

October 21, 2005

Via in-hand delivery & email

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, Maine 04333-0034  
[vanessa.j.leon@maine.gov](mailto:vanessa.j.leon@maine.gov)

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

Dear Superintendent Iuppa:

Please find enclosed the following:

1. Filing Cover Sheet.
2. Two hard copies of Pre-filed testimony of Steven P. Schramm with Exhibits A and B.
3. Two hard copies of Pre-filed testimony of Nancy M. Kane with Exhibits A, B and C.
4. Two hard copies of Pre-filed testimony of F. Kevin Russell with Exhibits A and B.

Per discussion with counsel of the Superintendent, Exhibit B to Mr. Schramm's testimony is not being sent electronically. This exhibit was previously filed as Attachment 11 to the Dirigo filing of September 19, 2005. Also note that Exhibit B to Mr. Russell's testimony is not being sent electronically as it was filed as Attachment 7 to the Dirigo filing of September 19, 2005.

Pursuant to the Superintendent's Second Procedural Order, the Board estimates that the direct examination of Mr. Schramm will take one quarter of an hour; the direct examination of Dr. Kane will take one quarter of an hour; and the direct testimony of Mr. Russell will take one quarter of an hour.

Since the Board will not have the direct testimony of the witnesses of the intervenors it cannot estimate the time for cross examination but would expect it to take no longer than 30 to 45 minutes.

The Board anticipates that it will be presenting rebuttal testimony on each of the issues presented. Rebuttal testimony should not take any longer than 30 to 45 minutes.

Thank you for your assistance with this matter.

Yours very truly,

/s/William H. Laubenstein, III

William H. Laubenstein, III  
Assistant Attorney General

WHL/elf

Enclosures

cc: William H. Stiles, Esq.  
Thomas C. Sturtevant, Jr., AAG  
Roy T. Pierce, Esq.  
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John Kelly, Esq.  
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Trish Riley

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 FIRST )  
ASSESSMENT YEAR )  
)  
)  
Docket No. INS-05-700 )

TO: Alessandro Iuppa, Superintendent of Insurance  
Attn: Vanessa J. Leon

Date Filed: October 21, 2005

Name of Party: Dirigo Health Board of Directors

Document Title: Pre-filed Testimony of Steven P. Schramm with Exhibits A and B.  
Pre-filed Testimony of Nancy M. Kane with Exhibits A, B and C.  
Pre-filed Testimony of F. Kevin Russell with Exhibits A and B.

Document Type: Pre-filed testimony

Confidential: No

Dated: October 21, 2005

Respectfully submitted,

/s/William H. Laubenstein, III

William H. Laubenstein, III  
Assistant Attorney General

1 STATE OF MAINE  
2 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION  
3 BUREAU OF INSURANCE  
4  
5  
6

7 IN RE: )  
8 Review of Aggregate Measurable Cost )  
9 Savings Determined By Dirigo Health )  
10 For the First Assessment Year )  
11 )  
12 )  
13 )  
14 )  
15 Docket No. INS-05-700 )  
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TESTIMONY OF  
STEVEN P. SCHRAMM

19 Steven P. Schramm called as a witness by the Board of Directors of Dirigo

20 Health, testifies as follows:  
21

22 Q: Please state your name, employer and business location.

23 A: My name is Steven P. Schramm. I am a World Wide Partner in Mercer's  
24 Government Human Services Consulting Practice. My office is located in  
25 Phoenix, Arizona.  
26

27 Q: Mr. Schramm, please describe your educational and professional background.

28 A: My educational and professional background is set forth in the attached  
29 curriculum vitae, Schramm Exhibit A. The Government Human Services  
30 Consulting Practice is dedicated to helping publicly sponsored health and welfare  
31 programs become more efficient purchasers of health care services. As the senior  
32 strategist for the Government Human Services Consulting practice, I have been

33 involved in the design, development, implementation, and evaluation of major  
34 statewide health care reform initiatives in the States of Arizona, Connecticut,  
35 Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New Mexico,  
36 Pennsylvania, Tennessee, and now here in Maine.

