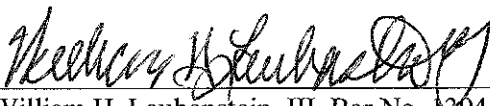


STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION  
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE )  
MEASURABLE COST SAVINGS )  
DETERMINED BY DIRIGO ) FILING COVER SHEET  
HEALTH FOR THE THIRD )  
ASSESSMENT YEAR )  
)  
)  
Docket No. INS-07-900 )

TO: Eric A. Cioppa, Acting Superintendent  
Attn: Vanessa J. Leon  
Bureau of Insurance  
Maine Department of Professional and Financial Regulation  
34 State House Station  
Augusta, ME 04333-0034

Date Filed: August 29, 2007  
Party: Dirigo Health Agency  
Document: Brief of Dirigo Health  
Document Type: Brief  
Confidentiality: None

  
William H. Laubenstein, III, Bar No. 1394  
Assistant Attorney General  
Office of Attorney General  
6 State House Station  
Augusta, ME 04333-0006  
(207) 626-8800

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

IN RE:           REVIEW OF AGGREGATE            )  
                  MEASURABLE COST SAVINGS )           BRIEF OF  
                  DETERMINED BY DIRIGO    )           DIRIGO HEALTH  
                  HEALTH FOR THE THIRD     )  
                  ASSESSMENT YEAR         )

DOCKET NO. INS-07-900

**INTRODUCTION**

This matter is before the Superintendent of Insurance pursuant to 24-A M.R.S.A. § 6913(1), which provides for the Superintendent’s review of the determination of aggregate measurable cost savings (“AMCS”) by the Dirigo Health Board of Directors (the “Board”). Following a public hearing, the Superintendent is to decide whether the AMCS determined by the Board is reasonably supported by the evidence in the record.

The Board made a determination of AMCS on July 26, 2007 after an adjudicatory hearing on July 23 and 24, 2007. The Board filed its determination and the record with the Superintendent on August 6, 2007. The proceedings before the Board prior to the filing with the Superintendent are fully set forth in its decision and will not be repeated here.

The Board determined savings in three initiatives: Hospital Savings (Case Mixed Adjusted Discharge) in the amount of \$70,600,000; Uninsured/Underinsured in the amount of \$6,343,400; and Health Care Provider Fees in the amount of \$5,200,000. From the total amount determined, the Board deducted \$4,000,000 because of overlap of the initiatives. The final amount of AMCS determined by the Board was \$78,143,400.

In accordance with a procedural order issued by the Superintendent on August 7, 2007, the Maine Automobile Dealers Association Insurance Trust (the “Trust”), Maine Association of

Health Plans (“MAHP”), Maine State Chamber of Commerce (the “Chamber”), and Consumers for Affordable Health Care (“CAHC”) filed briefs with the Superintendent on August 21, 2007. In their briefs, the Trust, MAHP and the Chamber (hereinafter “Payor Intervenors”) raise a number of issues with regard to the Board’s determination of AMCS. These issues include the reasonableness of the projection methodology adopted by the Board to determine savings from Case Mixed Adjusted Discharge (“CMAD”); compliance with statutory provisions and reasonableness of determination of savings from Uninsured/Underinsured; and reasonableness of attributing any savings to Health Care Provider Fees.<sup>1</sup>

For the reasons set forth below, the Superintendent should reject the arguments of the Payor Intervenors and find that the record reasonably supports the Board’s determination of AMCS in the amount of \$78,143,400.

#### **STANDARD OF REVIEW**

The statute governing the Superintendent’s review sets the standard of review: “The superintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the Board are reasonably supported by the evidence in the record.” 24-A M.R.S.A. § 6913(1) (C). The Law Court has analyzed the reasonableness standard in the context of arbitrary and capricious action.

Arbitrary or capricious action on the part of an administrative agency occurs when it can be said that such action is unreasonable, has no rational factual basis justifying the conclusion or lacks substantial support in the evidence. Hollon v. Pierce, 1968, 257 Cal.App.2d 468, 64 Cal.Rptr. 808, 815; Olson v. Rothwell, 1965, 28 Wis.2d 233, 137 N.W.2d 86, 89.

