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FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

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Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

Christopher T. Roach

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

Docket No. INS-08-900

**IN RE: REVIEW OF AGGREGATE MEASURABLE
COST SAVINGS DETERMINED BY DIRIGO HEALTH
FOR THE FOURTH ASSESSMENT YEAR**

PRE-HEARING BRIEF OF ANTHEM HEALTH PLANS OF MAINE, INC.

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Pursuant to the Superintendent’s Notice of Pending Proceeding and Hearing dated July 10, 2008 and Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures dated August 18, 2008, Anthem Health Plans of Maine, Inc. d/b/a Anthem Blues Cross and Blue Shield (“Anthem BCBS”) submits this Pre-Hearing Brief. Anthem BCBS intervened in this proceeding not to advocate for a specific dollar amount of aggregate measurable cost savings (“AMCS”) that should be found to have resulted from the operation of the Dirigo Health Reform Act (“Dirigo Act”), but rather to ensure that the AMCS methodologies are (1) reasonable and credible; (2) designed to calculate those aggregate savings that are attributable to the operation of Dirigo Health; and (3) reflect actual savings to the consumers and employers who will actually pay the savings offset payment (“SOP”).

Anthem BCBS had hoped that the methodologies and savings figures determined by the Board of Directors of the Dirigo Health Agency (“DHA Board” or “Board”) would reasonably satisfy these principles such that the SOP amount that will be charged to Anthem BCBS members (and all those with private medical coverage in Maine) is no larger than the savings actually accrued to those members as a result of the operation of Dirigo Health. The Board’s proposed savings figures, however, do not meet this fundamental objective.

INTRODUCTION

In this Year 4 proceeding, the Dirigo Health Agency (“DHA” or “Agency”) presented three initiatives—(1) reduction in cost per case mix adjusted discharge (“CMAD”), (2) reduction in bad debt and charity care (“BD/CC”), and medical loss ratio (“MLR”)—all with new methodologies and, together, purporting to show aggregate measurable cost saving at unprecedented levels; levels that exceed the approved AMCS in all prior years combined.

The CMAD regression methodology, which is supposed to isolate for the effects of the Dirigo Act, demonstrably does no such thing. It calculates Dirigo “savings” in a majority of states outside of Maine, something that even DHA’s primary consultant, Steven Schramm, testified would not happen if the regression model actually isolated for the effects of the Dirigo Act. Even if it had passed this most basic test of validity, all of the consultants—the intervenor consultants and both of the experts for DHA—agree that the model that the DHA Board adopted, the U.S. hospital regression model, is “inconclusive” and cannot be relied upon to calculate savings that are actually attributable to the Dirigo Act. The CMAD “savings” figure of \$119.4 million is all the more illusory when considering that it is suggested at a time when costs in Maine after enactment of the Dirigo Act are growing at 4.5%; much higher than either the national average (3.9%) or the Northeast (also 3.9%) during the same period. In light of these undisputed facts, the evidence in the record simply does not support the DHA Board’s CMAD determination and it must be rejected.

DHA also presented \$35.7 million in BD/CC savings, a figure that is way out of bounds with reason. That figure, approximately six times the BD/CC savings approved by the Superintendent in Year 3 and more than \$20 million greater than the BD/CC savings approved by the Superintendent in the first three years combined, is presented in a year when enrollment in DirigoChoice declined by 15%. To its credit, the DHA Board found the \$35.7 million offered by DHA’s consultants to lack credibility, but instead of adopting the reasonable and direct measure presented by Jack Burke, the Board adopted a methodology and calculation that were neither supported by any expert testimony or evidence, nor explained in any way. The Board’s determination of \$23.6 million in BD/CC savings appears to be a results-driven compromise that is four times the prior year’s approved savings and nearly \$10 million more than all prior years

combined. It is, accordingly, no more reasonably supported by the evidence in the record than was the original inflated figure proposed by DHA. The only BD/CC savings figure that is supportable, \$6.1 million, stems from the calculation presented by Mr. Burke.

The DHA Board's adoption of the \$6.6 million in "savings" associated with the medical loss ratio is equally puzzling. DHA's consultants conceded the truth: these "savings" are not savings to the Maine healthcare system; they are instead premium refunds from one insurance carrier (Aetna) to certain individual policyholders. No physician, hospital or other provider received any of the \$6.6 million. As such, no insurance carrier can attempt to recover one dime of that \$6.6 million in negotiations with those providers. As a result, if the MLR "savings" are included in AMCS and then in the SOP, Maine consumers of private insurance will be paying \$6.6 million in an SOP for which there are no corresponding savings. In the face of these direct facts, the DHA Board adopted the full \$6.6 million in MLR "savings." Affirmance of this decision would be irresponsible and unfair to Maine's insured.

As Justice Alexander warned in *Maine Association of Health Plans v. Superintendent of Insurance*, 2007 ME 69, 923 A.2d 918, left unfettered, the vagaries of the Dirigo Act could allow the DHA Board to identify as aggregate measurable cost savings "projected or even imagined savings based on economic estimates and unquantifiable predictions . . . in areas that have nothing to do with Dirigo Health or state-subsidized insurance generally." *Id.* ¶ 74 (Alexander, J., dissenting). The methodologies and resulting savings calculations presented by DHA and adopted by the DHA Board for Year 4 demonstrate that Justice Alexander's forewarning was apt.

The methodologies and AMCS approved by the DHA Board are not supported by the evidence in the record and must be rejected.

HOSPITAL SAVINGS INITIATIVE—CMAD¹

I. CMAD Facts

A. Development Of The Revised CMAD Methodology For The Year 4 Proceeding

In each of the first three years of the Dirigo AMCS proceedings, the DHA through its consultants submitted CMAD methodologies that purported to identify savings related to the Dirigo Act by using pre-Dirigo Act (*i.e.*, pre-2004) cost growth to project cost growth in the post-Dirigo Act period (*i.e.*, 2004 and after) and comparing that projection to the actual cost per CMAD. In each of those prior proceedings, the intervenors suggested: (1) that the rate of cost-growth in the pre-2004 period was abnormally high; (2) that it was unreasonable to have assumed that this abnormally high rate of cost growth would have continued in the absence of the Dirigo Act; and (3) that this abnormally high rate of cost growth was driving the “savings” that were calculated and then simply attributed to the Dirigo Act. The Superintendent in his decision following the Year 3 AMCS proceeding expressed similar concerns:

the passage of time makes the failure to control for other factors affecting costs increasingly problematic for the method, and at the same time makes other methods which control for these factors, such as multi-variate multi-state analyses, more feasible. The cost per CMAD method will soon reach the point at which its drawbacks prevent it from producing reasonably supported findings. While small random fluctuations in cost will occur in any year, the more serious threats to the persuasive power of this method would be raised by specific, additional credible explanations for the pattern of slower cost growth post-Dirigo.

(AMCS Year 3 Decision and Order dated September 17, 2007, Docket No. INS-07-900, at 12; *see also id.* at 9 (“Time both diminishes the relevance of the available pre-Dirigo historical data and assigns an increasingly disproportionate dollar value to small variations in the trend rate chosen to project forward from 2003.”).)

¹ For clarity, the facts and discussion concerning each of the three savings initiatives (CMAD, BD/CC, and MLR) are set forth below in turn.