37

38 Q: Mr. Schramm, please describe generally the work Mercer did on behalf of the  
39 Dirigo Health Agency.

40 A: Mercer assisted the Dirigo Health Agency with determining whether there were  
41 any savings associated with the Dirigo Health Reform Act. Our determination  
42 included working with the Agency and its consultants in examining the statute,  
43 cataloging the various impacts of Dirigo and Dirigo-related activities, identifying  
44 the associated populations and time frames impacted, and finally recommending  
45 proposed methodologies to capture those impacts. Dr. Nancy Kane, a professor of  
46 management with Harvard's School of Public Health, was primarily responsible  
47 for any hospital-related analysis due to her hospital financing expertise and  
48 previous work on behalf of Dirigo and the Hospital Study Commission. We then  
49 reviewed the proposed methodologies for consistency, reasonableness, and  
50 availability of data for calculating the impact of Dirigo. For year one of the Dirigo  
51 program, we identified 11 initiatives in five major areas — Hospital Initiatives,  
52 Insurance Carrier Initiative, Uninsured Initiatives, Certificate of Need/Capital  
53 Investment Fund Initiatives (CON/CIF), and Health Care Provider Fee Initiatives.  
54 In performing and reviewing the calculations for the 11 initiatives, we followed  
55 best practices in actuarial science, reviewed the reasonableness of assumptions

56 and calculations, and performed calculations that were credible, easily replicable,  
57 and readily validated.

58

59 Q: Mr. Schramm, did Mercer prepare a report estimating the impact of those 11  
60 initiatives on behalf of the Dirigo Health Agency?

61 A: Yes — The report is being offered as Schramm Exhibit B.

62

63 Q: Mr. Schramm, who was responsible for preparing Schramm Exhibit B\_?

64 A: I had primary responsibility and was assisted by F. Kevin Russell, Actuary and  
65 Principal at Mercer, and other members of my Mercer team.

66

67 Q: Mr. Schramm, can you describe Mercer's approach to this project?

68 A: Mercer's approach was to use the Dirigo enabling statute as our guide. The statute  
69 lays out the framework and time frames for estimating the impact of the Dirigo  
70 program in reducing the rate of growth in the health care system. The Dirigo  
71 program is composed of various initiatives and decisions made by the Dirigo  
72 Health Agency, the Hospital Commission, and other entities associated with,  
73 related to, or a result of, Dirigo. These programs and decisions impact multiple  
74 time frames and populations. Thus, the approach to estimating the impact of  
75 Dirigo must include multiple initiatives to be consistent with the statute and  
76 capture the full impact of Dirigo.

77

78 Q: Can you give us an example of the various time frames and populations  
79 impacted?

80 A: For example, for the Insurance Carrier Initiative, the voluntary limit on  
81 underwriting gain is a one-time initiative that applies to all insured individuals  
82 and measures savings during the time period covering fiscal years beginning on or  
83 after July 1, 2003 through June 30, 2004. For the Uninsured Initiatives, the  
84 avoidance of bad debt and charity care will only come about as a result of  
85 enrolling previously uninsured and under-insured individuals in new health care  
86 coverage. Thus, the Uninsured Initiatives only apply to previously uninsured and  
87 under-insured individuals, and for purposes of the year one calculation, it applies  
88 to the time period covering January 1, 2005 through December 31, 2005. Because  
89 these are two different populations and two different time periods, it would not be  
90 accurate or reasonable to use a single measure, nor would it be consistent with the  
91 statute. In a similar manner, in order to capture the full impact of Dirigo and meet  
92 the statutory obligation, it required 11 different initiatives to reflect the aggregate,  
93 measurable cost savings, which were reasonably supported by readily available  
94 data and information.

95

96 Q: Mr. Schramm, can you describe how the 11 savings initiatives follow the statutes?

97 A: The Hospital Initiatives came from Dirigo Act, which asks each hospital to  
98 voluntarily hold consolidated margins to no more than 3% for the hospital's fiscal  
99 year beginning July 1, 2003 and ending June 30, 2004 and to voluntarily restrain  
100 cost increases, measured as expenses per case mix adjusted discharge, to no more

101 than 3.5% for the same time period. Dr. Kane performed the detailed calculations  
102 on the Hospital Initiatives.

103 The statute also asks the cooperation of health care practitioners in controlling the  
104 growth of insurance and health care costs. In keeping with the guiding principles  
105 described in detail in our report, data is not readily available at this time to  
106 estimate the impact of other health care practitioners' voluntarily limiting the  
107 growth of insurance and health care costs. As a result, Mercer has not included an  
108 estimated impact in the first assessment year.

109  
110 The second area identified is the Insurance Carrier Initiatives. Under the Dirigo  
111 Act, each health insurance carrier licensed in this State is asked to voluntarily  
112 limit the pricing of products it sells in this State to the level that supports no more  
113 than 3% underwriting gain less federal taxes for the carrier's fiscal year beginning  
114 July 1, 2003 and ending June 30, 2004.