---

<sup>1</sup> The Payor Intervenors also claim that the proceedings before the Board did not comport with due process requirements. Since the Superintendent does not have the authority to rule on constitutional issues, the Board does not address this claim. The Board notes, as the Hearing Officer did in his order of July 15, 2007, that the Payor Intervenors are not strangers to these proceedings, had five weeks notice of the hearing before the Board and a full opportunity to present and cross-examine witnesses and to introduce exhibits. Under these circumstances, due process requirements were satisfied.

The party asserting arbitrariness and unreasonableness of action in the exercise by administrative officials of the police power of the State under a statute valid on its face has the burden of establishing the invalidity of the administrative action. Regularity is presumed. All legal intendments are in its favor. Its decision will be assumed to have been taken with full knowledge of material facts and in justification thereof. Milwaukie Company of Jehovah's Witnesses v. Mullen, 1958, 214 Or. 281, 330 P.2d 5, 11.

*Central Maine Power Company v. Waterville Urban Renewal Authority*, 281 A.2d 233, 242 (Me. 1971); cited with approval in *Help-U-Sell, Inc. v. Maine Real Estate Commission*, 611 A.2d 981, 984 (Me. 1992).

Under the holdings in these cases, the threshold for satisfying a “reasonableness” standard is quite low, and the burden on parties seeking to persuade the Superintendent that the Board’s determination is unreasonable is, conversely, quite high. This standard is not met by a demonstration that the Board could have reached a different conclusion; it is satisfied only if it can be shown that the Board’s determination has no rational factual basis in the record.

The current posture of this matter, as established by the legislature and the procedural orders of the Superintendent, establishes the Superintendent as a reviewing authority. As a reviewing authority, the Superintendent may not substitute his judgment for that of the Board and must approve findings of fact supported by substantial evidence. *International Paper Co. v. Board of Environmental Protection*, 1999 ME 135, ¶ 29, 737 A.2d 1047, 1054. The Superintendent is to give deference to the Board’s interpretation of a statute administered by it, unless the statute plainly compels a contrary result. *Thacker v. Konover*, 2003 ME 30, ¶ 14, 818 A.2d 1013, 1019 (citations and quotation marks omitted); *Maine Association of Health Plans v. Superintendent of Insurance*, 2007 ME 69, ¶ 46, \_\_\_ A. 2d \_\_\_. The burden of proof rests with the parties who seek to overturn the Board’s determination. *International Paper Co. v. Board of Environmental Protection*, 1999 ME 135, ¶ 11, 737 A.2d at 1050.

## ARGUMENT

### **I. The projection methodology for determining savings from CMAD is reasonable.**

This is the third year that the Board and the Superintendent have been faced with the daunting task of determining AMCS in accordance with 24-A M.R.S.A. §6913 and this is the third year that the Board has determined savings from CMAD using the projection methodology. The Superintendent approved savings from CMAD using the projection methodology in the first and second assessment years.

Simply put, and as explained in detail in the schramm-raleigh (“srHS”) Report to the Dirigo Health Agency for the third assessment year, the projection methodology projects the rate of increase in cost of hospital services from a base period and then compares the projected rate of increase with the actual increase in the year under consideration. AR 5322-5324. The methodology has been adjusted substantially since first introduced during proceedings for the first assessment year, and as adjusted this year in response to concerns expressed by the Superintendent and the Payor Intervenors, reasonably measures savings from hospitals’ efforts to limit the growth in CMAD. AR 5310-5313. The methodology was not developed from whole cloth by Dirigo Health or srHS. Rather, the methodology was developed by stakeholders as a way to determine if hospitals were meeting the voluntary targets established by the Legislature. AR 5414.

Payor Intervenors argue that because the methodology was not developed for the purpose for measuring AMCS it is not appropriately used as a tool for this purpose. While this argument on its face may have some appeal, standing alone, it does not warrant rejection of the methodology. This is particularly true since the Superintendent has found reasonably supported

by the evidence savings from CMAD in the first and second assessment years and the since to the extent hospitals are able to limit costs, they are in a position to reduce charges, a reduction that is then available to be used for the savings offset payments made by insurers and third party administrators.