Although DHA’s consultants in years past remained steadfast in testifying that the full measure of the difference in cost growth between the pre-Dirigo Act projections and the actual growth figures was properly attributed to the Dirigo Act, in the current Year 4 proceeding, both Mr. Schramm and Dr. Kenneth Thorpe conceded that these abnormally high levels of cost growth in the pre-Dirigo Act period were not expected to continue, with or without the enactment of the Dirigo Act. (*See* Schramm Hearing Testimony at 158:10-15 (Administrative Record “AR” Tab 2-60)² (“MR. STILES: In your experience is it reasonable to assume that hospitals are going to continue having cost growth at 11 percent and 9 percent indefinitely? MR. SCHRAMM: You would not expect that indefinitely.”); Thorpe Hearing Testimony at 165:2-10 (AR Tab 2-60) (“MR. STILES: Would you expect, Dr. Thorpe . . . that a statewide virtual hospital would continue to grow at 9 and 11 percent a year indefinitely? DR. THORPE: No . . .”).)

In response to the Superintendent’s criticism following the Year 3 proceeding, Mr. Schramm, DHA’s principal expert in all four AMCS proceedings, also modified his thinking on the ability of a regression analysis to actually calculate savings that could be attributed to the Dirigo Act. (*Compare* Schramm Year 1 Hearing Testimony at 18:4-10 (AR Tab 5-107): “[I]t is not physically possible to develop . . . a multi variant regression analysis to potentially isolate the impact of any one given change and ascribe it to Dirigo.” *with* Schramm Year 4 Prefiled Testimony at 10 (AR Tab 1-16): “This year’s methodology allows us to count savings directly attributable to Dirigo, by using regression models that isolate Dirigo’s impact . . .”).

² The DHA Board did not paginate the administrative record filed with the Superintendent and subsequently made available to the intervenor parties. The Board, however, did separate record evidence into numbered binders, which were further separated by numbered tabs. Anthem BCBS will thus refer to record evidence by its assigned binder and tab numbers (*e.g.*, “AR Tab 2-60” refers to binder 2, tab 60), and to further assist the reader, will also include citations referring to the particular document’s original pagination.

The question of whether and to what extent Mr. Schramm and his team were actually able to isolate for the impact of the Dirigo Act is key to whether the DHA Board properly relied upon the U.S. hospital regression analysis for calculation of the cost per CMAD component of the AMCS in this Year 4 proceeding.³

B. How A Properly Specified Multi-State, Multivariate Regression Analysis Is Supposed To Work.

At its core, a multi-state, multivariate regression analysis is intended to determine whether there is some correlation or association between a hypothesized independent or explanatory variable and the dependent variable. (*See, e.g.*, Dobson Prefiled Testimony at 11 (AR Tab 1-35); Maffei Prefiled Testimony at 5 (AR Tab 1-27).)⁴ It is important to note at the outset that a regression analysis does not establish a causal relationship between variables. Rather, all of the experts presenting testimony in this proceeding agree that, at best, a regression analysis that produces statistically significant results shows only that there is a correlation or association between the independent and dependent variables. (*See, e.g.*, Thorpe Hearing Testimony at 266:22-267:19 (AR Tab 2-60) (agreeing that “the best you can do” with a properly specified regression model is show a correlation or association); *see also* Dobson Prefiled Testimony at 11 (AR Tab 1-35); Maffei Prefiled Testimony at 5 (AR Tab 1-27).)

³ As will be explained more fully below, Mr. Schramm and his firm, schramm raleigh Health Strategy (“srHS”), actually made three attempts to develop a valid regression model, but based on the results, ultimately suggested blending two of the regression models together. The DHA Board rejected that approach, rejected as unsupportable the Cluster 1 regression analysis and adopted the U.S. hospital regression model for CMAD savings. As such, the focus of the CMAD section of this brief is on the U.S. hospital regression model.

⁴ To determine whether srHS’s Year 4 methodology was a valid tool for calculating AMCS, the Maine State Chamber of Commerce (“Chamber”) retained Dr. Allen Dobson (a PhD in economics with more than 20 years consulting experience in provider payment issues) to run various tests using the data relied upon by srHS and perform several reality checks with respect to the srHS-recommended savings. Dr. Dobson’s analysis was reviewed by Vincent Maffei (a former econometrics and statistics professor employed since 1987 as a forecasting and health economics expert at WellPoint), and also Jack Burke (a principal and consulting actuary at Milliman who testified on behalf of the Maine Association of Health Plans (“MEAHP”) in the Year 3 proceedings). Mr. Maffei and Mr. Burke, in addition to reviewing Dr. Dobson’s work, each examined the srHS model independently.

A regression model is only valid when it is "properly specified" (*i.e.*, controls for all the variables that could potentially affect the dependent variable) and establishes a "statistically significant" correlation between the dependent variable and the explanatory variables. (*See, e.g.*, Maffei Hearing Testimony at 119:4-8 (AR Tab 3-61) (“In order to get a valid model, you have to make sure [1] you have included . . . all of the major drivers of your dependent variable. [And (2)] You have to make sure you retain only those that have demonstrated to be statistically significant.”).) “Statistical significance” means that there is a high probability—at least 95%—that the change in the dependent variable due to a change in an explanatory variable is not the result of random variation. (*See* Maffei Prefiled Testimony at 7 (AR Tab 1-27); Dobson Prefiled Testimony at 24 (AR Tab 1-35).) If the regression model omits important explanatory variables, or does not establish statistically significant results, the science of statistics deems that model inherently unreliable and the results and conclusions drawn from the model invalid. (*See, e.g.* Maffei Prefiled Testimony at 5, 6, 9 (AR Tab 1-27).)

In this case, the purpose of the type of regression analysis suggested by the Superintendent in the Year 3 decision was to determine whether there was an association or correlation between the Dirigo Act (the independent variable) and changes in the cost per CMAD (the dependent variable). In order to determine whether there was such an association, the regression analysis should have done what Mr. Schramm suggested: isolate for the effects of the Dirigo Act by including all other potentially explanatory variables in the model and thereby assuring that the regression analysis was picking up only those changes in cost per CMAD that were actually associated with the Dirigo Act. (*See, e.g.* Schramm Hearing Testimony at 210:3-8 (AR Tab 2-60) (“MR. ROACH: So at its core, that’s what you’re attempting to do. You’re attempting, as you put it in your report and in your testimony, you’re attempting to isolate for the

effects of Dirigo, right? MR. SCHRAMM: Correct.”); *see also id.* at 99:20-23 (“MR. STILES: And you’re attempting to control for all of the variables that drive rates of cost growth measured on a cost per CMAD basis? MR. SCHRAMM: We are.”).) The corollary is that if the econometrician charged with performing the regression fails to include all potentially explanatory variables in the regression model, the regression output is invalid because it will show an association between variables that does not truly exist. (*See id.* at 211:4-212:6 (“MR. ROACH: . . . [Your analysis] assumes that you’ve controlled in your regression for all non-Dirigo related items, right? MR. SCHRAMM: Correct. MR. ROACH: Okay, and if the model wasn’t properly specified, your regression would include items that actually are not Dirigo related, in other words, savings that are not really Dirigo related, right? MR. SCHRAMM: It could.”); Thorpe Hearing Testimony at 263:19-22 (AR Tab 2-60) (“MR. ROACH: And again, that relies upon you having selected all of the variables that potentially explain the interactions, right? DR. THORPE: That’s right.”).)

The experts involved in this proceeding all also agreed that a properly specified regression model that actually isolated for the effects of the Dirigo Act would not calculate Dirigo savings in a state that does not have the Dirigo Act:

MR. ROACH: . . . What I mean is that if you were actually able to develop a regression analysis that truly isolated for only the effects of Dirigo, if you ran that regression in any other state that did not have Dirigo, it would not produce any savings?

MR. SCHRAMM: In the hypothetical construct, yes.

(Schramm Hearing Testimony at 217:22-218:5 (AR Tab 2-60); *see also* Dobson Hearing Testimony at 42:13-15 (AR Tab 3-61) (“You shouldn’t see savings for all of the other states when you use a model that purports to show Dirigo savings.”); Burke Hearing Testimony at 220:10-21 (AR Tab 1-29).)

