

STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

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

Docket No. INS-08-900)

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**BRIEF OF THE MAINE ASSOCIATION
OF HEALTH PLANS**

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, the Maine Association of Health Plans (“MEAHP”) submits this Brief.

I. INTRODUCTION

In a written decision dated August 11, 2008 (“Decision”) the Board of Directors (“Board”) of the Dirigo Health Agency (“DHA”) has approved aggregate measurable cost savings (“AMCS”) for the fourth assessment year (“Year 4”) in three categories: Hospital Savings (\$119.4 million); Uninsured/Underinsured (\$23.6 million); and Medical Loss Ratio (\$6.6 million). The board found no overlap among any of the three initiatives and approved a total of \$149.6 million for the Year 4 AMCS.¹

The Board for the fourth year granted MEAHP full party status as a matter of right as an intervenor. MEAHP member companies provide coverage through fully-insured and self-funded

¹ For purposes of this brief, we make reference to the Administrative Record, using the following convention -- Binder A, tab xx, page yy is referred to as AR A-xx-yy. The Board’s Decision was not filed with the Administrative Record when the Board filed it with the Superintendent on August 12. For ease of reference and to limit the length of this brief, MEAHP concurs with the points contained in sections I-III of the Decision, entitled Introduction, Procedural History and Adjudicatory Proceeding.

plans to approximately 680,000 Maine people. MEAHP supports the DHA's goals of expanding insurance coverage and controlling the growth of healthcare costs in Maine, as well as the overall objectives of the Dirigo Health Act. MEAHP has continued to have serious concerns, however, about the mechanism for financing the expansion of coverage through Dirigo Choice and in particular the Board's AMCS determinations each year, which becomes the basis for the Savings Offset Payment ("SOP"). It is critical that the Board's determination of AMCS – the precursor to assessing the SOP on all Mainers covered under fully-insured and self-funded plans - be calculated accurately. If AMCS is overstated and cannot be reasonably recovered by payors, it will cause an increase in the cost of health insurance and more Maine people to lose coverage, exactly the opposite result intended in the Dirigo Health Act.²

In Years 1 through 3, the Superintendent approved \$43.7 million, \$34.3 million and \$32.8 million, for a TOTAL of \$ 110.8 million in AMCS. This Year the Board has recommended \$149.6 million in AMCS, when srHS's own data shows that the CMAD cost growth rate in Year 4 (3.28%) was actually slightly higher than in Year 3 (3.17%).³ As will be set forth in detail below, MEAHP is extremely concerned that the Board has recommended a figure that is wildly inflated, based on fundamentally flawed assumptions that in some case directly contradict the Board's and Superintendent's decisions last Year, and lack any reasonable support in the record for any savings whatsoever.

For *hospital savings*, the Board adopted a new, mis-specified, multi-state multivariate statistical model to measure hospital savings based solely on a U.S. regression that lacks statistical reliability (only 45 % statistical significance), which DHA's own experts testified

² AR 5-99-4 (Fishbein Pre-filed Testimony); AR 5-98-3 to 4 (Rudin Pre-filed Testimony); AR 5-104-11 to 12 (Roberts Pre-filed Testimony).

³ AR 2-41 (Chamber Exhibit # 7, DHA Year 4 Report, col. III, p. 54 for 2006 and 2007).

could not be solely relied on to measure AMCS. Moreover, this model produces “savings” in 29 other states where the Dirigo Act obviously does not exist, with 15 states showing savings similar or greater than Maine. There is no reasonable support in the record for any Hospital savings on the basis of this methodology, which is flawed both in its assumptions and as applied.

For *Bad Debt and Charity Care (“BD/CC”) savings*, the Board found \$23.6 million in savings, a figure nearly four times that approved last year by the Superintendent, when enrollment in DirigoChoice has been frozen and has actually declined since Year 3. To reach this highly inflated result, the Board abandoned the approach both the Board and the Superintendent approved last Year in favor of a new, flawed multi-state multivariate statistical model to measure these savings, when the Superintendent did not direct DHA to do so, and when concrete data on how many previously uninsured people enrolled in Dirigo Choice and how many previously unenrolled people enrolled in the expanded MaineCare program in the measuring year (2008). Instead the Board adopted DHA’s new model which compares two projections, one in the presence of Dirigo using actual uninsurance rates through 2006 and then trending forward to 2008, and a new multi-state regression that projects uninsurance rates in the absence of Dirigo, and attributes the entire difference between these projections to the “global” impact Dirigo has had on uninsurance rates in all health insurance markets in Maine.

The Board adopted a flawed “projection” of actual insurance rates in Maine, by including a major, pre-Dirigo MaineCare expansion in the post-Dirigo period, thereby erroneously attributing Dirigo with 36,347 new MaineCare enrollees from July 1, 2002 to July 1, 2003 (before the Dirigo law took effect). When DHA’s experts corrected this error their regression model produced not \$35 million in savings, but \$41 million, which several Board members in the deliberations found contrary to common sense. The Board also ignored unrebutted evidence that

DHA's projection of actual uninsurance rates from 2006 to 2008 was unreasonable, in large part because three specific events explained more than 100% of the drop in uninsurance rates up to 2006, leaving no reasonable basis to assume further reductions at the same pre-2006 rate through 2008. The events causing a reduction in the number of uninsureds were the 2002 and 2005 MaineCare expansions and the 2005 commencement of enrollment in DirigoChoice.

The record contains no data whatsoever on the statistical reliability of the regression the Board adopted to calculate the "projected" insurance rate in the absence of Dirigo, nor even enough data for intervenors' experts to unwind this regression. As with hospital savings DHA's experts recommended a blend of two regression results, in this case from the US and Northeast, but the Board adopted the "Maine only" regression, (a) which was not even recommended by DHA's experts, and (b) for which DHA's experts provided no data on statistical reliability whatsoever.

As will be shown below, the Board has adopted Hospital and BD/CC AMCS figures based on two fundamentally flawed models that cannot be "fixed" and therefore MEAHP has offered alternative calculations prepared by its expert, Milliman, based on last Year's decision of the Superintendent.

For *Medical Loss Ratio ("MLR") savings*,⁴ the Board with virtually no debate whatsoever adopted the DHA-recommended figure with total disregard for the unrebutted evidence in the record (which DHA admitted in its pre-hearing brief and DHA's expert also admitted) that the refunds paid to insureds in one of Aetna's subsidiaries are not recoverable from anyone and can therefore never be "offset" against this portion of the AMCS/SOP

⁴ The Board also adopted DHA's recommendation to include no reduction for overlap among any of the initiatives, again without virtually no debate. MEAHP points out in section VI of this brief that this decision is without reasonable support in the Record.

assessment. There is simply no reasonable support whatsoever in the record for any savings in this category.

The Board's decision on all three initiatives raises extremely serious concerns about (a) its complete reversal from its and the Superintendent's decisions in Year 3 on reasonable recoverability of savings, and (b) the continually shifting ground of the Board adopting new and different initiatives for savings and models for attempting to calculate savings, with absolutely no reference to specific language in the Dirigo Act either authorizing the initiative or the methodology for measuring it. This demonstrates the unconstitutionally vague language in 24-A M.R.S.A. § section 6913(1)(A) of the Dirigo Act and the improper delegation of legislative authority to the executive branch agency, DHA.

II. STANDARD OF REVIEW

As noted in the Decision⁵, DHA had the burden of proving to the Board that its determination of AMCS is reasonable. The Superintendent must decide if the Board's recommended AMCS determination is reasonably supported by the evidence in the Record. 24-A M.R.S.A. § 6913(1)(C). The Superintendent has the authority to "issue an order approving, in whole or in part, or disapproving the filing." Id.

III. THE BOARD'S RECOMMENDED AMCS DETERMINATION IS NOT REASONABLY SUPPORTED (A) BECAUSE IT CONTRADICTS ITS OWN DECISION AND THAT OF THE SUPERINTENDENT FROM YEAR 3 BY IGNORING THE REASONABLE RECOVERABILITY OF SAVINGS, AND (B) BECAUSE IT DID NOT PROVIDE SUFFICIENT SUPPORT FOR ITS CALCULATIONS

A. Recoverability

DHA had the burden of proving at the adjudicatory hearing before the Board that recommended savings in each of the three initiatives are reasonable, accurate and recoverable by

⁵ August 11, 2008 Decision of the DHA Board of Directors, at 5.

purchasers of health insurance; it failed to meet this burden. DHA in its Pre-hearing Brief suggested a different standard, stating that the Board is “*not determining to what extent savings are recoverable...*” and that “*the Board is only assessing and quantifying the success of the Dirigo initiatives; it is not determining the implications of that success.*” DHA Pre-hearing Brief at 3 (emphasis added). Mr. Schramm explicitly states in his pre-filed testimony that he did not even attempt to determine what part of the savings is recoverable. (DHA Exhibit 2 (srHS Report) at 6), and that his contract with DHA did not even include this work. AR 2-60-144-146 (Schramm Hearing Testimony).

Through these statements DHA attempted to ignore clear precedent and re-write history. Last year the Board adopted Milliman’s approach to determining a reduced amount of savings in the Uninsured /Underinsured and Payments to Physicians initiatives on the grounds that it was unreasonable to assume that all of the savings proposed by DHA were available to be recovered. AR 5-101-8 to 9 (DHA Board Third Assessment Year Decision). The Superintendent approved the Board’s decision on this point. AR-5-100-15 to 18 (BOI Decision and Order, September 17, 2007). Likewise, the Superintendent last Year ruled that it was appropriate to consider the extent to which proposed savings relating to the hospital cost per CMAD initiative were recoverable from hospitals with poor or negative operating margins. AR 5-100-10 (BOI Decision and Order, September 17, 2007).

DHA admitted that recoverability is an appropriate factor to be considered, but only at the time that the Board assesses the SOP. AR 2-50-3 (DHA Pre-hearing Brief). The Dirigo Act, however, does not provide for any further adjudicatory hearing by DHA at the SOP phase. Moreover, the Dirigo Act does not provide for review of the DHA SOP assessment decision by the Superintendent, which is a key check and balance in the Act regarding the AMCS

determination. Recoverability is not a simple element to determine and quantify, but one that requires the give-and-take of the adjudicatory hearing process and its procedural safeguards, which are described below. Thus, on its face, what the DHA proposed would violate constitutional standards of due process.⁶ Even if DHA did hold a second adjudicatory hearing, it would without doubt involve many of the same issues, facts and arguments – an incredibly inefficient and costly exercise. In fact DHA has never held an adjudicatory hearing in assessing the SOP in Assessment Years 1, 2 and 3 and has never provided any of the corresponding procedural safeguards such as discovery, cross-examination of witnesses under oath, and pre-filing of testimony and reports relied upon by DHA. In fact, DHA has never inquired further into recoverability in prior years when making the SOP assessment.

In each of the three savings initiatives this year, the Board did not debate at all the extent to which any of the savings were reasonably recoverable by payors from providers. For both hospital savings and BD/CC savings, the regression models do not control at all for recoverability of savings. As noted above for MLR savings, the Board adopted without any

⁶ In addition to the above procedural due process issue, there are also constitutional issues arising out of the vagueness of the definition of AMCS in the Dirigo Act and as applied by DHA. Clearly the Dirigo Act itself nowhere contains the phrase “assessing and quantifying the success of the Dirigo initiatives” in connection with DHA’s obligation to determine AMCS. In fact, DHA’s latest iteration of the applicable definition of AMCS, the sheer vastness of the proposed AMCS figure, as well as DHA’s inconsistent and overlapping savings measures as pointed out in the Chamber’s pre-hearing brief. AR 2-55-17 to 18, proves that the consequences of an unconstitutionally vague statute, coupled with an unconstitutional delegation of legislative authority to the executive, are even more present than ever before. As Justice Alexander stated in his dissent in *Maine Ass’n of Health Plans v. Superintendent of Ins.*, 2007 ME 69, 923 A.2d 918 (“*MEAHP*”): “the ambiguity in [the Dirigo Health Act concerning the definition of AMCS in 24-A M.R.S.A. § 6913(A)] must [not] be resolved by delegating and deferring to the administrative agency, giving the agency license to assess offset payments according to whatever definition of “cost savings” the agency deems appropriate to meet its financial needs.” *MEAHP*, 2007 ME 69 at ¶ 63. Justice Alexander further pointed out that “[w]hen terminology in a statute is so vague and ambiguous that those regulated must guess at its meaning, and an agency is given license to act based on preferences or criteria so subjective that they are virtually unreviewable, we have held that such subjective license is an improper delegation of legislative authority to the executive.” *MEAHP*, 2007 ME 69 at ¶ 71. *MEAHP* therefore preserves its objection that §6913(1)(A) of the Dirigo Health Act as applied by DHA and the Board, constitutes an improper delegation of legislative authority, and also contains a lack of any reasonable standards or criteria for determining aggregate measurable cost savings, which renders it unconstitutionally vague.

debate the “savings” asserted by DHA, despite the admission of both its counsel and its expert that such “savings” are not recoverable.