A. Base Year. In his decision for the second assessment year, the Superintendent noted that “the further removed the year being measured is from the base period, the more tenuous the connection and the more questionable the assumption that all subsequent changes are related to Dirigo.” AR 2990-2991. In response to this concern of the Superintendent, srHS adjusted the base period for measuring CMAD by adding 2004 to the prior years’ base period of 2000-2003. This brings the base period within two years of the year being measured, the same interval accepted as reasonable by the Superintendent in the second assessment year.

In order to appropriately measure growth in CMAD in the absence of Dirigo, srHS adjusted actual CMAD for 2004 by adding the \$33.4 million savings from CMAD approved by the Superintendent for 2004, the first assessment year. While Payor Intervenors do not dispute the appropriateness of such an adjustment, they argue that the non-Dirigo related savings they calculated for 2003, using a base period of 1999-2002, should be added to the base period figure used for 2003. This argument ignores the fact that the purported savings are not Dirigo related, is subject to the “selectivity of data” objection raised by the Payor Intervenors to question the reasonableness of the methodology adopted by the Board and should be rejected by the Superintendent.

Intervenor Payors also argue that a more reasonable approach to the base period adjustment for Dirigo related savings would be to include 2005 in the base period and adding the \$14.5 million approved by the Superintendent for 2005, the second assessment year, rather than

the \$33.4 million, since the use of a more recent figure for the savings more accurately portrays the experience in Maine. A major flaw in this argument, aside from “selectivity of data,” is that the \$14.5 million is not an accurate reflection of experience in Maine in 2005. That number represented a compromise to account for perceived shortcomings in the methodology used for the second assessment year—shortcomings that have been addressed this year—and was derived from incomplete data used in calculating savings from CMAD. The evidence in this case shows that when calculated using actual data (and using the median as the measure of central tendency), the savings from CMAD for 2005 was \$43.8 million. AR 5326-5327.

Finally, the Board notes that srHS performed a number reasonableness checks, including a calculation of savings using different base periods and different measures of central tendency. All of these checks showed savings in CMAD. AR 403,4873-4874, 5313. These checks undermine the argument that srHS was selected the only base period that produced savings.

B. Disparity between CMAD savings for second assessment year and savings for third assessment year. Payor Intervenors argue that the methodology is unreasonable because its application produced widely disparate results for the second and third assessment years. A review of the record in this case shows, however, that a valid comparison cannot be made between the savings of \$14.5 million determined by the Superintendent to be reasonably supported by the evidence in the second assessment year and the \$70.6 million approved by the Board for the third assessment year. The reasons a valid comparison cannot be made, in addition to the adjustment to the base period discussed above, are as follows:

1. Forecast of future growth using the mean rather than the median. In the second assessment year, the Board and the Superintendent determined savings from CMAD using the median as the “measure of central tendency.” The median was used in order to offset

criticisms of the estimated savings derived by Dirigo Health's consultant for the second assessment year. AR 2983. The Superintendent recognized, however, and the Board agrees, that with a limited number of data points the median is a poorer measure of central tendency than the mean. AR 2981, 567,570-571. Accordingly, srHS used the geometric mean to estimate savings for the third assessment year and demonstrated in its report to Dirigo Health that the geometric mean is a more accurate way of predicting future growth in the cost of services. AR 5325-5326, 5344-5346.

2. Accounting for cost-based reimbursement. One of the criticisms of the estimate for savings from CMAD in the second assessment year was the failure to adjust for government reimbursements that are cost-based, including Medicare and Medicaid costs for critical access hospitals and Medicaid hospital outpatient costs in non-critical access hospitals. srHS has adjusted SFY 2006 expenditures to account for these government reimbursements. AR 5311, 5324 and Appendix E to srHS Report, AR 5342. srHS also took into account a criticism made by Payor Intervenors regarding the calculation of the number of discharges and adopted the Payor Intervenors's method to calculate discharges even though this method results in a lower, and thereby more conservative, discharge figure. AR 5323-5324.

3. Adjusting for hospital tax. In the Second Assessment Year, Dirigo Health's consultant did not adjust hospital expenses to account for the hospital tax. srHS made an adjustment for the hospital tax in estimating savings from CMAD for the third assessment year. The adjustment was made for the net cost of the hospital tax for the years of the tax--2004, 2005 and 2006. AR 5311, 5324 and Appendix E to srHS Report, AR 5342.

