

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)

FILING COVER SHEET
VIA ELECTRONIC AND U.S. MAIL

TO: Mila Kofman, Superintendent, Bureau of Insurance
Attn: Vanessa J. Leon (Vanessa.J.Leon@maine.gov)
Docket No. INS-08-900
34 State House Station
Augusta, ME 04333-0034

DATE FILED: September 5, 2008

PARTY: Maine Association of Health Plans

DOCUMENT: Brief of Maine Association of Health Plans

DOCUMENT TYPE: Reply Brief

CONFIDENTIALITY: None.

Respectfully submitted,

/s/ D. Michael Frink
D. Michael Frink, Esq., Bar No. 2637
Michael B. Peisner, Esq., Bar No. 3444
CURTIS THAXTER STEVENS BRODER
& MICOLEAU LLC
One Canal Plaza, Suite 1000
P.O. Box 7320
Portland, Maine 04112-7320
Tele: (207) 774-9000
Fax: (207) 775-0612
Email: dmf@curtisthaxter.com

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)

**REPLY 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 Reply Brief.

I. INTRODUCTION

The Brief of Dirigo Health (“Dirigo Brief”) fails to address numerous fatal flaws that the payor intervenors (“Intervenors”) raised concerning the new cost-per-case-mix-adjusted-discharge (“CMAD”) hospital (“Hospital”) and uninsured/underinsured (“BD/CC”) savings methodologies and related calculations, and the illogical, unreasonable and unsupported assumptions underlying the new savings category, the medical loss ratio/insurer oversight (“MLR”) initiative. The Dirigo Brief’s failure to address the core problems that the Intervenors identified concerning each of these methodologies resonates as a tacit admission that the problems remain. None of the points raised in the Dirigo Brief refutes these core problems, as will be discussed below. Left with no reasonable counterpoint, the Superintendent has little choice but to agree with the Intervenors’ unrefuted analysis of these new methodologies and to conclude that no reasonable support exists in the record for the Board’s determination of \$149.6

million in savings.

Rather than directly addressing these fatal flaws, the Dirigo Brief seeks to avoid the Superintendent's thorough and objective review of the evidence in the record by cloaking the Board's AMCS determination behind a curtain of deference and a plea for an incorrect, low standard of review in a case where an assessment/tax is to be levied on every person in Maine who is covered under a fully-insured or self-funded health plan. The Dirigo Brief is asking the Superintendent to ignore clear defects in each of these methodologies, abdicate her responsibility to independently review the reasonableness of the evidence in the record, and simply rubber-stamp the unreasonably supported assumptions and calculations that underpinned the Board's decision.

There is simply no reasonable support in the record for the models developed with the new methodologies and as applied by the Board, or for the corresponding savings calculations. Moreover, as will be discussed below, the Board without any discussion or explanation in its decision has completely reversed itself and ignored the Superintendent's Year 3 decision by adopting three savings methodologies that do not consider whether or to what extent any of the calculated savings is reasonably recoverable by payors from providers. MEAHP has intervened in this proceeding as in prior years primarily to ensure that the AMCS methodologies and the related calculations are reasonable and credible to reflect actual "savings" to the consumers and employers that will actually pay the SOP, so that the savings will offset the SOP. Adopting the methodologies approved by the Board and the resultant inflated AMCS determination, would destroy any remaining credibility in the AMCS/SOP financing vehicle among those who pay the SOP.

The Board bears the burden of proving the reasonableness of its methodologies and

calculations. The Superintendent plays a key role in determining whether the record contains reasonable, factual support for the nearly \$150 million in AMCS for Year 4. On the basis of such a review, the Superintendent should conclude that: (1) as a result of the numerous flaws in each of the three new methodologies, they are unreasonable means to measure Hospital, BD/CC and MLR savings and must be rejected; and (2) the alternative bases for determining Hospital and BD/CC savings presented by Milliman (and based expressly on the approved AMCS determination in Year 3) are reasonably supported in the record.

II. STANDARD OF REVIEW

Obviously aware of the fatal weaknesses in each of the three new savings methodologies and calculations, the Dirigo Brief has suggested that the Superintendent put on several sets of blinders before conducting her objective and impartial reasonableness review. All parties agree that the applicable standard of review provision in the Dirigo Act states: "...the [S]uperintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the Board are reasonably support by the evidence in the record." 24-A M.R.S.A. § 6913(1)(C) (emphasis added).

Not satisfied with this standard, the Dirigo Brief has cited a case appealed to the Law Court from the Probate Court involving the appointment of a guardian for the principle that unless there is "no record evidence" the Board's determination should be upheld. *See In re Cyr*, 2005 ME 61, ¶ 16, 873 A.2d 355, 360-61 (emphasis added). The Dirigo Brief apparently asks the Superintendent not to evaluate whether any such record evidence supporting the Board's determination is reasonable and to ignore the overwhelming evidence that it is not. In citing the case of *Griswold v. Town of Denmark*, 2007 ME 93, ¶ 9, 927 A.2d 410, 414-15, the Dirigo Brief failed to disclose the Law Court's critical point that "[s]ubstantial evidence [the applicable

standard of review in this appeal of a decision of a Board of Selectmen] exists when a reasonable mind would rely on that evidence as sufficient support for a conclusion.” *Id.* (emphasis added).