The Board has completely removed any consideration of recoverability from the Year 4 recommended AMCS determination. This action is 180 degrees – directly opposite from and inconsistent with – the Board’s own decision on two savings categories in Year 3 and from all three categories in the Superintendent’s decisions for Year 3. This completely unsupported action by the Board underscores Justice Alexander’s dissent in the Law Court’s decision in *Maine Ass’n of Health Plans v. Superintendent of Ins.*, 2007 ME 69, 923 A.2d 918 (“MEAHP”) “[w]hen terminology in a statute is so vague and ambiguous **that those regulated must guess at its meaning**, and an agency is given license to act based on preferences or criteria so subjective that they are virtually unreviewable, we have held that such subjective license is an improper delegation of legislative authority to the executive.” *MEAHP*, 2007 ME 69 at ¶ 71.

Moreover, the Board’s action in completely ignoring the critical issue of reasonable recoverability in its recommended AMCS determination confirms the worst fears of many who question this financing mechanism: The Board is asking the Superintendent to approve a \$149.6 million decision in a vacuum without regard to the consequences for hundreds of thousands of Maine people who pay for health insurance and the SOP assessment, and who are at risk of losing such coverage as premiums rise to absorb the SOP. What is equally troubling is the fact that in Year 3 DHA included “guiding principles” in its report, apparently acknowledging that if adopted by the Board and approved by the Superintendent, the recommended AMCS would become the basis for the SOP assessment. This Year, however, Mr. Schramm admitted that two of these principles – that the results be “auditable” and the methodology and calculations be “transparent” – were deleted. AR-2-60-130 to 131.

B. Support for Calculations

As noted above, the standard of review is that the Superintendent must decide if the Board's recommended AMCS determination is reasonably supported by the evidence in the Record. 24-A M.R.S.A. § 6913(1)(C). To the extent that the recommendation consists of numbers, that means that the Board cannot simply present the final numbers, but must show its calculations in a way that is reviewable. Otherwise, "reasonably supported" has no meaning. This is extremely important when as here the "savings" calculation forms the basis for an assessment on all those Maine people that pay for health coverage.

The DHA cannot, as an extreme example, have someone calculate the savings on an abacus, no matter how much time and thought go into the calculation, without documenting all material steps. There must be an auditable paper trail, or the electronic equivalent. Ridiculous as the abacus example is, what the DHA's experts produced on the BD/CC initiative was presented as "black box" results – they may as well have been produced on an abacus.

A multivariate, multi-state regression analysis is extremely complex and hard to verify. As will be seen below, the convention among econometricians is to run reliability tests on their data, and present the results of those tests as part of their report. srHS did not include such results in its June 2, 2008 report on either the hospital savings or the BD/CC initiative. It eventually produced such test results for the hospital savings initiative, but not on BD/CC. On the hospital savings initiative, it also produced for the intervenors' experts enough of the underlying data that intervenors could replicate the results. It did not do so on BD/CC, and moreover deleted some necessary data. More details are supplied below.

The Agency clearly did not meet its burden of proving that the regression calculations for the BD/CC initiative were reasonably supported. Interestingly, when srHS belatedly provided

the test results on the hospital savings initiative, those results showed that the findings were unreliable, so the Agency failed to meet its burden on that issue as well.

IV. HOSPITAL SAVINGS

The Board found \$119.4 million in AMCS for Year 4 in the category of Hospital Savings. DHA Decision, August 11, 2008 at 10. This is by far the largest category of savings approved by the Board for Year 4, and is over four (4) times the \$25 million that the Superintendent approved for Hospital Savings in Year 3⁷ (for Year 1, the finding was \$33.7 million, and for Year 2 it was \$14.5 million).

srHS did not present a clear explanation of its methodology. As interpreted by Mr. Burke in the Milliman report, srHS did not develop an estimate of CMAD cost growth in the absence of Dirigo and then compare it to actual cost growth in Maine in the presence of Dirigo. Instead, it developed two of its own flawed estimates – one in the absence of Dirigo and one in the presence of Dirigo – and determined savings to be the entire difference between its estimates. AR 5-97 (MEAHP Exhibit 2 (Milliman Report) at 2). Specifically, srHS used a three-year pre-Dirigo base period to project CMAD cost growth to 2007 in the absence of Dirigo. AR 4-64-54 (srHS Report Table 1, col. III, row entitled “Estimated 2007 (using Annual Growth Pre-Dirigo)”). It then used this three-year base period to project CMAD cost growth in the absence of Dirigo for three different “clusters” – the U.S., and clusters 1 and 2, to try to control for differences in Maine. Id. (col. IV, V & VI, row entitled “Estimated 2007 (using Annual Growth Pre-Dirigo)”; AR 2-60-22 to 28 (Schramm Hearing Testimony).

srHS then “projected” an “estimated” actual CMAD cost growth in the presence of Dirigo for 2007 for Maine and for each of three clusters. AR 4-64-54. srHS then subtracted the “Estimated 2007 Actual 2007” in the presence of Dirigo from the projected CMAD in the

⁷ AR 5-100-5 (BOI Decision and Order, September 17, 2007)

absence of Dirigo for Maine, and for each of the three clusters to calculate “savings.” Id. (Row entitled “Estimated 2007 Actual 2007 = savings per CMAD”).

The two cluster regressions that became part of the srHS recommendation were Cluster 1, consisting of the six (6) states of Colorado, Louisiana, Maine, Minnesota, New Mexico, and Utah, and all fifty states in the U.S. AR 4-64-52 to 53. srHS recommended a blending of the results from these two regression models – 75% US and 25% “Cluster 1.” Id. at 53.

These regression models were fundamentally flawed as presented to the Board, and produced results that were not reliable. Blending the results from the two regressions did not fix the problem. The Board rejected the blending, but adopted solely the least reliable piece of the blend – the piece as to which its experts agreed that “the Board couldn’t rely on that alone.” AR 2-60-238 (Schramm Hearing Testimony).

- A. The Board tried to follow the Superintendent’s recommendation from its Year 3 decision – to use a multivariate, multi-state analysis in determining hospital savings - but in Year 4, DHA used a flawed model and failed to come up with a supportable result, as determined by standard measures of statistical reliability, and thus the Board’s findings are not reasonably supported by the evidence in the record.**

In Year 3, the Superintendent rejected the Board’s methodology for calculating hospital savings, and said the following:

“The critical sources of concern in the methodology, which have been pointed out since Year One, have not been redressed sufficiently. The Superintendent recommends that a new analytical approach be taken in any future proceedings. In particular, given that any proceeding assessing SFY 2007 would allow assessment with four years of post-Dirigo data, it would be more feasible and more desirable in the future to assess Dirigo’s effect with a multivariate statistical model which incorporates cost and other data from both Maine and from other states.” AR 5-100-14

The Year 4 report used a multivariate, multi-state regression for the first time, but left unaddressed other problematic factors. The failure of the regression model still leaves the problems with the other elements of the methodology; these will be discussed later.

1. The model presented to the Board was fundamentally flawed.

A regression analysis tests a hypothesis, and needs to control for the other factors affecting the outcome. AR 4-84-11 to 12 (Dobson Pre-filed Testimony); AR 5-106-4 (Maffei Pre-filed Testimony). If it does not properly control for such factors, then (a) it will over-attribute, in this case to a factor, deemed the “Dirigo” factor, that, as a result does not measure savings due to Dirigo activity, but rather a whole host of macroeconomic changes from pre-July 1, 2003 to post-June 30, 2003⁸, and (b) it will fail tests of statistical reliability. AR 4-84-24 (Dobson Pre-filed Testimony). In this case, as will be seen below, both adverse consequences occurred.

2. DHA’s experts failed in their attempts to fix the model by blending the results of two flawed calculations.

DHA’s experts, schramm-raleigh Health Strategy (“srHS”), developed a multivariate regression model, and then tried using their model to compare Maine-related data to data from different clusters of states, before settling on a recommended blend of two of them – (1) all 50 states, to which they applied a 75% weighting, and (2) “Cluster 1,” consisting of the six (6) states of Colorado, Louisiana, Maine, Minnesota, New Mexico and Utah, to which they applied a 25% weighting. This blending resulted in a finding of \$147.9 million in purported savings. AR 4-64-53 (srHS Report).

However, the DHA experts were dissatisfied with each cluster individually – the US because the results of that regression were not statistically reliable,⁹ and the six-state cluster,

⁸ AR 4-84-16 (Dobson Pre-filed Testimony).

⁹ AR 2-60-194 to 195 (Schramm Hearing Testimony); AR 2-60-203 (Thorpe Hearing Testimony).

because of concerns about the size of the cluster and “clustering bias¹⁰.” As will be seen below, intervenors’ experts had much more fundamental concerns about the six-state cluster.

It is not valid to blend the results of a biased small sample with those of a statistically insignificant larger study, let alone at the 75% weighting level AR 3-61-144 (Maffei Hearing Testimony). DHA’s experts could not counter that point.¹¹

Jack Burke, from a renowned national actuarial firm Milliman, characterized the srHS report as “trying to use statistics to prove a point and then ignoring the rules of statistics.” AR 3-61-207 (Burke Hearing Testimony).

3. The Board compounded the problems by rejecting its experts’ recommended blending and going with a result as to which the experts said the Board could not rely on it alone.

The Board rejected the recommended blending and found \$119.4 million in savings¹² based expressly and solely on the results of the 50-state United States CMAD regression¹³ that the Board’s own expert stated was “inconclusive about whether or not the reduction in trend is attributable to Dirigo.” AR 1-16-19 (Schramm Pre-filed Testimony). The Board’s regression expert agreed that there was only a 45% chance that the savings shown were directly attributable

¹⁰ “Dr. Thorpe recommended that we do the U.S. hospital analysis, because, as he mentioned to us, there is a phenomenon known as clustering bias, and the concern is that by picking a particular subset of states, you are not getting a good match.” AR 2-60-230-231 (Schramm Hearing Testimony)

¹¹ Mr. Schramm said that blending is done frequently, but could not come up with any example of the type of blending done here.

“Mr. Roach: And do you have any examples of a situation in which you have an inconclusive, that is, not statistically significant to a 5 percent statistical significance level regression combined with a cluster subject to clustering bias?

Mr. Schramm: No”

AR 2-60-244-245 (Schramm Hearing Testimony).

¹² DHA Decision, August 11, 2008 at 8.

¹³ AR 3-62-53 to 55 (Board Deliberations).

to Dirigo. AR-2-60-203 (Thorpe Hearing Testimony). The normal standard of confidence in use of findings from a statistical model is the 95% probability level¹⁴; so this was not even close.

DHA counsel recognized the fatal weakness presented by this issue, and attempted to obfuscate the issue by saying that the standard of proof is that the “Board need only be convinced that it is more likely than not that the savings exist.” AR 2-50-7 (DHA Brief). But a 45% chance that the savings were directly attributable to Dirigo does not even meet that standard. What was discussed at the hearing was that sometimes it is acceptable to accept regression results in the 90 to 95% confidence range¹⁵, but nobody argued for accepting anything in a range comparable to the confidence level for the results of the srHS US regression.

Mr. Schramm agreed that the Board could not rely on the US regression alone. AR-2-60-238 (Schramm Hearing Testimony).

Yet the Board did rely on the US regression alone¹⁶.

There is no evidence from the Board’s deliberations that any of the Board members heard their experts’ advice on this point -- there was no reference of any kind in the deliberations on statistical significance, its function, or its meaning.

The findings adopted by the Board thus failed to provide reasonable evidence or support of any savings.

¹⁴ The most widely accepted standard for reliability is what Mr. Schramm refers to in his pre-filed testimony as a “p-value” of .05 AR 1-16-19 (Schramm Pre-filed Testimony; AR 3-61-36 (Dobson Hearing Testimony). This means that there is a 5% chance that the result is random, and thus a 95% chance that the result is explained by the model. DHA’s expert agreed at the hearing that the 5% level was the standard used for determining whether results were publishable. AR 2-60-83 (Schramm Hearing Testimony).

¹⁵ Dr. Dobson, on cross-examination was asked to confirm whether econometricians sometimes use a .10 statistical benchmark, and he said that it is only used under great scrutiny, with an enormous amount of pressure. AR 3-61-65 (Dobson Hearing Testimony).

