether generated by DHA's operations or not)." Tobin Prefiled at 10.

II. The Five Parts of DHA's Savings Calculation are Fundamentally Flawed

Even if the Legislature's "measurability," "aggregation," and "category," restrictions are ignored, and even if one were to disregard the admission of DHA's expert that its studies do not even purport to distinguish DHA-generated savings from other factors influencing health care costs in Maine, and even if one were to accept DHA's notion that all "savings" determined in DHA's studies should be credited to DHA, and even if one were to overlook Mr. Shiels' point that DHA's experts failed to verify through standard statistical tests of reliability that their conclusions were reasonable (Shiels Prefiled at 7, 9), the record will nevertheless demonstrate that DHA has failed to sustain its burden of proof as to any of the five categories of savings presented in this case.

A. DHA's CMAD and COM Estimates Are Fundamentally Flawed.

Maine State Chamber of Commerce witness Roland Mercier, a highly experienced hospital accountant and auditor, performed a "limited scope audit" to determine whether DHA expert witness Kane's CMAD study of Maine hospitals used correct input data. He found that "[i]n many instances . . . she used incorrect information," Mercier Prefiled at 12. After correcting for a series of errors and mistakes, Mr. Mercier's revised calculations reduced DHA's CMAD value from \$64,187,815 to \$38,047,344. *Id.* Thus, Ms. Kane's data input errors resulted in a \$26,000,000 overstatement of CMAD by DHA. Mr. Mercier's findings completely undermine the reliability of the Kane/Mercer study, and warrant rejection of the entire study on this ground alone.

Mr. Mercier also demonstrates that the DHA study produced highly anomalous results. A study that assigns \$5.6 Million of DHA-generated “savings” to a hospital whose costs *grew* from \$16.6 Million to \$19.5 Million in a single year, Mercier Prefiled at 16, should not be allowed to form the basis of a multi-million-dollar assessment for Maine’s health plans.

One would think that if DHA’s operations, in conjunction with the Legislature’s pleas (in Part F of the Dirigo law) for cost restraint, had in fact produced results, Maine payors would be able to confirm this. Unfortunately, the witnesses testifying in this proceeding who have direct experience in dealing with providers have seen little or no impact from the “Dirigo initiatives.” Dr. Fishbein of Aetna advises that for “the latest quarter for which data is available, the third quarter of 2005, [Aetna has experienced] a net trend of 9% above the third quarter in 2004.” Fishbein Prefiled at 10. Over the same period, Aetna has seen hospital costs for the top 25 DRGs increase, on a per-admit and per-day basis, by 8.8% and 10.2% respectively. Dr. Fishbein also notes that although Aetna has seen some reductions in charges by a few Maine hospitals, these were temporary, and “Aena has seen no net reductions in hospital charges either from these particular hospitals, or from Maine hospitals in general.” Fishbein Prefiled at 9.

CIGNA’s David Tobin noted a slight easing of hospital cost increases during the period under review in this case, and observed that if in fact Maine hospitals have enjoyed cost savings of the magnitude claimed by DHA they “do not appear to have passed more than a small portion of them on to us.” Tobin Prefiled at 8.

These witnesses are unanimous that the DHA’s CMAD and COM methodologies rest on the deeply flawed assumption that hospital charges to Maine payors are based on

the hospital's underlying costs. Fishbein Prefiled at 9; Tobin Prefiled at 10-11; Keane Prefiled at 6-7. DHA, which carries the burden of proof in this proceeding, has not submitted any evidence purporting to contest this point. In fact, as Dr. Fishbein explains, Rule 850 "largely eliminates the ability of health plans to exert any leverage" in negotiations with providers. Fishbein Prefiled at 10. See also McCormack Prefiled at 3.

Finally, MEAHP would point out that DHA's CMAD and COM methodologies, which assign 100% of all calculated saving to DHA, will, if adopted by the Superintendent, eliminate any financial incentive for Maine health plans or self-insureds to sponsor member wellness or disease management programs such as the program now in place and producing excellent results at Bath Iron Works (Kenney Prefiled). As Mr. Tobin observes, under the DHA theory advanced in this case, cost savings generated by such efforts "will be counted as a DHA-generated savings, resulting in an SOP assessment in a year or two." Tobin Prefiled at 10.