C. How The srHS Regression Analysis Actually Worked: (1) It Generated Significant “Dirigo” Savings In A Majority Of States Outside Of Maine; (2) It Ignored Variables That Likely Affected The Cost Per CMAD; (3) It Produced Statistically Insignificant Results.

1. The srHS Regression Analysis Generated Significant “Dirigo” Savings In A Majority Of States Outside Of Maine.

Rather than isolating for the effects of the Dirigo Act, the srHS regression analysis yielded “Dirigo savings” in 29 of 50 states, with 15 of those states experiencing “Dirigo” savings similar to or greater than Maine’s. (Dobson Prefiled Testimony at 28-29 (AR Tab 1-35).) For example, California shows a “Dirigo savings effect” of \$762 per discharge compared to the alleged Maine Dirigo savings effect of \$439 per discharge. (*Id.* at 28.) Florida demonstrated “savings” of \$561 per discharge. (*Id.*) The question of how a sophisticated regression model could calculate significant “Dirigo” savings in states other than Maine was answered upon examination of the srHS regression model.

The first answer lies in what the srHS model was, and was not, measuring. While labeled “Dirigo,” the Dirigo variable in the srHS regression model is not the Dirigo Health Reform Act or even the Dirigo Health Agency. (*See* Schramm Hearing Testimony at 210:9-211:9 (AR Tab 2-60).) It is instead simply a binary time variable that is “0” for all periods before state fiscal year 2004 and “1” for all periods that follow state fiscal year 2003. (*See, e.g.,* Maffei Prefiled Testimony at 3 (AR Tab 1-27); Dobson Prefiled Testimony at 22 (AR Tab 1-35).) Put differently, as used in the srHS regression analysis, “Dirigo” is simply a pre-Dirigo / post-Dirigo time trend that applies to all hospitals in the United States. (*See* Schramm Hearing Testimony at 175:22-176:12 (AR Tab 2-60) (conceding that the “Dirigo” variable is “just a time trend”).) This creates two fundamental flaws. First, the Dirigo variable (and the critical interaction terms that include the Dirigo variable) do not have a Maine-specific effect and thus are not capable of

distinguishing between changes in the cost per CMAD that are associated with the Dirigo Act versus those that are associated with any other factor. (*See, e.g.*, Maffei Prefiled Testimony at 29 (AR Tab 1-27); Dobson Prefiled Testimony at 22 (AR Tab 1-35); Burke Prefiled Testimony (Report) at 3-4 (AR Tab 1-29).) And second, by relying on a pre / post-Dirigo time trend, the srHS regression model, despite taking the form of a multi-state, multivariate analysis, continues to calculate savings to the Maine system based on the high rate of pre-Dirigo cost growth in Maine, thereby ignoring the Superintendent’s Year 3 directive to move away from the “tenuous connection between historic and current cost per CMAD.” (Year 3 Decision and Order at 9; *see also* Dobson Prefiled Testimony at 19 (AR tab 1-35) (“[T]he pre-Dirigo (2000-2003) and post-Dirigo (2004-2007) time trend remains a significant force in the srHS regression analysis.”).) This continued reliance on the abnormally high pre-Dirigo cost growth as a benchmark drives srHS’s projection of significant savings in a post-Dirigo period in which Maine’s cost growth of 4.5% exceeds the Northeast and U.S. growth of 3.9%. (*See* Schramm Hearing Testimony at 243:10-22 (AR Tab 2-60) (“MR. ROACH: Isn’t what’s driving your analysis the fact that in pre-Dirigo you’re using those three data points? MR. SCHRAMM: Yes, the pre-Dirigo period is 2000 to 2003. MR. ROACH: And post-Dirigo factually, putting aside pre-Dirigo, according to your data, costs in Maine, the cost per CMAD is growing at 4.5 percent, correct? MR. SCHRAMM: Correct. MR. ROACH: And costs in the U.S. overall are growing at 3.9 percent? MR. SCHRAMM: Correct.”); *see also* Thorpe Hearing Testimony at 263:23-264:13 (AR Tab 2-60) (conceding that the srHS data reflects higher post-Dirigo cost growth in Maine (3.9%) than it does in the Northeast (3.9%) and United States as a whole (also 3.9%).)

2. The srHS Regression Analysis Ignored Variables That Likely Affected The Cost Per CMAD.

In addition to using a generic time trend variable that purports to capture “Dirigo” related savings, the srHS regressions did not control for certain obvious factors that can influence a particular state’s rate of cost growth, including gross state product, employment growth levels, rate regulation, hospital competition, operating margins, insurance competition, hospital owner status, supply of physicians, managed care penetration and hospital physician relations. (*See, e.g., Dobson Prefiled Testimony at 8, 15 (AR Tab 1-35); Maffei Prefiled Testimony at 16-19 (AR Tab 1-27).*)

For example, employment growth affects cost per CMAD because when employment rates increase, more persons become commercially insured through their new employers, leading to increased hospital revenue and reimbursement at higher rates, as well as less pressure on hospitals to increase charges. (*See Maffei Prefiled Testimony at 16-19 (AR Tab 1-27); Maffei Hearing Testimony at 125:3-19 (AR Tab 3-61).*) The same holds true for operating margins: the higher a hospital’s operating margin, the less pressure to increase charges and cost per case should slow. (*See Maffei Prefiled Testimony at 19 (AR Tab 1-27); see also Thorpe Prefiled Testimony at 3 (AR Tab 1-17) (listing hospital margins as one of the “key factors that influence hospital costs”).*)

Beyond identifying critical variables that were missing from the srHS regression that *may* have a correlation to the cost per CMAD, both Dr. Dobson and Mr. Maffei provided unrefuted evidence that these missing variables likely *actually did* impact the cost per CMAD in Maine during the relevant period. (*See, e.g., Maffei Prefiled Testimony at 16-18 (AR Tab 1-27) (demonstrating that employment growth in Maine was stagnant in the pre-Dirigo Act period (which put pressure on costs), but then grew dramatically in the post-Dirigo Act period (which*

would have relieved the pressure on hospitals to increase costs)); *id.* at 19 (observing that after a demonstrable economic downturn, Maine experienced increases in hospital margins starting in the period after SFY 2003, coincident with the enactment of the Dirigo Health program); *see also* Dobson Prefiled Testimony at 15 (AR Tab 1-35) (“I Agree with Anthem witness Mr. Maffei that the failure to include economic or hospital financial variables contributes to an unreliable model.”).) Because the srHS model did not control for these explanatory economic variables, their influences on cost growth are picked up as “Dirigo” savings when clearly they are not. (*See, e.g.,* Maffei Hearing Testimony at 128:23-130:5 (AR Tab 3-61).)

3. The srHS Regression Analysis Produced Statistically Insignificant Results.

i. The Validity Of Regression Analyses Depends On The Statistical Significance Of The Tested Variables.

