Transcript of
Dirigo Health
BOARD OF DIRECTORS
AUGUST 29, 2005 Board Meeting

DR. ROBERT MCAFEE: OK, ladies and gentlemen, could we bring the meeting to order? We apologize for being a bit tardy today, and thank you all for being with us for this very significant meeting, the culmination of a great deal of work and effort by many people. To begin, we thank you all for the effort that you've put in to date. It's been an interesting process I understand, and we look forward to getting your recommendations and report. We're going to devote the meeting today to this initiative and discussion of the savings process payment and determination. We have our next scheduled meeting which is the day after Labor Day. We will do the rest of our business at that point. To bring you up to date, the 17th (that's a Saturday) is due date. Our recommendations from your endeavor are due in on the 17th of September. So we will have at least one and possibly two meetings between now and then in order to finalize our recommendations unless there's a uniform agreement at our next meeting. I expect that simply from the complexity of the issue there will be a number of questions that we'd like to formalize and a number of recommendations both broad and narrow, that the board wishes to make and at the same time, some declaration of future activities that we need to anticipate as a board to carry out our fiduciary responsibilities of our job here. Charlene Rydell, I believe is on the speakerphone, Charlene?

CHARLENE RYDELL: Yes, I am.

DR. ROBERT MCAFEE: Delighted to have you with us so the full board is here. In addition, we have our three non-voting members of the board, Commissioners Bruenn and Wyke, and from the Governor's Office Trish Riley. Also, Karynlee Harrington and Kirsten Figueroa, our financial person. For the format today, I'd like to begin with a presentation, perhaps a summation of where we are and how we got to this point. Perhaps those areas in which there has been some agreement or consensus. Then we'd like to hear from either side as where their recommendations would be in that area for which there has not been consensus or agreement to. I would hope, there is a large amount of information, I understand that, and I hope that each side will have the opportunity to take as much time and present as much as we possibly can to inform the board of your expertise and your feelings as to how we should come down on this particular issue. I will not go back and read to you the original bill, except that we are carrying out the intent of that and the determination of savings, also the payment. What has to do with the financial viability and the process of (inaudible) health as we now know it. And we'll be interested to hear what you have to say about it. Christine, did you wish to introduce our facilitator?

CHRISTINE BRUENN: Ann Gosline is the facilitator who was hired by the Bureau of Insurance, the Superintendent of Insurance to facilitate the working group meetings over the last few months. Whatever else we say about the product that comes out of that process, I think everyone would agree that Ann has done a great job of facilitating the past few months, so it is a pleasure to introduce her.

DR. ROBERT MCAFEE: Thank you, welcome her.

ANN GOSLINE: Tom Record will pass out what really is the first part of the information to you, and this report will give you an idea of the process we have been through so far in areas where there has been agreement. As soon as you have that report, I'll introduce you to the working group members. Some of them you know and some of them you may not know. On page two of the document, you'll see of the five Dirigo working group members, Karynlee Harrington has been one of those representatives. Pat Ende, Joe Ditre, Beth Kilbreth is here, Geoff Green I do not think he is here but maybe will come in later. Each side selected two permanent alternates; Kirsten Figueroa and Jack Comart. The working group members introduced representing the interest of Payers are John Benoit, Frank McGinty, James Reid (James has been driving up from New Jersey), Dan Roet, Sharon Roberts. The alternates have been Kristine Ossenfort and Bob Downs. The group has met on many occasions beginning June 30, at times for two full days a week, so it's been a great effort on everyone's part. The group has concentrated so far on those two charges with the shortest timelines. Yes.

UNIDENTIFIED FEMALE: I think there are people who are having trouble here on the phones.

ANN GOSLINE: Ok, shall I put the microphone right here?

DR. ROBERT MCAFEE: My concern is that on the issues that we've not reached consensus, if you could summarize the data and positions, that would be helpful.

ANN GOSLINE: The working group concentrated on coming up with a recommendation on paid claims and are working on recommendations concerning the charge to develop recommendations and methodology for computing measurable savings. And it is on those two charges that they will present their recommendations today. The working group is going to continue to meet to present recommendations on the other charges. That is what is coming. Turn to page three; the working group has developed a recommended definition of paid claims which is set out here. Let me just drop a footnote at this point and say there is one issue and only one issue that is not consensus. That is paid claims, but you will see in the overall definition there is agreement. I'm not going to go over the definition here unless you wish me to, but I certainly will if you wish me to. The definition is on page three and four, and on page five I would just note that the working group developed some general principles that guided its recommended definition of paid claims, including easy to understand, easy to communicate, administer a timeline. And perhaps most relevant, inclusive unless there is a policy reason for exclusion and equitable to all segments of the market. And back to page three, the definition starts with a statement that all payments made by carriers, third party administrators, employee excess carriers, provided under policy issued pursuant to the laws of this state that ensure Maine's residents will be included. And then it sets out exclusions. Most of exclusions are statutory exclusions or address the issue of parceling out what is an administrative expense. On page four at the top there is further extrication of the overall area of claims related expenses viewed in the nature of administrative expenses and that is laid out in some detail. I would like to ask the board, what is your pleasure; would you like me go over this in more detail, or only in the agreed upon part.

DR. ROBERT MCAFEE: My concern is on the issue, the last issue where consensus was not reached. If you could then summarize the data of the positions, that would be helpful.

ANN GOSLINE: Yes, well fortunately, they're summarized here on page six. The sole issue is not whether we reached consensus. The concern is whether the out of state services paid for Maine residents, should be included in paid claims. All of the members representing Dirigo, and a small minority of the members representing the interests of Payers recommend that out of state claims be included in the definition and they set out their reasons here for you. In essence, I will leave it for you to read, I think they would state that it was consistent under the principles developed under the statute. Avoided adding administrative complexity and was otherwise appropriate. A strong majority of Payers thought that these claims should be excluded for the three reasons set out below which are: that in their view, because out of state services were not impacted by Dirigo Health Reforms Initiative, they should not be subject to the assessment. Again no nexus between such claims and Dirigo, if they're included in the definition, many of those claims will be subject to taxation in another state, which will result in double taxation of those claims. And in the event you wish more detail, I know members of the working group will be happy to.

DR. ROBERT MCAFEE: Do you have a qualified figure roughly what this percentage might amount to in your definition of paid claims?

ANN GOSLINE: I believe the qualified figure was approximately 12% of otherwise countable paid claims. As you see this report is very short and the reason for that is that the working group spent a great deal of time discussing recommendations on the methodology for calculating measurable savings. I really mean it in a heartfelt way that I think this group has worked very hard on this issue and has resolved and narrowed a number of issues, but continues to have differing views on how and in some cases whether the savings should be calculated on certain initiatives. On the meeting on Friday the work group decided that the best way to present this to you was to present the different views in two separate reports. So that is what we have come to. Anything further?

DR. ROBERT MCAFEE: Does the board have any questions about the methodology or the general principles or the consensus statement that's before you at this time?

DANA CONNORS: I have probably dozens of questions, but this is the first time that we've actually received it, for my purposes. I speak only for myself, I would like to be able to absorb as much information from these people as possible today with the idea we're coming back to make decisions obviously today, that would be a disservice.

DR. ROBERT MCAFEE: I'm not asking for you to do that.

DANA CONNORS: Oh, I know, but I'd just like to state that I'd like to hear as much as possible with the idea that this is the beginning, not at the end of our consideration.

DR. ROBERT MCAFEE: Anything else?

UNIDENTIFIED FEMALE: Just on the terms of process. So is the next step for both sides to present not only on the savings but on the definition of paid claims when paid out of state. Because I don't want to pass the out of state issue by.

ANN GOSLINE: I think its safe to say that most efforts are focused mostly on the calculated monthly cost savings, but would be happy to make further statements to you . . .perhaps then when others come up from the working group, they will have additional things to say about out of state claims.

DANA CONNORS: I just have one more question. Ann, what is it that you have agreed upon and consensus has been reached? We are clear that a definition for paid claims with the exception that we are about to hear more about or at least in general. It is that essentially it?

ANN GOSLINE: I'm not sure I understand your question.

DANA CONNORS: There are several charges this group had. What have they reached consensus on?

ANN GOSLINE: The answer is that the definition of paid claims is the area in which there has been agreement. The group has focused really on the charge concerning paid claims and on charge D, which is the methodology for calculating measurable aggregate cost savings. Charge D, of course is the big one in terms of complexity, and as there is not consensus on that one, and the group has not otherwise been able to conclude its discussion on other areas, paid claims is the only area where they have reached consensus. I'm hoping there are some areas of agreement on some parts of calculating claims today.

KARYNLEE HARRINGTON: We've reached a consensus on the majority of the definition around paid claims, but there is one issue. So it's not complete, but we're almost there.

DR. ROBERT MCAFEE: Realizing that we've come a long ways from premiums to paid claims, and the declarative language with which we can and do agree with the exceptions that are listed there, I think that this is itself a landmark. I thank you for that, and understand the reason that we need to clarify some of these things with some discussion. So let's move on, then, to who is going to do what first? Shall we hear from you, Karynlee?

UNIDENTIFIED FEMALE: Karynlee would you like to present the report from the (inaudible) Dirigo?

KARYNLEE HARRINGTON: Good afternoon Dr. McAfee and the members of the Dirigo Board of Directors. As you know, my name is Karynlee Harrington and I am Executive Director of the Dirigo Health Agency and this afternoon I am here talking with you as a member of the 10-member working group established under Chapter 400, a result of LD1577. As Ann described, the working group has spent hours working through very complex issues. In fact we've had over 14 meetings, in a combination of half day and full day meetings. The feedback the agency has received during these discussions has been constructive and beneficial. You'll see as I walk through the attached document that we have agreed to amend approximately 2/3rds of our original proposal to accommodate the concerns raised by those representing the market. It is most unfortunate the group is not presenting one recommendation to you today. It would have been great if they were because then somebody else would be making the presentation. As previously stated, there has been a tremendous amount of effort but consensus wasn't reached even with the amendments we agreed to. The work group members who are representing the market have said publicly that our methodologies are flawed, arbitrary, and overstate things. With all due respect, we firmly disagree with this assertion. Our methodologies, we believe are reasonable, consistent and fairly measure savings in the system. It is not in our best interest to misrepresent savings. One of our guiding principles is that savings should not be overstated, nor should they be understated. Our methodology must be reasonable, and with as much precision as possible measure the impact of the Dirigo Health Initiatives on the rate of growth in the health care system. With more than six months behind us, we believe are methodology is reasonable and adequately measures savings that have accrued in the system as a result of the Dirigo related initiatives. Both the Dirigo Health Agency and the Governor's Office of Health Policy have been working with the following consultants as we work our way through the process. Nancy Kane, who has a DBA, is with the Harvard School of Public Health; Beth Kilbreth, a Ph.D. with Muskie School; in consultation with Cathy Shoen, who is Sr. Vice President for Research Evaluation for the Commonweatlth Fund; Mercer