115  
116 The third area in the Act is the Uninsured Initiatives. Savings Offset Payments are  
117 to reflect aggregate measurable cost savings, including any avoidance of bad debt  
118 and charity care cost to health care providers in this State, as a result of the  
119 operation of Dirigo Health and any increased enrollment due to an expansion in  
120 MaineCare eligibility occurring after June 30, 2004. The key language here is  
121 quote, "including any avoidance of bad debt and charity care." According to the  
122 Maine Hospital Study Commission, the uninsured and the under-insured are  
123 responsible for a significant portion of the bad debt and charity care incurred by

124 hospitals in the State of Maine. The cost of increased bad debt and charity care is  
125 ultimately borne by private payers in the form of cost-shifting and resulting rate  
126 increases to cover bad debt and charity care. As a result, any previously uninsured  
127 or under-insured individuals who receive insurance coverage as a result of the  
128 Dirigo program will result in the reduction of bad debt and charity care and, and  
129 in savings to the system through a reduction in cost-shifting to private payers.  
130 Mercer identified two potential areas of savings as a result of taking previously  
131 uninsured and under-insured individuals and providing them with health  
132 insurance. The first comes as a result of direct enrollment in the DirigoChoice  
133 program — reduction in bad debt and charity care due to previously uninsured  
134 individuals now being covered under the DirigoChoice program, and — reduction  
135 in bad debt and charity care due to previously under-insured individuals now  
136 enrolled in the DirigoChoice program.

137 The second potential area for savings comes from the enrollment of individuals  
138 previously uninsured or under-insured seeking out health insurance (other than the  
139 DirigoChoice program) that is due to the increased publicity and awareness of the  
140 value of health insurance, known as the “Woodwork Effect”. States that have  
141 undertaken major health reform initiatives as sweeping as Dirigo’s have seen  
142 substantial increases in their Medicaid/SCHIP and private health insurance  
143 enrollment. Thus, there is a reduction in bad debt and charity care due to  
144 previously uninsured individuals now enrolled in the MaineCare and SCHIP  
145 (CubCare) programs (MaineCare Woodwork), and a reduction in bad debt and  
146 charity care due to previously uninsured individuals now enrolled in private

147 insurance (Private Insurance Woodwork).

148

149 The fourth area of initiatives is the Certificate of Need (CON) and Capital  
150 Investment Fund (CIF) Initiatives. The CON and CIF initiatives provide savings  
151 by reducing the need for cost increases to the private payer. Due to the  
152 implementation of a moratorium on hospital CON and non-hospital CON  
153 spending and the implementation of a CIF which limits spending on new capital  
154 projects, both of which substantially reduce the amount of hospital spending, the  
155 need for payer rate increases is reduced. First, there is a reduction in hospital costs  
156 due to the CON moratorium and the CIF limits, and, second, there is a reduction  
157 in non-hospital costs due to the CON moratorium and the CIF limits.

158

159 The fifth area is the Health Care Provider Fee Initiatives. Similar to the Uninsured  
160 Initiatives, these initiatives identify savings that occur in the health care system  
161 due to reductions in cost shifting. According to the Hospital Study Commission,  
162 hospital and other health care providers must cost-shift to private payers to make  
163 up for the difference between Medicaid funding and costs. Thus, increased  
164 funding from Medicaid will reduce the need for cost-shifting to private payers.  
165 Therefore, savings will accrue to private payers as the need for cost increases  
166 from other payers will be reduced as additional cash is received by hospitals and  
167 physicians. There will be reductions in cost-shifting due to increased funding for  
168 hospitals, and a reduction in cost-shifting due to increased funding for physicians.

169

170 Q: Mr. Schramm, tell us about the process Mercer used to complete your  
171 calculations.

172 A: In calculating the aggregate measurable savings, as mentioned above, we  
173 developed a set of principles to guide our process. One of the key guiding  
174 principles was that the data sources used must be readily available, verifiable and  
175 auditable, and to the extent possible, used for other purposes as well. We did not  
176 independently verify the data used in the calculations; therefore, we wanted the  
177 data to be sufficiently robust and accurate as evidenced by their use for multiple  
178 other purposes, thus ensuring their accuracy and acceptability. The data,  
179 assumptions, and calculations were then reviewed for reasonableness,  
180 appropriateness, and accuracy for determining aggregate measurable savings.