Multivariate regression models are statistical analyses performed by econometricians and statisticians. A properly specified model that controls for all potentially explanatory variables will produce statistics that assist the researcher in determining whether the resulting correlation or association is real or instead may be the result of random variation. As alluded to above, in econometrics, this concept is called “statistical significance.” Dr. Dobson and Mr. Maffei both testified that in both the world of academia and in the “real” world of business, researchers presenting regression analyses must achieve results that at minimum reach a 5% level of statistical significance. (*See* Maffei Prefiled Testimony at 7 (AR Tab 1-27); Dobson Prefiled Testimony at 24 (AR Tab 1-35); Maffei Hearing Testimony at 119:24-120:12 (AR Tab 3-61) (observing that in his experience, statistical significance applies in the business world of economic forecasting just as it does in academia).) A 5% level of statistical significance means that there is at least a 95% probability that the results of the statistical analysis were not

generated by random variation. (*See* Maffei Prefiled Testimony at 7 (AR Tab 1-27); Dobson Prefiled Testimony at 24 (AR Tab 1-35).) Dr. Thorpe likewise testified that “most of the social sciences” require a minimum of 5% statistical significance; “that is, there is a 95 percent chance that the estimate is different from zero in this case.” (Thorpe Prefiled Testimony at 5-6 (AR Tab 1-17); *see also* Schramm Prefiled Testimony at 19 (AR Tab 1-16) (noting that “t-statistics less than approximately -1.6 are considered statistically significant at a 5 percent significance level”).) In fact, while both DHA consultants were understandably reluctant to concede the point given the actual results of their regressions, Mr. Schramm acknowledged that the only testimony before the DHA Board suggested that 5% was the standard for statistical significance. (*See* Schramm Hearing Testimony at 227:4-228:1 (AR Tab 2-60).)

While the expert testimony in the case supports the use of at least a 5% statistical significance requirement, as set forth below, the DHA Board’s adoption of the inconclusive and unreliable U.S. hospital regression model (which produces savings that likely were the result of random variation), renders any debate on statistical significance levels moot.

ii. All Experts Agree That The Results Of The U.S. Hospital Regression Were Inconclusive, Statistically Insignificant And Could Not Be Relied Upon To Measure Savings.

Even assuming the srHS regressions were properly specified and included all of the potentially explanatory variables, the only variables in those models that could calculate savings were (1) “Maine” times “Dirigo” and (2) “Maine” times “Dirigo” times “Year” (referred to herein as the “critical interaction terms”). (*See, e.g.*, Maffei Prefiled Testimony at 15-16 (AR Tab 1-27); Dobson Prefiled Testimony at 25 (AR Tab 1-35).) With the DHA Board’s adoption of the U.S. hospital regression, it is thus important to analyze whether those critical interaction

terms produced results that were reliable. The experts for both the intervenors and DHA agree they were not.

Using the data provided by srHS, Dr. Dobson, Mr. Maffei and Mr. Burke concurred that the “t-statistics” (the standardized output from regression analyses that indicate statistical significance) for the critical interaction terms were “not close” to the 5% statistical significance level, and accordingly any association between those interaction terms and costs per CMAD was likely the result of random variation. (*See, e.g.*, Dobson Hearing Testimony at 38:7-13 (AR Tab 3-61); Maffei Hearing Testimony at 122:18-22, 123:4-11 (AR Tab 3-61); Burke Hearing Testimony at 221:11-20 (AR Tab at 3-61).) In fact, the t statistics actually demonstrate to a very high probability that the “savings” produced by the critical interaction terms were really the result of random variation. (*See* Dobson Prefiled Testimony at 24 and Table 5 (AR Tab 1-35) (“Maine” x “Dirigo” and “Maine” x “Dirigo” x “Year” demonstrate a 95% and 89% probability, respectively, that the resulting “savings” were due to random variation).)

In his prefiled testimony, Mr. Schramm conceded that: “This means that this model [*i.e.*, the U.S. hospital regression model] is inconclusive about whether the reduction in trend is attributable to Dirigo, so it is inconclusive in its explanatory power.” (Schramm Prefiled Testimony at 19 (AR Tab 1-16).) In cross-examination at the hearing before the DHA Board, Mr. Schramm testified, repeatedly, as to the implications of the inconclusive results:

MR. SCHRAMM: We say it’s [the U.S. hospital regression] inconclusive about whether the reduction in trend is attributable to Dirigo.

MR. ROACH: And that followed your determination that none of the results that had to do with savings under your regression model were statistically significant, right?

MR. SCHRAMM: At a 5 percent significant level.

(Schramm Hearing Testimony at 228:5-13 (AR Tab 2-60).)

MR. ROACH: . . . In fact, putting aside our expert's testimony, let's just talk about your testimony, you agree the U.S. regression is inconclusive for savings, right?

MR. SCHRAMM: Yes, we've said that.

. . .

MR. ROACH: Okay. So the Board couldn't rely on that alone?

MR. SCHRAMM: Correct.

. . .

MR. ROACH: I said the Board couldn't rely on the U.S. regression analysis alone because you said it was inconclusive.

MR. SCHRAMM: Correct.

. . .

MR. ROACH: . . . If all you presented was a U.S. regression model, you, yourself, say that's inconclusive, right?

MR. SCHRAMM: Correct.

MR. ROACH: So they couldn't rely on that alone?

MR. SCHRAMM: Correct.

(*Id.* at 238:14-239:21.)

D. How The DHA Board Ended Up Adopting A Regression Model That DHA's Own Experts Opined Was Inconclusive And Could Not Be Relied Upon.

Mr. Schramm's testimony from the Year 1 proceeding in which he affirmatively stated that it would be impossible to develop a multivariate regression model that actually isolated for the effects of the Dirigo Act was borne out by what proved to be multiple unsuccessful attempts to put forth a valid analysis.

1. The First Unsuccessful Attempt - Cluster 2

- srHS initially decided to use a sample of comparison states to develop a benchmark trend to compare to the Maine experience. (Schramm Prefiled Testimony at 11 (AR Tab 1-16).)
- srHS, with the assistance of Dr. Thorpe, developed a clustering model to select the comparison states to develop the benchmark trend. (*Id.* at 11, 12.)
- The cluster consisted of eight states (HI, ID, ME, NE, NH, NM, RI, WV) and is referred to in the srHS Report as "Cluster 2," even though it was the first group of states identified. (Schramm Hearing Testimony at 228:16-18 (AR Tab 2-60).)

- srHS performed a regression analysis—again based on variables selected by Dr. Thorpe—to determine “savings” demonstrated by the Cluster 2 data, resulting in a projection of \$396.6 million of CMAD savings for Year 4. (srHS Report at 52 (AR Tab 1-10 (CD)).)
- Cluster 2’s near \$400 million savings figure—five times greater than the CMAD savings the Superintendent found reasonably supportable in the first three years combined—was so far afield from prior experience that srHS determined Cluster 2 was unreliable to calculate AMCS. (See Schramm Hearing Testimony at 228:22-25 (AR Tab 2-60) (acknowledging that Cluster 2 was “discarded because it was so out of bounds with prior calculations”); Schramm Prefiled Testimony at 18 (AR Tab 1-16) (“Cluster 2 was accorded 0 percent credibility because the final savings estimate . . . was inconsistent with evidence presented in past AMCS proceedings.”).)

2. The Second Unsuccessful Attempt - Cluster 1

- After discarding Cluster 2, srHS identified a second cluster of states to use as a benchmark. These six states (CO, LA, ME, MN, NM, UT) are referred to in the srHS Report as “Cluster 1.” (srHS Report at 52 (AR Tab 1-10 (CD)).) srHS projected \$233.4 million of savings for Cluster 1. (*Id.*)
- Due to the small size and limited observations of Cluster 1, Dr. Thorpe became concerned that the sample may be subject to “clustering bias.” Accordingly, he recommended that srHS create a model using all fifty states in the U.S. on a hospital-by-hospital basis as the benchmark. (Schramm Hearing Testimony at 231:5-10 (AR Tab 2-60) (“Dr. Thorpe recommended that we do the U.S. hospital analysis because . . . there is a phenomenon known as clustering bias, and the concern is that by picking a particular subset of states, you are not necessarily getting a good match.”); Schramm Prefiled Testimony at 11 (AR Tab 1-16) (“Upon review of the dataset developed based on the . . . clustering analysis, Dr. Thorpe also recommended we develop a regression dataset for . . . the United States (US), thus eliminating some of the concerns associated with any clustering bias.”).)