The Dirigo Brief next lists the various limitations on the Superintendent’s jurisdiction, which if adopted by the Superintendent would leave the Intervenors with no recourse but judicial appeal: legal issues like interpretation of the Dirigo Act, the constitutionality of the Act, or the due process rights of the Intervenors.¹ The Board’s adoption of two entirely new methodologies this year for Hospital and BD/CC savings, a totally new category of savings – MLR – and a nearly five-fold increase in AMCS from that approved in Year 3, graphically demonstrates the ambiguity of the Dirigo Act and proves the point made by Justice Alexander 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.

This year, the most disastrous example of this unconstitutionally vague statute and its self-serving application by the Board is the Board’s remarkable “about-face” from its own and the Superintendent’s decision in Year 3 on whether AMCS should be limited to savings that are reasonably recoverable from providers. The record is perfectly clear: last year the Board expressly and explicitly stated that it “shared the concerns” expressed by *MEAHP*’s expert Milliman that on two initiatives (BD/CC and payments to physicians) it was unreasonable to assume that all savings were available to be recovered and that a more accurate methodology would subtract available savings...to reach a determination of recoverable savings.” AR 5-101-8

¹ *MEAHP* preserves its due process claims and its claims that the Dirigo Act as enacted and as applied by the Board is unconstitutionally vague and constitutes an unconstitutional delegation of legislative authority to the executive branch agency. *See* *MEAHP* Main Brief at 6-8 and n. 6.

t0 9 (Board’s Year 3 Decision). On this basis alone the Board cut the savings figure proposed by the DHA staff in half for each of these initiatives: from \$14 million to \$6.3 million on BD/CC and from \$3.7 million to \$1.5 million for payments to physicians. Id. The Superintendent in Year 3 also explicitly decided to apply this recoverability adjustment to the hospital savings initiative, which resulted in a reduction of at least \$10 million (as part of a multi-pronged reduction). AR 5-100-10 to 11 (Superintendent’s Year 3 Decision).

Nowhere in the Board’s Year 4 decision is there even any mention of the word “recoverability,” much less an explanation as to how it completely reversed itself on this key point of massive consequences. In addition, the transcript of the Board deliberations reveals that the Board did not debate this issue at all. This reversal of position with absolutely no explanation by the Board, if adopted by the Superintendent, would completely undermine the credibility and sustainability of the SOP financing mechanism, and would embody one of the most glaring examples of an unconstitutional statute applied in an arbitrary and capricious manner by an agency granted an unconstitutional delegation of legislative authority. Again, quoting Justice Alexander:

“[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 ¶ 71.²

In short, the Superintendent must not defer to the Board and must reject the Dirigo Brief’s incorrect and self-serving pronouncements on the applicable standard of review, and

² MEAHP disagrees with the Board in its footnote 1 that recoverability is addressed in the SOP phase of this process pursuant to the Act. The Board has never in the previous three years considered recoverability at the SOP phase and has never held an adjudicatory hearing at that phase on this or any other issue. The only adjudicatory hearing and review by the Superintendent in the Act is at the AMCS phase. Given the self-serving nature of the AMCS/SOP determination for the interests of the DHA, it is clear that the intent and public policy of the Act was for the critical issue of recoverability to be subject the adjudicatory and review procedures at the AMCS phase. MEAHP preserves its due process claims on this point as well.

reaffirm that the Board bears the burden of proving that its determination for year 4 is reasonably supported by evidence in the record. The Superintendent must also preserve the integrity and credibility of the AMCS/SOP process by including a consideration of the reasonable recoverability of savings in all categories as her predecessor did last year. By adopting the Milliman alternative methodologies and calculations for Hospital and BD/CC savings and rejecting any MLR savings, the Superintendent can reasonably achieve both of these objectives.

III. HOSPITAL SAVINGS

A. The Dirigo Brief Does Not Refute or Even Discuss Numerous Flaws in the New Hospital Savings Methodology Recited in the Intervenors' Briefs and in the Hearing Before the Board

The Intervenors in their briefs as well as in the evidence introduced at hearing before the Board, highlighted numerous flaws which make the newly devised CMAD, multivariate regression model patently unreasonable to measure hospital savings. Yet the Dirigo Brief does not even discuss many of these flaws, including:

- the failure to reasonably isolate the effects of the Dirigo Act from other factors that cause reductions in the cost per CMAD and instead to rely primarily on a meaningless pre- and post- July 1, 2003 time trend;
- the lack of transparency in the srHS report, which resulted in the Board not understanding how the model worked and why it does not reasonably support the savings determination;
- the selective use of an unreasonably truncated three-year base period (CMAD growth trend for 2001-2003) (AR 3-61-230 to 231 (Burke testimony));
- the failure to disclose and reasonably address the large discrepancy between the Year 3 and 4 CMAD growth percentages for 2000-2001 (4.7% versus 11.26%), which inflates the base period and drives the Year 4 savings calculation (*see* AR 2-41 Chamber Exhibit # 7);
- reliance on the false assumption that Maine's "excess trend" in cost-per-CMAD pre-Dirigo would continue indefinitely absent Dirigo after July 1, 2003 and ;

- the failure to account for the fact that the model results in a five-fold increase in Hospital Savings from Year 3 to Year 4, even though the CMAD growth rate for these years per srHS's own numbers was virtually the same (*see* AR 2-41 Chamber Exhibit # 7 – showing CMAD growth rates for 2006 of 3.17% and for 2007 of 3.28%).