Government Services Consultant Group. Mercer has primarily provided the overall guidance in ensuring the methodologies are consistent, reasonable, and again adequately measures the impact of Dirigo on Maine's health care system. I think it's fair to say that the work group has some fundamental disagreements relative to the intent of the Dirigo law and the guiding principles specific to the method and calculation of savings. The primary areas of disagreement as we understand them are: line of sight, net results, cap on the amount of savings that can be used to determine the assessment, and replacing our COM, CMAD, and underinsured methodology with a hospital rating fee schedule. One of the fundamental disagreements between the members of the work group is that once we identify savings we must offset increases that occur in the system with those savings. The flaw in netting increases and decreases in determining the impact of Dirigo is that Dirigo cannot be held responsible for non-compliant hospitals whose cost growth in 2004 exceeded baseline targets. As you know, health care costs grow three times faster than inflation. Dirigo's goal is to reduce that rate of growth. Health care costs would grow absent Dirigo. Nothing in Dirigo is responsible for increasing the cost, so therefore it is inappropriate in our opinion to net them out. It's not reasonable to propose that reductions in the system be eliminated by increases in the system, when as you know, health care costs grow three times faster than CPI. Annual trend continues to be between 9 to 12%. The goal of the Dirigo Health Cost Initiative is to slow the growth rate down. The initiatives will not eliminate all cost growth in the system. Again, it's our goal to reduce the rate of increase. As a step towards controlling rate of growth in the cost of health care and health coverage, the legislature in Dirigo legislation, asked for the cooperation of hospitals and providers to comply with voluntary limits. We disagree in principle with the net argument, not because it reduces savings, the flaw is that, we know there are hospitals and insurance carriers that complied with and managed to the voluntary targets, that historically had margins and costs over the targets. And many did not. The hospitals are asked to reduce cost increases measured as expenses per case mix adjusted discharge and operating margins. These measures were proposed and supported by the Maine Hospital Association. The insurance carriers were asked to limit the pricing of the products themselves to a limit which supports no more than a 3% underwriting gain. As we walk through the matrix you all have in front of you we will get into some more specifics that surround that. The line of sight discussion: We believe that the law and vision of the voluntary approach is a shared responsibility between Dirigo Health and the market. Dirigo Health constructs the cost savings initiatives. The market ensures the savings are shared with consumers. Our preliminary data ensures us that there are savings associated with these voluntary measures, that we believe should be passed onto the consumer. The Dirigo law states that it is the hospital and insurance carrier's who are responsible for sharing those savings with the consumer through renegotiation for improved pricing. From our perspective, the agency is not in a position to negotiate better pricing on behalf of the carriers, and as such our role is limited to setting the targets. An ongoing challenge would be to recognize the limits of the voluntary system and the need to work on other methods that will pass through savings. The market place argues that any documented savings should be shared 50/50 between Dirigo and the market place. The payers would retain 50% of the savings and the agency would be able to use 50% of the savings for determination of the Savings Offset Payment. Dirigo was designed to be self-supporting by generating savings in the health care system that are at least enough to cover the program. That is the cost of the SOP would be offset by savings in the system. No new dollars would be required from payers to continue the program. The SOP is not a tax, but rather recaptures and reinvests savings. The savings offset payment is designed to recapture savings and reinvest them to sustain the program. The voluntary cost measures, if all parties comply, should achieve savings adequate to continue and sustain Dirigo and it's hoped, to provide additional savings for the market place. The law caps the amount of the assessment to 4% of paid claims, which based on some preliminary numbers provided by Maine Health Data Organization approximately $56M would represent a 4% assessment. A 3% assessment is approximately $42M. These numbers are just to be used as a benchmark. They are preliminary. They exclude out of state claims, but they include retiree plans, and when you go through our definitions you see that we agreed to exclude retiree plans from the definition of paid claims. So there not final numbers but just to give you a sense. The assessment cannot be more than what's been measured in savings and it can never be higher than the 4% cap of paid claims. To further restrict the savings available through the savings offset payment, goes beyond what we believe is the legislative intent. The work group representing the market will share with you a proposal that they presented to the work group that will replace our COM, CMAD, and uninsured measures. Their proposal is to measure average annual hospital increases. It will be represented as a more simple, and efficient calculation that provides a clear line of sight between the Dirigo initiatives and their impact on the prices paid by payers. It's easy to be drawn toward the argument that their methodology is much more simplistic and easy to understand versus what we've proposed, in that using what hospitals charge is a better indication of what payers pay. Our position is that health care is complex and no one pays charges and that it does not provide the direct line of sight that it is represented to provide. We believe this methodology is flawed for the following reasons: there is no case mix adjustment for in-patient care, there is no standardization of visits or visit mix on the out-patient side. The average charge may change just because the patients are sicker, using a different mix of out-patient services, or because hospitals are less efficient in rendering services or because doctors are less efficient in ordering tests and services for patients. Our focus on cost per case mix and out-patient adjusted discharge attempts to adjust for the case mix and out-patient mix variability, which are at the least particularly driven by patient need, not relative efficiency or inefficiency. We will use the data currently available that is verifiable. It's not perfect, but we do not believe it's arbitrary either. The payer's measure is far more apples to oranges both over time and across hospitals than what we propose in our CMAD methodology. We believe rate increases are not tied to actual payments or savings, and therefore do not contain the line of sight. Rates from our perspective do not measure anything. They are discounted and those discounts are not public. There are thousands of items hospitals set prices for each year which may or may not increase at the same rate, and private sector payments will vary with their mix of services which may or may not be reflected in the average price increase. With that I'm going to turn to the matrix that we handed out.

DR. ROBERT MCAFEE: Let me ask you one thing. The 50% of savings returned to DHA, where does that come from? What is the history of it?

KARYNLEE HARRINGTON: I think the history of that is and you'll see it the market side, in their guiding principles they believe that a portion of the savings should be returned or should stay with the payers. So if we were to demonstrate a $100M is savings, they believe $50M of that should be used to determine how much savings we can use to then make an assessment. So the issue is the savings, our assessment can never exceed the savings and there is a cap of 4%. What they are suggesting is that if we used the $50M in this example and if 4% of paid claims exceeded $50M, then we would have to have a lower assessment. Instead of us being able to use the full $100 M, we would base our amount of savings on half, and then we would only be able to assess no more than whatever that dollar amount was.

UNIDENTIFIED FEMALE: And then the other $50 M in your example stays with the insurers?

KARYNLEE HARRINGTON: The market will be able to provide you with a better description on this, but what we've understood the market's position is that the remaining $50 M would not be used in calculating. So, it's not that they're getting $50 M, it's inherently built into the pricing, but we wouldn't be basing our assessment on the much bigger number. The bottom line is this, if we needed a SOP of X amount and it was greater than the savings, this is the issue. They are proposing we limit the amount of the savings so we can limit the amount of the SOP. We would argue that the legislature did that in the law by limiting the savings offset to no more than 4% of paid claims and that's where the protection is. Ok, the matrix that we've handed out has a lot of information on it that is consistent with some of the earlier presentations of our methodology. I want to first walk through our guiding principles. In developing the method and calculation of the aggregate measurable savings, the following principles guided our process. The initiatives will be related to Dirigo Health Reform, consistent with Public Law 2003, Chapter 469. The initiatives are primarily voluntary. It's the responsibility of the market place to voluntarily comply with savings targets and to recapture savings in price negotiations. Data sources used must be verifiable. Savings should not be overstated or understated. Methodology must be reasonable and appropriately measure the impact of Dirigo Health on the rate of growth in the health care system. The process must be transparent and the savings will be used to sustain Dirigo Choice at no additional cost to the market. Additional savings will accrue to the market. What we've tried to capture in the matrix is the specific initiative which is listed on the far left hand side of the column, the statutory reference and then a high level overview of the methodology. I think to Dana's earlier point, this is a lot of information that we're throwing at you. I don't want to go into all of the specifics relative to the actual methodology and calculation at this meeting. But I think what makes more sense is that in a follow-up meeting you get your specific questions answered by the experts, by the actuaries from both sides that have been working on these proposals. So I'd just like to talk high level about the various initiatives. The first is the voluntary target relative to consolidated operating margins. And this is not a new initiative. This is what we had originally proposed back in April. What's changed about the initiative is that we have agreed with feedback from the work group that we only include those hospitals where the baseline margin is above 3%. And I should probably take a step back, when I say we've agreed, I want to make clear, I'm not representing that the Dirigo Board has agreed but rather that members on the work group representing the Dirigo side have agreed. The ultimate decision will be up to you all. Just a couple of points to note here. Although the aggregate operating profit for hospital-entities-only in 2004 was over $79M, our approach measures the hospital entity plus its subsidiaries. So hospitals that have funds in excess of costs are discretionary to the hospital. Hospitals use those excess funds to reinvest in reserves, buy equipment, buildings, technology, to purchase new services or programs. Our methodology will define consolidated margins after all these expenditures are netted out. And again, it's the hospital entities plus their subsidiaries.

UNIDENTIFIED FEMALE: What were those $79M again?

KARYNLEE HARRINGTON: The $79M number represents the aggregate operating profit of hospital entities in 2004, before those investments are made.

And again, our methodology will define consolidated margins after all these expenditures are netted out. Cost Per Case Mix Adjusted Discharge, which we refer to as CMAD. Our methodology measures savings resulting from decreasing rates of growth for hospital costs for per case mix adjusted discharge during the fiscal year July 1, 2003 through June 30, 2004. It is based on a cost and unit methodology proposed by the Maine Hospital Association. We will make a few minor modifications to the MHA template so we can do a year-to-year comparison and provide consistency within the measure over the period of analysis. Volume is adjusted in this methodology that MHA has proposed. There has been some concern over whether or not volume is adjusted. It is adjusted inherently in this methodology because it's a unit cost or cost for discharge, not total cost. Discharges have been adjusted for case mix and outpatient activity as well. I do have for all of you a copy of the methodology that was proposed by the Maine Hospital Association. Not all hospital fiscal years corresponded with the 7-1-03 to 6-30-04 dates described in the law. As such our calculation will weight the hospital fiscal year CMAD by the number of months of overlap with the fiscal year described in the law. The recommendation was made by the work group that the methodology should include an adjustment for hospital market basket inflation. And let me just back up to say that this has been a major learning experience for many of us on the work group relative to hospital financing and so on. I am not an expert on it. That's why we've hired consultants to help us weave our way through this. But what I can tell you is the hospital market basket rate of inflation costs reflects the rate of inflation for hospital input costs nationally. It looks at salaries, wages, benefits, labor, utilities, supplies. We've incorporated this into our methodology. Again, this was one of the recommendations made by the members of the work group representing the market and we felt that it was appropriate to make that sort of adjustment and as such we have revised our methodology to incorporate it. The other point to make is we have made some modifications relative to how we figure out a baseline average and we've again made that compromise based on feedback that was provided by the work group using a compounded approach versus just straight-line averages. Voluntary underwriting targets. Again, this is not dissimilar to what was originally proposed back in April, although we have made the following agreement. We have agreed that we will only include those carriers that voluntarily agreed to participate in the target. In 2004, underwriting gains or profit after taxes were over $50M in aggregate for the three largest insurers in the State. We've agreed that only those insurers that agree to comply with the measure, we will count toward any kind of savings.

UNIDENTIFIED FEMALE: Did we have several of them that did not agree?

KARYNLEE HARRINGTON: Just as a note, only one of the three largest insurers agreed to the voluntary target, and we are working with the Bureau right now to confirm. I believe the Bureau has provided us with an actual list of the carriers that have complied and I want to say it's six; with the exception of the one that I just pointed out, one of the three largest has agreed. The rest of the remaining carriers are much smaller. This has been a measure again that we initially proposed but it is a measure that we have again through discussion in this group, we have defined some of the specific methodologies. Let me just walk you some high level information relative to bad debt and charity care. What I've learned about public reporting of bad debt and charity care expense is that it varies by provider type and ownership status. Maine's 36 general acute care hospitals, all of which are non-profit provide bad debt and charity care information in their audited financial statements each year. The numbers we're using to measure the amount of bad debt and charity care is information that is publicly available along with additional information we've received from the survey of the acute care hospitals which was administered by the Maine Hospital Association. The survey provides supplemental information about bad debt and charity care related to physician practices that are part of the consolidated financial statements of health systems. Proprietorships and professional corporations of providers like dentists, physicians, pharmacies, do not publicly disclose their financial data so there's no centralized listing for those providers so as such we're not reporting any bad debt or charity care for those providers. Hospitals do have varying bad debt and charity care eligibility criteria. A charity care survey completed by hospitals indicated that 13 hospitals adhere to the minimum eligibility level to charity care required by the state which is a 100% discount of a family's income at or below 100% of federal poverty. Another 12 hospitals allow for a sliding scale for a 100% discount up to 150% of federal policy. Eight more hospitals have a charity eligibility policy that allows discounted or totally free care for individuals with income as high as 200% of federal poverty.