3. The Third Unsuccessful Attempt - U.S. Hospital Model

- Per Dr. Thorpe’s recommendation, srHS created a U.S. hospital model, which produced a Year 4 savings estimate of \$119.4 million. (srHS Report at 52 (AR Tab 1-10 (CD)).)
- As outlined above, srHS’s review of the U.S. hospital model output revealed that the interaction terms driving the \$119.4 million in savings did not come close to achieving “statistical significance.” This finding led both Dr. Thorpe and Mr. Schramm to the conclusion that the U.S. hospital model is “inconclusive” and cannot be relied on alone to determine AMCS. (See, e.g., Schramm Prefiled Testimony at 19 (AR Tab 1-16); Schramm Hearing Testimony at 238:14-23 (AR Tab 2-60); Thorpe Prefiled Testimony at 7 (AR Tab 1-17).)

4. The Final Unsuccessful Attempt - Blending Cluster 1 And The U.S. Hospital Model

- The Agency and its consultants chose not to present either Cluster 1 or the U.S. hospital model on its own to the Board. Instead, srHS decided to blend the results of the two analyses, affording 75% weight to the U.S. hospital model and 25% to the Cluster 1 model. (srHS Report at 52 (AR Tab 1-10 (CD)); Schramm Prefiled Testimony at 17-18 (AR Tab 1-16).) This blending technique resulted in a final savings number of \$147.9 million (almost six times more than the \$25 million the Superintendent found reasonably supported by the evidence last year). (srHS Report at 52 (AR Tab 1-10 (CD)).)
- Based on their review of srHS’s methodology, payor intervenors’ expert witnesses presented testimony at hearing and in prefiled submissions that the methodology recommended by the Agency and its consultants was fatally flawed, not grounded in sound statistical principles, and must be disregarded because, among other reasons: 1) the key variables driving the U.S. hospital analysis are not statistically significant ; 3) the Cluster 1 model relies on states with demographics not properly comparable to Maine; and 3) srHS’s attempt to blend the U.S. hospital model and Cluster 1 is both arbitrary and inappropriate statistical practice. *See generally* Dobson Prefiled Testimony (AR Tab 1-35); Maffei Prefiled Testimony (AR Tab 1-27); Burke Prefiled Testimony (AR Tab 1-29).)

5. The Board’s Determination Of CMAD Savings: Rejection Of Cluster 1 And Adoption Of The U.S. Hospital Model

After listening to testimony from all parties, the DHA Board rejected both the Agency’s reliance on Cluster 1 and its attempt to blend the results of the two models. (Year 4 DHA Board Decision at 8 (“The Board is not persuaded that Cluster 1 tracks Maine and finds the weighting of the U.S. hospital model and Cluster 1 to be arbitrary and not supported by the evidence.”)). The Board—contrary to the Agency’s own experts’ opinions—further determined that “the U.S. hospital model is the most credible and reliable indication of savings from CMAD,” and adopted the \$119.4 million of savings calculated by that model. (*Id.*)

II. CMAD Argument—The Evidence In The Record Does Not Reasonably Support the DHA Board’s Suggested CMAD Savings.

A. The U.S. Hospital Model Does Not Isolate For The Effects Of The Dirigo Act On Cost Per CMAD.

While there are points of dispute between the various experts in this case, all agree on the fundamentals that render the DHA Board’s determination of AMCS for CMAD fatally flawed. As set forth in detail in the above fact section, all of the experts agree that a basic tenet of a valid regression model is that it controls for other variables so that it isolates the effects of the hypothesized independent variable on the dependent variable.

Another fundamental principle is that a regression model can show association between variables even if the resulting association is actually due to random variation, rather than a true association. That is why the science of regression modeling requires that the results achieve statistical significance; so that the researcher can know whether the results have sufficient validity to be used to show a true association. (*See, e.g.,* Maffei Prefiled Testimony at 9, 10 (AR Tab 1-27).)

Although there are other flaws that would also invalidate the srHS regression models, we know directly from srHS that the regression upon which the DHA Board relied in finding CMAD savings fails both of these most basic principles, most easily demonstrated by: (1) the generation of “Dirigo” savings in states outside of Maine; and (2) the unanimous agreement that the U.S. hospital regression model was “inconclusive” and cannot be relied upon to calculate AMCS. Each is discussed in turn.

1. Because The srHS Regression Model Calculates “Dirigo” Savings In A Majority Of States Outside Of Maine, It Is Clear That The srHS Model Does Not Actually Isolate For The Effects Of The Dirigo Act.

Isolation of the effects of the hypothesized variable on the dependent variable is critical. If the researcher properly isolates for the hypothesized variable and achieves statistically significant results, the regression may show a valid association between the hypothesized variable and the dependent variable. (*See* Maffei Prefiled Testimony at 5 (AR Tab 1-27).) By contrast, if the researcher fails to isolate for the hypothesized variable, the results of the regression will pick up the effects of other factors that were not included in the regression and attribute those effects to the hypothesized variable. (*Id.* (“If the regression analysis mis-specifies the factors that are necessary to measure the dependent variable, the analysis will be inherently unreliable. Some or all of the impact of the omitted variables can be assigned to the included variables generating biased estimates of the true impact of the included variables.”).)

In this case, srHS was attempting to determine whether there was an association between the Dirigo Act and changes in the cost per CMAD. (*See, e.g.*, Schramm Hearing Testimony at 210:3-8, 99:20-23 (AR Tab 2-30).) Mr. Schramm admitted at hearing that if his model really did control for non-Dirigo phenomena, it would not show “savings” when replicated in states other than Maine:

MR. ROACH: [I]f you were actually able to develop a regression analysis that truly isolates for only the effects of Dirigo, if you ran that regression in any other state that did not have Dirigo, it would not produce any savings?

MR. SCHRAMM: In the hypothetical construct, yes.

(*Id.* at 217:22-218:5; *see also* Dobson Hearing Testimony 42:13-15 (AR Tab 3-61) (“You shouldn’t see savings for all of the other states when you use a model that purports to show Dirigo savings.”); Burke Hearing Testimony at 220:10-222:3 (AR Tab 3-61).)

Contrary to Mr. Schramm's testimony that a valid model that actually isolated for the effects of the Dirigo Act would not produce savings outside of Maine, Dr. Dobson's unrebutted analysis reveals that srHS's model produces a "Dirigo savings effect" in 29 of 50 states, with 15 of those states experiencing "Dirigo" savings similar to or greater than Maine's. (Dobson Prefiled Testimony at 28-29 (AR Tab 1-35) (*e.g.*, California shows a "Dirigo savings effect" of \$762 per discharge compared to the alleged Maine Dirigo savings effect of \$439 per discharge).) This most basic test of the model demonstrates that the srHS regressions are not actually isolating for the effects of the Dirigo Act and, accordingly, do not present a valid calculation of AMCS.

Though not intervenors' burden to explain the flawed results, the reasons the srHS regressions produce these invalid results are also clear: (1) the srHS models do not isolate for the Dirigo Act, but instead simply compare the pre-Dirigo Act period to the post-Dirigo Act period; and (2) the models do not include all the explanatory variables that drive costs and, as such, the models incorrectly pick up the effect of those variables as "Dirigo" savings. That is why states that are not even on the same coast as Maine reflect significant "Dirigo" savings. (*See* Maffei Prefiled Testimony at 30 (AR Tab 1-27) ("The srHS model is not in reality measuring cost growth decline that is correlated to [the Dirigo Act], but instead is simply measuring variations in the rate of cost growth across different states. Because of different economic, sociological, and regulatory conditions, there will be different rates of cost growth, both before and after 2004, among the states."); Dobson Prefiled Testimony at 29 (AR Tab 1-35) ("[T]he srHS model is not measuring cost growth decline that is attributable to the Dirigo Health Act, but as Anthem witness Mr. Maffei correctly recognized, instead simply measures 'variations in the rate of cost growth across different states.'").) For this reason alone, the

DHA Board's determination of AMCS related to CMAD is not reasonably supported by the record.