B. No Reasonable Support has been Provided for \$119.4 Million Savings

The Superintendent in Year 3 did recommend that DHA employ a multistate statistical model to calculate hospital savings. He did not direct DHA to continue the use of the CMAD methodology as part of that new model, and was critical of the “serious problems” with the CMAD approach that have “become worse with the passage of time.” AR 5-100-14.³ While MEAHP obviously agrees there are some savings due to the Dirigo Act, as evidenced by its alternative calculations of savings in two categories, the Dirigo Brief has unreasonably argued at pages 5-6 that the savings approved by the Superintendent in Years 1-3 somehow reasonably support a fivefold increase in hospital savings in year 4.

The Dirigo Brief at page 6 also unreasonably relies on the “observed CMAD data,” which it claims shows a “dramatic” reduction in the CMAD growth rate from the pre- to the post-Dirigo period, and which exceeds other states. Yet the Dirigo Brief does not acknowledge that the “observed” CMAD growth rate for 2000-2001 somehow without any explanation went from 4.7% in the Year 3 case to 11.26% in Year 4 based on srHS's own data. *See* AR 2-41 Chamber Exhibit # 7. Dr. Dobson at table 1 of his pre-filed testimony merely reproduced the srHS figures and did not independently generate these figures. Indeed Jack Burke testified that changing the CMAD growth trend percentage for that one year to the actual figure used by srHS in the Year 3 case would eliminate any hospital savings found by the srHS model, by reducing

³ As admitted by the DHA in its brief to the Superintendent in the Year 3 proceeding, the cost-per-CMAD methodology was not developed for the purpose of measuring hospital savings, but rather to gauge hospitals' compliance with voluntary targets contained in the Dirigo Act. Year 3 Dirigo Brief at 4.

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). This also completely destroys the Dirigo Brief's premise that the "empirical evidence" showed that there was a much greater drop in CMAD cost growth pre-versus post- Dirigo than elsewhere in the country, and that this presumed difference reasonably justified the whopping savings figure in Year 4.

Without even attempting to explain this glaring inconsistency the Dirigo Brief moves on to state that the statistical models srHS developed show that \$119.4 million savings based on the US - only regression is a "conservative" figure. MEAHP will address the Dirigo Brief's responses to the fundamental flaws in the Board's adoption of the U.S. regression below.

C. The Board Has Not Refuted Intervenors' Attacks on the Hospital Savings Determination

The Dirigo Brief attempts to dismiss each and every one of the flaws the Intervenors have pointed out on the grounds that similar flaws have been presented in prior years, but fails to point out that in each of the prior years, enormous reductions in savings (from those proposed by the DHA) have been approved by the Superintendent. The captions of the following subsections of this reply brief correspond to subsections in the Dirigo Brief.

1. The Savings Compared to Prior Years

The Dirigo Brief argues that the Superintendent should approve a five-fold increase in hospital savings because this year the new methodology is "more accurate." This is an unbelievable claim given the lack of statistical reliability for the U.S. regression and the admissions by both of DHA's experts that the Board could not rely on the U.S. regression alone. The Dirigo Brief also alleges at page 8 that this year's large difference in savings, compared to

savings approved in all prior years, is not a basis for rejecting the Year 4 determination, because “the reason for the difference is understood.” This claim is also unbelievable given the unrefuted observation by Dr. Dobson that srHS did not complete the steps normally required in this type of statistical analysis, which is absolutely critical to understanding the results of such an analysis.

He testified:

“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 standards.”⁴

Since srHS did not complete these critical steps, then the Board could not possibly have understood why the Year 4 savings figure was five times higher than Year 3 and why the Year 4 figure was nonetheless reasonable.

2. Board Reliance on the US Model

The Dirigo Brief has tried to parse the testimony of the Dirigo experts to avoid inescapable admissions: the U.S. hospital regression is inconclusive for savings (such as AR 2-60-238 - Schramm testimony); the U.S. hospital model is inconclusive as to whether the reduction in Maine’s CMAD growth can be attributed to Dirigo (AR 4-83-7 lns153-158 – Thorpe testimony) ; and the Board could not rely on the U.S. regression alone (AR 2-60-239 – Schramm testimony) The brief of Anthem Health Plans of Maine, Inc., at point III, definitively rebuts the

⁴ Dr. Dobson testified 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 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).

point attempted to be made in the Dirigo Brief. Moreover these experts proposed a blending of the U.S. regression model with the cluster 1 regression as a way to “borrow” statistical reliability, albeit improperly as the Intervenor’s experts testified. The Board rejected that blending and instead relied solely on the U.S. regression in direct disregard of their own experts’ testimony.