181

182 Q: What do you mean by aggregate measurable savings?

183 A: Aggregate measurable savings means combining all of the identified cost savings,  
184 across all initiatives because of Dirigo. Mercer used a global approach to  
185 measuring the cost savings. That is, we did not try to take each initiative and parse  
186 any one particular savings amount and attribute it to Dirigo. That is not a  
187 reasonable standard to be applied in the real world. The health care marketplace is  
188 an incredibly complex system and it is not possible to establish a control group or  
189 controlled environment to reliably isolate the impact of any one program or  
190 initiative in the absence of all other changes. Instead, our global approach  
191 recognizes that the impact of Dirigo is so broad, so sweeping, that it is the  
192 primary driver of reductions in the rate of growth of health care costs in Maine. I

193 believe, from participation in the working group, that there is a consensus that  
194 Dirigo is, in fact, the primary driver of reduced growth in health care costs and the  
195 cost of health insurance in the State of Maine since 2003. Further, Mercer took a  
196 conservative approach to measuring the impact of each of the initiatives. In this  
197 instance, conservative means that whenever Mercer estimated the reductions in  
198 the rate of growth of health care costs, our methodology was structured such that  
199 it could be clearly supported by available data and/or information. This  
200 conservative approach was based on applying assumptions that tended towards  
201 the lower bound of reasonable limits. For example, a criticism leveled against the  
202 State's methodology is that it does not include the increases measured for each of  
203 the initiatives. We requested on many occasions that the payer group identify all  
204 of the cost increases attributable to Dirigo and, in every instance they have stated  
205 that there are no cost increases attributable to Dirigo. Therefore, to include the  
206 cost increases calculated in each of the initiatives would require inclusion of those  
207 impacts that all sides agree are not attributable to Dirigo. This would actually  
208 increase the error of estimation in calculating the impact of Dirigo on cost  
209 savings. In keeping with our conservative approach, we have elected to use only  
210 those methodologies that can be clearly supported by available data and/or  
211 information.

212

213 Q: What is the impact of constantly using a global approach and such a conservative  
214 methodology?

215 A: Given the global approach to savings estimation, the methodology recognizes that  
216 it may be that not all of the savings calculated are directly attributable to Dirigo.  
217 But by consistently being conservative in estimating the savings, that is, requiring  
218 that the methodology be clearly supported by existing data or information and  
219 using assumptions tending towards the lower bound of reasonable limits, I am  
220 satisfied that, at a minimum, the calculated amount of savings has occurred as a  
221 result of Dirigo.

222

223 Q: Let's now move to the specific initiatives and calculations for which you will  
224 provide testimony. Can you describe those initiatives?

225 A: Yes — I will first address the CON and CIF Initiatives. Similar to the Uninsured  
226 Initiatives, there is not a specific target associated with the reduced spending due  
227 to the CON or CIF Initiatives, but instead savings can be measured due to the  
228 reduction in the need for cost-shifting to private payers. As this spending is  
229 reduced, the need for payer rate increases is reduced. Our methodology estimates  
230 savings associated with the moratorium on hospital and non-hospital spending  
231 that started May 1, 2003, and the implementation of the CIF which limits the  
232 hospital and non-hospital capital spending beginning January 1, 2005. After  
233 reviewing historical capital spending and projecting it to SFY04 and SFY05, we  
234 compared this projection to the actual spending that occurred and arrived at total  
235 savings. Total savings for these initiatives are \$9.8 million in year one.

236

237 Q: Mr. Schramm, are there other initiatives for which you will provide testimony?

238 A: Yes,- I will also address the Health Care Provider Fee Initiatives. The Health Care  
239 Provider Fee Initiatives are again similar to the Uninsured and CON/CIF  
240 Initiatives in that there is no specific target described in the legislation. Instead,  
241 these initiatives measure savings to the system as a result of a reduction in the  
242 need for cost-shifting to private payers. This reduction in cost-shifting, due to  
243 Health Care Provider Fee Initiatives, comes about in two ways. The first,  
244 reduction in cost-shifting and resulting savings to private payers, comes from an  
245 infusion of money into the hospital system which reduces the hospitals' need for  
246 cost increases from private payers. Our savings methodology measures the actual  
247 cash value of the new money to the health care system in the year in which it is  
248 paid. There are three sources of new money in Health Care Provider Fee  
249 Initiatives on the hospital side and one on the physician side. For hospitals, new  
250 money was added to the system as a result of the historical settlements (generally  
251 covering payments through SFY02), current settlements (generally covering  
252 SFY03 to SFY05), and prospective interim payment increases (generally covering  
253 SFY06 and last two quarters of CY06). For physicians, the actual cash payments  
254 for fee increases cover SFY06 and the last two quarters of CY06. In addition to  
255 the cash value of additional payments, the cost-shifting will also be reduced due  
256 to the "time value of money". This reduction in cost-shifting and resulting savings  
257 to private payers, known as the time value of money, accounts for the value of  
258 receiving those dollars earlier than anticipated. The time value of money only  
259 applies to two of the Hospital Fee Initiatives, the historical settlements and the  
260 prospective interim payment increases. As we know, however, the Dirigo Board

261 decided to include only the time value of money for the hospital payments of \$14  
262 million and the value of the actual dollars for the physician fee increases of \$12.3  
263 million.