There is one hospital that allows for sliding scales for individuals with incomes as high as 300% of federal poverty. Bad debt is recorded as expense in the income statement and charity care is recorded in the footnotes that go on to the audited financials. The data shows that most all charity care at the system level is provided by hospitals in the system. Bad debt and charity care, based on our analysis, are generally recorded as the value of charges foregone, which is the amount the hospital would have charged the patient, not what it actually cost the hospital. Based on the work that our consultants have been doing, the amount of actual costs related to uncompensated care is generally unknown. As such the measurement of bad debt and charity care is calculated based on valuing charges. Bad debt expenses as reported in audited financial statements reflects an estimate of what might not be collected on accounts receivable at the end of the hospital's fiscal year. The actual write off of a particular bill is triggered by events that may occur well after that year when the estimate of bad debts have been made. It can take a year or longer to make the determination that a particular account is uncollectable. After the bill is written off it may still be partially or fully recovered from the patient or the insurer and as such hospitals must estimate bad debt expense based upon their experience in collecting from specific types of payers. Based on our survey of hospitals the recorded difference from what is actually written off is not significantly different from estimated bad debt expense reported on the income statements. As we get through some of the details we can see that the difference in 2002/2003 was somewhere between 1 ½ to 3 ½%. The write offs were actually greater than the estimated bad debt expense reported in the audited financial statements. In the spring of 2004 the Maine hospitals were surveyed to determine what proportion of bad debt expense came from publicly insured, privately insured and self-paid patients. The privately insured is responsible for at least 30%. This is important to keep in mind as we talk about insuring the under-insured, which we'll talk about in a minute. The methodology in terms of how we're going to calculate, bringing people that were currently uninsured into Dirigo, what's the value of that, has not significantly changed from what we originally proposed in terms of looking at what is the bad debt/charity care in this state. How much is that is attributable to the uninsured? But here's where we have made a significant change. It was based on feedback from the market side of the work group. Mercer is creating a claims probability distribution table that will allow us to adjust for underlying risk to the population. In our original methodology we assumed everything was equal, so we're going to apply a per member per month to everybody at the same level. The fact of the matter is, as was raised in our work group, not everyone contributes to bad debt and charity care at the same rate. So our methodology will adjust for those who actually incur bad debt and charity care. This is a change in what we originally proposed and, I think, more appropriate when we're trying to understand what truly is the value. One of these things that we've talked about is the number of underinsured that our program is currently covering. And, when we look at Nancy Kane's work around the percentage of bad debt and charity care that is generated from the insured population, we began to do some research around underinsured and was there a definition of underinsured. After some work with the Commonwealth fund, and feedback from the market, we have devised a definition that I shared with you all relative to three criteria and if an individual met one of the three, they would be identified as underinsured based on the Commonwealth definition. The only information that we have on our members relative to their past insurance status is a result of the survey and the question that we've asked relative to what was your deductible? So when we cross walk that back to the criteria, the only criteria we could look at was the one that talked about deductibles. Not total medical expense but rather deductibles. The survey done by the Commonwealth Fund was a random national survey. They basically concluded that if your deductible is more than 5% of your income, then you meet the definition of underinsured. The feedback we got from the work group, and appropriately so, is that in Maine, that could be almost all of us, given levels of income. So we went back to the Commonwealth Fund and talked about if it would be reasonable to take an approach where we defined underinsured for households who have incomes that are under 200% of federal poverty and we define it at the 5% level. For households who have 200 to 299%, we used 10%, and then for those households with income over 300% we don't count. And that's not to say that they are not faced with high deductibles or potentially could be underinsured, but we would not count them in our measurement to try and capture what is the value of bringing these people into the program who are now getting a program with significantly lower deductibles and out of pocket costs. The work that we are currently in process with Mercer on is identifying, based on the household, how many uninsured people there are, how many people fall in the income range under 300% of federal poverty. We are building a claims distribution table for this group to determine what is appropriate for that category. The next initiative is number six on your matrix and this is a measurement for folks that were uninsured and as a result of we think the work we are doing around the purpose of getting people covered and highlighting the programs that are available for folks based on income, have come into MaineCare as a result of Dirigo Initiative. Again, in terms of the actual methodology, similar to what we've already stated, the compromise here is that we used only net MaineCare and SCHIP enrollees as of July 1, 2004. We also had some people on the Dirigo working group that suggested that there was a savings for people that were covered under MaineCare prior to Dirigo Choice, and as a result of Dirigo Choice, they were able to take on more hours, pick up additional earnings, and not fall off the cliff because they were able to join the program and get a significant discount on their Group B. Because we are paying providers for those folks that are in Group A, so for those folks that would typically be directly MaineCare, if they came into the program as Group A, we pay the physicians at the commercial rate rather than the MaineCare rates. There were some that suggested there were some savings connected with that because of the additional reimbursement and our compromise or what we agreed to in the work group is that we did not include any savings relative to that initiative. The next initiative, number seven, is uninsured private additional insured and again, there were some folks who were suggesting that with the press and all the discussion across the state around the importance of bringing people into the system, so that all of us who are currently in the system reap some savings. There has been discussion that by doing that we have brought people that are uninsured or previously uninsured into the system, maybe not through Dirigo, but through another carrier. We have said all along that is absolutely one of the goals of the program. We don't care in the end how people get covered, we just care that they get covered. That was one of the areas proposed in terms of trying to measure savings related to that. My perspective on this is that I think there is a possible initiative that we should look at but not for this first year. The reason I say that is the legislation requires me to report each year on the number of uninsured people in the state and each year how that number changes. The challenge with that information is it is not currently captured and reported. I think this is something that we want to pursue, and I think we should just not this first year. Number eight is Certificate of Need and Capitol Investment Fund Initiatives. And again, this is not a new initiative it has been previously proposed but there are some refinements or clarifications. Again, much of the changes have been made due to the feedback from the work group. The bottom line is that I think it is safe to say that the work group felt savings should be counted only in the year expenditures were avoided. We in principle agree with that. Mercer is building the lag table that attributes year one, two and three operating costs to the appropriate year in which they occur. Mercer will use this to determine the historic rate of CON approval. They will then look at the moratorium to determine what was expended. The delta, when compared to the historic is the savings if there is any. Mercer is comfortable that the concern for potential overlap with the measure is minimized as the calculations will be done in the year the cost is avoided. We have not been able to share with the work group to date the specific methodology other than what is outlined here in terms of this initiative. This has probably been the most time-consuming issue to get our hands around that Mercer is still working through. It has not been an easy process in terms of collecting the data, building the table, appropriately measuring and allocating expenditures. More to come on this, but I do want to underscore that we have not provided any more detail than what we're talking about now relative to CON. I won't go through the CON hospital/non-hospital sustained principle methodology. That brings us to initiative number 12. I think it's safe to say that this particular issue has created much discussion in the work group around whether this initiative is related to Dirigo. The conversations among the work group is that you may or may not disagree that there are savings related to cash flow, but I think the underlying issue is, how is the initiative is directly related to Dirigo. And we believe that the initiative is directly related to Dirigo. We've provided a statutory reference. The commission that studies Maine hospital is the commission that made the recommendation to make payments on historical settlements to increase the PIPP payment and to settle up on historical settlements.

(End of Side A)

KARYNLEE HARRINGTON: We believe that there is money that is going into the system that has an impact on cost shifting. That it reduces the amount of cost shifting or that it should reduce the amount of cost shifting. There are again, challenges to that argument. There are folks who believe that is absolutely not accurate. And so, I'll do my best to give you just a few more points on that and I think it's important that you hear from the other side and then we open it up to the entire work group to talk about this presentation and anything else that you might want to talk about. On the historic settlements there is approximately $90M that the State is paying to providers by the end of September when the total payment will be made. And there've been conversations where people have agreed that those dollars were never accounted for because hospitals never thought they were going to get those dollars. Kirsten, jump in if I'm not using the right technical terms, but those are dollars that they had assumed they were not going to get. So that is new money. But where it goes, I think is the question. And if it wasn't something that was accounted for, the question is did they borrow that money? Most hospitals wrote it off, and again, I'm probably not using the right technical accounting terms, but the question is "where did that money go?". And how as consumers, if the State is putting into the system millions and millions of dollars to reduce the cost shift, do we realize the benefit of that? And that is again under all three of these initiatives; the historic settlements, the PIP settlements and the increase in the PIPs are contentious elements that I think we need to work through. And then the last initiative, number 13, is the initiative relative to increased physician's reimbursement. And again, we were looking at the amount of physician payment increases to be paid during fiscally year 05/06 and the second half of calendar year 06. One of the potential compromises in this particular issue relative to the initiatives is relative to the time value of money. Geoff Green has been the person that has been the most engaged with this particular initiative and he can much better articulate our position relative to why we believe that this money in one way or another, whether it is the time value of money or some other form of measurement, should be counted as savings and passed on to consumers. OK

DR. ROBERT MCAFEE: Amazing, isn't it?

KARYNLEE HARRINGTON: I think with that, I will end and give my colleagues a chance to present their position. I do think that from our perspective the bottom line is that there are savings, we do not want to overstate the savings but we want to accurately reflect the savings. And that the methodology that we have been working on comes from a team of experts. This is not us sitting in a back room trying to figure out how to do this. This is with a highly credible group of professionals helping us figure out what works and doesn't work. I would like to add that the other group of members that we've been able to tap into their expertise on the other side of the work group has been valuable. They all have their own jobs, and they, again have attended 14 meetings. They've provided us with guidance that has only strengthened our methodology. But I think we do have some fundamental disagreements in terms of the intent of the legislation that puts a barrier up in terms of coming to consensus.

DR. ROBERT MCAFEE: Ok, any general questions, broader questions of what Karyn has presented to us?

DANA CONNORS: I'm not sure it's a question, I'm just trying to clarify as to your next to last point. I'm trying to understand the premise of it. The hardest part here, is to be honest, is you all are an excellent group, you spent countless hours on this struggling with issues and so many times I wanted to bring Kristine into my office and get a briefing when I knew that wasn't appropriate. I beg your forgiveness that some of these questions are pretty elementary. In that vein I ask the following: when you looked at the concept that you just discussed, if the hospitals are owed money and they don't get it, and later there is money forthcoming, the fact that they wrote it off meant that you had to pick up some bad debt or charity. But the money comes back into the system, the premise is to use all of that or part of that as savings. Is that right or did I miss the point?

KARYNLEE HARRINGTON: No, I think that is the point and I would ask Jeff to expand on it.

GEOFF GREEN: There are probably a couple of different scenarios we're dealing with here. Some of the payments to hospitals, historic settlements, go back to 1998. For those amounts we really do believe that hospitals are not carrying receivables for those very old amounts that were disputed, so there is not really a basis for carrying receivables for those amounts. So when that money comes in the door, our view is that is $90M coming into the system that directly or indirectly reduces the amount of costs that the hospital needs to shift to other payers. So that's the way we're looking at that. Increased PIP payments (prospective interim payments) that effectively pays a greater share of the money owed to hospitals when it's owed and therefore reduces the unpaid balance that they carry into the future that gets paid three years later when the cost settlement is done. So it's not one answer, the question as I see it, there are a couple of different scenarios operating here. I hope that helps.

DANA CONNORS: Yeah, it does. This would be an appropriate time next time to ask questions. It wasn't my point. I was just trying to understand it because I was having some difficulty. I saw it that dollars that they were owed, the premise is that they were written off, therefore it adds or gets shifted or those kinds of things. I was just trying to sort this out in my mind as we try to absorb the rest of this in a week's time. Thanks.

DR. ROBERT MCAFEE: Ok, Frank are you going to go for that?

CHARLENE RYDELL: (Inaudible)

DR. ROBERT MCAFEE: We'll get something faxed to you Charlene.

UNIDENTIFIED MALE: I'll distribute it to the rest of the members prior to making a statement.

DR. ROBERT MCAFEE: Even Mr. McGinty (inaudible). Just the other day I was appearing before you at a meeting when you were representing the bureaucracy at the State of Maine. I wanted to spend money, and you told me I couldn't.

UNIDENTIFIED MALE: Obviously he still hasn't forgiven you. He's still holding it against you.

DAN ROET: Good afternoon everyone, I'll try to speak loudly so that those behind can hear me. My name Daniel Roet and I'm Director of Human Resource Services at Bath Iron Works. I have 30 years of experience in designing, administering and financing employee benefit packages for large companies including health care programs. I've been in charge of employee benefits at Bath Iron Works for about 15 years. Prior to that I was at the Washington DC area. I worked at corporate headquarters, running their employee benefit programs for about 60,000 employees. I have an MBA in Finance, and sat for several actuarial exams. I am a member of the working group that represents insurers, self-insured gentilities and third party administrators. Frank McGinty, setting to my right, is a member of the working group as well. He will be presenting the methodologies of our side of the work has developed and is recommending to the board. At that time, I will distribute our handout, but before he does that I would like to make some opening comments. First, it was also our hope that we would be able to reach a consensus on what we were being asked to do. Our motivation to reach consensus was driven by both benevolent reasons and quite frankly for selfish reasons. If both sides of the working group were able to come to consensus on the methodologies used to support the savings for the savings offset payment, then a very strong alliance would be created between payers and Dirigo leaders that would financially ensure the ongoing operations of the Dirigo insurance program and the Maine Quality Forum. The Dirigo Insurance program will be insuring more and more uninsured and underinsured Maine residents. And the Maine Quality Forum, which is doing great work with continued improvement in the quality of health care services in Maine. On the other hand, the employers would be the beneficiaries of cost savings with a portion flowing back into Dirigo and a portion mitigating the large cost increases we have been experiencing over the past five years. With real savings flowing through to employers, employers will be strong allies of Dirigo leaders because the potential termination of Dirigo will eliminate the very savings that would accrue to them as a result of Dirigo. Therefore, we've had a real desire to reach a consensus on the methodologies that would support the savings offset payment. In early August, when Dirigo's consulting actuaries acknowledged that developing a methodology which can accurately measure most of the components that would constitute aggregate measurable cost savings resulting from the aspirations of Dirigo were not achievable in the timeframe slotted for this work group. The two working groups worked tirelessly to develop reasonable measures of aggregate, measurable cost savings. Unfortunately, as you know, the two working groups were unable to reach consensus despite numerous attempts to do. Since there are no rigorous actuary or financial methodologies that can attribute measurable cost savings directly to the operations of Dirigo, the methodologies produced and recommended to you today by both working groups will be flawed and arbitrary. We believe that the methodology of the Dirigo working group is so flawed and arbitrary that it does not meet the intent of the legislation which requires the savings offset payment be based upon savings resulting from the operations of Dirigo. We believe that the Dirigo working group methodology so inflates the measurement of aggregate measurable cost savings that the only thing it represents is a number. The number that will always show savings in any environment and under any circumstances whether through Dirigo or not. In fact, whether Dirigo exists or not. These attributes make the Dirigo working group's methodologies unacceptable to insurers, the self-insured and third party entities. Payers will have no confidence and every reason to believe that any savings offset payment that they pay will not be generated by aggregate measurable cost savings resulting from the operations of Dirigo. Instead, payers will categorize their disbursements as a tax on health care payments they make on behalf of their employees. Regardless of the categorization of legislation as a payment made from savings. This tax will affect employer's ability to invest in whatever market they operate in. While neither working group can fully meet the objective of the legislation which contemplates a measurement of savings that can be rigorous enough so that those who are responsible to pay the savings offset payment can be assured that the disbursements or some portion of the savings they accrued as a result of Dirigo operations. The working group, representing the insurers, self-insured entities and third party administrators believe that our methodology is less flawed and less arbitrary than the methodology developed by the Dirigo working group and better meets the intent of the legislation to measure aggregate measurable cost savings resulting from the operations of Dirigo. Frank McGinty will now present our methodologies and the reasoning behind them as well our concern regarding the Dirigo working group.

FRANK MCGINTY: As Dan is distributing the documents that we've shared with our counterparts that describes both an alternative method that payers and purchasers have proposed we'd like to discuss with you but also, it identifies for you what our concerns have been about a number of the methods proposed by Dirigo representatives of the work group.

DR. ROBERT MCAFEE: Just for purposes of identification, introduce yourself in terms of what you're currently in.

FRANK MCGINTY: My name is Frank McGinty. I'm Executive Vice President and Treasurer of Maine Health. Maine Health is a health system that includes Maine Medical Center, four other hospitals, and a number of other health care organizations.

UNIDENTIFIED FEMALE: You're now with Maine Health, but this presentation is not for the hospitals.