3. Attacks on the Models

a. Statistical Significance

Once again in the context of the dismal statistical significance of its U.S. regression, the Dirigo Brief leads off at pages 8 and 9 of this section with an attempt to lower the standard of review: “The Board need only have been convinced that it is more likely than not that the savings exist, and the Superintendent need only find that the Board’s determination, viewed in the light most favorable to the Board, is supported by evidence in the record.” The Dirigo Brief thus erroneously argues that if there is any evidence, whether reasonable or wildly ridiculous, it can find savings in any amount so long as some savings exist in some amount. This is not the reasonable position of neutral state agency, but obviously one of a agency with an enormous self-interest in the result.

The Dirigo Brief at page 9 then contorts the Intervenor’s argument that the dismal statistical significance of the “null hypothesis” (which shows that the results are at least as likely due to random variation as to the effects of Dirigo) means that there are no CMAD savings. Again the Dirigo Brief is trying to prove too much. The Board has the burden of proving the amount of savings supported by reasonable evidence in the record. The Intervenor has aptly demonstrated the lack of any semblance of statistical reliability of the U.S. regression model, the Board’s own experts’ unwillingness to rely on that model alone, and the unexplained yet highly

significant variation in the “empirical evidence” relating to CMAD growth in the srHS “observed” data in Years 3 and 4 for 2000-2001. Even if there are some hospital savings in Maine due to Dirigo, the Board has not met its burden of proving how much under their flawed US regression model.

b. Additional Variables

MEAHP will defer to the Maine State Chamber of Commerce (“Chamber”) and Anthem Health Plans of Maine, Inc. (“Anthem”) to address the Dirigo Brief’s responses to the Intervenor’s claims that the srHS models failed to include significant additional variables, and incorporates those points herein. The Dirigo Brief at page 10 erroneously construes the fact that none of the Intervenor’s retained experts to produce alternative multivariate statistical regression analyses as evidence to “undercut the credibility of Intervenor’s attacks,” and stating that if the Intervenor were confident of the results that they would have undertaken such an effort. The DHA for the fourth year has again spent nearly \$1 million to fund their experts’ work. The Intervenor does not have the burden of proof and moreover have a legitimate right to assume that DHA will engage experts who will in the public’s best interest develop a reasonable and credible methodology, subject to reasonable review and critique by the Intervenor, other parties and ultimately by the Superintendent.

c. Issues from Prior Superintendent’s Decisions

The Dirigo Brief sidesteps the fact that despite the Superintendent’s clear and unequivocal language in the Year 3 decision on each of these key adjustments, discussed below, three of them were not included in the Board’s Year 4 determination.

1. Hospitals with low or negative consolidated operating margins

This point on recoverability has been addressed above, however several additional points need to be made here. The Dirigo Brief at page 11 states that "...the Board was clear in its legal determination that recoverability is not an issue at this stage of the statutory process." The word "recoverability" or the phrase "stage of the statutory process" are never mentioned anywhere in the Board's Year 4 decision, nor is there any explanation whatsoever why the Board reversed itself and the Superintendent on this point from Year 3. It is completely unsupported and not credible that the Dirigo Brief asserts, therefore, at page 11, that this issue was dealt with by the Board in a "reasonable manner."

2. MaineCare Reimbursement

Again trying to parse Mr. Schramm's testimony the Dirigo Brief notes that he testified that MaineCare reimbursement cuts do not have a determinate effect on CMAD, but ignored the undisputed fact that as in prior years low levels of MaineCare reimbursement do affect cost-shifting. In fact in prior years the DHA has claimed savings due to payment of overdue MaineCare amounts due to hospitals on the grounds that such payments do reduce cost shifting. Moreover, the Dirigo Brief at page 12 asserts that there is no credible evidence in the record that there have been overall MaineCare reimbursement cuts by attacking MEAHP for its "hearsay" testimony about whether the MaineCare cuts were ever enacted, and attempting to discredit the MEAHP witnesses because of the "striking resemblance" of testimony on a completely separate procedural point⁵. In fact the Superintendent in the Year 3 decision explicitly found that such cuts did occur and took effect in SFY 2005 and 2006, based on evidence presented at last year's

⁵ The testimony cited by the Board appears at page 2 of both the Rudin and Fishbein testimony and relates to procedural matters having to do with the compressed schedule of the case and the lack of time to prepare fully for the hearing, which applied to both witnesses. It has nothing to do with any substantive issue in the case. AR 5- 98 - 2 and AR 5-99-2.

hearing, AR 5-100-12, and this year the Superintendent can and should take administrative notice of that finding in last year's decision.

Moreover, the Superintendent for at least the past two years has expressed grave concerns about the impact on these cuts on the CMAD growth rate. Last year he made a \$10 million adjustment for this fact. The Dirigo Brief mistakenly states at page 12 that the Board "quite properly could have rejected [the MEAHP witness's] testimony on credibility grounds.⁶ The Board's decision to ignore the well-settled facts on this issue and the Superintendent's decision from Year 3 is not reasonably supported and must be rejected.