264 .Q: Mr. Schramm, are there any changes you wish to make to Schramm Exhibit B?

265 A: I would note that Appendix E has been revised by Dr. Kane as indicated in an  
266 attachment to Dirigo's Witness Designation. As a result of this revision, the  
267 savings realized from the voluntary limit on consolidated operating margin is  
268 unchanged at \$8.8million I would also note the Appendix F has been revised by  
269 Dr. Kane as indicated in an attachment to Dirigo's Witness Designation. As a  
270 result of this revision, the savings realized from voluntary limit on increases in  
271 CMAD is now \$64.2 million and not \$75 million.

272 Also, there are two more clarifications we would like to make. First, on page 17  
273 and 18 to say that Collectively Renewable category is where some, but not all, of  
274 the non-group medical insurance would be recorded. Secondly, on item C on  
275 page 20 – the number of under-insured Mainers (34,475) was taken from a report  
276 provided by the Dirigo Health Agency on September 6, 2005 rather than the  
277 Household Survey prepared by the Institute for Health Policy of the Muskie  
278 School of Public Health (Appendix H of the Mercer Report contains the correct  
279 source reference).

280

281 Q: Mr. Schramm, do you adopt Schramm Exhibit B as revised as part of your  
282 testimony?

283 A: Yes — I do.

284

285 Dated: October 21, 2005

286

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STEVEN P. SCHRAMM

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 )  
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Docket No. INS-05-700 )

TESTIMONY OF  
NANCY M. KANE

Nancy M. Kane, called as a witness by the Board of Directors of Dirigo Health,  
testifies as follows:

Q: Please state your name, employer and business location.

A: My name is Nancy M. Kane. I am a Professor of Management in the Department  
of Health Policy and Management, Harvard School of Public Health. My office is  
located in Boston, MA.

Q: Please describe your education background.

A: I graduated from Simmons College in 1972 with a Bachelor of Science degree in  
Physical Therapy. I received in 1975 a Masters in Business Administration, General  
Management, and, in 1981, a Doctor of Business Administration, Business Policy, both  
from the Harvard Graduate School of Business Administration. My professional  
background is set forth in the attached resume, Kane Exhibit A.

Q: Please describe the work you did on behalf of the Dirigo Health Agency.

A: I took primary responsibility for calculating the Savings Offset Payment (SOP) amounts attributable to the voluntary limits on hospital cost per Case Mix Adjusted Discharge (CMAD) and on hospital Consolidated Operating Margin (COM) for the Dirigo Fiscal Year beginning July 1, 2003 and ending June 30, 2004.

Q: Were there any constraints on the work you did? If so, please describe them.

A: There were some constraints. First, the data available to calculate the Case Mixed Adjusted Discharge (CMAD) and Consolidated Operating Margin (COM) were limited to publicly available data sources that could be obtained within the time constraints imposed by the Dirigo Health Reform Act for reporting the SOP.

Second, the definition of Case Mixed Adjusted Discharge and Consolidated Operating Margin were limited by the language of the Dirigo Health Reform Act and subsequent debate and compromise within the context of the Commission to Study Maine's Hospitals.

Third, the calculation of the Savings Offset Payment (SOP) is limited to the role that hospitals were expected to play in generating cost savings. It does not address whether every health insurance carrier and health care provider has demonstrated that best efforts have been made to ensure that a carrier has recovered savings offset payments through negotiated reimbursement rates as required by the Dirigo Health Act. As the Hospital Study Commission stated in its report to the Maine Legislature, insurers have an obligation to use their purchasing power to obtain excellent quality care, to broker lower prices and return most savings resulting from reduced prices to their customers. The Commission's report is Attachment 15 to the Dirigo Filing. My SOP calculations do not take into account how well the insurance carriers have performed their brokering role.

Q: You mentioned the Hospital Study Commission. What was the Hospital Study Commission?

A: The Hospital Study Commission was created by the Dirigo Act and charged with examining Maine's community hospitals, focusing on quality, access and costs.

Q: Did you participate in any way in the work of the Commission?

A: Yes, I did. I provided the Commission with historic information on hospital costs, profits, uncompensated care, utilization, organizational structures and financial performance. I wrote an article for the Maine Policy Review summarizing some of the findings from these analyses. With regard to hospital costs, I participated in the discussions both within the Commission and separately directly with David Winslow of the Maine Hospital Association regarding what the Commission should recommend as target measures and how values for these targets should be determined in future years.