The inclusion of an additional year in base period, the use of the geometric mean as the measure of central tendency, the accounting for cost-based reimbursement and the

adjustment made for the net cost of the hospital tax have substantially improved the methodology for estimating savings from CMAD and result in an estimate of savings of \$70.6 million that is reasonably support by the record and should be approved by the Superintendent.<sup>2</sup>

The Board therefore requests that the Superintendent find that savings from CMAD in the amount of \$70.6 is reasonably supported by the evidence.

**II. Methodology to estimate savings from Uninsured/Underinsured is reasonable.**

srHS employed a new methodology for estimating savings from enrollment of persons in DirigoChoice who were previously uninsured or underinsured and savings from enrollment of persons in MaineCare as a result of the expansion of eligibility who were previously uninsured or underinsured. The new methodology measured “new money” in the health care system based on claims incurred. AR 5314-5315, 5328-5321 and Appendix H of the srHS Report, AR 5347-5349. The Board accepted the “new money” approach recommended by srHS but estimated savings based on calculations proposed by Jack P. Burke, principal and consulting actuary at Milliman. Mr. Burke made some changes to the methodology, the most critical of which were an adjustment (“induced utilization”) for an increase in demand for services and an adjustment for new money that is actually available for the savings offset payment (“savings available”). AR 6777-6779.

Payor Intervenors raised a number of concerns about the assumptions and calculations made by srHS, including the inclusion of pharmacy claims and the definition of uninsured. The adoption by the Board of the calculations made by Mr. Burke renders moot most of these concerns since Mr. Burke made adjustments to account for the variability of medical claims,

---

<sup>2</sup> MAHP proposed an alternative methodology that purported to compare growth rates on an annual basis and working from this premise argued that since the growth rate for 2005-2006 was substantially the same as the rate for 2004-2005, the savings from CMAD for 2006 should also be substantially the same. AR 6956. The flaws in this methodology, as pointed out by Steve Schramm, managing director of srHS and by Jack P. Burke, render the methodology unreasonable. AR 350-351 and AR 344.

which include pharmacy claims; made adjustments for persons who are only uninsured for a portion of a year; and made adjustments for the fact that only a portion of underinsured services are uncompensated. AR 6780-6782.<sup>3</sup>

The Board therefore requests that the Superintendent find that savings from the Uninsured/Under-Insured in the amount of \$6,343,400 is reasonably support by the evidence.

### **III. Provider fees reduced the need for cost shifting.**

The Board approved savings from an increase in Prospective Interim Payments (“PIP”) to hospitals and an increase in fees paid to physicians. As in the first and second assessment years, the savings from PIP is based on the time value of money but calculated for the third assessment year on present value basis as directed by the Superintendent in year two. AR 5316-5317, 5332-5333. The savings from increased physician fees is based on the increase in reimbursement in CY2007. srHS included in its estimate, however, only the reimbursement for the first six months of CY2007. AR 503.

Payor Intervenors, as in prior years, object to any saving from the PIP payments, arguing that the payments represent amounts already due, address cash flow and do not represent an increase in revenue available to reduce the need for cost shifting. They also argue that to the extent the increase in payments are, or can be invested, Medicaid regulations require that investment income be offset against interest expense and are used in the CMAD calculation. Notwithstanding such objections, the Superintendent approved saving from the increase in PIP payments in prior years and the Board requests that savings from the increase in PIP payments be approved for the third assessment year.

---

<sup>3</sup> Payor Intervenors also argue the “new money” approach is contrary to the plain language of the statute. The Board disagrees. The statute does not state how bad debt and charity care is to be measured. The “new money” approach, measuring as it does claims paid, is a reasonable method of determining the reduction in the cost of bad debt and charity care.

With regard to physician fees, Payor Intervenors, once again, object that the increase in fees is long overdue and that to the extent physicians must turn over 100 percent of the increase to Dirigo Health as a savings offset payment, there is no opportunity for cost shifting. The Board acknowledged the concerns of the Payor Intervenors with regard to the ability of physicians to pass on to consumers and insurers the full increase in fees and made a reduction in the amount of savings calculated by srHS. AR 9.