3. Outpatient Utilization

As Mr. Burke stated in his pre-filed report,

"...the CMAD calculation can inflate admissions when the outpatient utilization and charges grow faster than the inpatient cost per case, thereby deflating the average CMAD growth. This phenomenon is still a problem in the current calculation. By all accounts, outpatient charges have increased faster than inpatient, especially in Maine. AR 5-97 AR 5-97 (MEAHP # 2, Burke Report & Burke Exhibit # 4 – Outpatient Visits Data).

This unrebutted evidence in the record shows that in Maine outpatient visits are increasing much faster than the national average. The record contains no evidence whatsoever that srHS attempted to ascertain how much Maine hospitals have increased their outpatient charges/prices relative to inpatient charges. In fact Mr. Schramm admitted that his team never interviewed a single hospital representative on any issue relating to the srHS new methodologies.

⁶ Dr. Fishbein's testimony was well-founded and based on reasonable inquiries: "We contacted the MHA to go over this and they furnished us with a very useful table, attached as Fishbein Exhibit 5, that provides the background for these numbers. This Table summarizes the MaineCare budget cuts implemented by the Maine Legislature for the 2004-05 biennium. . . . I understand from information received from the Maine Hospital Association that these MaineCare reimbursement policies have continued into Dirigo Year 4. Even if the State made no additional cuts in Year 4, those policies continue to cause significant cost-shifting, the prior cuts continue to have a cumulative impact on hospital margins, and MaineCare continues to be very late in making payments, causing negative impacts on hospitals' cash flow. It would be improper for the Board to ignore all of these impacts in setting AMCS for Year 4, especially in light of the Superintendent's decision on this point last year." AR 5-99-10 (Fishbein Pre-Filed Testimony).

Yet even though the Board bears the burden of proving the reasonableness of its determination, it did not even mention this oversight and the potentially enormous impact of inflated outpatient discharges, ignoring completely the Superintendent's decision last year in which he reduced the hospital savings figure by \$10 million on this point. AR 5-100-14. Finally, if srHS could not figure out a way to include a factor as important as this (especially since the Superintendent used it as a factor to substantially reduce last year's AMCS) 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 it, or (ii) cost per CMAD is not the proper measuring tool for hospital savings.

d. Difference between Fitted Prediction and Observed

The Dirigo Brief claims at page 12 that MEAHP misinterpreted the discrepancy between the CMAD actual versus predicted under the U.S. model in columns III and IV of DHA Exhibit 10 – Yr 4 AMCS Summary of CMAD Calculations. AR 4-72. MEAHP based this critique on Dr. Dobson's testimony that fitted values using the Maine-specific characteristics from a "virtual hospital" in the U.S. regression (column IV) should reasonably approximate the actual CMAD Maine figures (Column III). This large disparity for each year demonstrates, according to Dr. Dobson, that something is fundamentally wrong with the regression model. To quote Dr. Dobson:

"Another element missing was an explanation of significant discrepancies. An important one is the huge difference between actual Maine cost per CMAD numbers and those predicted for Maine using the US regression model. For example, the actual number shown for 2007 is \$7470, versus \$10,293 predicted....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 . . . 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."

Dr. Thorpe at hearing agreed that such differences should be troubling:

“If they (projected 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,⁷ Dr. Thorpe changed the subject and talked about the goals of the regression analysis. AR 2-60-142 to 143 (Thorpe Hearing Testimony).

Now the Dirigo Brief at page 13 takes an equally troubling detour and claims that if the figures in column VI were recalculated using average hospital values for total beds and interns/beds, the predicted values would closely track the actual CMAD observed and would result in the same savings. It even produces a new table that is not in the record using data that is not explained with the cryptic reference to (AR 4-65, dha_dataset20mdb,CMAD_Fitted Values.xls). Neither MEAHP’s counsel nor its expert could locate the table on page 13 of the Dirigo Brief in that dataset or even find the numbers referred to in the brief. The unrebutted fact remains that Dr. Dobson would have expected the actual and fitted values to be reasonably close, which they clearly were not, and if there was a discrepancy for srHs to have explained it in the report, which they did not. This after-the-fact attempt to re-create the key table on the hospital savings initiative graphically demonstrates that there is no reasonable support for this methodology or any associated savings in the record.

e. Savings in Twenty Nine Other States

Again seeing that its methodology is on the ropes, the Dirigo Brief at page 14 argues that the analysis simply looked at national averages for cost growth and some like Maine had higher rates and some had lower rates. However as Mr. Burke pointed out, that is all the srHS model did to determine savings in Maine: it took Maine’s lower than average cost growth and compared

⁷ Both were looking at the differences between columns III and IV of DHA Exhibit 10 (AR 4-72).

it to the average and attributed it all to Dirigo as savings, without making any attempt to determine if that hypothesis was in fact correct:

“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).

As Dr. Dobson testified:

“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.

D. The Alternative Hospital Savings Calculation by Milliman, Based on the Year Three Decision of the Superintendent, Provides the Only Measure Reasonably Supported by the Record

The record does not reasonably support any measurable hospital savings using the methodology adopted by the Board. 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). Neither this methodology nor this calculation was reasonably refuted by any party.

MEAHP urges the Superintendent to adopt a number no greater than Milliman's figure, and to provide the other relief set forth in paragraphs 1-3 in the Conclusion to the MEAHP main brief.