B. DHA Has Failed to Offer a Reasonable Calculation of Bad Debt, Charity Care and MaineCare Enrollment Increase-Related Savings

In the one category of savings for which DHA can legally claim entitlement to an SOP, DHA failed to conduct a reasonable and reliable study to determine actual results. The Association has co-sponsored, with the Maine State Chamber of Commerce, the testimony of Mr. John Shiels to address this point, among others. MEAHP fully endorses Mr. Shiels' testimony on this issue (Shiels Prefiled at 26-31): DHA has used "guesstimates," rather than actual data, for uncompensated care, has erroneously valued uncompensated care on a charges basis rather than on an actual cost basis, has assumed, with absolutely no basis in evidence, that providers have passed along 100% of these "savings" to payors, has arguably inflated the savings value by including an extra six

months of savings through use of a calendar-year (rather than a fiscal-year) basis for developing enrollment figures, has failed to offer any justification for its attribution figures, and has failed to “control” for the unpaid co-payments and deductibles portion of bad debt costs.

DHA’s key assumption on the highly theoretical “woodwork” effect is that coverage expansion resulting from DHA’s efforts actually encouraged many of those already eligible but not enrolled in MaineCare to enroll. Specifically, Mercer assumed that half of the increase in MaineCare enrollment in the test period is attributable to this “woodwork” effect. However, Mr. Shiels observes that MaineCare enrollment has been trending upward at a rate of about 3.5% per year since 2001, and the experience during the test period was about 2.5%, or below the historical trend. Shiels Prefiled at 30. Mr. Shiels used California experience and research findings that for each newly eligible uninsured child enrolled in the program, about .86 children who were already eligible for Medicaid also enrolled in Medicaid. Although when adjusted by Mr. Shiels, these measures appear to have generated \$1,000,000 in total savings to *providers* (Shiels Prefiled at 30-31), the fact that DHA has failed to show that any portion of these supposed savings has been passed along to payors precludes assigning any amount of savings credit to this category.

C. DHA’s Hospital Fee Payment Initiatives Should Not Be Included in the Savings Calculation

Mercer folded in \$14.4 Million of savings due to accelerated MaineCare payments to hospitals based on the “time value of money” allegedly gained by eliminating the customary three-year reimbursement cycle. Mr. Shiels correctly observes that the law does not permit savings calculations to be based on projected

savings, thus disqualifying this category of savings per se, and, further points out that, in any event, only this year's savings should be counted in this year's calculations. Shiels Prefiled at 34.

DHA again failed to offer any evidence that any of this alleged reduction in costs to hospitals has been or will be passed through to payors and consumers. Therefore, the Board's finding on this issue is per se unreasonable, and no savings should be included in the Superintendent's calculations.

D. DHA's Physician Fee Payment Initiative Savings are Highly Speculative

DHA counted as savings about \$12.3 million in increased MaineCare payments to physicians over SFY 2006 and SFY 2007 (which have yet to be implemented) by assuming that the full amount of these payment increases will be passed back to payors and consumers in the form of reduced prices for health services. DHA has not proven that any such increased payments to physicians will be passed back to payors and consumers. Indeed, research cited by Mr. Sheils suggests that only between 20 and 40% in changes to physician reimbursement in public health programs is passed back to privately insured people. Shiels Prefiled at 35.

Moreover, DHA's calculation included payment increases for an 18-month period (i.e., 7/1/05-12/31/06). This methodology should only include one year's worth of savings in this year's calculation. All payments discussed by Dirigo on this issue appear to be prospective in nature and it is therefore premature to include any savings in this year's calculation.

With these adjustments, Mr. Sheils calculated that the savings due to this initiative would be about \$1.8 million, Shiels Prefiled at 35, but again, DHA has not proven that

even this amount will be passed back to payors and consumers. Therefore, the Superintendent should allow no savings on this point.

E. DHA's Certificate of Need ("CON") and Capital Investment Fund ("CIF") Initiative Savings Should Be Rejected

DHA estimated the effect of CON and CIF initiatives on health spending based upon the stream of revenues estimated for each of the projects approved by the state over the 1999 through 2005 period. Mercer then compared these revenue streams with a projection of what spending for approved projects would have been in the absence of the program. Mercer assumed the revenue streams for each approved project drop to zero after the first three years, even though these projects will continue to be in operation. This assumption erroneously and significantly reduces spending for these projects in 2004 and thereafter, and erroneously attributes such "reductions" to DHA. This assumption wrongly gives the appearance of a dramatic reduction in spending in these years relative to the historical trend, inflating the estimate of savings. Mercer also improperly measured savings for two years: SFY 2004 and SFY 2005.

Mr. Shiels observed that DHA's approach assumes the avoidance of operating costs incurred by facilities, such as CMMC's cardiac care center, before construction of the facility is even completed. Shiels Prefiled at 32. Clearly, Mr. Shiels' characterization of DHA's calculation as being "fatally flawed and unreasonable in that it fails to reflect reality" is accurate, Shiels Prefiled at 33, and warrants rejection of this adjustment.