FRANK MCGINTY: No, I was asked to serve as a member of the work group by Dana Connors, representing the payers and purchasers. Maine Health, in addition to being the largest provider in health care services in the State is also one of Maine's major employers. We sponsor a $50M dollar a year health insurance program with roughly 12,000 people covered. And so, as I served on the work group, I was there as an employer and purchaser as well as someone who could add a perspective about hospital finance to the discussions of the work group.

DR. ROBERT MCAFEE: Ok, thanks.

FRANK MCGINTY: But again, I want to say first that I'm sure Dan and other members of the work group appreciate as much as I do, the willingness on the part of our counterparts representing Dirigo have listened to the concerns we've expressed and have been willing to make changes to their original proposals as they were outlined to us a few weeks ago by Mercer in response to the concerns that we've addressed. There is more agreement than not on several the methods of savings that Karynlee described to you. For example I believe that changes had been made in the method of estimating savings resulting from hospitals that historically had operating losses above 3% to reduce those is a change with which we agree. Similarly I believe we are now in agreement on the method of measuring savings resulting from our deliberate actions by insurers that have had underwriting gains greater than 3% and agreed to reduce those below 3%. There are also potentially areas of agreement in the case of measured savings resulting from some of the certificate of need related activities, some of the measurements of charity care, bad debts and their impact on hospital's prices and therefore the private sector's activities. Although I think it's fair to say that in those last two cases there's a lot of information we don't have today that prevents us from knowing that we have a meeting of the minds. But, let me start by saying that I do come, as I mentioned in response to the last question from a health care organization that includes a number of hospitals. I told my colleagues, I told the representatives of Dirigo, and of course during the work group deliberations that I do believe that the establishment of a voluntary target of 3.5% increase in hospital cost for adjusted discharge has had beneficial effect on health care spending in Maine. And hospitals across the state have responded affirmatively to that challenge by the governor and the legislature to limit the increase in our expenses. With my colleagues, though, pressing for some assurance that restraint, that moderation in the increase in hospital spending actually came to benefit them in the form of reduced increases in hospital prices. It is more difficult for me to be confident that happened. Right about the same time that the governor signed the Dirigo Health Reform Act, he signed a budget that included substantial reductions in payments my Maine Care for services provided to MaineCare beneficiaries. Over $40 M in 2004, we cited a greater increase in 2005. So even though hospitals expense increases may have moderated, it’s not clear with the information available to me that that moderation resulted in a lessening of the rate of increase in charges by hospitals to the private sector. It is employers and employees who are ultimately called on to pay the savings offset payment. And so, as we talked about how we could respond to the need to search for areas of agreement, what the Payer Group determined was that despite Mercer’s assertion that it would be difficult or impossible to establish a direct connection between Dirigo activities and reductions in spending that we would be willing to attribute to Dirigo. Savings that could be shown that have resulted from a lessening of the rate of increase of hospital charges. Yes, as Karynlee mentioned, there are a lot of factors that affect hospital charges, including, as I said a moment ago, increased hospital expenses, changes in payer mix and what the hospital paid for care or what the hospital operating margin goals are. All that has an affect. All those effects are in some ways effects that Dirigo sought to influence. And so the purchasers said that if you can show us how that the rate of increase in hospital charges has slowed, we are prepared to attribute a substantial share of the measured savings to Dirigo. And again, going back to the discussion that Karynlee had with you. It's important you understand that purchasers have two points of view that are in need of amplification here. The first is that when a method of measuring savings makes it impossible to truly isolate the impact of Dirigo and there are lots of other things happening, then it's unreasonable to hold Dirigo to an impossible standard and say it can't prove the entire savings or a particular part of the savings were attributable to Dirigo, and therefore no savings should be taken into account. What we're saying instead is, that such a method is employed then we have to recognize that there are those multiple impacts that we're measuring the outcome or the effect of and we have to attribute some fair portion of the measured impact to Dirigo and attribute the remainder to the other. The second issue that the Payers would have you consider is that whatever the measured savings is that some part of those savings need to be left with the employees or employers who are buying and paying for health insurance all across the State. The Dirigo Health Reform Act is intended not only to extend coverage to people who have Dirigo Choice, but to make it easier for employers like Bath Iron Works or Maine Health, companies with five employees or two employees to buy private health insurance. To the extent that you choose to recapture all of the measured savings in the form of a savings offset payment in order to support the Dirigo Choice program. No matter how worthy that is, if you do that, you will have deprived the rest of the private sector, who are paying the savings offset payment of some of the benefits they were expecting to derive from the program. So again, we've described for you the two issues that we want you to take into account. How much of any measured savings you can fairly attribute to Dirigo and how much of those savings attributable to Dirigo do you think it is fair to recover to support the Dirigo Choice program knowing that is other people who are struggling to pay health insurance premiums that are going to have to make those savings offset payments.

CARL LEINONEN: If I may, Frank. I understand both points. I guess what leaves me a little bit perplexed about the latter point about some portion of the savings to employers and employees which clearly is a goal. I don't think anyone would dispute it is a desirable outcome. Doesn't the legislation define for us the caps on how much of any savings could be used to support Dirigo on an ongoing basis. Isn't that defined in the statute? Are you suggesting a different measurement or a different amount than that is automatically set aside in the legislation here?

FRANK MCGINTY: No, my understanding, Carl, is that the legislation establishes a maximum of 4%. But how much of that 4% is needed in a year, we believe that is a decision for this board to make. And how much of the savings that you believe has been achieved, you believe it would be appropriate to take in the form of a savings offset payment. We also believe it is a policy decision for this board to make.

CARL LEINONEN: Ok, but isn't that something you can really only grapple with once you know what the amount of savings is and you know what the amount of and then make decisions on what actually need to operate the program. Before you even have a figure of savings, how do you determine x percentage goes here and x percentage goes there.

FRANK MCGINTY: I guess what we have said, I think, is that when a method is chosen to estimate savings, that by its very nature it is impossible to contribute the measured savings solely to Dirigo, we propose a 50% attribution.

CARL LEINONEN: Where does that figure come from?

FRANK MCGINTY: Just a view that it is appropriate that the several hundred thousand people who pay health insurance should derive at least as much benefit from the Dirigo health activities as the several thousand people who will receive the subsidies made possible by the savings offset payment. And again, it's an arbitrary figure that is based on that principle. The willingness to provide payments that support Dirigo but a belief that employers and employees all across the state who are struggling to pay for health insurance should get some relief too.

CARL LEINONEN: I certainly would agree with that but, wouldn't some of that relief also come from reduction in the rate of increase in hospital charges and insurance charges.

FRANK MCGINTY: Not if you take the entirety of the measured savings in the form of savings offset payment.

CARL LEINONEN: Granted, you have unity there. No one has suggested that at this point, have they?

FRANK MCGINTY: I don't know. I don't know what the measure savings will be. On the second point, the question of how much should be taken. We would agree with the statement you made a few minutes ago. But that's a decision this board can only make once they know what the measured savings are, what you believe those programs requirements are. But again, we want you to understand, there's a difference between what we call attributions and we call recovery, and we believe that you have an obligation or at least a responsibility to address that.

CARL LEINONEN: Could I just, does that mean that you are suggesting a specific share for Dirigo?

FRANK MCGINTY: We've suggested 50/50 on the attribution of savings to Dirigo. We've not made any specific statement of position regarding the share of the savings that can be used to support Dirigo Choice. And within our group, and I think with representatives of Dirigo, we talked about a sliding scale, which the lower the measured savings, the higher the percent will support being captured by Dirigo to support the Dirigo Choice subsidies. But we've not fixed on any percentage for that second question. On page three of document that Dan distributed. There's a formula at the top of the page that I don't want to try to explain to you. There is a formula that can be used to determine what a hospital can charge in a year in order to meet its expenses, achieve the operating margin it is seeking, given its payer mix, what it can expect to receive from Medicare, Medicaid, what it expects in the form of Charity Care and bad debts. And again, a pretty straightforward approach to determine what the hospital prices need to be to cover those financial requirements. It is there only for that purpose. Let us make clear that this approach, using hospital charges is one that at least in our view does capture many of the elements of the health care system that the Dirigo Health Reform Act intended to positively impact. Expenses, charity care and bad debts, and operating margin to name three. At the bottom of the page is the approach that, I guess I suggested when my colleagues decided they wanted to go with charges as a way of measuring savings. Essentially what we did is we took an approach like the one Mercer had described to us in the measurement of hospital's operating margins or costs per adjusted discharge and made significant improvement in our perspective. We said let's use the same approach. Let's look at what hospital price increases have been in the three years prior to the first Dirigo year, determine what the average was for each hospital during that period of time, and then compare that historical rate of increase to the actual increase in prices during the first Dirigo year. We should do that for each and every hospital and if in the end, it was clear that the range of increase in hospital prices had been slow, lower in that first Dirigo year than it had been in that historical period, we re prepared to say we would consider the difference to be the savings to which Dirigo can properly can claim a legitimate share of those savings. We would attribute 50% of those savings to Dirigo. Now, some of the things that Karynlee told you are correct. Some, I would disagree with. It is true that very few people actually pay the full amount charged by hospitals, but it's also true that the private sector in Maine most people pay through an insurer or a TPA that's negotiated a contract with a hospital that requires a payment of specified percentage of the amount charged. So in the end, the obligations for those individuals are determined by the rate of increase in what the hospitals charge. Not perfect, to be sure, but it seemed to us to be a reasonable approach to addressing that issue.

REBECCA WYKE: I appreciate your candidness on the fact that the prices are not what people pay. My question to you is, for instance the pharmaceutical industry puts a price out there that nobody pays. The average wholesale price is like a sticker price. And because, quite understandably, the prices are negotiated differently with different providers, such as the insurance company and hospitals. So why can't we use the actual prices, what people are actually paying, rather than this charge?

FRANK MCGINTY: Let me point out that until very recently at least, the federal government required and hospitals charged all people the same amount for the same services. We are required to do that even though the federal government and state government pay us dramatically less than the cost of the care provided to Medicare and Medicaid beneficiaries. So most of the reason that there is a difference between the amount charged by hospitals and the amount we actually receive is attributable to the unwillingness and ability of those two payers to pay the full cost of their beneficiaries' care. In the private sector, I do think you could move to a situation, we looked at the net amount paid by the private sector as opposed to the total amount charged to the private sector in a year. Where complicated to be sure, the data wouldn't be as quickly or easily retrieved, but that is a very real possibility so if that really is an issue of concern, I would say that is a possibility we should pursue. The net amount paid will reflect any discounts that different payers have negotiated from the charge. We could compare whether that amount has increased more or less in the first Dirigo year than it had in the prior years. Frankly, that would give Dirigo the benefit not only not only of any slowing of increase in hospital prices but also any improvement of the payers negations with hospitals. But we were told you were operating under extremely tight deadlines. One of the problems identified with the approach that I just described to you is that you haven't been using the data for some time. You have to build a case that you have to present to the Superintendent in just a couple of weeks. So there would be a data collection requirement that we recognize is a burden. But again, we would be quite willing to talk about refinements to this approach using increases in the amount actually paid by the private sector as a measure of savings by the different Dirigo activities if that's the way people really wanted to go.

DAN ROET: Your suggestion is a great suggestion and we would welcome it, and the only reason why we didn't adopt it in these recommendations was because of the difficulty of being able to administer, and we recommended that if this were adopted we go to the actual amounts paid by commercial insurers by looking at the charges less the discounts.

REBECCA WYKE: I guess at this point it is my understanding that that data cannot be attained and that is basically that is one of the reasons why we're not doing that at this time, correct?

DAN ROET: We raised the possibility but we didn't follow it up because of the short timeframe, but in fact, this data may be being collected by the Maine Health Care organization. But I can't say that with 100% certainty that it is.

FRANK MCGINTY: There are other potential sources of the information. Hospitals could identify without great difficulty not only their total net patient services revenue, but in their audited financial statements, but also the amount they have received from Medicare, and Main Care. And the difference, by and large, within 1 or 2% would be the amount paid by the private sector. When you try to factor out VA, Champus, and other government programs, it's a lot more complicated. But if you really did want to focus on the private sector's obligations, you could do that with a high level of confidence in the result without turning yourself inside out to try to get the perfect answer.

REBECCA WYKE: Mr. Chairman, I have a question. Was that ever discussed in the working group?

FRANK MCGINTY: When we were bringing forth our proposal to go to charges rather than costs, we did propose that.

REBECCA WYKE: How long ago would that have been?

FRANK MCGINTY: Probably within the last week.

REBECCA WYKE: Would that have been late-breaking, in terms of when it came forth.

FRANK MCGINTY: Well, late breaking in the sense that the discussion didn't start until August 2nd on the savings offset payment. So we've only been discussing it for 3 ½ weeks.

REBECCA WYKE: I have a private insurance, and isn't it true, that I would not pay the charge amount. I would also pay a discounted price based on whatever. So who pays the full charge?

FRANK MCGINTY: People who do not have a party bargaining on their behalf, who has negotiated a contract for less than the full charge. People who have limited means, and qualify for hospital's reduced prices or free care.

REBECCA WYKE: So the vast majority of the people who pay the full charge are people who don't have insurance, or the underinsured. That's basically the bad debt and charity care we've been talking about.

FRANK MCGINTY: Well, if they don't have insurance coverage and they are low income, most hospitals in Maine will provide their care without any expectation of payment.

REBECCA WYKE: But you assess the full charge only on those occasions?

FRANK MCGINTY: Yes, very very recently, like in the few months. We've been required by federal law since 1966 to charge all people the same amount for the services they've received.