IV. UNINSURED/UNDERINSURED SAVINGS

A. The Dirigo Brief Does Not Refute or Even Discuss Numerous Flaws in the New BD/CC Methodology Recited in the Intervenor's Briefs and in the Hearing Before the Board

As with Hospital savings, the Intervenor's in their briefs as well as in the evidence introduced at hearing before the Board, highlighted numerous flaws which make the newly devised BD/CC, multivariate regression model patently unreasonable to measure uninsured/underinsured savings. Yet the Dirigo Brief does not even discuss many of these flaws, including:

- the failure to present any reliability statistics on the BD/CC regression in the absence of Dirigo;
- the lack of transparency in the inputs and underlying data which prevented Intervenor's experts from being able to understand and unwind the regression;
- Mr. Burke's critique showing that there were three "shocks" to the Maine system that more than explained the drop in uninsurance rates in Maine from 2003-2006;

- the “common sense” problem with moving the post-Dirigo period up to 2004 and thereby removing a large drop in uninsurance rates for 2003 not related to Dirigo and yet the srHS regression model producing a jump in “savings” from \$35 to \$51 million;
- the fact that the Superintendent approved savings for this category in Year 3 without even suggesting that the model or calculation was unreasonable or should be replaced with a regression model, and;
- the Board in a tortuous, marathon deliberation ultimately rejected the Milliman alternative based on last year’s approved model against the better judgment of all veteran Board members.

B. The Board Has Failed to Provide Reasonable Support for \$23.6 Million Savings

In attempting to find reasonable support for its adoption of this new regression model, the Dirigo Brief at page 15 again cites historical evidence of approved savings. It fails to point out that the Board determined an amount this year that is greater than the total amount approved by the Superintendent in all prior years for this category. The Dirigo Brief also cites “empirical” evidence that there has been a dramatic drop in Maine’s uninsurance rates as compared with other states to reasonably support a four-fold increase in BD/CC savings over Year 3. The Dirigo Brief does not mention that Dirigo’s consultants tried to claim credit for Dirigo causing the biggest drop in the uninsurance rates, due to a MaineCare expansion enacted in 2002 before Dirigo took effect. Nor does the Dirigo Brief mention that when their consultants appropriately moved the post-Dirigo period forward to 2004, their regression model in the absence of Dirigo caused the “savings” figure to increase, against all common sense, from \$35 to \$51 million. The Dirigo Brief also failed to rebut the testimony of Mr. Burke that the three identified shocks to the system, the 2002 and 2005 MaineCare expansions and the Dirigo Choice enrollment, which began in 2005 but has been frozen throughout 2008, the measuring year, more than explained the drops in the uninsurance rates through 2006, giving no reasonable basis to project continued drops in the uninsurance rate in the presence of Dirigo from 2006 through 2008.

In addition, the DHA's new "black box" regression model to predict the uninsurance rates in Maine in the absence of Dirigo lacks even enough data in the record for Dr. Dobson to replicate and understand it. The model totally lacks transparency and the Board clearly did not understand how it worked, or why it produced a bigger savings number if the pre- and post-Dirigo period was adjusted as described above. The Dirigo Brief states at page 15 that the \$23.6 million figure was a conservative compromise, when it is four times as great as the Year 3 savings and there are fewer people enrolled in DirigoChoice this year than last. Even the Board's experts did not propose the Maine-only regression, and they provided absolutely no explanation of what the regression reliability statistics were, nor the key background that Dr. testified should be provided in this type of analysis:

coming "back and ... say[ing] why we think our findings are valid and ...how we interpret the coefficients to show the thing we're looking for whether the coefficients were valid ." AR 3-61-17 to 19 (Dobson Hearing Testimony).

There is no reasonable support in the record for this new methodology nor any savings calculated thereunder.

C. The Dirigo Brief Has Not Refuted the Intervenors' Attacks on the BD/CC Savings Determination

Again for ease of reference the captions of the following sub-sections of this reply brief correspond to subsections in the Dirigo Brief.

1. The Savings Exceed Those Approved in Prior Years

The Dirigo Brief attempts at page 16 to defend this huge increase over historically approved BD/CC savings by stating that the amount of increase alone is not a reason to disapprove the savings determination, "particularly where the reason for the difference is understood." The hypothesis has been articulated by srHS and is quoted in the Dirigo Brief:

“The methodology this year captures the total reduction in uninsurance due to Dirigo, including the reduction caused by the effect the Dirigo initiatives have had in lowering the rate of increase in private health insurance premiums.” Dirigo Brief Brief at 16.

How and why this new model produces such enormously increased “savings” was not understood by the Board. In fact, because srHS did not explain how they interpreted their coefficients, did not show how the purported reduction in the uninsurance rates was due to Dirigo and did not explain whether the coefficients were valid, there is no reasonable basis for anyone to understand the reasons for the huge jump in BD/CC savings from all prior years to Year 4. This is particularly glaring in the face of unrebutted testimony from Mr. Burke that the above-referenced three shocks to the system more than explained the drop in uninsurance rates through 2006, with no such shocks experienced in 2007, nor in 2008 to date, nor expected during the remainder of this year.

2. The Maine Model was not Recommended by Dirigo Experts

First, MEAHP preserves its due process claim that because DHA’s experts did not even propose using the Maine-only regression, the Board should not have relied on it. There is absolutely nothing in the record from srHS proposing the use of the Maine-only regression. The reasonable inference to be drawn from this fact is that srHS did not believe it should be relied upon, even for the purposes of “blending” the results with the US regression.

3. The Results Do Not Seem Right to Intervenors’ Experts

The Dirigo Brief at pages 16-17 again uses a misplaced blanket attack, this time directed at Mr. Burke’s credibility, and claims he made just “naked assertions” about what he would expect if the post-Dirigo period were moved from 2003 (as in the srHS report) to 2004 (not to 2005 as alleged in the Dirigo Brief at page 17). Mr. Burke in his own report and again in his live testimony explained that simply by moving the post-Dirigo date to 2004, the savings would drop

to roughly \$7 million, consistent with last year's approved figure. .AR 5-97 MEAHP # 2 Milliman Report at 7-8). He also pointed out in the hearing that column VII in MEAHP Exhibit 7⁸ shows that srHS's own reasonableness check⁹ 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).¹⁰

The Board's experts did not produce, according to Dr. Dobson, enough underlying data to understand and unwind this regression. It is disingenuous for the Dirigo Brief to assert that Mr. Burke should be discredited because he did not undertake an independent regression in a category for which the Superintendent did not direct that such a model be used. It is particularly disturbing that the Dirigo Brief sees fit to characterize Mr. Burke's testimony on this issue as “just naked assertions” given the depth and detail of his testimony that a fair reading of the record would reveal and especially when the Board and the Superintendent last year both relied on his opinions on this issue for making the approved BD/CC savings determination.

4. Regression Analysis Output was not Provided

On this point the Dirigo Brief at page 17 does not even address MEAHP's claim that srHS did not provide any statistics that demonstrated the reliability of the coefficients used; instead the Dirigo Brief responds that they did provide the regression output. Indeed, buried on a compact disc at the end of an eighteen page document are some regression output data. Nowhere

⁸ a copy of a supplemental version of DHA 18 in DHA Exhibit 3A. AR 4-65 (CD).

⁹ DHA Exhibits 18 and 3A, column VI. AR 4-65 (CD).

¹⁰ 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).

in the record is there a table of reliability statistics such as t-statistics as were belatedly produced for the hospital savings regressions in DHA Exhibits 11 and 12. *See* AR 4-73 & 74.

The Dirigo Brief still has not cited to anything in the record stating that the Board had any basis to know that the projections of the uninsurance rates in the absence of Dirigo were valid. Dirigo counsel did not even ask its experts at the hearing if the BD/CC results were reliable. Even if the reliability statistics could be developed from this output data, the srHS report totally lacks transparency on this point and cannot be a reasonable basis to determine BD/CC savings. Moreover, as Mr. Burke testified, the BD/CC regression in the absence of Dirigo is such a poorly specified model in that predicts very low uninsurance rates, and takes credit for other programs reducing the rate of uninsurance in Maine. He gave several specific examples of why the absence of Dirigo regression model was mis-specified and unreasonable. AR 4-328-330.¹¹ Whether this mis-specified model reliably predicts what it's told to predict belies the fact that it is being told to predict something wholly erroneous. The Superintendent should not subscribe to the notion that BD/CC savings should be determined by trying to estimate what uninsurance would have been in the entire state based on a multi-state regression

¹¹ 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 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).

analysis, rather than counting up the people enrolled in the Dirigo-related programs. Or to put it as eloquently as Board member David:

“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.

D. The Alternative BD/CC Savings Calculation by Milliman, Based on the Year Three Decision of the Superintendent, Provides the Only Measure Reasonably Supported by the Record

The record does not reasonably support any measurable cost savings on bad debt and charity care using the methodology adopted by the Board. The obligation to measure savings is on DHA, and not on any intervenor. Mr. Burke testified that srHS’s 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 Superintendent last year. This results in 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). Neither this methodology nor this calculation was reasonably refuted by any party.

MEAHP urges the Superintendent to adopt a number no greater than Milliman’s figure, and to provide the other relief set forth in paragraphs 4-7 in the Conclusion to the MEAHP main brief.

V. MEDICAL LOSS RATIO

It is undisputed that the \$6.6 million in MLR can never be recovered by any provider. That means that no insurance carrier can recover that \$6.6 million in its contract with a provider

and, accordingly, insurance premiums will not, and cannot, be reduced to reflect that \$6.6 million refund. There is no mention of the MLR provisions in any AMCS provision of the Dirigo law; 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. The Superintendent must consider the reasonable recoverability of these refunds – as her predecessor did on all three initiatives last year - and reject this category as not reasonably supported in the record. Otherwise the Board is free to assess the full amount of these unrecoverable refunds as part of a savings offset payment when there is no possibility for such an offset and no subsequent review by the Superintendent.

Failing to reject this category of savings at this juncture would constitute yet one further example 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 II.