¹⁶ “The original motion was having approved the methodology to utilize only the cluster that is the United States as an entirety and, therefore, the figure of 119.4 million dollars.” AR 3-62-53 to 54 (Dr. David, Board Deliberations).

The above should be a conclusive reason for rejecting the figure adopted by the Agency for hospital savings. The next logical step in the analysis can be part B, on an alternative method for calculating such savings.

However, Sections 4 to 13 of this part A are presented for further corroboration, if needed, on the failure of the methodology.

4. The only finding in the Board’s experts’ report which came close to meeting a standard test for reliability was in an opportunistically segregated “cluster,” subject to such biases that it should not have been included; ultimately the Board rejected any use of this cluster.

As noted above, srHS recommended a blend of the findings of their 50-state model with those of the six-state Cluster 1. For Cluster 1, they found a 94.5% level of confidence for one of their Dirigo factors; the savings predicted by this model were estimated at \$233.4 million. AR 1-16-19 (Schramm Pre-filed Testimony).¹⁷

But the six states used in Cluster 1 were Colorado, Louisiana, Maine, Minnesota, New Mexico and Utah. AR 4-64-52 (srHS report). Intervenors raised numerous issues about that selection, including the differences from Maine in the demographic and geographic profile of such states,¹⁸ and the fact that the model did not correct for extraordinary events, especially in the post-Dirigo period, such as Hurricane Katrina, which hit Louisiana and caused a double-dip recession there in the post-Dirigo period. All of those factors have effects on the percentage of people covered by medical insurance, but those factors were not controlled for in the regression

¹⁷ The p-value cited was .055 AR 1-16-19 (Schramm Pre-filed Testimony)), meaning that it was slightly above the normal 5% test. The p-values for other Dirigo values in that cluster were higher. AR 4-84-32 (Dobson Pre-filed Testimony; the same table is at AR 4-74 (DHA Exhibit 12)); AR-2-60-63 to 65 (Dobson Hearing Testimony)

¹⁸ There were no Northeastern states other than Maine, but three Southwestern states – Utah, New Mexico and Colorado, with among other characteristics making them different from Northeastern states, significant Hispanic populations. Louisiana’s population is 33% black. Maine has a median age of 41; Utah’s is 28. AR 5-106-20 to 21 (Maffei Pre-filed Testimony).

models.¹⁹ Intervenors also raised the problem of statistical bias with such a small sample – 6 states for 7 years is only 42 observations,²⁰ (hospital cost data for the two state clusters was compiled and compared on a statewide, not hospital-specific basis).

The deliberations show that the Board members understood the criticism of Cluster 1. Their ultimate decision was to disregard the clusters and go with the US regression. DHA Decision, August 11, 2008 at 8; AR 3-62-32 to 55 (DHA Board deliberations). Again, there was no discussion by the Board of statistical significance, or any recognition that the only finding on cost per CMAD savings coming close to statistical significance was from the Cluster 1 regression.

By rejecting any use of Cluster 1, the Board also rejected its experts' recommended blending of the results of Cluster 1 with the results of the US model. Instead, the Board adopted a figure with no statistical significance, and thus failed to provide reasonable evidence of any savings.

5. The Board's experts' report lacked transparency – it did not give the Board enough information to understand the methodology used, or the failure of the cost per CMAD regression.

A normal report on a regression analysis lays out the background of how the regression model works in several steps, and then reports on the reliability of the findings, using statistical standards²¹. The srHS report, initially dated June 2, 2008²², did none of this, except for

¹⁹ AR 5-106-20 to 221 (Maffei Pre-filed Testimony)

²⁰ AR 4-84-32 to 33 (Dobson Pre-filed Testimony); AR 3-61-42 to 43 (Dobson Hearing Testimony)

²¹ Dr. Dobson, the Chamber's regression expert, said that reports on econometric regression analysis normally do the following – "You start with your theory, what do we expect to find? . . . Then we lay out the model . . . We usually give a formal $Y = A + B$. . . there is a formula. But really importantly at this step in the game, we say these are the coefficients we use. We provide a literature review and say other folks have done stuff like this . . . Then you postulate a set of variables. And these are the variables that do two things and this is really important. You have a set of control variables. We want to make sure we're not confusing the program effect with other effects . . . this is why we have them, this is why we expect them and what we expect them to do and this is how we're going to

presenting the variables used in the model and their definitions, and did not report on the weakness of the results of the cost per CMAD regression. This was an important point in the testimony at the hearing by Dr. Allen Dobson, the expert on regression analysis presented by the Maine State Chamber of Commerce. AR 3-61-16 to 19 (Dobson Hearing Testimony). In fact, the first place in the record where information on the reliability of the cost per CMAD findings was reported was Mr. Schramm's pre-filed testimony and related exhibits, which was not produced until over three weeks later. AR 1-16-18 to 19; AR 1-18-Exhibits 11 and 12. Dr. Dobson complained that it took him (a PhD economist, who had a team of experienced workers helping him) "a couple of weeks of investigation" to figure out what the statistical significance was from the srHS data. AR 3-61-70 to 71. (Dobson Hearing Testimony).

Another element missing was an explanation of significant discrepancies. An important one is the huge difference between actual Maine cost per CMAD numbers²³ and those predicted for Maine using the US regression model.²⁴ For example, the actual number shown for 2007 is \$7470, versus \$10,293 predicted. As stated by Dr. Dobson, "my experience is you should become reasonably close. Like I find differences of one and two percent, three percent. Like I go into a state and say your state is one or two percent inefficient, I got some questions at me . . .

use them at the end to show what we're looking for. In this case, the power of the Dirigo program to reduce CMAD. . . then we run the regressions. We then show our coefficients, each and every one. We show the standard errors, we show the probability, the .05 level we heard so much about yesterday. Then most importantly we come back and we say why we think our findings are valid and this how we interpret the coefficients to show the thing we're looking for. AR 3-61-17 to 19 (Dobson Hearing Testimony).

²² AR 1-9-3 (DHA's Witness, Expert, Methodology and Document Disclosure, June 2, 2008)

²³Column III on page 54 of the srHS report. AR 4-64

²⁴ Column IV on page 54 of the srHS report. AR 4-64

Here we've got, is it 7's versus 10's [*a difference of over 30%*]? That's a lot of difference. I can't explain it."²⁵

Dr. Thorpe agreed that such differences should be troubling: "If they (real data) were completely at odds with what the underlying data were showing us, that would trouble me." AR 2-60-93 (Thorpe Hearing Testimony). But when asked to compare the numbers which concerned Dr. Dobson,²⁶ Dr. Thorpe changed the subject and talked about the goals of the regression analysis. AR 2-60-142 to 143 (Thorpe Hearing Testimony).

Mr. Schramm admitted that the guiding principles of (a) transparency, and (b) having auditable and verifiable documentation, were stated in the srHS report for Year 3 and in the first draft of the srHS report for Year 4, but were deleted from the final report for Year 4. AR 2-60-130 to 131 (Schramm Hearing Testimony). The only attempted rebuttal on the transparency issue (in the context of the bad debt and charity care methodology) was on the points that the experts provided data and answered intervenors' questions. AR 3-61-271 to 273 (Thorpe and Schramm Hearing Testimony). There was no attempt to present testimony explaining the lack of any information on reliability for the first three weeks of a short review process.

The record shows that srHS backed away from the principle of transparency, stuck with its inconclusive findings, and delayed even reporting about their fatal unreliability.

6. The model did not include enough relevant variables to isolate the effects of the Dirigo Act, and ended up with a meaningless measure of a time trend triggered by the date pre- and post- June 30, 2003

A regression model uses a formula to test a hypothesis. The factors that influence the outcome must be included as variables and measured to the extent possible. If all of the proper

²⁵ AR 3-61-48 to 49 (Dobson Hearing Testimony). Dr. Dobson also said "one possible explanation is that the model misspecification is somehow missing some important drivers that allow you to really predict Maine accurately." Id. at 48.

²⁶ Both were looking at the differences between columns III and IV on page 54 of the srHS report (AR 4-64).

variables are included, and the hypothesis is correct, then the regression will prove the hypothesis and provide the proper measurement of whatever it is seeking to measure. If the formula is missing key variables, their omission is likely to bias the effects on those variables which are included, and provide an unreliable result. This is called “mis-specification.” AR 5-106-5 (Maffei Pre-filed Testimony). DHA’s regression consultant, Dr. Kenneth Thorpe, agreed at the hearing that “omission of a relevant variable from hospital cost function analysis would generally bias the coefficient estimates of those variables that are included.” AR 2-60-202.

Intervenors produced a wealth of testimony, described below, from both lay witnesses with knowledge of Maine, and from experts with knowledge and experience in measuring factors in medical costs, on the importance of several variables and factors that were not covered by the srHS regression model. The conclusion reached from their testimony is that either (a) any “savings” measured by the srHS model would be unreliable, because the effects of the combination of all these factors would be included in the model as part of the “Dirigo effect” and/or (b) the failure to control for all these factors would make the model so unstable that it would fail.

Both effects happened. The failure of the model was described above. And the “Dirigo” variable ended up being nothing more than a measure of the passage of time. For the period before July 1, 2003, it has a value of zero (0), and for the subsequent period it has a value of one (1). While use of such a “binary variable” is a standard technique in regression analysis to measure the effects of an intervention once it is isolated,²⁷ srHS did not use enough variables to isolate for the effects of the Dirigo law. DHA may as well have been measuring for the effects of the fact that the Red Sox won the World Series in 2004, and that the Yankees have not won

²⁷ AR 2-60-209 to 212 (Schramm Hearing Testimony).

the Series since then. AR 5-97-Burke Exhibit 2, pages 2-4. Part IV.A.8 below provides a dramatic illustration of how the “Dirigo variable” did not measure the effects of Dirigo.

Some important variables that were omitted included employment growth,²⁸ hospital competition, insurance competition, the supply of physicians, the existence of certificate of need programs and other government regulations, and hospital owner status.²⁹ The model also does not factor in the effects of the cost cycle.³⁰ See the discussion at A.9 and A.10 below.

And the ultimate proof that the model did not include enough variables to account for the other forces affecting medical costs in Maine, is that the model failed standard tests for statistical reliability. See points A.3 and A.4 above.

²⁸ Economic variables such as employment growth are strong drivers of total health care costs. AR 5-106-16 (Maffei Pre-filed Testimony); AR 4-84-15 (Dobson Pre-filed Testimony). Mr. Maffei testified that he has developed regression models using economic variables in 14 states. And in all of them, economic variables such as employment growth had some of the most dramatic measurable effects, with the highest degrees of statistical significance. AR 3-61-125. Moreover, he reported that Maine had a longer employment growth recession during the years in question than the rest of the United States, so it was an important factor to control for in a multi-state regression. The DHA experts testified that they did not include employment growth as a variable, because they were measuring cost per CMAD, which is cost per discharge, whereas employment growth affects total costs. AR 2-60-58 (Thorpe Hearing Testimony). However, (a) they were measuring trends in growth of aggregate cost per CMAD, and employment growth does affect such trends, and (b) the DHA Board was charged with measuring total savings; if the experts could not figure out a way to control for a factor as important as employment growth in a cost per CMAD regression, then either (i) the experts should have figured out a way to adjust their results to take account of changes in employment growth, or (ii) cost per CMAD is not the proper measuring tool.

The DHA experts also said that they included a variable for the uninsurance rate, which is an economic variable. AR 2-60-218 to 219 (Schramm Hearing Testimony). But Mr. Maffei disagreed on the adequacy of the substitution in a multi-state regression, because of wide differences in rates of medical insurance coverage among states. AR 3-61-127-128 (Maffei Pre-filed Testimony).

²⁹ AR 4-84-14 to 15 (Dobson Pre-filed Testimony). DHA’s experts’ excuse for omitting each of these variables was the same – that each such factor does not change over time in a state like Maine. AR 2-60-60 to 61. (Schramm Hearing Testimony). But there is no evidence that DHA’s experts tested this assertion, using either Maine data or the data from other states to which Maine was being compared.

³⁰ The cost cycle is a powerful force at the national level; individual states’ experience with the cost cycle is not always in sync with the national cost cycle. AR 5-98-5 to 6 (Rudin Pre-filed Testimony). A model that ignores this factor risks further biases. Here again, the reason for omitting it was that it does not affect unit costs. AR 2-60-62. (Schramm Hearing Testimony).

7. The model did not control for three factors used by the acting Superintendent to make substantial reductions to the AMCS for Year 3.