REBECCA WYKE: You said that no body pays that except the people who don't have some sort of insurance coverage.

FRANK MCGINTY: No, there are people who have insurance coverage, who's coverage is arranged by a company that has not negotiated a contract. Those people pay full prices.

REBECCA WYKE: And is that the largest group of people who would pay full price? I'm just trying to clarify in this meeting. The issue only came up a couple of weeks ago and did you raise it as offering to use your formula with the actual cost paid, or the net charge paid versus the full charge, when you brought it forward?

FRANK MCGINTY: When we first discussed the idea, it was to use hospitals approved price increases. Concern was expressed about both availability of that information and also about whether or not those price increases reflected the actual increase in the private sector's payments. Because people may have negotiated different discounts. At that point, I think, our group said there were a couple of ways you could use to address those concerns. One would be to go to a cost for adjusted discharge method which would not required Dirigo to go to hospitals and ask for approved prices increases, and second would be to look at the actual net amounts paid by the private sector. But again, like Dan said, the Mercer materials were first presented us on August 2nd, which was within the next week and ½ we advanced this idea for consideration of our counterparts. It was only 1 to 2 weeks that we've had any opportunity to discuss this with our counterparts.

REBECCA WYKE: I'm just clarifying here. No one has asked health data organizations whether they have that information or not?

FRANK MCGINTY: We have not. Just as we don't know whether or not this approach that we have suggested will produce a greater estimate of savings attributable to Dirigo than the approaches that we have described to you. Our group decided that they were comfortable advancing this idea without knowing the answers to that question because they thought this was credible approach that they could directly tie to the way they priced their products. The way the employers see the premiums changing over time. They were willing to accept that outcome whether that was more or less costly. No, we haven't tested it in any way.

REBECCA WYKE: But you do have consulting actuaries, and your consulting actuaries received any analysis form them on whether or not this would be a greater or lesser expense.

FRANK MCGINTY: We have consulting actuaries that have produced studies for us. I think it's fair to say that they have addressed this issue.

CARL LEINONEN: What do you mean, has addressed this issue?

FRANK MCGINTY: We have been trying to track the proposed methodology from Mercer with our methodology. All the data has been incomplete in the year that the savings would be based on. It's not a complete set of data that would give us any answers to what we're proposing because all the data for the year that we would be collecting the data for is incomplete.

CARL LEINONEN: And again, that work was done after the proposal was advanced.

REBECCA WYKE: At least I understood the methodology that Karynlee was describing when she was up here. I understood this, but it seems to me that most of the people who are paying for hospitals are not paying this rate, and so when you say that your methodology that is less arbitrary, nothing could be more arbitrary than putting than charge on the end, when you never actually paid that charge. So I have trouble. .

FRANK MCGINTY: The important point that I made that obviously didn't make clearly enough is that if I am covered under a health plan that has negotiated a 5% discount with Maine Medical Center, even though the actual net amount my employer pays is not the full amount charged by the medical center, it still is likely to be 95% of that amount in both the year before Dirigo, and the year after Dirigo. And so the question is, does the medical center's price increase slow. Was it a lower increase in the first Dirigo year than it was in previous years. Because even though I'm not paying the full price, if it was a lower increase, I would have benefited from that. There would be savings attributed to Dirigo. If the increases didn't slow, and I was still paying 95% of those prices then I obviously wouldn't be getting the kind of break people hoped Dirigo would provide. But you're right, not everybody. Only a small fraction of the people pay the full charge. But in my experience in the commercial insurance market in Maine, the vast majority of people pay for the hospital care on the basis of defined percentage of the charge. So when the charge increases by 8%, their net payments will go up by 8%. If the charge goes up by 4% because Dirigo had done some good things, their net charge will go up by 4%. If you can show us that the price increase slowed, we will attribute that slowing to Dirigo, and attribute a healthy share of the savings to Dirigo.

CARL LEINONEN: I followed it Frank, and it's all logical. I guess where I had trouble with anybody's presentation, is the decision to increase the price. A lot of factors go into that and the change in price, the delta for price, could be from a variety of factors other than Dirigo, or in spite of Dirigo. So Dirigo could have some impact which reduced the actual cost to the provider, yet if the provider decides to increase the price for a variety of factors, good bad or whatever. So your rate might track it if you assume a 1 to 1 correspondence between any impact of Dirigo and an impact in price. Automatically because of the money the sum was the same and it's the same amount. That doesn't happen. I think what we're all dancing around is the problem that even if there are savings, how do we know those savings have been extracted all. And what confidence do have that those savings are being extracted. The very point that we have that when you have voluntary targets, you don't have control of the pricing, you don't even know what your real cost is, there is a lot of concern that there would have a much more positive impact, but it's being lost because of pricing decisions.

FRANK MCGINTY: I said at the outset of this discussion, I believe that the increase in hospital costs is slowing. I also believe that some part of the benefit of that was lost due to the reduction in Medicare payments. If you don't think that's appropriate to take into account, please remember that view when we talk about budget initiative in a few minutes.

REBECCA WYKE: If you believe that the reduction in Medicare payments had an affect, then the increase in Medicare payments will also have an affect.

FRANK MCGINTY: And if someone can show that there has been an increase in Maine Care payments, I will fall out of this chair. We should talk about that in a few minutes. We do think it's important that we talk about this briefly. Let's talk about change in hospital's charge for costs of adjusted discharge. Principle method that the Dirigo representatives for the work group proposed. Our concerns regarding that approach are outlined here: One that you just asked about, there is no clear line of sight between that slowing of the increase and hospitals cost for adjusted discharge and the actual obligations of the private sector. That's just as much a concern to Dan and the other members of Mercer's work group as it was to you in the question proposed to me. I will tell you that even though Karynlee has outlined for you a couple of improvements made to the approach, the approach remains egregiously flawed. Egregiously flawed because it takes into account only hospitals whose cost for adjusted discharge increase by a lower amount in the Dirigo year than it did during the historical period. Now we believe that the Dirigo Health Reform Act challenges all hospitals to slow the increase in their health care spending. The question, we think is appropriate to measure is whether the increase in the cost of all hospital care was impacted positively by the Dirigo Health Reform Act. And if it is, there are people who believe that it's appropriate for a share of those measured savings to be attribute to Dirigo. I will tell you this that is unjustified and unwarranted for someone to say, that because a hospital's cost for adjusted discharge increased by 5% in that first Dirigo year, that hospital had not made a bonafide effort to meet the voluntary limit of 3.5%. I can tell you that you can take two hospitals that turn themselves inside out to reduce their budgets to a 3.5% increase. At the end of the year one will be at 5% and the other at 1%. The reason for that is that one of them will have to experience a decrease in activity during the course of the year that will drive up its measured cost for adjusted discharge increase. The other will have experienced and increase that's driven it down. You cannot, in good conscience, move forward with a method that only works when a hospital experiences decreases and measure those as savings that are attributable to Dirigo. At best, only a part of those savings will be attributable to Dirigo, and the other to many factors that had nothing to do with Dirigo. More importantly, the reason hospitals are getting down to the 3.5% is the mirror of the reason that other hospitals are getting above the 3.5%. And you've got to blend them all together to look at the hospital system in Maine and see whether the rate of increase in the cost of hospital care slows. If it did, fine. Count that as savings, attribute a large share to Dirigo and use to make the savings offset payment. The method that you have set before you be staff will measure savings, not only in the first Dirigo year, but in the year before Dirigo was met. It'll measure savings in 1995, it'll measure savings in 1985, it'll measure savings anywhere, any time, any place, because it's a method that has only that possible outcome. It's a method that says 38 of the 39 hospitals said no and with a disregard of voluntary limits. One hospital actually has a cost per adjusted discharge incurred lower than the norm. Even if you didn't set out to do that, that would make a savings. Again, it's not reasonable to attribute to Dirigo the increase. You put it all together and if the rate of increase is a lesser rate of increase, you've got to have a measure of savings, because along the way the public or private purchaser may not have benefited in that. Nevertheless, if you're going to take that approach we think that's an improvement that has to be made.

UNIDENTIFIED FEMALE: (inaudible) hospitals count savings any time, any where, whether…

FRANK MCGINTY: I think so, because if you look at any historical period, I guarantee you that with hospitals in any year since 1995 that in the last three years, if they have had a rate increase, maybe two of them, maybe ten of them, maybe 20. You'll find that every year, find a hospital that have the benefit of increase in benefit of a volume increase, go down or have a decrease in the cost per adjusted discharge, it's just a mathematical certainty. You've built a formula that can only produce one result.

TRISH RILEY: That measure was negotiated as a compromise with the Maine Hospital Association and proposed by them.

FRANK MCGINTY: Its one thing to say to hospitals do everything you can to reduce the rate of increase and your cost per adjusted to 3.5%. You've heard me say, I think all or virtually all our hospitals in Maine took that to heart and set out with that goal in mind and trimmed spending accordingly. I'll also tell you at end of the year, whenever you look at that picture, you will see hospitals that budgeted 3.5% and did a whole lot better. You will have increases of 1.1%, or 1.5% or 2% because they trimmed budget expenses to 3.5% increase then saw their volume rise in the course of the year. And since anywhere from a quarter to a third of their costs are fixed, depreciation on their building, interest expense on their loans, it drove down their cost per adjusted discharge and measure improvement. And conversely there will be hospitals that turn themselves inside out to produce that 3.5% budget, kept their spending at or below the budgeted level and when you look at them, will only be at 5% because their volume went down and they had fewer adjusted discharges and that elevated the increase and what we're saying is if you are to take that into account, you have to look at all the hospitals. You have to say that yes, there were some that went down from 5% in their budget and would up with 1.1% and others that started out with 3.5% in their budget went up to 5% because their volume plummeted during the course of a year cost of adjusted discharge. But again it's an approach that says, we're only going look at those hospitals that have a lower rate of increase and then measure as I told you. I believe you will always find in every single year from hospitals that fit that description while show a savings and that has nothing to do with Dirigo.

REBECCA WYKE: Then what you're saying is let's suppose every hospital took it to heart and said I'm going to shoot for savings in my system because of the health care crisis and the Dirigo Health Reform Initiative. Some may make 4%, and some 2%. What your'e saying is that every hospital should be taken into account. If it's true that every hospital tries to keep their costs down because of the Dirigo Health Initiative, isn't there albeit probably not incalculable, savings in every single hospital attributable to Dirigo. And then we calculate that savings, understand connected then Dirigo savings for every single entity in the system when in fact in would Dirigo has never said slow the rate of growth. But, why Dirigo savings with every single instance in the system when in fact it was Dirigo. Dirigo has never said it's going to stop growth, it is simply trying to slow the rate of growth.

FRANK MCGINTY: You've used an important word in your question several times. That's the word system. Dirigo is intended to slow the increase in cost in our hospital system in Maine and ultimately it is the increase in the cost of our hospital system that we're using as a basis for the savings offset payment. If only hospitals in Southern Maine responded affirmatively to the Dirigo program, not hospitals in Northern Maine. If all your savings were in Southern Maine, would you have only a Southern Maine savings offset payment. You have a statewide assessment and from our perspective that's why we have to look at the cost of the hospital system. In your example, I would agree with you, I think that in that example every hospital would have done something that contributed to slowing the cost of the system and so if the measure of increase that is more than it had been in their historical data, I would say, that their fair share of their earnings was due Dirigo. But you can't do that by looking at only the ones that round out below 3.5 or below where they had been before.

REBECCA WYKE: Why would you add back in the other cost?

FRANK MCGINTY: Because of the fact that a hospital for example the one I created with an increase of 5%, which was not the result of any disregard for the voluntary challenge, not the result of any better or poorer management and ultimately because of the fact that it wound up at 5 is going to affect his health insurance payments. It's going to affect my insurance payments. And it's going to affect that in the same way that your savings offset payment affects them. It's going to affect your savings offset payment, whether or not it ends up in a hospital that winds up with 5% or 2%. Look at the cost of the hospital system as a whole, if it goes up at a slower rate, take credit for it. If it doesn't go up at a slower rate, I don't how you can say that there are savings for the payers. What we're saying is there a fundamental disagreement on savings that drive

UNIDENTIFIED FEMALE: (inaudible)

FRANK MCGINTY: Yes, and you measure that by looking at the rate of increase in total hospital spending, and if it's lower than it has have been, take credit for it. Buy you can't get to that conclusion by looking at only half the hospitals that now have a rate of 5% and third they and they alone set out provable income. If you go forward on that basis, I fear that and prove that and you've left without some of the support that you've been given

REBECCA WYKE: I have one further question. What if we used half the hospitals?

FRANK MCGINTY: I think the most , I think it would probably be closer to 50% of claims expense and 45% of premium. Services savings presentation this afternoon…

ROBERT MCAFEE: Would your approach be stronger if it was mandatory?

FRANK MCGINTY: Our case would be stronger if we knew that every hospital had made that effort. I believe every hospital did. I can't guarantee that. Let me tell you that, even if I didn't believe that to be true, even if I only believed that three-fourths or seven-eighths of the hospitals made that effort, I'd still say you've got to count them all. The question is whether the Dirigo voluntary approach was accepted, that challenge that was for all hospitals, slow the increase in all hospital spending, because ultimately, it's to the purchasers, that you're turning to make the savings offset payment. They're affected not by some hospitals, but as I said earlier, by all.

CARL LEINONEN : I don't…that doesn't lead us down the road that we should have mandatory targets so that we have some assurance that there is the effort and that it should be square equitably across the system.