2. All The Experts Agree That The U.S. Hospital Model Adopted By The Board Is “inconclusive” And Cannot Be Relied On To Calculate AMCS.

Even if srHS had properly specified its regression model such that it actually isolated for the effects of the Dirigo Act and, hence, would not produce significant savings in states outside of Maine, the CMAD savings adopted by the Board would still be unsupported by the record because, as the Agency's own consultants have repeatedly testified, the U.S. hospital model is “inconclusive” and cannot be relied on to calculate AMCS.

All of the experts agree that the critical interaction terms that drive savings in the U.S. hospital model (“Maine” x “Dirigo” and “Maine” x “Dirigo” x “Year”) are “not close” to a 5% significance level, and any “savings” result is more likely than not due to random variation.⁵

Dr. Dobson

Q. Is the U.S. model even close to statistical significance with respect to the savings –

A. Well, the two variables that I care about, Maine times Dirigo and Maine times year times Dirigo, they're not even close.

(Dobson Hearing Testimony at 38:7-13 (AR Tab 3-61); *see also* Dobson Prefiled Testimony at 26 (AR Tab 1-35) (“[A]ll of the Maine and Maine / Dirigo related variables have no statistical significance, and therefore, there is no statistically significant Dirigo Health Act impact for Maine.”).)

⁵ This agreement is not surprising given that the interpretation of “t statistics” and other standardized output from regression analyses that indicate statistical significance are not open to subjective judgment. (*See, e.g.*, Maffei Prefiled Testimony at 13 (AR Tab 1-27).)

Mr. Maffei

Q. With respect to the U.S. hospital regression, do either of those critical interaction terms, Maine cross Dirigo and Maine cross Dirigo cross year [reach] statistical significance to five percent?

A. They do not. They do not come close.

...

Q. And what are the implications of the fact that neither one of those critical interaction terms reached that statistical significance level?

A. Well, even if we had a properly specified model that fulfilled all of the classical criteria, what this is saying is that it appears that nothing more than random variation is generating the values of the coefficients.

(Maffei Hearing Testimony at 122:18-22, 123:4-11 (AR Tab 3-61).)

Mr. Burke

Q. With respect to the U.S. regression in particular, what is the statistical significance or lack thereof, for example, Maine cross Dirigo cross Year?

A. Well, it's so far away from being significant it's essentially proven that it's random. . . . And the same thing for Maine times Dirigo.

(Burke Hearing Testimony at 221:11-20 (AR Tab 3-61).)

In their prefiled testimony, both Mr. Schramm and Dr. Thorpe agreed that the U.S. hospital model was “inconclusive” because of the lack of statistical significance. (Schramm Prefiled Testimony at 19 (AR Tab 1-16) (“[The U.S. hospital] model is inconclusive about whether the reduction in trend is attributable to Dirigo”); Thorpe Prefiled Testimony at 7 (AR Tab 1-17) (“The US hospital model is inconclusive as to whether [the] reduction can be attributed to Dirigo.”).) At hearing, Mr. Schramm conceded that his use of the term “inconclusive” for savings was based on the fact that the critical interaction terms rendered statistically insignificant results:

MR. ROACH: And based on that, you determined that the U.S. regression model had statistically insignificant results, right?

MR. SCHRAMM: We say it's inconclusive about whether the reduction in trend is attributable to Dirigo.

MR. ROACH: And that followed your determination that none of the results that had to do with savings under your regression model were statistically significant, right?

MR. SCHRAMM: At a 5 percent significant level.

(Schramm Hearing Testimony at 228:2-13 (AR Tab 2-60).)

Mr. Schramm also conceded the import of the statistical insignificance/ inconclusive results of the U.S. hospital regression model, ultimately admitting that the DHA Board could not rely on the U.S. hospital model to determine AMCS:

MR. ROACH: . . . [Y]ou agree the U.S. regression is inconclusive for savings, right?

MR. SCHRAMM: Yes, we've said that.

...

MR. ROACH: Okay. So the Board couldn't rely on that alone?

MR. SCHRAMM: Correct.

(*Id.* at 238:14-23.)

MR. ROACH: . . . [T]he Board couldn't rely on the U.S. regression analysis alone because you said it was inconclusive.

MR. SCHRAMM: Correct.

(*Id.* at 239:4-7.)

MR. ROACH: . . . If all you presented was a U.S. regression model, you, yourself, say that's inconclusive, right?

MR. SCHRAMM: Correct.

MR. ROACH: So [the Board] couldn't rely on that alone?

MR. SCHRAMM: Correct.

(*Id.* at 239:13-21.)

As previously explained, the t statistics demonstrate that it is highly likely that any cost per CMAD “savings” produced by the U.S. hospital model’s critical interaction terms were the result of random variation. (See Dobson Prefiled Testimony at 24 and Table 5 (AR Tab 1-35).) This significance level is so far removed from the 5% level that anchors the science of statistics (rather than a 95% probability that the results are not due to random variation, the critical savings terms show a 95% and 89% probability that the results are due to random variation), there is no reasonable argument in support of the Board’s decision to rely on the U.S. hospital model. Put differently, it perhaps should go without saying that a calculation of AMCS that DHA’s own experts agreed likely includes “savings” that were not attributable to the Dirigo Act or the operation of Dirigo Health does not provide a valid measure of AMCS.

For all of these reasons, it was erroneous for the DHA Board to have relied upon a regression analysis that all of the statistical and econometric experts in the proceeding—including DHA’s own experts—agreed was inconclusive and unreliable. There simply is no evidence in the record supporting any reliable hospital savings calculated by the U.S. hospital model.

B. The srHS Regressions Do Not Follow The Statutory Requirements For Calculating Cost Per CMAD.

Even if the srHS regression models isolated properly for the effects of the Dirigo Act (which they demonstrably did not) and produced statistically significant/conclusive and reliable results (which they demonstrably did not), Mr. Schramm conceded at hearing that srHS’s formula used to calculate cost per CMAD does not follow the parameters set forth in the legislation that authorizes the calculation of AMCS.

The srHS methodology purports to calculate savings on a cost per CMAD basis as a result of the voluntary cost growth limits imposed on Maine’s hospitals by the Dirigo Act. (*See, e.g., srHS Report at 9 (AR Tab 1-10 (CD)).*) The Dirigo Act provides a specific formula for each hospital to measure its cost per CMAD, which is:

- (1) Calculating the hospital’s total hospital-only expenses;
- (2) Subtracting from the hospital’s total hospital-only expenses the amount of the hospital’s bad debt;
- (3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the state during the hospital’s fiscal year; and
- (4) Dividing the amount reached in subparagraph (3) by the product of:
 - (a) The number of inpatient discharges, adjusted by all the payer case mix index for the hospital; and
 - (b) The ratio of total gross patient services revenue to gross inpatient service revenue.

22 M.R.S.A. § 1721 (a copy of the public law enacting the statute is included at AR Tab 5-95-A.) The statutory formula further provides that calculation of a hospital’s total “hospital-only expenses” should not include certain nonhospital cost centers such as swing beds and hospital-owned physician practices. *Id.*

At hearing, Mr. Schramm conceded that his CMAD formula did not match that provided by the Legislature:

MR. STILES: Does [the statutory formula] match the formula that you’ve used in your regression analysis?

