STATE OF MAINE
DHA AGENCY

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVING FOR THE FOURTH ASSESSMENT YEAR (2009)	))))	MAINE STATE CHAMBER OF COMMERCE PRE-HEARING BRIEF

FILING COVER SHEET

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Pursuant to the Procedural Order dated May 20, 2008, the Maine State Chamber of Commerce (the "Chamber"), by and through its attorneys, hereby submits its Pre-Hearing Brief.

PROCEDURAL HISTORY

On March 7, 2008, the DHA Agency ("DHA") Board of Directors ("Board") published a Notice of Pending Proceeding and Hearing ("Notice"). The purpose of the hearing is for the Board to determine the aggregate measurable cost savings ("AMCS"), including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1)(A). The Notice set the intervention deadline for 3:00 p.m. on May 23 and scheduled the hearing to begin at 9:00 a.m. on July 22, 2008 and to continue on July 23 if necessary. Notice Section 1. