

October 17, 2005

Via mail & 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

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 Dirigo Health Response to Second Information Request of the Superintendent.
3. Attachments 1 through 4.

Thank you for your assistance with this matter.

Yours very truly,

/s/William H. Laubenstein III

William H. Laubenstein, III
Assistant Attorney General

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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 17, 2005

Name of Party: Dirigo Health Board of Directors

Document Title: Dirigo Health Response to Second Information Request of the
Superintendent, w/Attachments 1 through 4.

Document Type: Response to Information Request

Confidential: No

Dated: October 17, 2005

Respectfully submitted,

/s/William H. Laubenstein

William H. Laubenstein, III
Assistant Attorney General

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

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS) **DIRIGO HEALTH RESPONSE TO**
DETERMINED BY DIRIGO) **SECOND INFORMATION REQUEST**
HEALTH FOR THE FIRST) **OF THE SUPERINTENDENT**
ASSESSMENT YEAR)
)
)
Docket No. INS-05-700)

The Board of Directors of Dirigo Health responds to the Second Information Request of the Superintendent of the State of Maine Bureau of Insurance dated October 11, 2005 as follows:

- (1) Please summarize the timeframes described in the Final Report in a table with the following structure: (i) One row for each savings component identified in the report; (ii) First column contains description of the savings component; (iii) Second column describes the time period in which the savings are incurred; (iv) Third column indicates the Dirigo program year to which the savings apply (iv) Fourth column describes the time period from which data were drawn for each of the data sources used in the calculation of that savings component; (v) Fifth column explains the rationale for using the SOP estimate from the time period identified in Column 2 as first year savings (e.g, savings from SFY04 as savings for SFY05).

Response No. 1: Attached is the completed above table:

(1)	(2)	(3)	(4)	(5)
Savings Initiative	Time Period in which savings occurred	Dirigo program year to which savings apply	Time Period from which data was drawn	Rationale for using the SOP estimate from time period in column (2) as first year savings
Consolidated Operating Margin (COM)	SFY04		HFYs adjusted to SFY01 - SFY04	
Case-Mix Adjusted Cost per Discharge (CMAD)	SFY04		HFYs adjusted to SFY00 - SFY04	
Voluntary Underwriting Gain (VUG)	CY04		CY00 - CY04	
Un- and Under-Insured	CY05		CY03?	
MaineCare and Private Woodwork	SFY05		CY03?	
Hospital CON/CIF	SFY04 & SFY05		SFY99 - SFY06 Approvals	
Non-Hospital CON/CIF	SFY04 & SFY05		SFY99 - SFY06 Approvals	
Hospital and Physician Fee Initiatives	Payments to be made 7/1/05 - 12/31/06		Hospital and Physician Fee Initiatives worksheet	

SFY = State Fiscal Year (e.g. SFY04 = 7/1/03 - 6/30/04)

CY = Calendar Year (e.g. CY04 = 1/1/04 - 12/31/04)

HFY = Hospital Fiscal Year (varies by hospital)

Inquiries Related to CMAD

- (2) Please verify that the CMAD calculation uses a case mix index calculated from all discharges, not just from Medicare discharges.

Response No. 2: CMI is based on all discharges. Documents responsive to request No. 2 are appended hereto as Attachment #1 and # 2.

- (3) Please explain how Dirigo determined savings shown in the SFY 2004 CMAD calculations are true savings and not just costs deferred until SFY2005 through delayed spending or accounting changes.

Response No. 3 P. L. 2003, chapter 469, Section F-1, Voluntary Limits to control growth of insurance and health care costs. As part of the Dirigo Reform, in order to control the rate of growth of costs of health care and health coverage, the Legislature asks the cooperation of health care practitioners, hospitals, and health insurance carriers. How hospitals achieve the 3.5% CMAD target – whether through increased volume, accounting changes, changes in supply contracts, or any other administrative change - is not addressed by the statute. In a voluntary system it is the responsibility of the market to ensure that savings are realized.

Inquiries Related to COM

Are the cost savings estimated in the COM savings calculation (which included three hospitals after exclusion criteria were applied) different from the dollar amount that would result if the same criteria had been applied to any other year? That is, if hospitals with margins averaging in excess of 3% in the three prior years, and a reduction to the margin in the following year relative to that average were chosen, would similar savings be shown even in the absence of Dirigo?