FRANK MCGINTY: My own view is that you secured the same moderation and increase in hospital spending, voluntary effort that you would have achieved with a full regulatory program, without being spared, but without the time it would have taken you to establish that program, and all of the other unforeseen, unwanted consequences.

ROBERT MCAFEE: I think it's very safe to say I think everyone was pleased with that. And you need to be congratulated.

FRANK MCGINTY: I would like to talk to the budget initiative.

ROBERT MCAFEE: Please, go ahead.

FRANK MCGINTY: You all need to understand that the first of the budget initiative identified $90 that (inaudible), as a result of a settlement, litigation brought against the state of Maine by a number of hospitals, a number of years ago, for violations of federal law, state law, and the state's own errors, that we believe began during Governor's King's administration. And for several years, Governor's King's administration, and one year, Baldacci's administration, refused to act on hospitals' appeals for those specifics. To his credit, when Governor Baldacci learned of that, he ordered the Department of Human

Services to begin processing the appeals. We got the hearing officers in a binding where the state's actions were clearly (inaudible). And so, hospitals began settlement discussions with the administration. And again I give the Governor's credit and the credit of his staff. They were able to negotiate the settlement of those old claims the hospitals had brought against a prior administration that continued on until earlier this year. And that's all been settled, and as Karynlee told you, or Geoff told you, $90 M we paid to hospitals about 60%, 55% of what we were actually owed. We agreed to accept that in order to make the settlement possible. But I honestly don't believe anybody in this room can look at that and say, "That is a result of the Dirigo program or any of the activities carried out under the banner of Dirigo. " It certainly wasn't Dirigo that committed the offenses, the violations of federal law or state law. It wasn't Dirigo that ordered the state's hearing officers not to process the appeals for years. And I don't think it was Dirigo that settled this matter. So, again, from our perspective, if you look at these issues, and you look at the law, and the law says that you can claim credit for savings resulting from the activities of Dirigo, we honestly don't believe we can count that $90 M. Now, with respect to the periodic interim payments, yes, there's about $100 M worth of conditional, periodic, and prospective payments. The weekly payments that made the hospitals for the care of the Maine care beneficiaries. To the governor's credit, he included that in the budget. It certainly will be helpful to hospitals. But you need to understand, hospitals finished the last fiscal year, owed $200 M by the state's reckoning for what we should have been paid for the care of the

MaineCare beneficiaries. And despite this increase in weekly periodic payments, we're going to finish this fiscal year owed at least $220 M. So, the governor and the legislature put additional money in the program to prevent the debt from spiraling out of control. And again, I will not tell you that it's not helpful. It's helpful to all hospitals. It's very helpful to some that are at the end of their line of credit, because they have been waiting for years to be paid amounts owed them by the state of Maine, with MaineCare beneficiaries. And again, maybe you can argue about the time value of money, that those hospitals no longer need to borrow, will accrue to their advantage and should be taken into account as a Dirigo initiative, but we think that's a real stretch. I've got to tell you, my health system, three hospitals that went two full years without making their health insurance payments to Maine Health. Now, one of them received a settlement this past year. The other two I hope, as a result of this increase in periodic interim payment will begin to be able to pay MaineHealth for their health insurance. But I've not been charging them interest at all on their overdue payment, and that's not gonna produce any savings for them that they can turn into a reduction in price. They charge that for the care of its employees. So, again, we take a very, very dim view of the budget initiative as either Dirigo initiatives or initiatives in the result in savings to private purchaser. With the effect of the increase in position payments, I mean, what we're talking about is increasing physician payments from around 45% of what Medicare pays to around 56 or 57% of what Medicare pays. So we go from being paid terribly to being paid pretty bad.

ROBERT MCAFEE: Not so terribly.

FRANK MCGINTY: Not so terribly, but not so good. From our perspective, that's not likely to allow Maine physicians to reduce the charges that they make for the services they provide to their patients. It may enable some of them to continue to accept MaineCare patients without limiting their practices, but it's not going to result in any reduction in their charges. And more than that, virtually all private payers in Maine pay physicians on the basis of a fixed fee schedule that's less than their charges, so even if they were willing and able to reduce their charges for some patients, and their attraction is probably not that much higher than hospitals that pay the full charge, for the vast majority of people they serve, although it's helpful, although it would help for them to continue to serve MaineCare patents, it's not going to allow them to reduce their prices to others. So, again, we just need you to understand we have those very significant concerns about the budget initiatives that are identified here as resulting in savings for the private sector that you can legitimately recapture in the form of savings.

REBECCA WYKE: Mr. Chairman?

ROBERT MCAFEE: Yes.

REBECCA WYKE: Help me to understand. In all those years, during the King administration when the state wasn't paying what was owed the hospitals, who bore the increase of costs that you were (inaudible)? Wouldn't that have been passed on to payers?

FRANK MCGINTY: Had we been receiving that money, we would have been able to reduce the regular increase in our charges to the private sector.

REBECCA WYKE: So because you couldn't you had to pass on the costs, basically, to the payers.

FRANK MCGINTY: That's right. It became part of their costs.

REBECCA WYKE: So I think the theory isn't so much that this money is somehow the direct result of the Dirigo initiative, as now that it has come into the system, there should be some benefit that accrues to the payers of the system. There shouldn't just be a windfall for the hospitals that this money is now there, and that when you can't go back and make it good for ten, twelve years ago, when this started, you can do something now for the payers within the system, by helping bring costs down, overall, through the formula that Dirigo has. I think that's what the theory is here, not that there's some magic relationship.

FRANK MCGINTY: Well, that's an interesting theory. The problem is that the law requires that relationship. The law requires that you identify the savings resulting from the Dirigo Health Initiative.

REBECCA WYKE: So what I don't understand…

FRANK MCGINTY: No other savings, in my view, our view, are lawfully considered.

REBECCA WYKE: So, this is something that I think we need to look at, as a group, not this second, but it seems like it's a little bit have it both ways. That when the state isn't paying you enough, those costs get passed on to the other payers in the system. But when the state makes up for a wrong in the past, or begins prospectively, making interim payments that are higher, that somehow there's no relationship there. And that's what I have a little trouble with today.

FRANK MCGINTY: Well, I am shocked that you have trouble with that as the State's Chief Financial Officer. I've got to tell you that there is a world of difference between increases in MaineCare payments and paying your debts a little bit quicker than you've paid them in the past. The day MaineCare payments truly are increased to hospitals, hospital price increases will come down. I have absolute confidence in that. I know that to be true.

REBECCA WYKE: I'm sorry I disappointed you as the state's chief financial officer, but I am saying that I think there is a relationship and I don't think you can have it both ways. And I'm not saying that as the state's chief financial officer, I'm saying that as someone sitting here trying to understand your point, Mr. McGinty.

FRANK MCGINTY: Well, my point is that there's a world of difference between change in cash flow, paying something, a debt a little bit quicker than would otherwise be paid, and actually increasing the payment you're going to make for a service provided. The state of Maine has not increased the payments it's going to make for MaineCare beneficiary services in 2006. You're going to pay us the same amount you paid us in 2005, which is the same amount you paid us in 2004, and the day you actually do increase those payments, I assure you, hospitals, at least the ones I can speak for will reduce our prices to everybody else we serve.

REBECCA WYKE: And can I just say that I think it's inappropriate for you to say what you just said to me? That if you want to criticize my line of thinking, that's fine. I'm trying to understand what it is that you're saying. I don't believe that I have implied that you're not good at your job. So, I just think it's inappropriate.

FRANK MCGINTY: I apologize.

REBECCA WYKE: I'm not asking for your apology, but I do think that it's important that we be able to discuss these things without having to attack each other.

FRANK MCGINTY: I agree. Although you didn't ask for my apology, I offer it.

ROBERT MCAFEE: Frank, let me just make a personal observation about the Medicaid settlement money and the timing of payment. And I think that it would be remiss for people not to understand that it was with a strong endorsement of the governor's office, and many people around this table, in written recommendation to the governor, that this process begin as quickly as possible. Those of us that are close enough to clinical practice have seen the erosion of a healthcare system, not just in the hospital structure, but more importantly, in rural Maine, of doctors struggling to subsidize the care of their patients which they still feel is so critically important and that the opportunity for the $3 M increase aggregate for positions to compete against all the other appropriations bills this year, I think, is an expression of the governor's office and the governor's himself, support that this was…it had to be done or the entire system is gonna start crashing down here. Not that that necessarily is a scientific formula that allows us to recover, claim that. But I happen…I wish to thank those who did influence the process now, because it had not been influenced to the degree that $90 M was pried out of that until now. Okay, why don't you…what else we got? Got anything else on this issue? Go ahead, Mary.

MARY HENDERSON: So, this is a…and I didn't think to cut off anything that they want to add, but I do have a…this is just a pure math question. If there was, and I understand the point you're trying to make about whether it was related to the Dirigo Health Reform Legislation or not, so just setting that aside for a second, just the math. During those years, when the state failed to pay whatever the appropriate amount was, and that has now settled, you offset some of the costs to the hospitals themselves by passing on the underpayment, basically, to other payers, right? And so there was sufficient…so now having been paid, and I understand there's a big difference in the time value of the money here, but now having been paid, have you essentially as hospitals, not have you, but the cost of essentially, been both recouped it from payers and from the state, and then the second half of my question is is what was the value of, I've heard something about write-offs, in this, and I don't know if it's writing off the same thing that they thought you should be paid and what you were paid. And how much…what value is that to the hospitals? So two questions.

FRANK MCGINTY: Two questions. Let me answer the second one first.

MARY HENDERSON: All right.

FRANK MCGINTY: I can’t tell you that every hospital would have done this, but I think the way they should have done it would be for them to have booked each year what they actually believed that they were owed by MaineCare, and then establish a reserve equal to the amount that was in dispute. And so the net amount that would have been reflected in their financial statements would have been the difference between the total on one hand, and the reserve on the other. And that’s not uncommon. Every year, hospitals file cost reports with Medicare and Medicaid, MaineCare, and have to make estimates of what we think we’re entitled to be paid. And every year, Medicare or Medicaid, MaineCare, come up with a different number. Sometimes it’s a few thousand dollars apart, sometimes it’s hundreds of thousands or million dollars apart. So, you set up a reserve, Mary, to cover the possibility, that as you’re booking, won’t be recovered ever. So, again, in this case, where state was saying, “No, we’ve changed our principles of reimbursement, you’re no longer entitled to reimbursement as a disproportion share hospital,” I don’t think hospitals could have done anything but reserve a higher amount than what they thought they were entitled to, if they prevailed and that (inaudible).

MARY HENDERSON: I’m sorry, I don’t understand what you mean by reserve. Does that mean…was there a financial gain from having done that, that should be considered in this equation? Either a tax gain or, what’s…what does the term write off mean compared to that reserve?

FRANK MCGINTY: Let’s say that you thought you were owed $10M by the state.

MARY HENDERSON: Right.

FRANK MCGINTY: And $1 M of that was in dispute.

MARY HENDERSON: Okay.

FRANK MCGINTY: You might have on your books $10 M receivable, and a $1 M reserve, so the net amount that you would actually record as income in that year for the financial statement would be $9 M.

MARY HENDERSON: Right.

FRANK MCGINTY: Now, let's say two years later, you settle up with the state and you get $9.5 M. You write off the other half a million. You're never gonna get that. Out of your picture entirely, and you book that extra half a million dollars as income, in the year that it's received.

MARY HENDERSON: Alright. Okay.

FRANK MCGINTY: Now, with these litigation settlements, hospitals have been carrying on their books for years, some expectation of payment, but probably with that fully reserved, because it was in litigation.

MARY HENDERSON: So, none of that, essentially, was written off as "never going to be received?"

FRANK MCGINTY: Well, I don't know that.

MARY HENDERSON: By the hospitals? Is that what you're saying?

FRANK MCGINTY: Because you could have hospitals, as I said, after three years, we just can't keep doing this.

MARY HENDERSON: Right, at some point then, with some hospitals probably wrote that off.

FRANK MCGINTY: But again, if they had reserved, if they had reserved…

MARY HENDERSON: And maybe some didn't? Maybe some did?

FRANK MCGINTY: If they had reserved the full amount, it was never reflected in their net patient service revenue with their financial statement anyway.

MARY HENDERSON: I don't know why that's not.

REBECCA WYKE: If they showed it as accounts receivable for those prior years, and it was now collected don't go back to those prior years, so it would not show up. New income in the current year, correct? Or the year that we're talking about in terms of making payment? Not as show up as new revenue, when here you're making hospitals write off debts the years before. If what you're saying is true, if most hospitals debit accounts receivable, then this is kind of a non-issue.

FRANK MCGINTY: Not unless they reserved against the accounts receivable. You can't go back and restate, here are new financial statements, so we have been owed $10M, as an example, and $1M was the amount in dispute, we then receive that $1M in 2005, we'll record that $1M as income in the year ending September 30, 2005. So, it will show up as income to us this year. And in fact, the agreement negotiated with the state says that hospitals receiving this money will not have that counted against their operating margin in the year they received it, for the purpose of determining whether or not they complied with the 3% voluntary maximum on operating budget. So, in this case, I think it almost all will be income in whatever years the hospitals receive it.

MARY HENDERSON: My first question was didn't you already pass on those costs to the consumers?