Among the factors ignored by the srHS model were three important factors that the acting Superintendent used in reducing the AMCS in Year 3:

“Specifically, the Board’s determination does not consider the potential effect of hospitals with negative margins (the estimate above indicated \$11 million as an effect of one assumption about this issue), the effect of cuts in MaineCare (up to \$30 million), and the difficult to quantify, but potentially important, issue of rising hospital outpatient prices artificially deflating the cost per CMAD figures over time.” AR 5-100-14.

The acting Commissioner concluded that those three factors had an average effect of “at least \$10 million per issue.” AR 5-100-14.

Hospital operating margins remain an important factor. A hospital with a low or negative operating margin is not going to pass on savings, and will try to increase charges. AR 5-104-3 to 4 (Roberts Pre-filed Testimony). The total operating margin for all Maine hospitals in 2006 was \$89 million³¹, which is less than the proposed \$119.4 million approved by the Board for hospital savings. The DHA experts testified that they did not use it (a) because hospital charges show up on both sides of the cost per CMAD formula, and cancel each other out,³² and (b) because hospital margins affect recoverability, and srHS was hired only to calculate “savings” and not recoverability. AR 2-60-144-146 (Schramm Hearing Testimony). However, (i) they were measuring trends in growth of aggregate cost per CMAD, and hospital margins do affect such trends, (ii) the acting Superintendent’s decision in Year 3 addressed recoverability issues on this very point, and (iii) the DHA Board was charged with measuring total savings; if they could not figure out a way to include a factor as important as hospital operating margins in a cost per CMAD formula, then either (i) the experts should have figured out a way to adjust their results to

³¹ AR 1-35 -35 (Dobson Pre-filed Testimony); AR 3-61-53 (Dobson Hearing Testimony).

³² AR 2-60-58 to 60 (Thorpe Hearing Testimony).

take account of changes in hospital operating margins, or (ii) cost per CMAD is not the proper measuring tool.

The reductions in the MaineCare reimbursement levels in prior years continue to reduce hospital margins, and cause hospitals to shift more of the burden to other payors. AR 5-99-8 to 11 (Fishbein Pre-filed Testimony). At the hearing, Mr. Schramm gave a detailed explanation of how changes in government reimbursement levels affect different parts of the cost per CMAD formula at the same time, with inconclusive results. AR 2-60-53 to 57 (Schramm Hearing Testimony). However, (a) they were measuring trends in growth of aggregate cost per CMAD, and changes in government reimbursement levels do affect such trends, (b) the acting Superintendent's actions and statements in Year 3 should have provided sufficient direction for controlling for this factor, and (c) the DHA Board was charged with measuring total savings; if they could not figure out a way to include a factor as important as changes in government reimbursement levels in a cost per CMAD formula, then either (i) the experts should have figured out a way to adjust their results to take account of changes in government reimbursement levels, or (ii) cost per CMAD is not the proper measuring tool. Mr. Schramm also said that percentage of Medicare and Medicaid days were part of the variable sets for some models, but admitted that rates of payment were not, and that lower rates would impact the hospitals. AR 2-60-181-182.

The cost per CMAD calculation can also be distorted, unless controlled for, when the outpatient utilization and charges grow faster than the inpatient cost per case, thereby deflating the average cost per CMAD growth. The Year 4 regression did not take this factor into account, again despite the acting Superintendent's actions and statements in Year 3, and even though

outpatient discharges in Maine have been growing much faster than the national average. AR 5-97 (Burke Pre-filed Testimony, Exhibit 4).

8. The unreliability of the “Dirigo savings” as calculated by the DHA experts is further demonstrated by the fact that “Dirigo savings” can be found in 29 other states – the DHA experts did not effectively isolate the real effects of Dirigo.

The Chamber’s expert, Dr. Dobson, ran the srHS regression model on all 50 states, and found “Dirigo savings” in 29 of them, including 15 with similar or greater “savings” than Maine. AR 4-84-28 (Dobson Pre-filed Testimony). This shows that the Dirigo variables are not that at all, since Dirigo is not responsible for activity in states such as California. At the hearing, Dr. Dobson said the following:

“What it showed is . . . that the other states show savings because their model has two components in it that are nationally reflective and not just Maine reflective. . . . [W]hat happened is their model predicts savings elsewhere. And in a lot of the work I do, once you find that finding, you go back to the drawing board.” AR 3-61-41 (emphasis added)..

“So what we have found is the Dirigo methodology applied to other states shows Dirigo savings which, of course, just doesn’t make any sense. . . You shouldn’t see savings for all of the other states when you use a model that purports to show Dirigo savings.” AR 3-61-42.

DHA’s experts did not go back to the drawing board, but attempted to present their findings as conclusive.

DHA attempted to rebut this criticism with an explanation that what Dr. Dobson really found from his tests on the other states was whether each state had costs per CMAD above or below the national average. AR 2-60-89 to 91 (Thorpe Hearing Testimony). The logical conclusion of this point is that (1) either 29 other states had “savings,” as defined by the srHS model, or (2) all srHS effectively tested for was whether Maine had costs per CMAD above or

below the national average, and not whether there were any savings from Dirigo. As stated by MEAHP expert witness Mr. Burke:

“the 50 state analysis of savings that . . . Dr. Dobson prepared shows that you can produce savings in any state. All it shows is that it’s above the mean but that’s all that happened in Maine – it’s above the mean... What you want to try to do with statistics then is show that that’s not random. And that ‘s where significance being so poor comes into play.” AR 3-61-192 (Burke Hearing Testimony).

On cross-examination, Mr. Schramm agreed with the following statement – “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.” AR 2-60-217 to 2181 (Schramm Hearing Testimony).

This is a powerful indicator that the model did not isolate for effects of Dirigo, and thus measured only a time trend, which is how Dr. Dobson characterized it. AR 3-61-42. DHA may as well have been measuring for the effects of the fact that the Red Sox won the World Series in 2004, and that the Yankees have not won the Series since then. AR 5-97-Burke Exhibit 2, pages 2-4).

- 9. The “savings” shown by the DHA model were calculated by using as their base a three-year period before July 1, 2003 when there was high cost per CMAD growth, and then attributing all reduction in that growth in the subsequent period to the Dirigo Act. The model thus unreasonably locks in an artificially high pre-Dirigo cost per CMAD growth rate and assumes it would have continued forever, thus inflating the “savings” attributable to Dirigo.**

To develop the projected CMAD cost growth in the absence of Dirigo, the srHS model trended the “pre-Dirigo CMAD” to 2007, using a multiple regression of other states that controls for the impact of non-Dirigo factors on hospital costs. AR 4-63-13 to 14. This “pre-Dirigo”

period was July 1, 2000 and ending June 30, 2003.³³ As noted by intervenors, medical costs tend to move in multi-year cycles, with periods of rapid increase followed by periods of low or more moderate increases. The cycle happens on a national level, but what happens in an individual state does not always mirror the national cycle. AR 5-104-4 to 6 (Rudin Pre-filed Testimony).

A three-year period, such as that used by srHS for its pre-Dirigo base period, captures only a small part of the cycle. The graph of the cost cycle included in the record shows (a) that on a national basis the cycle took 14 years to go from one peak (in 1988) to the next (in 2002), and (b) that nationally, the three-year period used by srHS as “pre-Dirigo” were three of the highest years in the cycle, and (c) the post-Dirigo period was one when cost increases were generally moderating across the country. AR 5-104, Rudin Exhibit 2 (Rudin Pre-filed Testimony). Note that this graph is of the rate of growth in costs – there are no years on the graph when costs were not going up in an absolute sense. In response to a question about the proper time frame, MEAHP expert witness Mr. Burke said:

“I would say 10 or 15 years of actual CMAD . . . and then you had a model that . . . predicted CMAD for 10 or 15 years and hopefully caught an inflection point where it starts from going up to going down or [vice versa] . . . Then I would be willing to rely upon a model . . . with significance that was showing close correlation with the history to see what might have been the effect. But . . . you need to demonstrate that you created a model that is predicting CMAD. And you can’t do it in three years. There are basically three years of trends and the statistics here show we haven’t done that. We haven’t specified it enough. I have a model that predicts future insurance company costs, and if I have seven years of history, I’m not yet comfortable that I’m not subject to some of the biases that we talked about.” AR 3-61-230 to 231 (Burke Hearing Testimony)

The DHA’s experts never explained why they picked such a short pre-Dirigo period.

They acknowledged that data was readily available for a longer period. AR 2-20-106-107

(Schramm Hearing Testimony).

³³ This basic fact on the methodology is not plainly set forth anywhere in the srHS report for Year 4, but needs to be gleaned from a number of references in the record – yet another example of the lack of transparency of the report. It was not a contested point.

Thus, not only did srHS ignore a powerful force affecting medical costs, but their selection of a base period is likely to have distorted the effects of that force on medical costs in Maine, inflating the “savings” which they purported to measure.

10. Looking at the actual year-by-year numbers (the “descriptive statistics”) further explains what were purported to be shown as “Dirigo savings,” and much of what the model shows is reversion to the mean

Maine had a dramatic drop in its rate of cost per CMAD increase in the 2002 to 2003 period (pre-Dirigo), and then the rate started to go back up again, well into the Dirigo period. This is illustrated by Table 2 in the Pre-filed Testimony of the Chamber’s regression expert, Dr. Dobson, which uses the srHS numbers as its source. AR 4-84-8. The post-Dirigo rate of cost per CMAD increase has generally been above national rates of cost per CMAD increase. [AR 4-84-8.

When asked about this, DHA’s regression expert, Dr. Thorpe, said that he likes to look at multiple years, in order to smooth out the effects of years like 2002-2003. AR 2-60-165 (Thorpe Hearing Testimony). But, as noted above, the “multiple years” that srHS used for comparison were three years at the top of a national 14-year cycle³⁴, and the srHS regression model did not control for the cost cycle at all. AR 2-60-62. (Schramm Hearing Testimony).

As stated by Mr. Burke, “using any three-year period to lock in a high CMAD increase rate that is forever projected into the future to represent what would have happened is unreasonable. The pre-SFY 2004 period is a small period that does not represent an underlying fundamental Maine specific ‘force of CMAD cost growth trend.’” AR 5-97, Burke Exhibit 2 at 4 (Burke Pre-filed Testimony)

What Dr. Dobson did was look at the graph of basic numbers (what he calls “descriptive statistics”), and that shows that the 2002-2003 was not an aberration that should be “smoothed

³⁴ Shown on the chart at AR 5-104, Rudin Exhibit 2 (Rudin Pre-filed Testimony).

out,” but an indicator of a significant trend. Mr. Schramm admitted that they did not “prepare any descriptive statistics for the variables in the data to see if there were measures of central tendency.” AR 2-60-133 (Schramm Hearing Testimony)

As noted above, what happens in an individual state does not always mirror the national cycle. Maine hospitals were regulated by the Maine Health Care Finance Commission (“MHCFC”) until the mid-1990s. Hospitals often play “catch-up” after the removal of regulation, leading to a peak in Maine that may have been higher than the peak in the national cost cycle. AR 4-84-8 to 9 (Dobson Pre-filed Testimony). So it is likely that the three-year sliver of the cost cycle used as the “pre-Dirigo” period captured a period when Maine was in the beginning of a decline from a high peak, but the absolute numbers remained high. The steepest part of the decline happened before Dirigo, as illustrated by Dr. Dobson’s chart, and then Maine cost increases went above national rates again.

The model demonstrates a pattern called “reversion (or regression) to the mean,” which means that in testing a before and after period, a high value in the earlier period is likely to revert to a lower value in the later period. Mr. Burke gave an example – a CFO for a hospital or some other large organization who grants a 10% pay increase two years in a row to a large employee group does not really expect to be able to provide that kind of increase in the third year. AR 3-61-187 to 189 (Burke Hearing Testimony). Both Mr. Schramm and Dr. Thorpe essentially acknowledged the validity of that pattern, when they admitted that it is not “reasonable to assume that hospitals are going to continue having cost growth at 11 percent and 9 percent indefinitely”³⁵ though they later contradicted themselves - when asked specifically about

³⁵ AR 2-60-158 and 165 (Schramm and Thorpe Hearing Testimony)

whether regression to the mean had anything to do with reductions in cost growth after Dirigo, they both disagreed. AR 2-60-286 to 87 (Schramm and Thorpe Hearing Testimony).

Thus it is no wonder that the srHS model, “measuring” \$147 million in cost per CMAD “savings” purported to have been caused by Dirigo, failed to pass standard tests of statistical significance – the “savings” were by comparison to the peak of a long-term cycle, and the model did not control for the effects of that cycle.