Response No. 4 The data necessary to calculate fiscal year-adjusted consolidated margins for 2000 or earlier in order to generate a three-year baseline for target years prior to 2004 was not prepared as it was not applicable.

Please provide a “hospital example” of the COM calculation, comparable to the one provided for CMAD on page 4 of Attachment 12A of the filing.

Response No. 5: Hospital A Dirigo-Fiscal-Year Adjusted Revenues, Expenses,
Operating Income:

	A	B	C	D
(1) Year	2004	2003	2002	2001
(2)Revenue	78587	69856.75	61855.25	42544.5
(3)Expense	75985.25	67664.25	59175.25	39920.25
(4))Operating Income	2601.75	2192.5	2680	2624.25
(5) Operating Margin	0.033107	0.031386	0.043327	0.061682

1. Average “baseline” operating margin is line 5, (Cols B+C+D)/3, or .0454.

2. 2004 “expected margin = baseline operating margin * 2004 Revenue (line 1 Col A): $.0454 * \$75,587 = \$3,573$
3. 2004 “actual margin” =line 4 Column A = \$2,602.
4. SOP - $\$3573 - \$2602 = \$971$.

Inquiries Related to Uninsured Savings Initiatives

Can you explain why the charges used in the bad debt and charity care calculations were not reduced to reflect the degree to which payments from commercial insurers are less than charges?

Response No. 6: P.L. 24-A M.R.S.A. §6913(3) says that “Savings offset payments must reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as the result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.” Charges were used in this calculation because that is how hospitals measure the cost of bad debt and charity care in their own hospital financial statements. We were determining what reduction would occur in those charges due to enrollment into DirigoChoice and MaineCare. In other words, in this calculation, bad debt and charity care costs, as measured by the hospitals, is reduced by charges (not an estimated payment amount) when those people enroll. Therefore, savings is the charges amount since this is the amount saved in the system when the uninsured and underinsured are enrolled.

Please provide the latest Dirigo enrollment reports used by the Dirigo health agency to monitor enrollment levels, with monthly enrollment data detail from inception to the most recent period for which data are available.

Response No. 7: Document responsive to Request No. 7 is appended hereto as Attachment #3.

Please explain in detail the rationale for applying Mercer's probability distribution to the estimates for bad debt and charity care – Is Mercer assuming that costs for increased service use due to insurance coverage should be included in the SOP? If not, what is the rationale? Also, please provide additional detail which shows all data and mechanics of the calculation.

Response No. 8: The claims probability distribution was applied to the initial per member per month (PMPM) amount to reflect the difference in bad debt and charity care risk between the average uninsured/underinsured person and those that would enroll in DirigoChoice or MaineCare. The count of persons used in this calculation includes all those who were uninsured/underinsured, including those who had no medical costs. It is Mercer's experience that those who enroll first when eligibility rules are expanded are those with higher than average expected costs, in part due to known medical conditions. This selection assumption recognizes only the level of utilization while uninsured/underinsured. The increased utilization due to availability of services after becoming insured, which is not counted in Mercer's calculation, is a separate matter that also should be considered in the expectation of costs for those covered by DirigoChoice. This is not included in Mercer's calculation because our intent is to only remove those bad debt and charity care costs that would be savings to the system.

In Appendix H (Step F)– Uninsured and Underinsured and Appendix L (Step

E) – MaineCare Woodwork show where the initial PMPM average cost is multiplied by the factor developed by the claims probability distribution to get the resulting PMPM cost for those expected to enroll. In other words, a 36% increase was made to the original PMPM average amounts to account for the selection effect of those electing to enroll. The claims probability distribution is presented in the last page of Appendix H. Data used to calculate the claims probability distribution was developed from Mercer’s proprietary database.

What is the rationale for assuming that 50% of MaineCare enrollments are due to Dirigo? Please provide detail, including the relationship between Dirigo and increasing MaineCare enrollment, and how secular trends in Medicaid eligibility were adjusted for in the calculation.