Q: Are there any particular meetings of the Commission that you believe are particularly relevant to this proceeding?

A: Yes. On September 27, 2004, David Winslow of the Maine Hospital Association, Jim Parker of Anthem and I made presentations and participated in discussions on the status of voluntary targets for Maine's hospitals.

Q: Did you prepare a report regarding the work you did for the Dirigo Health Agency?

A: Yes, I did. My report, as revised, is titled "Revised Final Report to Dirigo Health Agency: Savings Offset Payment: Voluntary Operating Profit Limit" dated October 13, 2005 is attached as Kane Exhibit B. In addition, I did a report, as revised, titled, "Calculation of Savings Offset Payment Related to Limits on the Growth in Cost per

Case-Mix Adjusted Discharge” dated October 13, 2005, which is attached as Kane Exhibit C.

Q: Did anyone assist you in your work?

A: I had primary responsibility, but was assisted by the Maine Hospital Association, which provided the template and 2003 data for calculating hospital expenses in the CMAD. Michael Kane assisted in developing the electronic COM data base from hard copy hospital audited financial statements. Mercer assisted in the review of my calculations.

Q: Are there any changes you wish to make to Kane Exhibit B or Kane Exhibit C?

A: No.

Q: Do you adopt Kane Exhibit B and Kane Exhibit C as part of your testimony?

A: Yes, I do.

Dated: October 21, 2005

Respectfully submitted,

Nancy M. Kane, D. B. A.

1 STATE OF MAINE  
2 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION  
3 BUREAU OF INSURANCE  
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7 IN RE: )  
8 Review of Aggregate Measurable Cost )  
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15 Docket No. INS-05-700 )  
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TESTIMONY OF  
F. KEVIN RUSSELL

19 F. Kevin Russell called as a witness by the Board of Directors, Dirigo Health,  
20 testifies as follows:

21 Q: Please state your name, occupation, employer, and business location.

22 A: My name is F. Kevin Russell. I am a consulting actuary and a principal in  
23 Mercer's Government Human Services Consulting Practice. My office is located  
24 in Phoenix, Arizona.

25  
26 Q: Mr. Russell, please describe your educational and professional background.

27 A: My educational and professional background is set forth in the attached  
28 curriculum vitae, Russell Exhibit A. As an actuary for the Mercer Government  
29 Human Services Consulting Practice, I have had primary actuarial involvement in  
30 the financial analysis and/or managed care rate development for publicly  
31 sponsored health care programs in a number of states. Also, let me be clear that  
32 my testimony today is for my work at Mercer on the Dirigo program; I am not  
33 speaking on behalf of the American Academy of Actuaries.

34

35 Q: Mr. Russell, did you participate in the preparation of Mercer's report, which is  
36 labeled Schramm Exhibit B and is Attachment 11 to the Dirigo filing?

37 A: Yes, I did.

38

39 Q: I am going to show you Schramm Exhibit B. Is this the report you are referring  
40 to?

41 A: Yes, it is.

42

43 Q: On which of the initiatives identified in the report will you be providing  
44 testimony?

45 A: I will testify on the Insurance Carrier Initiative and the Uninsured Initiatives.

46

47 Q: Mr. Russell, does the report provide details on the calculations for the Insurance  
48 Carrier Initiatives?

49 A: Yes, it does. We measured savings of \$11.2 million, with \$11.0 million attributed  
50 to the largest health insurance carrier in the state, Anthem Health Plan of Maine.

51

52 Q: Mr. Russell, have you reviewed the results of the payor group's calculation of the  
53 Insurance Carrier Initiative ?

54 A: Yes, I have.

55

56 Q: I am going to show you what has been marked as Russell Exhibit B and is  
57 Attachment 7 to the Dirigo filing.

58 Q: Is this the calculation you are referring to?

59 A: Yes, it is.

60

61 Q: Would you describe the differences between that calculation and Mercer's  
62 calculation?

63 A: Yes. The payor group's calculation used underwriting gain from all lines of  
64 accident and health business and used all federal income tax, both tax on the  
65 underwriting gain and tax on the investment gain. Mercer's calculation used only  
66 underwriting gains from lines of business that were, in our opinion, directly  
67 connected to Dirigo's Medical Benefit Cost Initiatives. For those carriers that  
68 filed the Orange Blank (Health), we excluded the Non-Health line of business, as  
69 well as the Disability Income line of business.