The Board therefore requests that the Superintendent find that savings from the increase in PIP payments in the amount of \$3.7 million and savings from the increase in physician fees in the amount of \$1.5 million are reasonably support by the evidence.

#### **IV. Overlap.**

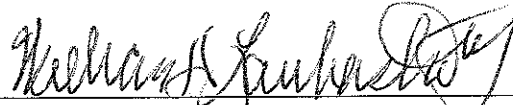
In recognition of the potential overlap in the various saving initiatives, srHS and the Board reduced savings by \$4.0 million. AR 5318-5320. The \$4.0 million calculation was based on srHS estimate of savings from CMAD in the amount of \$70.6 and savings from Uninsured/Under-Insured in the amount of \$14.0. The reduction of savings from Uninsured/Under-Insured by the Board from \$14.0 million to \$6,343,400 would result in a reduction in the overlap amount, and thereby necessarily raise the total of AMCS. The record does not contain a calculation of AMCS taking into account the reduction Uninsured/Under-Insured and the impact on the Overlap and the total AMCS. In light of this, the Board suggests that it would be reasonable not to adjust AMCS for the reduction in Uninsured/Under-Insured.

**CONCLUSION**

For the foregoing reasons, the Board requests that the Superintendent find that AMCS in the amount of \$78,143,400 is reasonably supported by the evidence in the record.

Respectfully Submitted,

Dated: August 29, 2007



William H. Laubenstein, III, Bar No. 1394  
Assistant Attorney General  
Office of Attorney General  
6 State House Station  
Augusta, ME 04333-0006  
(207) 626-8800

Counsel for Dirigo Health Agency

**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:

1. The original and two (2) hard copies via U.S. Mail addressed to:

Eric A. Cioppa, Acting Superintendent  
Attn: Vanessa J. Leon, Docket No. INS-07-900  
Bureau of Insurance  
Maine Department of Professional and Financial Regulation  
34 State House Station  
Augusta, Maine 04333-0034

2. One (1) hard copy via mail addressed to the Superintendent's legal counsel:

Thomas C. Sturtevant, Jr., AAG  
Office of the Attorney General  
6 State House Station  
Augusta, ME 04333-0006

3. One (1) hard copy via U.S. Mail addressed to the Superintendent's consultant:

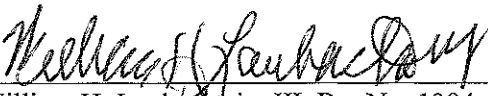
John Kelly  
Compass Health Analytics, Inc.  
477 Congress St., 7<sup>th</sup> Fl.  
Portland, ME 04101

4. One (1) identical electronic copy addressed to the following pursuant to the August 7, 2007 Order on Intervention and Procedures and the parties' Designation for Service List filed in this matter:

Vanessa J. Leon	<a href="mailto:vanessa.j.leon@maine.gov">vanessa.j.leon@maine.gov</a>
Thomas C. Sturtevant, Jr.	<a href="mailto:tom.sturtevant@maine.gov">tom.sturtevant@maine.gov</a>
Jennifer Willis	<a href="mailto:jennifer.willis@maine.gov">jennifer.willis@maine.gov</a>
John Kelly	<a href="mailto:jck@compass-inc.com">jck@compass-inc.com</a> and <a href="mailto:jh@compass-inc.com">jh@compass-inc.com</a>

Mia S. Poliquin Pross, J.D.	<a href="mailto:mpross@mainecahc.org">mpross@mainecahc.org</a>
William H. Stiles, Esq.	<a href="mailto:wstiles@verrilldana.com">wstiles@verrilldana.com</a>
Roy T. Pierce, Esq.	<a href="mailto:rpierce@preti.com">rpierce@preti.com</a>
D. Michael Frink, Esq.	<a href="mailto:dfrink@curtisthaxter.com">dfrink@curtisthaxter.com</a>
George M. Linge, Esq.	<a href="mailto:glinge@curtisthaxter.com">glinge@curtisthaxter.com</a>

Dated: 8/29/07

  
\_\_\_\_\_  
William H. Laubenstein, III, Bar No. 1394  
Assistant Attorney General  
Office of Attorney General  
6 State House Station  
Augusta, ME 04333-0006  
(207) 626-8800