F. DHA's Insurance Carrier Savings Initiatives Calculation is Unreasonable, and in any Event, Including Such "Savings" Would Be Bad Public Policy

For this calculation, DHA only counted carriers that, according to Mercer's calculations, restrained underwriting gain ("UG") for July 1, 2003 through June 30, 2004.

Mercer calculated the four-year historical average underwriting gain for each carrier. To be included in this calculation, a carrier must have experienced at least a 3% per year average underwriting gain. For carriers that meet these tests, only the portion of gain in the test period above 3% is counted. About 98% of savings on this issue was attributed to Anthem. There are several fundamental flaws in this reasoning.

First, for Anthem, Mercer excluded data from the first half of 2000, apparently because in that year Blue Cross and Blue Shield became Anthem BCBS of Maine. This omission roughly doubled the Mercer savings calculation by excluding underwriting gains for a period when the underwriting cycle depressed gains throughout the industry. This methodology artificially inflated the average UG used as a baseline for Anthem. Using the full year of 2002 would have dropped Anthem's historical average underwriting gain to below 3 %, thereby excluding its data from consideration

In addition, DHA once again did not "aggregate" the data regarding this initiative, as there was no offset of those carriers with less than 3% underwriting gain in the test period against those with more than a 3% UG.

Finally, the logic of including voluntary restraint of UG in the calculation of savings is fundamentally flawed. Any alleged savings from this initiative will be re-distributed among all carriers when the SOP is levied based on each carrier's respective share of total paid claims, regardless of whether the carrier had a sufficient historical average underwriting gain to be included in the calculation, and regardless of whether each carrier achieved a gain of more than 3 % in the test period. As Mr. Tobin points out, acceptance of DHA's methodology would effectively compel those carriers not included in the calculation to subsidize any carrier that was included, potentially allowing a carrier

to force other carriers (and, ultimately, the other carrier's customers) through the DHA SOP process to pay for a new product launch or to absorb the carrier's cost of underpricing its competition. Tobin Prefiled at 11-13.⁹

Allowing any portion of DHA's UG calculation to be included in savings would be unreasonable and unsound public policy.

CONCLUSION

For all of the above reasons, the Superintendent should disapprove the DHA September 19, 2005 filing because the aggregate measurable cost savings contained therein are not reasonably supported by the evidence in the record of this proceeding.

Dated: October 24, 2005

Respectfully submitted,

D. Michael Frink (Bar No. 2637)
Kimball L. Kenway (Bar No. 1349)
CURTIS THAXTER STEVENS
BRODER & MICOLEAU LLC
One Canal Plaza / P.O. Box 7320
Portland, Maine 04112-7320
(207) 774-9000

⁹ In MEAHP's view, the utter illogicality of including savings alleged to have been produced via the underwriting gain restraint initiative within the ambit of "aggregate measurable savings" for the purposes of Section 6913(1) tends to show that no portion of the results of the "Part F" initiatives in the Dirigo law should be included in the total savings calculation.

CERTIFICATE OF SERVICE

I hereby certify that on this date the foregoing document was served on the following parties via hand delivery on Monday, October 24, 2005:

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional and Financial Regulation
#34 State House Station
Augusta, ME 04333-0034
Vanessa.J.Leon@maine.gov

I further certify that the foregoing documents were served on counsel of record in this case via electronic mail and hand delivery, as follows:

William Laubenstein, III, Esq.
Department of the Attorney General
6 State House Station
Augusta, ME 04333-0006
bill.laubenstein@maine.gov

Compass Health Analytics, Inc.
Attn: John Kelly
465 Congress Street, 7th Floor
Portland, Maine 04101
jck@compass-inc.com

Thomas C. Sturtevant, Jr.
Assistant Attorney General
Office of the Attorney General
#6 State House Station
Augusta, Maine 04333-0006
Tom.Sturtevant@maine.gov

William H. Stiles, Esq.
Verrill Dana, LLP
One Portland Square
Portland, ME 04112-0568
wstiles@verrilldana.com

Christopher T. Roach, Esq.
Pierce Atwood, LLP
One Monument Square
Portland, ME 04101
croach@pierceatwood.com

Rufus E. Brown, Esq.
Brown & Burke
85 Exchange Street, Ste. 201
PO Box 7530
Portland, ME 04112
rbrown@brownburkelaw.com

Roy T. Pierce, Esq.
Preti Flaherty Beliveau Pachios & Haley, LLP
One City Center
P.O. Box 9546
Portland, ME 04112-9546
rpierce@preti.com

Dated: October 24, 2005



D. Michael Frink, Bar No. 2637