70

71 Q: Let me stop you there. What do you mean by the Orange Blank?

72 A: I mean the National Association of Insurance Commissioners statutory financial  
73 statement for health insurers. Its cover is orange.

74

75 Q: Mr. Russell, you may continue.

76 A: We excluded the Long Term Care, Dental Only, and Vision Only lines of  
77 business, since Dirigo did not focus on nursing homes, dental, or vision costs. We  
78 excluded the Medicare Supplement line of business because the allowed charge  
79 for hospital and professional provider services provided to traditional Medicare  
80 beneficiaries is determined by the Centers for Medicare and Medicaid Services  
81 (CMS), not a contract between the provider and the insurance carrier. We

82 similarly excluded Title XVIII Medicare and Title XIX Medicaid lines of  
83 business (risk contracts for Medicare and Medicaid), since reimbursement levels  
84 for these contracts are generally based on, or in consideration of, CMS and state  
85 Medicaid agency reimbursement schedules.

86

87 Q: What would have been the result in your calculations if you had included these  
88 lines of business?

89 A: To have included these lines of business would have resulted in a savings offset  
90 payment that used a base amount that was too large, since it would have included  
91 lines of business not directly affected by Dirigo's Medical Benefit Cost  
92 Initiatives.

93

94 Q: So, what lines of business remain?

95 A: The lines of business that remain are Comprehensive (Hospital & Medical),  
96 Federal Employees Health Benefit Plan, and Stop Loss. These lines of business  
97 include the medical insurance subject to the reimbursement level contracts  
98 between the carrier and the provider, so they are directly affected by Dirigo's  
99 Medical Benefit Cost Initiatives. We calculated the federal income tax used as a  
100 deduction to the underwriting gain as just that portion of the tax attributed to the  
101 underwriting gain on the selected lines of business, which excluded the tax on the  
102 underwriting gain on the excluded lines of business and excluded the tax on  
103 investment gain. The investment gain for a year is earned mainly on the original  
104 capital and retained earnings of the carrier, with only a small portion being earned  
105 on the cash flow from operations for the year.

106

107 Q: Are there other differences between the payor group calculation and Mercer's  
108 calculation?

109 A: Yes. There is a difference between the payor group calculation and Mercer's  
110 calculation in the calculation of a baseline underwriting gain net of federal income  
111 tax. The payor group's calculation uses equal weights for each year 2000 through  
112 2003. Mercer's calculation uses a dollar weighting. The estimate of the liability  
113 for claims incurred but unpaid has a direct dollar-for-dollar impact on the  
114 emergence of underwriting gain in a particular year. In Mercer's dollar weighted  
115 calculation, there is no effect from the estimation error in the liability for unpaid  
116 claims at the end of the years 2000, 2001, and 2002, since the end of year estimate  
117 becomes the beginning of year estimate for the following year.

118

119 Q: Again, let me stop you. What do you mean by estimation error in the liability?

120 A: At the time the financial statement is put together an accrual must be made for the  
121 cost of medical services rendered through the end of the accounting period that  
122 have not yet been paid as of the end of the period. By necessity, this must be an  
123 estimate, since many of the services will not yet have been billed, much less  
124 claims sent to the insurer or paid by the insurer. The difference between the  
125 estimated value used in the financial statement and the true value that will  
126 ultimately be revealed over the coming 18 to 36 or more months is the "error of  
127 estimation". The existence of this error of estimation does not necessarily mean  
128 that a blunder was made in a calculation, only that the ultimate revealed cost will  
129 not precisely match the estimate made earlier.

130

131 Q: Please continue.

132 A: For the payor group's calculation, the error of estimation for these liabilities does  
133 affect the result. Results for both methods are affected by the estimation error in  
134 the liability for unpaid claims at the beginning of 2000 and at the end of years  
135 2003 and 2004.

136

137 Q: Are there any other differences between the payor group method and Mercer's?

138 A: Yes. Mercer's calculation included only financial results from those carriers  
139 which affirmatively responded to the request from the Bureau of Insurance to  
140 limit their underwriting gain less federal taxes to 3 percent. Among those that  
141 responded affirmatively was Anthem Health Plan of Maine (Anthem), so Mercer  
142 included their results for years 2000 through 2003 in the base calculation. We did  
143 not include partial year 2000 financial results for Blue Cross Blue Shield of  
144 Maine, the predecessor organization to Anthem. Blue Cross Blue Shield was a  
145 not-for-profit carrier; Anthem is a for-profit carrier. In my opinion, the baseline  
146 underwriting gain calculation for a for-profit carrier is better made using for-profit  
147 data than including data from a time period when a predecessor organization  
148 operated as a not-for-profit. The payor group calculation for Anthem included  
149 Blue Cross Blue Shield results for partial year 2000.