11. The model developed two flawed estimates – with and without Dirigo – and erroneously calculated savings as the difference between the estimates, rather than developing an estimate absent Dirigo and then comparing it to actual cost per CMAD growth in Maine. This inflated the amount of “savings.”

The Board’s experts did not compare actual cost per CMAD Maine data with a set of comparison data assembled by their model. Instead, they constructed an estimate/projection of Maine cost per CMAD in the presence of Dirigo, when actual figures exist, and compared that with estimates of cost per CMAD for several larger geographic groupings, each used as a proxy for Maine in the absence of Dirigo. AR 3-61-189-90 (Burke Hearing Testimony). In fact srHS used the actual cost per CMAD data in Year 3, and the numbers differed substantially from the estimates it used in Year 4.³⁶ That alone should have indicated that something was wrong with the model.

One of the key effects of using these estimates is that it caused the figure for measuring Maine cost per CMAD trends to increase, especially in the pre-Dirigo period. For example the number for the rate of cost per CMAD increase from 2000 to 2001 used in Year 3, based on the actual Medicare cost data (with a number of appropriate adjustments to the data set in a manner consistent with prior years not made in the Year 4 calculations³⁷), was 4.65%; the number used

³⁶ AR 4-90 (Chamber Exhibit 7)

³⁷ AR 3-61-193, 195 (Burke Hearing Testimony)

in the srHS report in Year 4, based on srHS's model, was 11.26%,³⁸ which did not include the type of adjustments made in the Year 3 calculations. Mr. Schramm acknowledged the discrepancy, and the fact that this would cause a huge difference in the calculation,³⁹ and admitted he did not compare the Year 4 CMAD values with those for Year 3. AR 2-134 to 135. Despite failing to conduct this most basic comparison/reasonableness check, Dr. Thorpe and Mr. Schramm several times in his testimony underscored how the validity of the model and the huge increase in alleged savings in Year 4 were both borne out by what their "raw" data was telling them. AR 2-60-38 to 39, 24 (Thorpe Hearing Testimony); AR 2-60-79 (Schramm Hearing Testimony). As shown by Mr. Burke, the MEAHP witness from the consulting actuarial firm Milliman, changing the number for that one year to the actual figures would eliminate any hospital savings found by the srHS model, by reducing Maine's pre-Dirigo growth rate from 7.8% to 5.6% -- this would make the difference between the pre- and post-Dirigo periods in Maine 1.1%, versus 1.5% for the US. AR 3-61-195-197 (Burke Hearing Testimony). He further stated:

"The other big picture test again is post Dirigo [Maine cost per CMAD] is growing faster than the rest of the country . . . if growth in Maine continues to grow faster than the United States out in the future, as long as it's growing slower than 7.8 percent, they will continue to find more and more savings every year." AR 3-61-198 (Burke Hearing Testimony).

12. DHA's experts conducted no interviews with hospitals to confirm or refine their hypothesis, or to give a reality test to the results of their regression

Regression analysis cannot exist in a vacuum. The people performing the analysis must be able to gauge whether their model is capturing the right factors, or coming up with an absurd

³⁸ AR 4-90 (Chamber Exhibit 7)

³⁹ AR 2-60-280-282. (Schramm Hearing Testimony).

result. Normally the way to do that is to conduct some interviews as part of the process. As the Chamber's regression expert, Dr. Dobson, said in his pre-filed testimony,

“Generally, it is advisable to employ numerous methods in studies such as this one. . . . For example, srHS could have supplemented its regression calculations with key-informant interviews, such as hospital finance personnel. Ideally regression results would be validated with consistent results from other approaches. It does not appear that srHS performed such approaches.” AR 4-84-18

Mr. Schramm admitted that they “didn't do any key informed interviews” despite a memo he did in 2005 on the desirability of doing interviews. AR 2-60-143 to 144 (Schramm Hearing Testimony); *see* AR 5-95(E) (Chamber Exhibit 12(E) including copy of 2005 Mercer memo). So when their calculation of hospital “savings” of \$147 million failed to pass standard tests of statistical reliability, they did not undertake a reality test.

13. Cost per CMAD is a tool designed to measure individual hospital performance; using aggregate cost per CMAD to measure total hospital cost savings is fraught with problems not adjusted for by DHA's model

Cost per CMAD is a tool designed to measure the cost containment performance of individual hospitals. It was not designed to measure state-wide hospital cost savings. AR 5-106-28 (Maffei Pre-filed Testimony). It is based on a complex formula set forth in the Maine statutes⁴⁰.

In his Year 3 decision on AMCS, the acting Superintendent said he had “serious problems with the cost per CMAD methodology,” citing its inability to factor in hospital operating margins, the effect of cuts in MaineCare, and other factors. AR 5-100-14. Yet in Year 4, srHS again did not adjust for these factors, citing their inability to make them meaningful using the cost per CMAD formula (see discussion at point A.7 above).

⁴⁰ Public Laws of 2005, Chapter 394, Section 4.1.B., found at AR 5-95-A (Chamber Exhibit 12-A). Mr. Schramm admitted that the formula used in the srHS did not follow all steps of the statutory formula. AR 2-60-110-112 (Schramm Hearing Testimony).

Savings must be measured against total expenditures. Total expenditures are calculated by multiplying cost by volume. Cost per CMAD is a measure of per-unit cost. Decreases in the unit cost of a procedure can induce more purchases of that procedure, resulting in greater expenditures and lower savings. The srHS model calculated total hospital costs by multiplying cost per CMAD by total number of discharges. So if lowering the cost of a particular procedure induces greater utilization, or if volume increases for any other reason, the lower per-unit cost is multiplied by the total number of discharges, making savings appear to be greater. But in actuality, expenditures have gone up. Dr. Dobson views that as the “fatal flaw of the CMAD analysis” AR 4-64-37 (Dobson Pre-filed Testimony); AR 3-61-44 to 45 (Dobson Hearing Testimony).

The findings of the srHS model on hospital savings failed to meet standard tests of statistical reliability. It may not have been possible to pass such tests with a cost per CMAD-based model.

B. With no savings proven by the Board, and no reasonable basis to fix the model, MEAHP urges the Superintendent to find hospital costs savings no greater than the \$21,187,761 estimated by Milliman

DHA has failed to prove any measurable cost savings. In Milliman’s Report, Mr. Burke stated that the srHS methodology was fundamentally flawed in its assumptions and in the misuse of underlying data, and that therefore no small adjustment can be made to create a reasonable and supportable estimate of savings. AR 5-97 at 6; see AR 3-205 to 207 (Burke Hearing Testimony). The obligation to measure savings is on DHA, and not on any intervenor. Nevertheless, without suggesting that the new srHS model proves that any savings are due to the operation of the Dirigo law, MEAHP actuarial consultant Milliman estimates \$21,187,761 in hospital savings, with the calculations shown on Attachment I to its report (at AR 5-97).

Milliman started from the Superintendent's findings for Year 3 of \$25 million in hospital savings, and made adjustments for (a) the impact of Maine cost per CMAD growing about .3% faster than national cost per CMAD, and (b) the change in adjusted discharges used in each year's srHS report.

As a further reasonableness check on this alternative calculation, srHS's own data shows that the CMAD cost growth rate in Year 4 (3.28%) was actually slightly higher than in Year 3 (3.17%) AR 2-41 (Chamber Exhibit # 7, DHA Year 4 Report, col. III, p. 54 for 2006 and 2007).

MEAHP urges the Superintendent to adopt a number no greater than Milliman's figure.

V. BAD DEBT AND CHARITY CARE

Last year the DHA Board itself accepted as reasonably supported the non-regression methodology put forth by DHA and its experts, srHS, subject to several adjustments proposed by MEAHP's expert, Milliman. This approach was approved by the acting Superintendent as being reasonably supported⁴¹ and did not direct DHA to develop new methodology, especially since there is reported data on how many previously uninsured people enrolled in Dirigo Choice and how many previously unenrolled people are enrolled in the expanded MaineCare program in the measuring year (2008).

Nonetheless, the DHA Board, without any direction to do so by the Superintendent, has approved a new BD/CC methodology which includes a complex multivariate, multi-state regression, using a series of flawed underlying assumptions. In approving this new methodology, the Board found \$23.6 million in AMCS for Year 4 in the category of Bad Debt and Charity Care ("BD/CC"). DHA Decision, August 11, 2008 at 10. This is almost four (4)

⁴¹ AR 5-100-15 to 18 (BOI Decision and Order, September 17, 2007)

times the \$6.3 million that the Superintendent approved for BD/CC in Year 3⁴² Again, the Board's decision, and its experts' report on which the Board relies, provide no reasonable support for finding any savings, and the Superintendent should reject the finding.

Appendix I to the srHS report⁴³ contains a summary of the BD/CC calculations by Dr. Kenneth Thorpe. Dr. Thorpe calculated rates of "uninsurance" using actual Maine data through 2006, then projected forward what he calculated as the Maine trend for the next two years to come up with a projected uninsurance rate for Maine in 2008 in the presence of Dirigo. He then compared that number with rates projected from three other projections in the absence of Dirigo, developed through a multivariate, multi-state regression model – one to calculate a comparison with the Northeastern states, and the second with the US as a whole, and the third to calculate a comparison with what he projected from the 1999 to 2006 trend for Maine. AR 3-61-263 to 267 (Thorpe Hearing Testimony); AR 4-64-74 (Agency Exhibit 2 (srHS report); *see* DHA Exhibit 16, AR 4-78 columns VIII-X). Any difference found by the comparisons was attributed solely to Dirigo. The results shown on DHA Exhibit 16 were then used to develop the savings calculations in DHA Exhibit 18. AR 4-80.

Dr. Thorpe recommended a blending of the results from two of the referenced regression models – 75% US and 25% Northeast. He felt this was warranted because, with other health care reform initiatives in the Northeast, it was not necessarily a good proxy for Maine without Dirigo. AR 3-61-266 to 267 (Thorpe Hearing Testimony); AR 4-64-74 (Agency Exhibit 2 (srHS report)).

⁴² AR 5-100-5 (BOI Decision and Order, September 17, 2007)

⁴³ AR 4-64-66 to 80

Nothing was reported as to the statistical reliability of any of the regression models, or as to why Dr. Thorpe did not recommend the results of the Maine-only calculation. Nevertheless, the Board adopted the results of the Maine-only calculation. AR 3-62-99 (Board Deliberations).

- A. The DHA Board’s determination of \$23.6million in BD/CC savings is not reasonably supported by the evidence in the record.**
 - 1. DHA did not meet its burden of proof – it presented no evidence on the reliability of the DHA regression calculations on projected uninsurance rates for Maine in the absence of Dirigo; its model lacks transparency.**

It is the DHA’s burden under the Dirigo Law to prove that its determination of AMCS is “reasonably supported by the evidence in the record.” 24-A MRSA §6913(1)(C.)” In their presentation to the Board on the hospital cost initiative, DHA’s experts presented evidence as to how their regression analysis measured up against standard tests of statistical reliability. As discussed in Part IV.A.3. above, their models failed, but at least the experts eventually presented the evidence. On BD/CC, they presented no such evidence on the reliability of their findings. DHA counsel did not ask either expert witness anything about their level of confidence in any of the BD/CC findings, either at the hearing or in pre-filed testimony.

Clearly, DHA did not meet its burden of proof as to the reliability of the regressions used to develop the absence of Dirigo projections for the BD/CC savings calculation. Given the DHA’s experts’ willingness to try to pass off regression results on the hospital savings initiative that were unreliable, the Board had no basis for confidence in their experts’ recommended regressions for the BD/CC initiative, and even less basis for confidence in a number not recommended by those experts, the Maine-only regression in column X of DHA Exhibit 18. AR 4-80..

The lack of reliability statistics is part of a basic problem with the Year 4 srHS report– its lack of transparency, as discussed above under the hospital savings initiative at point IV.A.5.

The evidence filed by DHA on BD/CC is even less transparent than what it filed on the hospital savings initiative, especially considering the exhibits which srHS eventually provided to supplement the hospital savings initiative section of their report.⁴⁴

The standards for transparency on regression findings were spelled out by Dr. Dobson in the context of the cost per CMAD findings -- reports on econometric regression analysis normally lay out the model, usually giving the mathematical formula. They then provide a literature review – as to what other similar studies have done. They then show the coefficients, the standard errors (using the .05 level). Then, they say why they think the findings are valid, and how they interpret the coefficients. AR 3-61-17 to 19 (Dobson Hearing Testimony). The report itself did not include much more than a description of the variables and tables of findings.