MR. SCHRAMM: No, this does not match the formula

(Schramm Hearing Testimony at 111:25-112:5 (AR Tab 2-60).)

MR. STILES: . . . [W]here does your analysis subtract for swing beds?

MR. SCHRAMM: We have not adjusted for that.

(*Id.* at 115:6-9.)

MR. STILES: Where does your methodology adjust for hospital owned physician practices?

MR. SCHRAMM: It does not adjust for that.

(*Id.* at 115:10-12.)

The DHA Board obviously does not have the authority to change a legislative directive and Mr. Schramm conceded that the calculation presented to the Board does not follow that legislative directive. Thus, for this additional reason, the calculation of AMCS for CMAD adopted by the DHA Board is not supported by the evidence in the record.

For all of these independent reasons, as well as those set forth in the briefs of the Chamber, MEAHP and the Maine Automobile Dealers Association Insurance Trust (the “Trust”), incorporated herein by reference, the CMAD savings suggested by the DHA Board are not reasonably supported by the evidence in the record and should be rejected in their entirety.

C. In Contrast To The Superintendent’s Prior Decision, The Year 4 Methodology Fails To Account For Recoverability.

While applicable to all of the savings initiatives presented by DHA, even if the CMAD savings methodology did not suffer from the numerous fatal flaws outlined above, it would remain invalid because it does not take account of recoverability of the purported “savings.” Despite the Board and Superintendent’s past recognition that not all “savings” are recoverable, none of the Agency’s proposed methodologies for Year 4 take recoverability into account. Rather, they simply attempt to measure hospital cost savings; assume that all of those “savings” result in corresponding reductions in the charges paid by private payors; and then attribute all of those “savings” to the operation of Dirigo Health.

Q. Mr. Schramm, did you attempt to determine what part of the savings are “recoverable” by the intervenors or what part is appropriate to include in the Savings Offset Payment (SOP) assessment?

A. No.

(Schramm Prefiled Testimony at 6 (AR Tab 1-16).)

MR. STILES: So you've made no analysis of whether it's even conceivable that the hospitals could pass along the savings that you've projected to insurance carriers?

MR. SCHRAMM: We have not.

(Schramm Hearing Testimony at 146:6-10 (AR Tab 2-60).)

This is clearly at odds with past precedent and defies logic. What was true last year is also true this year: simply because a hospital's costs may be reduced does not necessarily mean that hospital is able to pass along those cost reductions in the form of a reduction in its charges for services. srHS's failure to account for recoverability in Year 4 is unreasonable, contrary to last year's determination by the Superintendent, and results in an inaccurate calculation of the actual "savings" to the Maine system.

UNINSURED INITIATIVES—BD/CC

I. BD/CC Facts

A. The Use Of A Direct Measure And The Superintendent's "Reasonableness" Test

In past years, the Superintendent approved BD/CC savings based on a direct measurement of how many Mainer's Dirigo Choice and the Dirigo-related MaineCare expansion were newly insuring, finding \$2.7 million of savings in Year 1 and \$5.5 million in Year 2. In Year 3, the Superintendent approved a savings figure of \$6.3 million, based on a calculation developed by MEAHP expert Jack Burke. In that same Year 3 proceeding, the Superintendent articulated a "final test of the overall reasonableness" for BD/CC savings: whether the proposed figure is consistent with prior years' results when adjusted for changes in enrollment. (AMCS Year 3 Decision and Order at 18 (approving Burke's \$6.3 million figure in part because it "is not inconsistent with the \$5.5 million found reasonably supported in Year Two, when adjusted for growth in enrollment during the intervening year . . .").)

B. The Year 4 Methodologies

For Year 4, rather than continue with the direct measurement of insureds approved by the Board and the Superintendent in past years, srHS worked with Dr. Thorpe to develop a multi-state, multivariate statistical model that purportedly compares the rate of uninsurance in the absence of Dirigo to the rate of uninsurance in the presence of Dirigo. (Schramm Prefiled Testimony at 20 (AR Tab 1-16).)

srHS performed multiple regressions, using the United States, a collection of Northeast states and the pre-Dirigo Maine experience to calculate Maine's uninsurance rates in the absence of Dirigo. The various regressions resulted in savings calculations of \$16.9 million (Northeast), \$23.6 (pre-Dirigo Maine), and \$41.9 million (U.S.). (srHS Report at 74 (AR Tab 1-10 (CD)).)

srHS did not rely on any of the BD/CC regression models alone, but rather blended the Northeast model (25% weight) and U.S. model (75% weight) to arrive at a savings calculation of \$35.7 million. (*Id.* at 18, 74.) srHS did not give the pre-Dirigo Maine model any weight in its savings calculation. Neither did Mr. Schramm or Dr. Thorpe mention the pre-Dirigo Maine model at hearing or in their prefiled submissions.

Dr. Dobson and Mr. Burke reviewed srHS's BD/CC analysis and presented testimony at hearing and in prefiled submissions that the new methodology did not accurately calculate savings to the Maine healthcare system due to a reduction in bad debt and charity care. As an initial matter, intervenors' experts questioned the usefulness of a regression methodology when everyone agrees that the actual data is readily available. (*See, e.g.*, Schramm Hearing Testimony at 293:7-295:2 (AR 2-60) (acknowledging that there exists "concrete data" on the number of insureds enrolled in DirigoChoice and the Dirigo-related MaineCare expansions for the current measuring period).) They also noted the discrepancy between the recommended Year 4 savings

(\$35.7 million) and the savings approved in prior years (never higher than \$6.3 million and totaling a combined \$14.5 million in savings for the prior three years), and the fact that enrollment in the Dirigo Choice program had actually declined significantly in the measuring year. (*See, e.g.*, Dobson Prefiled Testimony at 38-43 (AR Tab 1-35); Burke Prefiled Testimony (Report) at 7-9 (AR Tab 1-29).)

Mr. Burke also presented an alternative approach to calculate BD/CC savings. Starting with the BD/CC savings approved in Year 3 and making adjustments to reflect current data, Mr. Burke calculated Year 4 savings at \$6.1 million. (*See* Burke Prefiled Testimony (Report) at 11 and Attachment II (AR Tab 1-29); Burke Hearing Testimony at 343:21-345:20 (AR Tab 3-61).)

C. The Board’s Savings Determination

After hearing testimony from all parties, the Board concluded that the weighting of the U.S. model and Northeast model was “arbitrary and not supported by the record.” (Year 4 DHA Board Decision at 9.) The Board further determined that the evidence supported a finding of BD/CC savings “in the amount of \$23.6 million set forth in table 3 of Appendix I to the srHS Report.” (*Id.*) This \$23.6 million figure is the savings calculated by the pre-Dirigo Maine regression model, for which srHS gave no weight in its model and offered no supportive testimony. (*See* srHS Report at 74 (AR Tab 1-10 (CD)).)

II. BD/CC Argument—The BD/CC Savings Determined By The Board Are Not Reasonably Supported By The Record.

A. The Pre-Dirigo Maine Model Adopted By The Board Was Not Supported By Any Party, And Is Not Anywhere Explained.

As an initial matter, the pre-Dirigo Maine regression model found at Appendix I, Table 3, Column 10 of the srHS Report and the \$23.6 million in savings generated by that model were not supported by any party to this proceeding. As previously explained, srHS did not give any

weight to the pre-Dirigo Maine model in its recommended savings calculation. Mr. Schramm and Dr. Thorpe did not even mention the pre-Dirigo Maine model at hearing or in their prefiled submissions. There is no narrative discussion of the model in the srHS Report. As such, there is not enough evidence in the record for the DHA Board to understand what the pre-Dirigo Maine regression model is even calculating, let alone to determine savings based on that model. On this basis, the Board's adoption of the pre-Dirigo Maine model is, on its face, arbitrary and unreasonable.