Response No. 9: This calculation was made to reflect the additional enrollment in MaineCare during the time period after June 30, 2004 per the statute. Mercer’s calculated the increase in MaineCare (and SCHIP) enrollment by comparing unduplicated counts of enrollees for SFY04 to SFY05. The total increase in MaineCare (and SCHIP) was an unduplicated count of 7,763 enrollees as shown in Appendix L. The 50% factor was used to take into account that only a portion of the growth was due to publicity surrounding Dirigo.

Is Dirigo calculating the savings for new MaineCare enrollees using the estimates it calculated based on charges? If so, should these charge-based amounts be reduced by the ratio of MaineCare reimbursements to charges? Please explain.

Response No. 10: As in the answer to Question 6 above, charges were used because that is how hospitals measure bad debt and charity care costs on the hospital financial statements. This bad debt and charity care cost is not reduced on those financial statements by estimates of MaineCare reimbursement to charges. A portion of that becomes savings when people enroll into DirigoChoice and MaineCare. Mercer is determining the loss amounts, as measured by the hospitals' accounting methods that will no longer exist due to people (who were incurring bad debt and charity care) who are now enrolling in MaineCare.

Inquiries Related to CON/CIF

In light of the wide year-to-year variations shown in Appendices M and N of Attachment 11 in the volume of CON projects prior to Dirigo, how can the variation in the year after Dirigo be attributed to Dirigo?

Response No. 11: Since there exists large variations from year to year as well as from one project to another, Mercer's approach was to use an averaging technique that combines first, second and third year costs to help smooth wide variations. We consistently applied this technique to both the base period (SFY01-SFY03) as well as the savings measurement period (SFY04-SFY05). We then projected what the costs would have been in the absence of Dirigo and compared that to what actually happened. The difference of projected costs to actual costs is the resulting savings.

The useful life of these projects is clearly more than three years, however since the data included in a CON application is only the first three years of operating

costs, we did not attempt to subjectively extrapolate the information beyond the first three years. Further, we would need to apply the CON data for the last few decades in order to review costs for the entire useful life for previous projects that would still show useful life for the time periods shown in Exhibit M & N.

The largest variation in costs for Exhibit M & N occurs during SFY04 in Exhibit M. This period covers SFY02-SFY04 using the averaging technique described above. The moratorium covers 5/03-5/04 and the CIF began on 1/1/05. The time period for the largest drop in cost overlaps the time period for the Moratorium and therefore is attributed to Dirigo under this methodology.

The spending in SFY 2004, as shown in the 2004 column of Appendices M and N, reflects CON approvals for SFY 2002, 2003, and 2004. Since only 2004 approvals could be affected by Dirigo, how can the overall spending level for 2004 be attributed to Dirigo? Could the relatively high hospital spending during the base period of 2001-2003 be partly attributable to the high volume of hospital CON approvals in 2001? Could the relatively low hospital spending level in 2004 and 2005 be partly attributable to the low volume of hospital CON approvals in 2003? Since the 2001, 2002 and 2003 approvals were already known, could a better projected level of 2004 spending have been determined by taking those approvals into account?

Response No. 12: Due to the large variation in the projects, Mercer used a three year smoothing technique to reduce the variations between years as well as across projects. The average base year costs were then projected using HMBI to SFY04 and SFY05. Under this approach, projected SFY04 costs include the average of the base period (SFY01-SFY03) trended at HMBI compared to what actually

happened in SFY04 on the approved CON applications. (The actual expense for these projects is not reported in the CON data.) The resulting savings of \$2.7 million are shown in Exhibit M.

The specific questions for number 12 tend to point to a different approach than the one described above. Alternative methodologies may exist which may or may not be reasonable.

Attachment 14 indicates that the CON moratorium applied to letters of intent between August 3, 2003 and May 4, 2003. Since this period fell within SFY 2004 and a higher volume of hospital CONs were approved in that year than in either of the previous two years, how can hospital savings be attributed to the moratorium? Were hospitals and other providers aware of the impending moratorium before it was imposed? If so, could they have avoided the impact by filing a letter of intent before August 3, 2003?

Response No. 13: The time period for the Moratorium is 5/2003-5/2004, not 8/3/2003-5/4/2003. May, June, and July 2003 were part of the moratorium by emergency order.