The DHA experts did provide some additional data to intervenors' experts, following requests, but certain data was deleted, making it impossible for Chamber regression expert Dr. Dobson to replicate the regression.⁴⁵ As stated by Mr. Burke, "I think whatever this model does, and if Mr. Dobson couldn't figure it out, it's hidden pretty well." AR 3-61-328 to 329 (Burke Hearing Testimony). Dr. Thorpe acknowledged the deletion; his excuse was that it was "in order to save the memory." AR 3-61-272 (Thorpe Hearing Testimony).

DHA's apparent defense on failure to meet its burden of proof on BD/CC is illustrated by a line of questioning from its counsel in direct examination of the DHA expert witnesses, to the effect that its experts provided everything requested by intervenors and answered all their questions. AR 3-61-272 to 273. But it is the Agency which has the burden of proof. The

⁴⁴ There was nothing on BD/CC comparable to Exhibits 11 and 12, which srHS eventually provided and which show the results of standard tests of statistical reliability on their cost per CMAD regressions. AR 4-73 and 4-74.

⁴⁵ "statistical programs were written that included instructions to delete interim datasets that were key to the analysis, output needed to evaluate results from the regression analysis was missing and the process used to 'un-log' regression results were not detailed." AR 4-84-40 (Dobson Pre-filed Testimony)

Agency would have to meet that burden in this proceeding with the Superintendent, even if there were no intervenors. And the Agency has not met that burden of proof.

As noted above in the discussion of hospital savings under IV.A.5, the record shows that DHA's experts backed away from the principle of transparency. In the case of BD/CC this led to no reasonable support for finding any savings.

The above should provide conclusive reasons for rejecting the figure adopted by the Agency for bad debt and charity care. The next logical step in the analysis can be part B -- returning to the calculation method approved last year by the acting Superintendent.

However, Sections 2 to 4 of this part A are presented for further corroboration, if needed, on the failure of the methodology, and the recognition of such failure by a majority of the members of the DHA Board.

2. The Board's experts used an unreasonable model to predict uninsurance rates in the absence of Dirigo.

Mr. Burke testified in detail about the unreasonableness of the srHS regression model used to predict uninsurance rates for Maine in the absence of Dirigo, as reflected in DHA exhibit 16, columns VIII-X. AR-4-78.

"I think those are unreasonable predictions of what un-insurance would have been in Maine. I think whatever this model does, and if Mr. Dobson couldn't figure it out, it's hidden pretty well. But whatever the model does, I don't think it's predicting Maine's un-insurance in the absence of Dirigo very well." AR 3-328-329 (Burke Hearing Testimony).

Mr. Burke gave several specific examples of why the absence of Dirigo regression model was mis-specified and unreasonable. AR 4-328-330.⁴⁶

⁴⁶ Mr. Burke testified: "Start with 2003 as an example. The number coming out of their model which in theory controls for everything and we don't want to get back into have you controlled for everything appropriately. But I think a very important point here is there has been some kind of shocks to the Maine system during this period that I don't think are controlled for and the evidence shows it. The prediction for 2003 is 14.37 [in DHA Exhibit 16, column XIII]. The actual is a large decrease [for 2003] to 11.79 [column I]. And going forward off of that, the

3. The Board’s experts used an unreasonable projection of “actual” uninsurance rates in the presence of Dirigo to 2008 from 2006 actual

The uninsurance rates used by srHS for 2007 and 2008 (in the presence of Dirigo) are projections of a purported trend from the 2003-2006 period, without any demonstration that such trend continued (if it even existed). Dr. Thorpe admitted that they were projections. AR 2-60-300 (Thorpe Hearing Testimony).

As reported by Milliman⁴⁷, the reductions in the number of uninsured persons during the 2003-2006 period were more than 100% attributable to three specific events: (1) the 2002 MaineCare expansion, which, as reported below, added about 36,347 enrollees, (2) the DirigoChoice program, which added over 12,000 enrollees⁴⁸, of whom 35% reported being previously uninsured, for about 4,200 enrollees and (3) the 2005 expansion of MaineCare to Parents of Children, which was part of the Dirigo legislation and added about 5000 enrollees. The srHS figures that Milliman cites show that, after going down in 2003 (the first full year after the 2002 event), the number of uninsured increased in the 2004-2005 period, so it is not at all clear that the number would have further decreased in the two years after the 2005 event.

numbers coming down a little bit but fundamentally we’re off by several points already.” ...”so I think...coming up with a model and saying I think it would have been 14.37 dropping to 13.5 [absent Dirigo –column VIII] is unreasonable especially since there was a massive MaineCare expansion [pre-Dirigo]in 2003. And you talk about the Woodwork Effect, in addition to the 17,000 that signed up in basically that first year, there were another 21,000 that signed up in the traditional Medicaid program that first year [pre-Dirigo]. So the un-insurance rate came down dramatically from 13 to under 13. And that obviously without being picked up in the projection of in the absence of Dirigo... And that was not due to anything Dirigo did...Then another shock was the DirigoChoice program frankly. And Dirigo gets credit for signing up 5,000 previously uninsured and helping the other 7,000. And this model doesn’t control for that obviously. And so it’s another variable that mis-specified in picking what you’re going to use to project in the absence of Dirigo because there is no variable that controls for that.” AR 4-328-330 (Burke Hearing Testimony).

⁴⁷ AR 5-97 (Burke Pre-filed Testimony, Burke Exhibit 2 (Report) pages 8 to 9)

⁴⁸ The number of enrollees was initially higher, but was down to 12,050 by 2008. AR 5-97 (Burke Pre-filed Testimony, Burke Exhibit 2 (Report) page 11)

As Mr. Burke explained, the only net decreases in the number of uninsured happened when there was a “shock to the system” caused by MaineCare expansion and/or by the start-up of DirigoChoice. AR 3-61-332 to 333 (Burke Hearing Testimony). Dr. Dobson found that there were no such shocks to the system after 2006:

“Likewise, there has been no significant increased enrollment in the Dirigo Health Act MaineCare parent’s expansion from 2007 to 2008. Enrollment in DirigoChoice has actually declined since 2007. Therefore srHS model over-estimates the expected reduction in uninsurance rates.” AR 5-104-40 (Dobson Pre-filed Testimony)

The numbers used by Dr. Thorpe for projected decreases in uninsurance were 7414 in 2007 and 5276 in 2008,⁴⁹ with no evidence that there were any “shocks to the system” in those years comparable to the two shocks that caused the actual decrease of 7837 in 2006.

A majority of the DHA Board, in their deliberations, initially rejected Dr. Thorpe’s methodology,⁵⁰ including his projections, with statements like the following from Mr. Beal:

“[T]here were these active moments in the uninsured level that Burke called shocks...I don’t see in the record that there have been such similar changes since then. That’s why I would tend not to believe that that trend should be relied upon to determine the savings.” AR 3-62-14.

While these Board members eventually changed their votes to end a deadlock on non-substantive grounds,⁵¹ the above remains valid – there is nothing in the record that supports a projected decrease in the number of uninsured people in Maine after 2006, a key element of the model used by Dr. Thorpe in each calculation.

⁴⁹ AR 5-104-39 (Dobson Pre-filed Testimony). Dr. Thorpe agreed that the numbers on that table were the right numbers, assuming that the Excel spreadsheet properly derived them from the numbers which Dr. Thorpe used AR 3-61-280 to 281. The numbers shown on that table for the number of uninsured for the years through 2006 are the same numbers as are shown in the table from Mr. Burke’s report included in the text above.

⁵⁰ See point C below

⁵¹ Id.

4. The findings are grossly biased by the unreasonable, unsupported inclusion of 2003 as part of the post-Dirigo period; if it were not included, this factor alone would reduce the recommended savings by 75%, to \$7.2 million.

The srHS report included 2003 in the “post-Dirigo” period for purposes of the calculation. This was an unsupported attempt to have DHA take credit for a significant MaineCare expansion, effective October 2002, to cover the non-categorical adults, which contributed to an increase in MaineCare enrollees from July 1, 2002 to July 1, 2003 of 36,347 persons. Milliman finds that if 2003 were shifted to pre-Dirigo in the srHS calculation, it would reduce the BD/CC savings about 75%, to \$7.2 million. AR 5-97 (Burke Pre-filed Testimony, Burke Exhibit 2 (Report) page 8). As Mr. Burke testified, column VII in MEAHP Exhibit 7⁵² shows that srHS’s own reasonableness check⁵³ showed an even lower number - \$2.1 million – thus confirming the impact of making this adjustment:

“...if you don’t give Dirigo credit for the first MaineCare expansion, their reasonableness check is two million.” AR 3-61-335 (Burke testimony); *compare* AR-5-103 (column VII) *with* AR-4-80 (column VII).⁵⁴

There is no supportable reason to include 2003 in the post-Dirigo period, other than to grossly inflate the BD/CC number. The statute calls for calculation of:

“aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.” 24-A M.R.S.A. §6913.1.A (emphasis added)

⁵² a copy of a supplemental version of DHA 18 in DHA Exhibit 3A. AR 4-65 (CD).

⁵³ DHA Exhibits 18 and 3A, column VI. AR 4-65 (CD).

⁵⁴ Mr. Burke also testified that srHS’s reasonable check on the impact of moving the post-Dirigo period forward to 2004, may be more accurate given that srHS produced DHA Exhibit 3A electronically and Mr. Burke made the calculations on paper, and given the large number of Maine people multiplied by a small difference to calculate the figure. He also testified that Column VII is not part of the srHS regression and is therefore “followable” but columns VII-X were the results of the regressions and were not. AR-61-335 (Burke testimony).

Clearly the 2002 expansion of MaineCare eligibility is outside the scope of this provision of the Dirigo Health Reform Act. And, given that DHA did not begin issuing DirigoChoice medical insurance coverage until 2005, there is no supportable argument that Dirigo had any effect on DirigoChoice enrollment in 2003. AR 4-84-38 to 39 (Dobson Pre-filed Testimony).

Dr. Thorpe's excuse for putting 2003 into the pre-Dirigo period was that he had used calendar-year data,⁵⁵ but srHS had adjusted other calendar year data to put it into June 30 fiscal years for the cost per CMAD analysis.⁵⁶ Dr. Thorpe acknowledged the large shift attributable to about 17,000 new enrollees in MaineCare resulting from the 2002 MaineCare expansion. AR 3-61-312 to 314 (Thorpe Hearing Testimony). He also acknowledged that if 2003 had been included in the pre-Dirigo data, it would have caused the pre-Dirigo decline in uninsurance rates to be even greater than his calculation showed. AR 3-61-283 (Thorpe Hearing Testimony).

Dr. Thorpe also responded to the issues about 2003 with revised Exhibits 16 and 18, with the savings findings increased to from \$35 million to \$41.8 million. AR 5-103 (MEAHP Exhibit 7). This is completely illogical, since the largest decrease in Maine uninsurance rates in all of the examined years, occurred in 2003.⁵⁷ He nevertheless stuck with his findings (which in some places were reported as in the range of \$51 million). He explained this as follows:

“The reason why when you move the start year further on down that you get bigger savings is if you look at the actual experience in Maine's un-insurance rate between 2005, 2006 versus the U.S. trends, they are dramatically different. The un-insurance rates go down a percent point which is a tremendous reduction in numbers, and it goes up slightly nationally. And if you start this earlier, the trend that we're trying to project is not as big a reduction in the uninsured. So if you actually started in 2003, that is the lowest savings number. If you started in the area they were pushing us to

⁵⁵ 10 (Thorpe Pre-filed Testimony)

⁵⁶ AR 4-84-38 to 39 (Dobson Pre-filed Testimony)

⁵⁷ See A.3. above.

start at, you get up to 51 million in savings numbers.” AR 3-61-317 (Thorpe Hearing Testimony)

This result and response is a dramatic illustration of how flawed the regression model was. It was cited as a factor for the initial rejection of the Thorpe recommendation by the experienced DHA board members. See point C below.

5. The contention that the Dirigo Act has decreased uninsurance rates by causing a reduction in insurance premiums is not reasonably supported.

Among the reasons given by the DHA’s experts for the global, indirect approach of measuring BD/CC savings is that

“Dirigo has had multiple, overlapping impacts on the health care expenditures in Maine, including reducing premiums and generating more competition for all health care purchasers. These changes increase enrollment into health care insurance by making premiums more affordable. AR 4-64-16 (Agency Exhibit 2 (srHS report))

When asked about how this is evidenced, Dr. Thorpe talked about all categories of coverage, from various MaineCare programs, to employer-sponsored insurance, without referencing any direct evidence of increased enrollment in any of them (other than what has been described above for the MaineCare expansions). AR 3-61-319-320 (Thorpe Hearing Testimony)

On employer-sponsored insurance, Dr. Thorpe said:

“given the savings we have demonstrated in the CMAD analysis and, indeed, if you go to Mr. Schramm’s testimony and look at the premium growth in Maine relative to the national average where they are converging and going down, that has also empirically resulted in an increase in the share of the population with employer-sponsored insurance.” Id.