FRANK MCGINTY: Some hospitals, yes, hospitals are setting their prices, in 1998 and 1999 and 2000, they were doing that, without the benefit of knowing they were gonna receive that money. And some hospitals may have been able to recover that, with higher prices, and others may have sustained a lawsuit, because they were unable to get that. What they do with the money now, their efforts (inaudible).

ROBERT MCAFEE: Christine.

CHRISTINE BRUENN: I have a question on another subject, just kind of stepping back for a minute. I think we've listed to presentations, and I've had the benefit of listening to a working group for the last couple of months. It seems that these are all reasonable people with different perspectives coming up with reasonable ways of approaching that, and yet, the process has failed to reach consensus. Is there any chance that we ought to take into account that compromises could be made that each side, either intellectually or for other reasons, wouldn't (inaudible) like today, so that they might make, for purposes of reaching a consensus (inaudible), that we ought to take into account, as we go over the next week or two, before we meet again.

FRANK MCGINTY: I would hope so. I think Ann said it at the start. Apparently, we've been working under an extraordinarily tight timeframe, and it hasn't bee conducive to trying to work out some of those difference. There have been changes made from Dirigo. We appreciate it. Obviously, we are apart on a couple of issues. And whether or not we can come together, I don't know, but I don't think anybody who said they're not gonna try.

CHRISTINE BRUENN: Do you feel you have the support of not only your working group, such that you could go to them and say, "Look, you've made all these arguments about A, B and C, and we really hated C, but we've done what we wanted on C. So we've decided to go with this package?" Will they back you or will they be relitigating it in front of the Superintendent of Insurance? Because I think that's really the key (inaudible) here, is, can…you know, even before the board makes a decisions, if the two groups could come together and put one package in front of this group, the board would be more likely to take it, but we would have to be worried about (inaudible) later.

FRANK MCGINTY: I'll try to answer that. As for that question, and plus, you have this close to use, by the working group, Virago, and now her answer is, and I think the real answer is, without if we were able to come to consensus on these issues, we would do our best to try and sell that to other payers in the group, whether insurers, CPAs or self-insureds. But we don't represent every single employer, every single insurer, every single CPA. So we can't be sure that nobody's gonna look at this, but we would get our commitment to try to settle a compromise, so that all of the individuals that are in those groups.

CHRISTINE BRUENN: Is there a difference in some way between reaching a consensus, which is everybody coming to a place where they can say they support this, vs. reaching a compromise, which is a sort of give and take and some parties, some get a little bit more of what they wanted on that. That can also be a consensus product, even though in compromise, you have a sense of whether that makes it harder to sell it to a constituency, if you compromise?

FRANK MCGINTY: We thought that the approach that we offered represented a substantial compromise. You need to understand that there are people who are subject to this payment who were not prepared, and they still may not be prepared, to accept that compromise, as we know it, because for them, they don't see the direct connection, between the Dirigo initiatives and that result, because we were willing to say we saw, at least indirect attribution of a share of the measured savings to Dirigo and to other factors. So I don't want you to not think that those kind of discussions have occurred. They have. As Dan said, there are lots of self funder employers, lots of TPAs, lots of insurers that have been following this closely, and while we tried to get the benefit of their views, and it was all under discussion, again, we can't find them. We can only do what Ann said, and that's the best we can to persuade them that they can (inaudible) is a reasonable thing for them to support. And I think we told the Dirigo folks when they asked us, that we would also do what we could and review the entire procedure, to persuade the superintendent that it was reasonable. Again, that's different than saying we could prevent other people, that would be by what we (inaudible).

DAN ROET: Yeah, I think Christine keyed up something that I just want to pursue for a bit. I know there's others that want to speak. It raises the comment, but also a question, excuse me, a question going forward. The comment is this, you know, I think she is on the money. We now have an issue that is no less complicated than it was before. Charges, challenges, as they're called here, to your group, that now we deal with, significant work has been done, but reaching consensus on a package that is challenged, that is controversial by many definite definitions, depending on who you speak to. But I get the working group that we have were ten people with substitutes that were committed to making this work, and of finding a way to move us forward, in the interest of this agency, as a voting board member, you know, that could be of service. Because if there's any way…we make a recommendation, as I recall, by the 17th, to the Superintendent of Insurance, and we are aided and assisted by as much agreement as possible, and by as much consensus, and it is consensus is a give and a take process, but I guess, I don't know what the intent is here, Karen Lee, but I…as we move forward, I guess I've got to say the best interest of this program, with the minds that we have in that working group, both in terms of your abilities and your attitudes, our greatest hope is that we can come to together to a place that we all stand united because this issue is one that the state watches us very closely and we have an ultimate responsibility to do what's right and do the best we can and I think we put ten people together that represent the people of the state in a very fine fashion, and I would hope that we continue that effort while we pursue ours. And I guess, in reference to pursuing ours, you know, I asked this out of ignorance, I would like to know, (inaudible) Christine or Karynlee, however, to advise us on, and to guide us on our responsibilities, our authority, how will we not just proceed as a board vis-à-vis meetings, public hearings, whatever. But what is our authority as individual board members? What are we permitted to do or to not do? What can we do to help us better inform ourselves, knowing that we've got a very few days and a whole lot of responsibility, notwithstanding the fact I hope is done for us by continuing effort with the people that have been brought together, because I think they are our best hope. Where do we go from here? How do we proceed in that process?

KARYNLEE HARRINGTON: Let me just…

DAN ROET: At some point. You don't have to do that right now, but before we go home.

ROBERT MCAFEE: Let me suggest again, our next meeting will be predominantly a presentation from those providing more precise actuarial data to us from each side. To flesh out some of these broad recommendations, accompanying a policy that either side has suggested to us. We're gonna ultimately have to adopt a series of recommendations, accompanied by some financial allocation, and defend those, based upon our best individual and collective judgment. We will have some expertise on the Attorney General's Office who will accompany us through this because it is a legal document. At the same time, we go back to our original charge from the Dirigo bill itself, and what this SOP is all about.

DAN ROET: Yes, I understand.

ROBERT MCAFEE: I keep trying to say something else other than SOP. But I think the board will…and that's what I think today we need to look at the opportunity for another meeting between the day after Labor Day and the final submission so we'll have to have the opportunity to do that. Going to have to adjust your calendars a little bit in order to make that happen. You want to add to that?

KARYNLEE HARRINGTON: Just add that our counsel was supposed to be here today, and unfortunately had an emergency and is not with us. But what I'd like to do is have a conversation with him and I'll get an e-mail out to all of you relative to the questions you're asking, legal obligations, what can the board do and not do relative to understanding what's been presented? The workgroup has worked under some very, as you know, rigid criteria, in terms of part of the challenge has been, you know, we haven't been able to talk as openly as we probably wanted to, just given that everything is public, in terms of notice of meetings and so on and so froth, so we've had some logistical challenges, and that's why we wanted Bill to provide some guidance to the board, in terms of how we go forward. I think Mercer is open to being here and providing the specific answers to your questions. I think it would be absolutely critical that we have the actuary that's been working with the other folks in the work group be here as well, that you get the two different opinions, relative to the methodology, and so on.

REBECCA WYKE: In the interim, are there plans for the working group to continue its work? Or would last Friday be the last meeting? What is the plan going forward now?

KARYNLEE HARRINGTON: Ann, I think, may want to respond to that.

ANN GOSLINE: The working group has no meetings scheduled between now and September 14, which means that there rally isn't the opportunity work through further, unless we schedule something to try and see…

REBECCA WYKE: Without a decision on the part of the working groups? Not to continue to work on issues that there was an agreement on? Or was it just serendipitous that they didn't?

ANN GOSLINE: Well, I would say unserendipitous would be a better word. Let me, Karen who we are working through…

GEOFF GREEN : I thought today was kind of a deadline.

ANN GOSLINE: What Geoff is saying is that we were kind of working under the theory that today was the deadline for giving the best thoughts to date, the best thoughts on this particularly difficult charge. That being said, I'm already getting evil looks from the working group. I'm about to ask if…I know the week of the 7^{th} is extremely difficult for anyone to meet, we looked at calendars and it was a nightmare. I did not ask people about the rest of this week. Charlene, if you could see the looks I'm getting, but nonetheless, I don't know if it's worth my asking the work groups if they would take just a second in the hall to determine whether it's possible to meet this week or not. Are you willing to walk out in the hall and at least entertain that question.

REBECCA WYKE: Well, I guess I would also ask…the board has some deliberations to do. And we have, the plan as I understand it is to at least hear from one actuary and maybe two next week, to fully understand and be able to ask for the questions to gain a greater understanding of these methodologies.

And then there may be some discussion of our board and then some deliberations, it works from within the board, the way it is going to try to reach any questions the board might have following, if you are saying a decision it has to be made.

ROBERT MCAFEE: I think, at this point, I'm not too sure what I individually would…those are questions I would like to have help with. I'm not so sure I would charge the committee to meet again, I would want right now. I think the idea of after our next meeting, for this board to say, "Is there an advantage to help us reach our deadline by asking the group to reconvene again, agreed on short notice?" We can reserve that decision until that point. I know time is short, we're coming back from the summer and September is a horribly busy month. But it seems to me rather than simply ask you to meet for meetings sake, unless we've got two or three very concrete issues we need to have solved with some urgency, it might not be the wisest thing to schedule without that particular agenda? John, did you have something?

REBECCA WYKE: That really is the essence of my question, because I think at this point, I don't know what I would be asking the work group to do, but there is a possibility that after we hear the presentation in the next week, that there would be something. And I'm just saying whether the…I'm asking whether the working group would be there or willing to respond (inaudible) and after.

ROBERT MCAFEE: Well, we can only ask. John Benoit, and then Ann.

JOHN BENOIT: I was just going to add that late Friday there was an effort to do precisely what you're asking us to do now. We met in caucus outside the public hearing to try to articulate, if you will, the various compromises or concessions that we needed to reach, and they really fall in three distinct area, and I guess the one thing that I would ask the board, if they were so inclined is to provide some direction because some of the board members asked questions that caused, I think, both sides to say perhaps there's a greater opportunity than what we previously may have thought and those are that the purchasing community is keyed on price, because they need a line of sight to go to the purchasers and say that the effects of Dirigo Health has passed on savings that we can identify. So, price is key to us, and Mary raised that and that was very helpful. The second area was this notion of netting or aggravation. And again, Carl raised a question in that area, that again, it's very important for the purchasers to look at the system of care, versus just those where savings has resolved itself. And then the last one is really those issues that are, if you will, directly related to the operation of Dirigo Health, and that brought us to the issue of attribution and then cost sharing below that, again, helping discussions across the board in those three areas. If the board could share, perhaps with us, what its tolerance in some of those difficult topics, I think it might help the workgroup to figure out where it needs to ay its pension. Short of that, I think that reconvening us is going to result in continuation of agreement to disagree.

MARY HENDERSON: I think for me, that's a question, if we see after our next meeting, that there are two or three unanswered questions that the workgroup could be helpful in solving for us, that's the time for us to beg you to consider those and provide us what expertise you can before the deadline. You understand the deadline is set not by us but by legislation and by the Superintendent's Office. So, we are bound by this, and I'd like to have six more months to debate this, but I'm not so sure we'd be any further on than we are right now. I think, given the idea of a deadline is for us to move on, and that's where we stand to me. Ann, did you have another comment you want to make?

ANN GOSLINE: No, I'm in agreement with the general.

DANA CONNORS: Let me just say one thing. I do agree with that approach. It make s a lot of sense. Karynlee, I guess my request of you, I think you've already responded to, already, and bears repeated, is that it's extremely important for us as a board to know under what means and guidelines and authority that we act, vis-à-vis public hearings and all the things that we need as a board to be cognizant of, in terms of procedure. The other part of that is to advise us, from the Attorney General's point of view, as to the appropriate role between now and the meetings. Can we seek information other than throughout our own means by researching this? What is the appropriate role because this is not…this is a little unusual, because it's going from us to the Superintendent of Insurance. He holds the formal adjudicatory hearing, but nonetheless, we have responsibilities contained as an authority that we must adhere to and I'd really like to see how we are authorized, under what basis, as well as our role as individual board members, so much depends upon us not kicking that…that football in the wrong direction.

ROBERT MCAFEE: Let me, in as much as every meeting we have, we do have an opportunity for public input, inasmuch as some members of the committee are here today. I guess I missed Jim Reed, he must have just snuck out on me. He'd come a long ways and I wanted to congratulate him and thank him for his participation, but anybody else from the committee of ten want to make any comment? I don't want to rehash all issues, but anything to enhance or embellish the presentations from either side? John Bennoit, anything you want to say? Dan?

DAN ROET: Not offhand.

ROBERT MCAFEE: Joe Ditre?