150

151 Q: Mr. Russell, let's now move to the Uninsured Initiatives. Can you describe those  
152 initiatives?

153 A: Yes. These initiatives come directly from the Dirigo Act, which states that  
154 savings offset payments must reflect aggregate measurable cost savings, including  
155 any avoidance of bad debt and charity care cost to health care providers in this  
156 State, as a result of the operation of Dirigo Health and any increased enrollment  
157 due to an expansion in MaineCare eligibility occurring after June 30, 2004. The  
158 savings follow from a reduction in the need for cost-shifting, such as that which  
159 comes from a reduction in bad debt and charity care.

160

161 Q: What do you mean by cost-shifting?

162 A: When a provider, such as a hospital or physician, perceives that reimbursement  
163 from a source (such as the self-pay (uninsured), Medicare, or Medicaid) is  
164 insufficient, the provider may seek to charge its other customers (those covered  
165 by commercial insurance) higher amounts to make up for the perceived  
166 insufficiency.

167

168 Q: Thank you. Please continue.

169 A: The Uninsured Initiatives are a measurement of the indirect savings which result  
170 from a reduction in the need for cost-shifting. The need for cost-shifting is  
171 reduced when hospitals' need to charge private payers for the bad debt and charity  
172 care of the uninsured and under-insured is reduced. Mercer identified four  
173 potential savings initiatives, but was only able to provide estimated impacts for  
174 three of those initiatives in year one.

175

176 Q: What are those initiatives?

177 A: In the Mercer report, these initiatives are numbered 4, 5, 6, and 7. The three  
178 initiatives for which Mercer estimated the impact of the Dirigo program are: (4)  
179 reduction in bad debt and charity care due to the previously uninsured enrolling in  
180 DirigoChoice; (5) reduction in bad debt and charity care due to the previously  
181 under-insured enrolling in DirigoChoice; and (6) reduction in bad debt and charity  
182 care due to the previously uninsured enrolling in MaineCare/SCHIP (MaineCare  
183 Woodwork), which, when combined, resulted in savings of \$5.7 million for year  
184 one. In keeping with our guiding principles, consistent up-to-date data is not  
185 readily available at this time to estimate the impact of (7) the increase in private  
186 insurance. Therefore, Mercer has not included an estimated impact in year one for  
187 (7) and has recommended that the Board revisit this initiative in year two to  
188 determine if data is available to estimate the impact of this initiative.

189  
190 Q: Please explain what you mean by “woodwork”.

191 A: The “woodwork effect” is a term describing the increase in enrollment in  
192 Medicaid and S-CHIP programs not due to changes in the number of persons  
193 eligible by reason of income, but rather from those persons not enrolled although  
194 they meet the requirements (other than not having made application). The increase  
195 in publicity and/or new enrollment procedures results in these persons coming  
196 “from out of the woodwork” to make application and become enrolled. For  
197 example, publicity in mid-1998 concerning Indiana’s new S-CHIP program  
198 resulted not only in the expected enrollment of those eligible for S-CHIP, but also  
199 in an increase in Medicaid enrollment. The publicity for S-CHIP (with its less  
200 stringent income eligibility criteria) resulted in people applying who turned out to

201 be eligible, but had not previously applied, for Medicaid (with its more stringent  
202 income eligibility criteria). In particular, TANF Adult Medicaid enrollment,  
203 which had been on a steady downward track, reversed course and began monthly  
204 increases when S-CHIP enrollment began, even though S-CHIP was restricted to  
205 children 18 years old and younger.

206

207 Q: Mr. Russell, are there any changes you wish to make to your portions of the  
208 Mercer report?

209 A: Yes, I'd like to make a clarification on pages 17 and 18 to say that the  
210 Collectively Renewable category is where some, but not all, of the non-group  
211 medical insurance would be recorded. Also, on page 20 – the number of under-  
212 insured Mainers (34,475) was taken from a report provided by the Dirigo Health  
213 Agency on September 6, 2005 rather than the Household Survey prepared by the  
214 Institute for Health Policy of the Muskie School of Public Health. (Appendix H  
215 of the Mercer Report contains the correct source reference.)

216

217 Q: Mr. Russell, do you adopt the portions of Schramm Exhibit B concerning the  
218 Insurance Carrier Initiative and the Uninsured Initiatives as part of your  
219 testimony?

220 A: Yes, I do.

221

222 Dated: October 20, 2005

223

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F. KEVIN RUSSELL

224