But as noted above, (a) the cost per CMAD “savings” reported by srHS are highly suspect – the regression results are unreliable, and Maine’s growth rate in the post-Dirigo period has been higher than national averages, and (b) the number of uninsured people projected by DHA’s experts in both the presence and absence of Dirigo is not reasonably supported. These

experts used an indirect approach to measure the amount, without interviewing anybody or seeking any other empirical evidence to check on the measure.⁵⁸

Moreover, Dr. Thorpe's assertion deals with premiums, and srHS did not measure premiums. Cost per CMAD is, by definition a measure of costs. As stated by Adam Rudin, an actuary employed by CIGNA, "Health insurance premiums usually go in a cycle which is similar to the cost cycle, but usually lagged behind the cost cycle." AR 5-98-6 (Rudin Pre-filed Testimony). So Dr. Thorpe had no reasonable evidence for his indirect indicator (premium levels), let alone on any decreases in uninsurance rates other than those caused by the DirigoChoice program and MaineCare expansions described above.

Finally, Mr. Burke unequivocally testified that this global approach was unreasonable:

"especially here where we had a methodology that was approved and Superintendent didn't say change it and numbers were pretty definable. The notion of... saying "I'm going to try to estimate what it would have been in Maine to begin with and then – but basically to say ...everything that affects uninsured is somehow related to the Dirigo activity I think is an unreasonable approach....We can go on for days probably introducing evidence of other things that happened that affect the uninsured from carrier products, income, you know. And I don't think they have controlled for everything, and I don't think this is a reasonable approach both in concept – even if they were doing a good job of predicting un-insurance, I don't think you can attribute it to Dirigo. It's just a global Maine impact. That part is unreasonable as well." AR 3-61-336 to 337.

B. With no savings proven by its experts, and no reasonable basis to fix the model, the Board should have returned to proven methodology and found BD/CC savings no greater than the \$6.1 million estimated by Milliman

DHA has failed to prove any measurable cost savings on bad debt and charity care. The obligation to measure savings is on DHA, and not on any intervenor. Mr. Burke testified that the srHS new BD/CC regression model could not be reasonably modified to calculate savings. AR 3-61 at 343. Nevertheless, MEAHP and its expert, Milliman, recommended a return to the more direct method approved by the DHA Board and the Bureau of Insurance last year. This results in

⁵⁸ AR 3-61-309-310 (Thorpe Hearing Testimony)

a \$6,081,710 BD/CC figure, down from \$6.3 million last year, as a result of a decline in the DirigoChoice enrollment from 14,185 to 12,050, more than offsetting the MaineCare expansion increase in enrollment from 5,100 to 5,597 (MEAHP Exhibit 1, Burke Exhibit 2 (Report) Attachment II).

C. Despite fatal flaws in the model and as applied, the Board arbitrarily and capriciously and with no reasonable support in the record rejected the alternative calculation by Milliman, based on what the Board and the acting Superintendent adopted in year 3.

The transcript of the Board's deliberations this year shows a remarkably arbitrary and capricious reversal of position on methodology which the Board approved in year 3, with no reasonable support for reversal on the record. The Board conducted an initial debate, with veteran Board members Beal, David and Commissioner Head strongly favoring adoption of the Burke approach, consistent with last year's decisions by the Board and the Superintendent. Mr. Beal noted that the Board approved \$6.3 million last year and the Superintendent approved that figure, noting it was "not inconsistent" with the Year 2 approved amount of \$5.5 million. AR 3-62-6. He also noted that the srHS proposed \$35.6 million was almost six times more than the amount approved in Year 3. He was persuaded by Mr. Burke that with no identifiable shocks in 2007-2008, it was questionable whether srHS was correct in assuming the trend in reducing the number of uninsureds would continue as projected and that Burke's alternative calculation of \$6.1 million was credible. Id.

Commissioner Head found no evidence in the record that srHS adjusted their calculation to account for the lack of any new shocks to the uninsurance rates in 2007 and 2008, and noted that the Board had a number approved last year by the Superintendent. She also noted that srHS had presented a completely different methodology and stated "but I don't think the figure that results from schramm-raleigh on this issue is defensible." Id. at 8.

Dr. David advocated going with the Burke analysis. He was very concerned that the srHS model “went up” from \$35 million to \$51 million when they adjusted for when the Dirigo impact started, and that it was “hard . . . to wrap around” using the new analysis and getting such a huge variation in enormous numbers compared to “doing it without the [new analysis]” and getting \$6 to \$7 million using last year’s model. *Id.* at 9. Even new Board member Turowsky agreed that she was somewhat persuaded by Mr. Burke that srHS did not make their case when the post-Dirigo period was moved to 2004 and was concerned about the “huge difference” that resulted. *Id.* at 10-11.

Chairman McAfee noted that last year’s figure was realistic, proven by the data, easy to measure and approved by the Superintendent and he was “bothered” by the fact that there has been no new enrollment in DirigoChoice since September and that made this enrollment “not quite as impactful, perhaps, as it was this past year.” *Id.* at 11. Veteran member Beal agreed, stating that he was frustrated that DirigoChoice enrollment, which has been the driver of reduction in the uninsured, has been frozen, and he found a “credibility issue” because he has been through this process in prior years. *Id.* at 12. He stated:

“...statistics are great, but you have to compare the statistical results to what we know or have reason to believe has happened in the real world. I’m afraid that the reduction in our uninsured . . . has come to a screeching halt in the last year because of the funding difficulties in the agency. And I guess I would temper great statistics by my perception of reality. And that’s the reason I would propose the . . . 6.1 number.” *Id.* at 13.

“srHS ... essentially [used] a straight-line statistical trend extension; I think whenever you have a trend extension – I’m not a statistician – you’re assuming that the same conditions will have been in place. And we know that there was – there were these active moments in the uninsured level that Burke called shocks...I don’t see in the record that there have been such similar changes since then. That’s why I would tend not to believe that that trend should be relied upon to determine the savings.” *Id.* at 14.

Despite this unrelenting criticism of the srHS methodology and demonstration of the lack of reasonable support for it in the record, the Board tabled further discussion of the BD/CC determination until they voted on the hospital savings initiative, because they did not have unanimous support to adopt the Burke alternative. AR 3-62-19. It should be noted that the Dirigo Act requires five (5) Board members to vote in favor of an action for it to be effective. 24-A M.R.S.A. § 6904(6), and there were at the time of deliberations only five voting members in office and present.

When the Board again took up the BD/CC savings issue, the veteran Board members still saw no basis for the nearly six-fold increase from the year 3 savings, as recommended by Dr. Thorpe. For example, Mr. Beal said the following:

[The Burke number is] “far more objectively determinable, the number of uninsured from which we derive the uninsured from, the bad debt and charity [*sic*] gain, the use of trending as Dr. David points out, depending on which periods you use comes up with wildly huge numbers. To me there is just no essential grounding in our experience that that trend continued in either the 51 million or the 35 million...” Id. at 60.

“So if the Superintendent this year is going to apply another overall reasonableness test then I doubt if 35 million will meet that reasonableness test. Now, if we have some compelling reason to think that there has been this very large five or six times increase in the amount of savings for bad debt and charity care, well, that would overcome that kind of reasonableness test. I frankly didn’t see that the trending calculations which were presented to us by the agency provided that kind of overwhelming evidence.” AR 3-62-72.

New Board member Turowsky agreed with these concerns, stating:

“The intervenors suggested that . . . the years be parsed out differently. . . And the common sense application to that should have resulted in a decrease . . . of the \$35 million. . . . So it did not seem common sense that when you applied [the srHS methodology], that it went up that dramatically...How that got parsed out is problematic.” Id. at 60.

New Board member McAlaney stated that she:

“liked the [srHS] methodology, having not been here before. I liked the methodology as far as the bad debt and charity care ...and I am inclined to go with ...the schramm-raleigh report.” Id. at 58-59 (emphasis supplied).⁵⁹

There is no clear indication in the record that this Board member understood how the model purported to calculate the Dirigo Act’s effect on reducing health insurance premiums to reduce uninsurance rates, and indeed there is no reasonable support in the record for anyone to understand how the model accurately measured this hypothesized effect. This is a classic example of the result of impermissible license given by an unconstitutionally vague statute to an agency to act based on preferences or criteria so subjective that they are virtually unreviewable, *See MEAHP*, 2007 ME 69 at ¶ 71.

Commissioner Head still advocated to reject the srHS methodology:

“[B]ad debt and charity care is much... more of a Maine-based discussion because all of the providers and hospitals are here. So I don’t think there was any direction given by the superintendent on how to figure this out....I have some difficulty with getting comfortable with a purely statistical analysis when many of the pieces of information appeared, at least last year, to be available and we came to an agreement on what the appropriate number was. ...So I did not care for the use of trending methodology by schramm-raleigh...it didn’t take into account factors that we are very clear did happen and likely to happen in the future. So if you accept the methodology, then that figure is just going to keep gong down, and I don’t think that’s realistic.” AR 3-62-64 to 65.

“I thought the decision last year and the methodology used last year on this issue was appropriate and I see no reason to change that.” Id. at 66.

“If you look at the decision and order on this issue from last year, the superintendent goes back to review the history of this number and the year before – it would be year two, based on overall reasonableness, a figure of 5.5 was approved. If you go to 5.5 to 6.3 and then now this year the Burke figure is 6.1, to me that is much

⁵⁹ This same Board member added the statement: “I would like to see a way to get something that might be less than the 35, particularly when you go back and look at the discussion around the 51, that there is – in my mind, there has to be somewhere to get because six [million] is—my instinct is that there is more out there than that.” Id. at 71. And later in the debate in reference to the Milliman alternative, said: “...it doesn’t give me a comfort level.” Id. at 85 (emphasis supplied).₂

more...supported by evidence in the record that the figure offered by Schramm this year. Id. at 71-72.

Veteran Board member Beal, referring to (and quoting from) page 18 of the Year three decision, agreed:

“one final test of the overall reasonableness of this result,’ the 6.3 [million dollar finding] ‘is that it is not inconsistent with the \$5.5 million amount found to be reasonably supported in year two.’” So if the superintendent this year is going to apply another overall reasonableness test then I doubt if 35 million will meet that reasonableness test. Now, if we have some compelling reason to think that there has been this very large five or six times increase in the amount of savings for bad debt and charity care, well, that would overcome that kind of reasonableness test. I frankly didn’t see that the trending calculations which were presented to us by the agency provided that kind of overwhelming evidence.” Id. at 72.

Despite nearly an hour of advocacy by the veteran contingent of the Board to adopt the Milliman model and calculation, the same Board member, new to the Board this year – who did not participate last year – heard the impatience of the other Board members,⁶⁰ and deadlocked the Board, by making it clear that she was not willing to accept the Milliman alternative calculation⁶¹ and by making statements like “I think our responsibility as a board is to make a decision and to stay here until we make a decision.”⁶²

The veterans continued to protest as to how the report did not make sense. For example, Dr. David said:

“I cannot get in my head why the actual number of apples in the bushel is wrong and I need to do a projection of what my bushel might look like with my virtual trees and coming up with another one.” AR 3-62-90.

⁶⁰ AR 3-62-79 (Dr. David: “ Not wishing to spend my weekend in this charming room, I will say that if my fellow board members can convince me that we should use this methodology, then I would use it for Maine.” He also stated: “...I’m not with all deference to the Maine Legislature and its inability to appoint the rest of the board because I happen to believe in the other (Milliman) methodology. But like I said, I’m not going to sit here all weekend.” Id. at 80.

⁶¹ AR 3-62-76

⁶² AR 3-62-88

Eventually, Dr. David stated that he had:

“...come up using Burke’s numbers and the cost per uninsured, **and I realize it’s a methodology that isn’t out there in front of you**, but it happens to work out within a million of the Maine model only that srHS has come up with. And so I could probably, for a different mathematical reason, but I could support the Maine only schramm-raleigh number.” *Id.* at 98 (emphasis supplied).

On the basis of a methodology that is not anywhere in the record and unknown to anyone but Dr. David, the veterans, breaking the deadlock, completely reversed their prior position (to go back to the Year 3 approach), and joined in unanimous approval of the \$23.6 million findings of the Thorpe model in year 4 based on Maine only. AR 3-62-99. No Board member mentioned the fact that Dr. Thorpe had accorded zero weighting to the Maine-only findings in making his recommendation.