VI. OVERLAP

The Dirigo Brief at page 18 argues that the Intervenors speculated that there may be overlap between the initiatives but provided no evidence or analysis that overlap exists. This assertion is false. Mr. Burke explained how, given the two new intersecting regression methodologies for Hospital and BD/CC savings, any reduction in bad debt at the hospital would reduce the pressure on the cost per CMAD for the remaining, paying patients and would

therefore be reflected in the Hospital savings calculation. AR 5-97 MEAHP Exhibit # 2 Milliman Report at 10. He also explained that because both the Hospital and BD/CC methodologies are attempts at estimating macro measures of changes in the economy, rather than any direct savings from Dirigo, he believed them to be unreasonable and the related calculations to be without any reasonable support. Nonetheless, if the projected savings are preserved in any amount using the srHS methodologies, he stated that the savings attributable to the reduction in the bad debt should be reduced by 66% to reflect the overlap with the hospital calculation. Id.

It should be obvious that 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 experts' only attempt at an explanation of why that is not the case 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).¹²

The Board bears the burden of providing reasonable support in the record that no overlap exists and this convoluted statement does not do so. 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 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).

Finally, 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

¹² There is a similar statement at AR 1-16-24 (Schramm Pre-filed Testimony).

and charity care. As such, any MLR savings would overlap with the cost per CMAD or BD/CC estimates. AR 5-97 (Burke Pre-Filed Testimony, Burke report at 11).

VII. CONCLUSION

For all of the reasons set forth above and in the reply briefs of the Maine State Chamber of Commerce, Anthem Health Plans of Maine, Inc., and the Maine Automobile Dealers Association Insurance Trust, the Board's determination of AMCS is not reasonably supported by the evidence in the record and, accordingly, must be rejected. MEAHP requests that with respect to each of the DHA savings initiatives, the Superintendent should grant the relief as specified in paragraphs 1-11 in the Conclusion to MEAHP's main brief.

Dated: September 5, 2008

/s/ D. Michael Frink
D. Michael Frink (Bar No. 2637)
Michael B. Peisner (Bar No. 3444)
Curtis Thaxter Stevens Broder &
Micoleau LLC
One Canal Plaza/P. O. Box 7320
Portland, Maine 04112-7320
Telephone: (207) 774-9000
Attorneys for Maine Association of
Health Plans

CERTIFICATE OF SERVICE

I hereby certify that on September 5, 2008, a copy of the foregoing **Reply 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:

Mila Kofman, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-08-900
Bureau of Insurance
Maine Department of Professional and Financial Regulation
#34 State House Station
Augusta, Maine 04333-0034
3. One (1) hard copy filed via U.S. Mail addressed to the Superintendent's legal counsel:

Thomas C. Sturtevant, Jr.
Assistant Attorney General
Office of the Attorney General
#6 State House Station Augusta,
Maine 04333-0006
4. One (1) hard copy filed via U.S. Mail addressed to the Superintendent's consultant:

Compass Health Analytics, Inc.
Attn: James P. Highland, Ph.D.
477 Congress Street, 7th Floor
Portland, ME 04101
5. One (1) identical electronic copy filed and served pursuant to paragraph II(B)(2) and (C) of the order, as follows:

Superintendent's legal counsel	Tom.Sturtevant@maine.gov
Superintendent's consultant	jh@compass-inc.com
Consumers for Affordable Health Care	Mia S. Poliquin Pross, Esq. mpross@mainecahc.org
Maine Automobile Dealers Association Insurance Trust	Roy Pierce, Esq. rpierce@preti.com

Anthem Health Plans of Maine, Inc. d/b/a
Anthem Blue Cross and Blue Shield

Christopher T. Roach, Esq.
croach@pierceatwood.com

Maine State Chamber of Commerce

William H. Stiles, Esq.
wstiles@verrilldana.com

Dirigo Health Agency

Michael J. Colleran, Asst.A.G.
michael.colleran@maine.gov

One (1) hard copy served via U.S. Mail addressed to the parties pursuant to their respective designation for service lists:

Consumers for Affordable Health Care

Mia S. Poliquin Pross, Esq.
39 Green Street
P. O. Box 2490
Augusta , ME 04338-2490

Maine Automobile Dealers Association
Insurance Trust

Roy Pierce, Esq.
Preti Flaherty Beliveau &
Pachios, LLP
45 Memorial Circle
P. O. Box 1058
Augusta, ME 04332-1058

Anthem Health Plans of Maine, Inc. d/b/a
Anthem Blue Cross and Blue Shield

Christopher T. Roach, Esq.
Pierce Atwood LLP
One Monument Square
Portland, ME 04101

Maine State Chamber of Commerce

William H. Stiles, Esq.
Verrill Dana, LLP
One Portland Square
P. O. Box 586
Portland, ME 04112-0586

Dirigo Health Agency

Michael J. Colleran
Assistant Attorney General
6 State House Station
Augusta, ME 04333-0006

/s/ D. Michael Frink

D. Michael Frink, Esq., Bar No. 2637

Michael B. Peisner

Curtis Thaxter Stevens Broder &

Micoleau LLC

One Canal Plaza/P. O. Box 7320

Portland, Maine 04112-7320

Telephone: (207) 774-9000

Attorneys for Maine Association of

Health Plans