B. The \$23.6 Million Savings Determined By The Board Fails The Superintendent's "Final Test Of Reasonableness."

Even if adoption of the pre-Dirigo Maine regression model were supported by evidence in the record (which it is not), it would still fail the test of reasonableness. In Years 1 through 3, the BD/CC savings approved by the Superintendent ranged from \$2.7 million in Year 1 to \$5.5 million in Year 2 and \$6.3 million in Year 3. The savings recommended by the Agency and its consultants in Year 4 skyrocketed to \$35.7 million, almost six times what the Superintendent determined reasonable in Year 3. The \$23.6 million in savings ultimately approved by the DHA Board are almost four times higher than last year's approved figure. This huge jump in "savings" could only be supported by huge increases in enrollment. However, it is uncontested that there was no significant increase in MaineCare enrollees from 2007 to 2008 and enrollment in Dirigo Choice actually declined significantly during the measuring period, by 15% from an average of 14,183 enrollees to only 12,050. (Burke Prefiled Testimony (Report) at 11 (AR Tab 1-29).) Based on these facts alone, the Board-approved \$23.6 million in savings must be rejected.

As with CMAD, it is not intervenors' burden to explain why the savings put forth by DHA are on their face unreasonable, but it seems clear that the srHS methodology inflates the

savings because it relies on an improper projection of the uninsured rates in the absence of Dirigo and ignores the major MaineCare expansions that were either not due to Dirigo or are not expected to continue on a regular basis.

C. The Only Potentially Valid BD/CC AMCS Calculation For Year 4 Is The Alternative, Direct Measurement Presented By Jack Burke.

DHA bore the burden of providing a supportable methodology and calculation and the BD/CC AMCS calculation put forth by the DHA Board is not supported by the evidence in the record and must be rejected, resulting in no BD/CC savings for Year 4. While intervenors are not charged with the responsibility of providing alternative calculations, should the Superintendent be inclined to consider alternatives to simply rejecting the unsupportable methodology adopted by the DHA Board and, hence, finding no BD/CC savings for Year 4, Mr. Burke presented a supportable methodology.

Starting with his Year 3 calculation of \$6.3 million—which was approved by the Board and the Superintendent—Mr. Burke adjusted for the current enrollment and trended the net savings forward one year at 7%, resulting in estimated savings of \$6.1 million. (*See* Burke Prefiled Testimony (Report) at 11 and Attachment II (AR Tab 1-29); Burke Hearing Testimony at 343:21-345:20 (AR Tab 3-61).) Unlike the Agency’s projection, this estimate relies on the actual Maine experience and passes the Superintendent’s “reasonableness” test, and therefore is the only credible BD/CC calculation before the Superintendent.

For these reasons, as well as those set forth in the briefs of the Chamber, MEAHP and the Trust, incorporated herein by reference, the \$23.6 million in BD/CC savings suggested by the DHA Board are not reasonably supported by the evidence in the record and should be rejected. The only calculation of BD/CC savings that is reasonably supported by the evidence is Mr. Burke’s calculation of \$6.1 million.

INSURER OVERSIGHT INITIATIVE—MLR

I. MLR Facts

The Agency and its consultants also presented a new savings initiative in Year 4: purported “savings” derived from a comparison of the ratio of insurers’ medical expenditures over premiums to medical loss targets established by the Legislature. The basis for these savings was a \$6.6 million refund made by Aetna to certain of its small group policyholders as a result of its failure to meet a 78% loss ratio over a 3-year period on medical expenses. (srHS Report at 19-20 (AR Tab 1-10 (CD)).) The Agency and its consultants recommended that this \$6.6 million refund be included in AMCS in its entirety. *Id.*

Intervenors’ experts and carrier witnesses presented testimony that the Aetna refund represents savings to individual policyholders, not the Maine health care system, and thus can never be recovered by the health insurance carriers or third party administrators who must initially pay the SOP. (*See, e.g.*, Burke Prefiled Testimony (Report) at 11 (AR Tab 1-29); Fishbein Prefiled Testimony at 12-13 (AR Tab 1-31).) That means that, if included in AMCS and ultimately the SOP, consumers will pay \$6.6 million more in SOP than they possibly could have “saved,” a result that is contrary to the purpose of the SOP. Mr. Schramm corroborated this point, agreeing that the refund went directly to a specific subset of policyholders, and not to any physician, hospital or other provider.

Q. The \$6.6 million in refunds, I think you testified goes directly from Aetna to certain of its policyholders, right?

A. It does.

Q. There is no amount that goes to any physician, right?

A. Correct.

Q. There is amount that goes to any hospital?

A. There is not.

Q. No amount that goes to any other provider. It goes right in their pockets alone; is that right?

A. To the insureds, correct.

Q. To the specific subset of Aetna insureds, right?

A. It does.

(Schramm Hearing Testimony at 365:1-14 (AR Tab 3-61).)

Notwithstanding this unrefuted fact, the Board approved the \$6.6 million in MLR savings. (Year 4 DHA Board Decision at 9.)

II. MLR Argument—The “Savings” Approved By The Board Are Admittedly Non-Recoverable, And Therefore Are Not Properly Included In The AMCS Calculation.

The Board-determined \$6.6 million in “savings” for the MLR initiative will never inure to the benefit of the Maine healthcare system, and thus are not properly included in the determination of AMCS for Year 4. The basis for the MLR initiative are refunds made by Aetna to certain of its policyholders as a result of the 78% loss ratio requirement. As Mr. Schramm testified at hearing, these premium refunds to policyholders are not savings to the healthcare system and, in any event, cannot be recovered in insurance carriers’ contracts with hospitals or physicians because those hospitals and physicians have not experienced any cost decrease as a result of those refunds. (Schramm Hearing Testimony at 365:1-14 (AR Tab 3-61).) If included, consumers will pay \$6.6 million more in SOP than they possibly could have recovered in “savings” due to the Dirigo Act. This is inconsistent with the Superintendent’s prior determinations and the purpose of the Dirigo Act. The DHA Board’s inclusion of \$6.6

million in AMCS for MLR is not reasonably supported by the evidence in the record and must be rejected.

OVERLAP

Maine consumers of private insurance should have to pay an SOP that is no greater than the actual savings that have resulted from the Dirigo Act. For the reasons set forth above, each of the savings initiatives adopted by the DHA Board suffer fatal flaws and must be rejected in their entirety. Putting to one side all of the significant flaws that render each one of the savings initiatives put forth by DHA unsupported in the record, as the Superintendent has found, even valid savings calculations must be reduced to the extent the initiatives overlap. To do otherwise would require Maine consumers to “double pay” for savings and, accordingly, violate the central premise that consumers should not pay more in an SOP than is actually “saved” as a result of the Dirigo Act. (*See, e.g.*, Burke Prefiled Testimony (Report) at 10 (AR Tab 1-29).) While for the reasons set forth above, none of the savings initiatives adopted by the DHA Board are supportable, to the extent the Superintendent adopts any savings for any of the initiatives, those savings must be reduced for overlap.

CONCLUSION

For the reasons set forth herein and in the briefs of the Chamber, MEAHP and the Trust, the methodologies adopted by the DHA Board fail to accurately determine aggregate measurable cost savings resulting from the operation of Dirigo Health, and, accordingly, the evidence in the record does not reasonably support the Board’s calculation of AMCS.

DATED: August 26, 2008

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CERTIFICATE OF SERVICE

I hereby certify that on August 26, 2008, a copy of Anthem Health Plans of Maine Inc.'s Pre-Hearing Brief was served on each of the persons listed below via hand delivery and electronic mail in the manner described in the Superintendent's Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures dated August 18, 2008:

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