The Board has not provided reasonable support in the record for the new methodology (which they clearly did not even understand) and the Superintendent should determine zero savings or at a minimum adopt the year 3/Milliman approach and find \$6,081,710 .

VI. THE DHA BOARD’S DETERMINATION OF \$6.6 MILLION IN MEDICAL LOSS RATIO (“MLR”) SAVINGS IS NOT REASONABLY SUPPORTED IN THE RECORD.

In Year 4, for the first time, the DHA Board approved \$6.6 million in “cost savings”⁶³ due to the fact that Aetna Life Insurance Company (“Aetna Life”) paid a refund of \$6,563,907 to certain policyholders as a result of the operation of the Medical Loss Ratio (“MLR”) provisions of the Dirigo legislation, which are found at 24-A M.R.S.A. §2808-B(2)-C.

A. There is no basis in the Dirigo statute to treat MLR refunds as savings

AMCS is calculated pursuant to the following provision in the Dirigo Health Act:

“[T]he board shall determine annually not later than August 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any

⁶³ DHA Decision, August 11, 2008 at 10.

increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.” 24-A M.R.S.A. §6913.1.A (emphasis added).

There is no mention of the MLR provisions in any AMCS provision of the Dirigo law, including the above definition; similarly there is nothing in the MLR provisions tying them back into the AMCS calculation. If any connection was intended, then the law should have specified that these refunds should have been sent directly to the Dirigo Health Agency or retained by the carrier and designated specifically as constituting “savings” under that law.

As discussed below, there is no logical basis to conclude that refunds to individual policyholders resulting from the application of the MLR provisions of the law should be treated as savings to the health care system, to be included as part of AMCS.

This is yet one further demonstration of the unconstitutional vagueness of the AMCS statute and the unconstitutional, improper delegation of taxing authority to the Executive Branch, as discussed above in part III.

B. The Board’s decision resulted from faulty analysis

The facts on the MLR situation were presented in the following testimony from Dr. Daniel R. Fishbein, the Head of Aetna’s National Health Plan Alliances business:

“The Dirigo legislation added subsection 2-C to 24-A M.R.S.A. §2808-B. This subsection requires health insurers to review the premium levels and related medical costs associated with their small group book of business. If total medical costs are found to be less than 78% of total premiums, the insurer must refund a percentage of the premium back to current in-force policyholders. The analysis must be done on an entity-by-entity basis.

Aetna has offered different types of plans through separate entities -- (a) HMO and POS plans through Aetna Health Inc., and (b) PPO and indemnity products through Aetna Life Insurance Company.

Due to Aetna’s structure, we were not allowed to combine and report on our entire book of small group business in Maine, as other insurers have been able to do. Looked at as a whole, our complete book of small group business in Maine would have surpassed the 78% benchmark. However, when they were separated

by legal entity, our HMO business, which had higher medical costs, passed the benchmark, but our PPO business, which had lower than expected medical costs, did not.

The refunds were calculated in accordance with Maine Small Group law, using a rolling 36-month timeframe, from July 1, 2004 through June 30, 2007. We reviewed medical costs and premium levels this period for both of our subsidiaries doing business in Maine. We determined that employers with small group health policies currently written by Aetna Life Insurance Company were entitled to a refund, and refunds were mailed by March 1 to about 1,000 customers. Many other Aetna policyholders were not affected by the refund. The total amount of the refund was approximately \$6.5 million.” AR 5-99-12 (Fishbein Pre-filed Testimony).

It is impossible to conceive of how payment of a refund results, in and of itself, in any savings to anybody who does not actually receive the refund.

The DHA in its filing and testimony do not demonstrate any AMCS as a result of the Aetna Life refund. The only evidence submitted consists of conclusory statements in the srHS report,⁶⁴ and a copy of the letter submitted by Aetna Life with attached calculations.⁶⁵

There were, in fact, no savings for the following reasons. First, those Aetna-covered employers and their employees entitled to receive the refund have already received the benefit of that refund. For them to pay this amount back as part as part of the AMCS/SOP assessment removes that benefit, and defeats the purpose of the medical loss ratio provision in the Dirigo legislation. Second, for employers and their employees insured through employer groups and employees covered under any other fully insured and self-funded plans (including plans offered by another Aetna entity), they have received no refund and yet would under DHA’s methodology be assessed a portion of the AMCS/SOP. This is unreasonable as there is no “offset” of any savings to these groups whatsoever against the proposed AMCS/SOP assessment.

⁶⁴ AR 4-64-19 (srHS report)

⁶⁵ Id. at 81 to 83

In fact these refunds can never be recovered from anyone by any insurer or anyone else. DHA flatly admits this in its brief. AR 2-50-10. Mr. Schramm testified that none of these refunds goes to any physician, hospital or other provider; it only goes to the specific subset of Aetna insureds. AR 3-61-365 (Schramm Hearing Testimony). As such the refunds are not savings to the healthcare system and should not be included in AMCS for Year 4.

It was absurd for the Board to have adopted this new category of savings with no reasonable support for finding any savings under it.

The Board acted in a vacuum, without any discussion of the underlying basis for this new category of savings or these very arguments as to why it should not be included as part of AMCS⁶⁶, and with no discussion at all of the illogical assumption that a figure that can never be recovered from anyone can be included as part of AMCS.⁶⁷

VII. THE DHA BOARD'S DETERMINATION OF ZERO OVERLAP IS NOT REASONABLY SUPPORTED IN THE RECORD

In Year 4, the DHA Board found no overlap among the initiatives for which it found AMCS.⁶⁸

⁶⁶ The following was the only significant discussion of MLR at the deliberations before the Board unanimously approved the \$6.6 million figure:

“Mr. Beal: Then if we start with the MLR of 6.6 million which is what schramm-raleigh suggested, that seems corroborated by the Cigna [sic.] submission. I don't see any significant dispute that that's the proper number.”

...

Dr. McAfee This is based upon the testimony from Aetna, the 6.6 million that they returned.

I think there was a good debate in our book about this that there is a possible adverse effect that can occur with using a medical loss ratio, but I do think that the proven actions that happened this year identified as savings.” AR 3-62-4.

⁶⁷ The Board also violated procedural due process violation in its failure to consider recoverability at this time; this had the effect of postponing the decision on recoverability until the stage at which it sets the savings offset payment. No adjudicatory hearing is held at that time and that determination is not reviewable then by the Superintendent, thus removing the procedural safeguards that have been set up for the determination of AMCS.

⁶⁸ DHA Decision, August 11, 2008 at 10 to 11.

A. Hospital Savings and BD/CC do overlap because the Board adopted DHA's new global models for each category

As described in earlier sections of this brief, in Year 4 the AMCS which the DHA Board found for Hospital Savings and BD/CC were both based on indirect estimations based on multivariate, multi-state regression models.

The approach was described as follows: "We are taking a much more global view in Year 4 by incorporating all of the impacts that Dirigo has had on the marketplace in Maine, since Dirigo has driven down the rate of growth of health care expenditures in Maine." AR 1-16-21 (Schramm Pre-filed Testimony).

Using an indirect global approach on two elements of healthcare costs is much more likely to pick up the same elements twice. Yet the DHA's expert's only attempt at an explanation makes no sense:

"the Year 4 analysis for BD/CC includes only those costs, charges, and discharges that would have existed in the absence of Dirigo as well as in the presence of Dirigo. Thus, the CMAD estimates are not any different (in the presence or absence of Dirigo) as they are already incorporated in the existing BD/CC expenditures and utilization." AR 4-64-20 (srHS Report).⁶⁹

But if a hospital (whose costs are measured under the cost per CMAD calculation) receives a higher percentage of payment of its charges because it is incurring a lower amount of bad debt, that reduces the pressure on that hospital to collect more money from paying customers, and this reduction should be captured in the cost per CMAD calculation. AR 5-97, Burke Exhibit 2, page 10 (Burke Pre-Filed Testimony).

The BD/CC savings accrue to all providers, but srHS has already captured the hospital portion in the CMAD regression. Milliman, relying on the Hadley/Holleran sources used by srHS, finds that 66% of uncompensated care is for hospitals (the remainder being for physicians

⁶⁹ There is a similar statement at AR 1-16-24 (Schramm Pre-filed Testimony).

(14%) and community health clinics (20%)), and accordingly recommends that if any savings figure is derived from the srHS analysis, the total SOP be reduced by 66% of the amount of the final BD/CC savings.

Therefore, the DHA Board should have reduced its total AMCS by 66% of the AMCS which it found in the BD/CC category. The overlap adjustment should have been \$15.58 million:

$$66\% \times \$23.6 \text{ million} = \$15.58 \text{ million}$$

If Milliman's recommendations for both CMAD and BD/CC were followed, there would be no need for an overlap adjustment, since it is built into Milliman's calculation. AR 5-97, Burke Exhibit 2, page 10 (Burke Pre-Filed Testimony).

B. Overlap is also likely with the unrecoverable MLR

While DHA did not prove any recoverable savings from the MLR initiative, DHA claims that if there were any savings from such initiative, they would make insurance coverage more affordable, allowing more people to buy insurance and reducing the amount of bad debt and charity care. As such, any MLR savings may overlap with the cost per CMAD or BD/CC estimates. AR 5-97 (Burke Pre-Filed Testimony, Burke report at 11).

VIII. CONCLUSION

For all of the reasons set forth above and in the briefs of the Maine State Chamber of Commerce, Anthem Health Plans of Maine, Inc., and the Maine Automobile Dealers Association Insurance Trust, MEAHP requests that with respect to the following DHA savings initiatives, the Superintendent should:

1. **Hospital savings** – Reject the multistate multivariate US regression model as an unreasonable, fatally flawed approach for measuring Hospital Savings, and should

therefore reject the related calculation of \$119.4 million as determined by the Board as not being reasonably supported by the evidence in the record.

2. Direct DHA to develop a statistically reliable, transparent and accurate methodology for isolating the true effects if any of the Dirigo Act in producing Hospital Savings in future years which is reasonable and credible and addresses the numerous flaws documented in the record and outlined in this brief.
3. Adopt the Milliman approach for the Year 4 AMCS determination of Hospital Savings (based on the Superintendent's decision in Year 3) in the amount of \$21,187,761 as being reasonably supported by the evidence in the record.
4. **Uninsured/Underinsured** – Reject the Board's new, multistate multivariate model comparing flawed projected Maine uninsurance rates in the presence of Dirigo with a flawed projection of those rates in the absence of Dirigo based on a "Maine only" regression, as an unreasonable, fatally flawed approach for measuring savings.
5. Reject the Board's calculation of \$23.6 million savings as not being reasonably supported by the evidence in the record.
6. Direct DHA to return to the methodology the Superintendent approved in Year 3 for measuring Uninsured/Underinsured Savings.
7. Adopt Milliman's approach for the Year 4 AMCS determination of Uninsured/Underinsured Savings (based on the Superintendent's decision in Year 3) in the amount of \$6,081,710.
8. **Medical Loss Ratio** – Reject the Board's inclusion of this category of savings and its calculation of \$6.6 million savings as not being recoverable.

9. **Overlap** – If the Superintendent adopts the Milliman alternative calculations for the Hospital and Uninsured/Underinsured savings and rejects any MLR Savings, then the Superintendent should conclude that there is no overlap as it is accounted for in the Milliman calculations.
10. In the very unlikely event that the Superintendent were to approve as reasonably supported both the Board’s Hospital Savings and Uninsured/Underinsured Savings methodologies and calculations, the Superintendent should find that the Hospital cost per CMAD Savings and the Uninsured/Underinsured Savings overlap and that the Uninsured/Underinsured Savings calculation should be reduced by 66% (the portion relating to the cost of uncompensated hospital care).
11. In the very unlikely event that the Superintendent approves any MLR Savings, the Superintendent should conclude that such savings would overlap with the Uninsured/Underinsured savings.

Dated: August 26, 2008

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5.

CERTIFICATE OF SERVICE

I hereby certify that on August 26, 2008, a copy of the foregoing **Brief of the Maine Association of Health Plans** was filed and served pursuant to paragraphs II(B) and (C) of the Superintendent's order dated August 18, 2008, as follows:

1. One identical electronic copy was filed by 3:00 p.m. with the Superintendent of Insurance addressed as follows: Vanessa J. Leon at vanessa.j.leon@maine.gov
2. The original and two (2) hard copies filed via U.S. Mail, postage pre-paid, addressed:

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