JOE DITRE: I do. Just on a couple things. Just in terms of from a consumer perspective, who, as the ultimate payer of all care, and I want to recognize that, when this was negotiated, the savings offset payment, we negotiated that offset, that there would be no new net costs to any of the payers, that the reason we were negotiating that, was that the insurers had secured the pass group of the assessment to us as the ultimate payers, so we wanted to be assured that no new net costs would come to us as the ultimate payers, as in as payers, so I don't want that to be lost, in your deliberations. The second thing that I would offer as a guide, in terms of your deliberations is the statutes. The statutes is what guided the state, what they decided would guide the entire process. There is no 50/50 share in the statute. There is no line of sight in the statute. There is no net as the payers or the large businesses and insurers are persuading you that the…their definition of aggregate means net, I can assure that that's not a definition of aggregate. With regards to 50/50, I would offer this. When you went from premiums to paid claims, that's a difference in deferred premiums to paid claims. It's about 25% of the total that that, in essence, was the 50/50. When the definition of paid claims excluded 14% of in state cost sharing that comes to consumers, that was the reduction in the face on the amount upon which the employers and insurers have to pay the assessment. That, too, reduced that based, and therefore, that is the 50/50, if not more. That's the point here. With regards to the net, we didn't take…when we were deliberating, we didn't, the Dirigo proof didn't attribute 100% of the gains and losses to Dirigo. The trend analysis picked up the non-Dirigo gains and losses. We only measure the gains and losses that are beyond the trend in 2004. And to the extent that Dirigo was the only game in town, we think that it's reasonable to assume that any reduction is due to Dirigo. Now, we've asked the employer and the insurers to provide us with any savings that they believe that the programs that they operate would have produced so that we can take those savings out of the total savings and say, "Alright, these savings are due only to Dirigo." But although we've had a lot of talk today about all these other factors, none of them have been offered, none of them have been given to us as to what are these other things? And I, who have been doing this work for twenty years, have seen costs steadily rise, regardless of the efforts, and these are important efforts, that employers are making, to try to improve the quality of breakdown costs. When that greater increase continues, then I say, and I see one year in which that rate of increase has come down, even though those same efforts continue, then you have to attribute it, in my mind, to, or at least a portion of that, to Dirigo. And a final thing that I would say with regards to, again, the line of sight. The statute is your guide. There's a difference between saying where there's savings, which is what the statute asks you to determine. Where did they go? Where did they go is a relevant, it's an important question, but to your deliberation, your determination, you don't have to answer that question. And I would assert looking at the increase in the net operating gains, some of the insurers, and carriers that did not participate in the Dirigo effort, going some of them 4.5, some of the 12.3, I can make a reasonable assumption where those savings went. But I can say that the determination that you're required to make, what were the savings and then calculate the savings offset payment. So, for those reasons, I think that the statute is your guide, none of the things, while worthy of consideration, but not required by the statute of what the payers have offered you today. And knowing that it's my members who are employees of these big employers that are going to ultimately pay more or see reduced benefits, or see increased cost share. We're willing to pay, we're willing to share the savings, we're willing to see more people covered. In fact, we want that to happen. And so, increasing the base upon which you lay the assessment is an okay thing with us, as long as those…that amount is used to cover more of our brothers and sisters in the State of Maine who have no coverage at all, and no security from financial ruin.

ROBERT MCAFEE: Thank you, Joe. Sharon, any comments?

SHARON: I think given the time I will pass, thank you.

ROBERT MCAFEE: Pat Ende?

PAT ENDE: I'm out.

ROBERT MCAFEE: Kristine? Anybody else from the public wish to make a comment? Yes, sir?

BRUCE GERRITY: If I could, just briefly. My name is Bruce Gerrity, I represent a couple of the trusts that are very interested in this process. The Automobile Dealers Help Trust and the Independent Bankers Trust, and I will agree with one thing Mr. DeTragis said, the statue really has to be your guide. With all due respect to the efforts by both sides of the working group, we think that both of those analyses are flawed and have strayed a little bit from the statute. You have to determine aggregate savings, which means you just can't look at the plus side. That's sort of like saying, "I'm an account savings deposits that go into my savings account, but I'm not gonna count withdrawals." You can't look at the resolution of a near decade old lawsuit, and say, since money was paid, that's savings. On the other side of the coin, I don't think it's appropriate to say since Mercer has flatly said they cannot attribute savings directly to Dirigo, they've said that, and they've said that on more than one occasion, we'll come up with an alternate methodology to help you. I don't think they can do that. I'll stop right there, knowing that you have an adjudicatory hearing of your own, to hold under the statute, under Section 810, and I'll wait for your adjudicatory hearing before I make further comments, and then I'll make further comments when the bureau holds its adjudicatory hearing.

ROBERT MCAFEE: Okay. Thank you.

STEVEN HANSER: I'm Steven Hanser, I'm a member of the public, I just wanted to (inaudible) one quick anecdote, don't think it's funny or not (inaudible), I actually have a…one of my best friends, who doesn't have health insurance, and he's going to be going on health coverage soon. And I just wanted to say that he basically had a choice to make, you know, on whether to continue to go to to the hospital and not have, you know, go to the hospital and therefore be a burden to the system, or to go on health insurance that's paid for by the state. So, that's a decision and he's decided to go on MaineCare. Now, it's complicated, but from what I've heard today it makes sense that the hospitals do benefit from that scenario. Now, it is complicated. It is complicated. I'm not saying that the savings are direct, they attributed to Dirigo. Dirigo did another (inaudible), and therefore, a portion of the savings probably can be attributed to the system, and therefore, indirectly to Dirigo.

ROBERT MCAFEE: Thank you for your comment. Any…anything else? Alright, let me…let me thank you all for coming today. Let me also remind you that, to not lose sight of the goal. You have to live in the United States and you don't have health insurance, you have a 25% increased mortality in any given year. As I look back on my career of trying to do the very best cancer care, of trying to do the very best kidney transplants, to do the very best vascular surgery, it pales by the comparison of providing health insurance to someone who doesn't have any. And I hope that in our zeal to try and get through that (inaudible), we don't lose sight of its achievability here in the State of Maine. We have some very unique problems, but we also have some very wonderful assets, and I think they're represented by people on both sides of our ten person committee. I think the presentations today, by and large, have been very positive and I thank you all for bringing those here. Those of you who haven't read the piece in the New Yorker by Malcolm Gladler, I recommend it to you, the current issue, with a tattooed gentleman on the front. He separates those who support health insurance and those who have the social insurance model versus those in the so-called actuarian model, and it's an age related concept as to whether one in the social insurance believes that the young should help pay for the old to an insurance model. Actuarily, those who are in their 20's should pay considerably less for insurance because of their considerably less susceptibility to disease. He does end up with an interesting argument that says it (inaudible) health savings accounts, while benefiting some, may turn out to the be the very antithesis of universal coverage and may indeed, be the most expensive alternative that we face today. Which I thought was an interesting spin on something that was (inaudible) as much important to the niche that it provides as Dirigo does for the niche that it provides. I recommend it to you because I think Dirigo is sort of a little of either. I think as we've heard today and will hear even more so at the next meeting, a lot of actuary (inaudible) in (inaudible) that dictates how we run this agency. At the same time, I think there is a social insurance commitment, that once everyone is covered, we all are going to be a heck of a lot better off here in the state of Maine. I didn't mean to give you the benediction here, but…Karynlee?

KARYNLEE HARRINGTON: Just one. It's a response to Dana's question. We're planning a board meeting in the afternoon, and Mercer is in the process of confirming that they can get here from Arizona on Tuesday. I will know by the end of today. My question is can we confirm this afternoon, that we will have actuaries that represent the payer side of the work group here on Tuesday as well?

DANA CONNORS: I don't know. We didn't know that that was a requirement until today so…

KARYNLEE HARRINGTON: Well, I don't know that it is a requirement.

ROBERT MCAFEE: Not a requirement, an option.

DANA CONNORS: (Inaudible).

KARYNLEE HARRINGTON: Can I…I think one of the impasses on the COM, CMAD was kind of the legislation that required, it's presented in April. It's part of what Dirigo is. This new approach on price, we're having, trouble understanding collectively, is available? I think you said that there has been analysis, if we could get some more numbers and some more meat on that proposal, it would be extremely helpful. Because it was…I think your suggestion that the payers has some of those. I think that…I think that's a request from both ways, too. I mean, we're trying to understand yours, we don't follow it.

UNIDENTIFIED FEMALE: Even the data sources, independent of the numbers, just the data sources of where that one (inaudible) is realistic. So, I guess that would be helpful.

UNIDENTIFIED FEMALE: (Inaudible) I get (inaudible) on Tuesday or what board is going to (inaudible). It's hard to know if that's what would be appropriate by then.

ANN GOSLINE: Should I work with Kristine?

ROBERT MCAFEE: Any information we can receive on that Tuesday would be helpful. This board is trying to do the right thing. We have listened very eagerly today to the information that you have presented, and I think it's been very informative, and I want you to know it's been very helpful. Thinking about it, we're getting down to crunch time here, and anything you can help us, will be an advantage. Mary, did you have some point?

MARY HENDERSON: Well, I don't…it would be very good to just have one side here, and not interpret back for it. And I would…I definitely don't want to be…to have the board come up with a decision and then form an opinion and then have new information appearing before the Bureau of Insurance, that we, that somehow, have never been produced, from your actuaries. So, I'd like all the information that we need to make a decision.

ROBERT MCAFEE: Let me also ask the board…

MARY HENDERSON: It's not clear to me if there's gonna be a hearing. I guess that's what I'm not clear on.

ROBERT MCAFEE: No, no, Tuesday's not the hearing.

DANA CONNORS: It's sorta like today. Present and discussion.

KARYNLEE HARRINGTON: Are you looking for the adjudicatory hearing?

MARY HENDERSON: Well, I don't…I'm not sure I know what the process is going forward. I'm just trying to determine.

DANA CONNORS: That was my question, yeah, if you'd let us know that.

MARY HENDERSON: I just know (inaudible) before and (inaudible) on that.

KARYNLEE HARRINGTON: I will e-mail the board the information, more details relative to the process. What I can confirm is we're not having a public hearing.

UNIDENTIFIED FEMALE: An adjudicatory hearing?

KARYNLEE HARRINGTON: We're not having an adjudicatory hearing, and we're not having a hearing here with the board that we noted and so on and so forth. We'll have a board meeting open up to public comments just like we're doing today, and then the formal hearing will be the adjudicatory hearing.

CHARLENE RYDELL: Can I make a comment?

ROBERT MCAFEE: Yes, go ahead, Charlene.

CHARLENE RYDELL: I don't know if this will be helpful or not, but I look upon next week as an opportunity for us to learn more in depth about each of the proposals so that we gain a great understanding, and all I would ask is that each of the group bring to next week's meeting those people who can help us gain that understanding. We have to make a decision, we want to make a decision based on what we were hearing, on as much information as possible and as clear an understanding of the methodology and consequences of choosing one or another, or methodologies. And I understand we can never know everything. But we're gonna have to make our decisions without knowing everything and…but I think we know too little right now. I think there are other people who have different kinds of expertise, other than the actuaries who could help us. I also had one request. If it is at all possible to make this meeting slightly later. Next week is the holiday so I need to get (inaudible).

ROBERT MCAFEE: The meeting is on Tuesday.

CHARLENE RYDELL: Right, so I will not get out in time to make the 1:00 o'clock meeting on Tuesday.

ROBERT MCAFEE: What time would be good for you?

CHARLENE RYDELL: Well, perfect would be 2:00, but if can't do it later than 1:30, that would still be helpful..

ROBERT MCAFEE: 1:30? Let's try 1:30, sometimes it'll try to get there, let's say, 1:30.

UNIDENTIFIED FEMALE: Could I make one…?

ROBERT MCAFEE: Let me ask you, on the 14th, which is a Wednesday, the Governor's press conference at 10:00 that morning, some of us will be here for it. I know there are a couple of you who are available. Were we to have an 11:15 meeting that day, is that okay…Dana?

DANA CONNORS: I have no idea.

UNIDENTIFIED FEMALE: This is the following…

ROBERT MCAFEE: This is the following…

UNIDENTIFIED FEMALE: Wednesday.

DANA CONNORS: That's a meeting for us, our second meeting? Jeez, I'd have to check, but…

UNIDENTIFIED FEMALE: What day are we talking about now?

ROBERT MCAFEE: The 14^{th}, Wednesday the 14^{th}.

CHARLENE RYDELL: At what time?

ROBERT MCAFEE: Well, 11:15, 11:30.

CHARLENE RYDELL: I think I'd be able to do that.

ROBERT MCAFEE: Let's look at that tentatively, because it's…some of us are here anyway, in the morning, and it might be convenient to have (inaudible) to say that we…we may not use it, but I suspect we will.

KARYNLEE HARRINGTON: Can I make one just additional comment, if I can, in response to what Charlene's asking? I think that there are some issues that whether the board needs to decide, that whether we have actuaries in here or not, are not going to help you in terms of deciding some of the fundamental questions around netting. I think John laid it out very nicely, the line of sight issue, and the issue around late…some of those things, I do think the actuaries will help answer some of the specific questions we may have. But there are some fundamental issues that we need guidance from the board on, relative to our intent to legislation, direction…

DANA CONNORS: Can you help us in that respect by knowing that we've only got a couple more meetings, and if I hear you correctly, from what the Attorney General has advised, it's not adjudicatory hearing, it's regular meetings and so forth. In the interest of time, is there a way that you can sort of categorize some of those issues so that we know what the sticking points are and we know some of those fundamentals…otherwise, we're gonna be chasing time all over the place, and we'll never get to the issues we need. Yeah, give us some sense of priority of order of those types of things that will help guide us, and to a degree, you can give us some advance to thing about it would be helpful.

KARYNLEE HARRINGTON: What I'd like to propose, is I'll summarize, briefly, opening comments, and I guess I would ask members of the work group, I think that's probably a document you would like to see, and potentially add comments to…I can give you my perspective and what I think the issues are, but I think it might be helpful for other members to review it, so I will try and get something out.

DANA CONNORS: Yep.

KARYNLEE HARRINGTON: (Inaudible) 'til Monday? We'll work in something by the middle of the week?

DANA CONNORS: Perfect. Good.

ROBERT MCAFEE: Okay? Thanks again, everybody, we're adjourned. Thank you, Charlene.