Since our method uses a three-year averaging approach and tends to be conservative as described above, savings are attributed to the Moratorium since actual costs for SFY04 covers SFY02-SFY04, which is more than the projected costs for SFY04.

The Dirigo Health Agency has no knowledge that hospitals and other providers were aware of the impending moratorium before it was imposed.

Please list the CON applications disapproved due exceeding the Capital Investment Fund (CIF). If there were none, how can savings be attributed to the CIF?

Response No. 14: There were no CON applications disapproved during the CIF.

However, four letters of intent were withdrawn during SFY05. These four projects did not include operating costs, but the capital costs were very high for three of the four withdrawn projects. Rather than attempting to speculate what the first three years of operating costs would have been for these projects, Mercer only used approved projects that included three years of operating costs in performing the calculations. This further illustrates the conservative and reasonable approach used for the CON/CIF.

Inquiries Related to Physician Fee Initiatives

Please provide the rationale for assuming that physicians cost shift (i.e., that they have the power to increase their commercial fees when government fees are decreased), and that these fee amounts can be decreased by commercial payers when government fees increase. Please include discussion of the manner in which commercial physician fees are established in Maine, and references to research literature that provides evidence of a cost-shifting process operating within the physician services sector.

Response No. 15: Most commercial health insurance companies pay for physician services on the basis of a fee schedule. These fee schedules, in turn, are predicated on the usual and customary (sometimes alternatively referred to as reasonable and customary) charges for services in a geographic area, with the insurer paying a percentage of the prevailing fee, with the upper limit on payment being the actual charges levied for a service. To our knowledge, actual payment rates utilized by commercial payers in this

state are not publicly available because they are proprietary. As noted by the Bureau of Insurance on its website (www.maine.gov/pfr/ins/glossary.htm), insurers may contract with an independent service to conduct surveys of charges in a given geographic area; alternatively, an insurer may simply rely on its own claims experience to track prevailing charge practices.

There are three notable exceptions to this practice. The first relates to physician payments under risk contracts related to coverage by Health Maintenance Organization (HMO) plans. Although there can be a range of contractual arrangements between the physician providers and the plan itself, one such arrangement can provide a capitation payment to participating physicians for each HMO member enrolled in any given physician practice. That capitation rate does not vary with the volume of service provided by the participating physician to an enrolled member; it is simply a flat, monthly fee paid by the plan to the doctor for caring for the plan enrollee. There are variations in this type of payment arrangement ranging from a full risk agreement (which would meet the description set out above) to a modified risk agreement that might be as simple as a small monthly fee paid to the plan member's primary care physician for the management and coordination of the member's care, with all other services reimbursed on a fee for service basis. While Maine has had some experience with full risk HMO contracting, most of the managed care activity in this state falls into the category of modified risk agreement, with participating physicians actually at little, if any, risk at all.

The second exception to the use of usual and customary charges as a basis for payment is the existence of global fees established between some commercial insurers and certain physician practices for the provision of certain cardiac care. These arrangements blend payment for professional services and hospital services into a single, global contracted

payment for complex cardiac surgical interventions. The increase in physician consolidation in some Maine markets has increased pressure by physicians for specially negotiated fee arrangements (Dykman A and Hess P. “Survey of Health Plans Concerning Physician Fees and Payment Methodology.” Medicare Payment Advisory Commission, June 2003.

The third exception pertains to the influence of “Rule 850” which is unique to Maine. Briefly, this insurance rule requires plans’ provider networks to satisfy minimum access standards. In order to meet those standards, plans may find they have to pay providers – including physicians and, in particular, specialists – higher rates than they would otherwise pay, to ensure their members have timely, local access to care.

The use of usual and customary charges for particular geographic areas does not leave physicians without influence over the payment rates. Physician practices are businesses like any other. Charges for particular services are established on the basis of the cost of producing services – including supplies, labor (including the physicians’ salaries), insurance, billing and so on – as well as the cost related to losses attributable to bad debt and charity care or to shortfalls in payments made by government payers. While the base cost of producing one 15 minute increment of service may be \$60, the practice wishing to remain in business will mark up the base price to cover the costs associated with uncollectible accounts. To the extent these costs are *not* covered by an insurance plan’s payment rates will influence a practice’s decision regarding participation in the plan’s network.

A major survey conducted for the Medicare Payment Advisory Commission and cited above found that health plan identify three factors when establishing physician payment

rates. These are: the impact of the payment rates on claims costs and premium levels; the impact of the payment rate on the plan's ability to maintain an adequate physician network; and the competitiveness of the payment rate *vis a vis* competitors' payment rates.

The consolidation of physicians into larger negotiating blocs in Maine's urban areas and the influence of Rule 850 in Maine's more rural markets introduce supply side pressure into the marketplace, providing physicians with the capacity to ensure that all of the costs of producing services – including bad debt and charity care – are being met by those paying for care.

Research shows that there are two ways in which low public payor reimbursement to non-hospital physicians can increase cost shifting: (1) direct cost shifting (in which physicians secure higher reimbursement from private payors), and (2) indirect cost shifting (decreased access due to physicians' seeing fewer public pay patients in response to low payment rates, which subsequently causes hospitals to face more bad debt and charity care). Relevant citations are listed below.

1. "Survey of Health Plans Concerning Physician Fees and Payment Methodology," Prepared For the Medicare Payment Advisory Commission by Zachary Dyckman, Ph.D. Peggy Hess, MHA, June 2003

2. "Physicians' Responses to Medicare Fee Schedule Reductions," J.M. Mitchell, J. Hadley, and D.J. Gaskin, *Medical Care* (October 2000): 1029–1039

3. “Can Hospitals And Physicians Shift The Effects Of Cuts In Medicare Reimbursement To Private Payers?” Paul B. Ginsburg, Health Affairs, web exclusive, 08 October 2003.

Inquiries Related to Time Value of Money

(17) Please show the calculations of \$14.0 million of savings to hospitals due to the time value of money. This response should include the following:

a) A schedule of amounts and date(s) of payments in the absence of Dirigo.

Response: Not applicable.

b) A schedule showing the assumed revised date(s) of payments that reflect the earlier payment dates because of the impact of Dirigo.

Response: See response to Request No. 17 (f).

c) These schedules of amounts should be broken out by fiscal year.

Response: See response to Request No. 17 (f).

d) What are the sources of funds for these payors that enable them to accelerate the timing of payments by 36 months as asserted in the filing?

Response: The source of funds is the State of Maine. The funding that made it possible to accelerate the timing of payments by 36 months was requested by the Governor, increased by the Legislature, and reflects recommendations of the Commission to Study Maine’s Hospitals, and was approved by the Legislature as part of the budget for the FY06/07 biennium. The Commission to Study Maine’s hospitals was created as part of the Dirigo initiative.

- e. What is the basis for the comment: “the hospitals were not planning on receiving any of this money” in Page 8 of Dr. McAfee’s cover letter of September 19?

Response: The statement on Page 8 of Dr. McAfee’s September 19, 2005 letter to Superintendent Iuppa refers to a table that summarizes the types of hospital settlements included in the analysis: “...hospital payment amounts, those amounts which are considered new money (ie. the hospitals were not planning on receiving any of this money)...” The phrase within the parenthetical specifically refers to the historic settlements. The basis for this comment is that due to the age of these claims and the fact that they were disputed, it would be unlikely that hospital financial statements and/or budgets would reflect these payments.

- f. Please summarize the amounts appropriated by the Legislature for the purpose of settling hospital obligations in the various budget periods that are affected. This schedule should have enough detail to allow an observer to confirm that the Legislature has made available an incremental or additional amount of funds as asserted in Dr. McAfee’s letter of September 19.

Response: The amounts for the historical settlements for SFY99 – SFY02 were paid in full on September 30, 2005; 36 months earlier than required.

For the PIPS, document responsive to Request No. 17 (f) is appended hereto as Attachment #4.

(18) Please confirm that the payments in the time value of money analysis are all from Maine Care and not from any other payors.

Response No. 18: Confirmed.

Dated: October 17, 2005

Respectfully submitted,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

CERTIFICATE OF SERVICE

I, William H. Laubenstein, III, Assistant Attorney General for DIRIGO Health, do hereby certify that on this date the foregoing document was served on all counsel of record via U.S. first class mail, postage prepaid, and electronic mail as follows:

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Dated: October 17, 2005

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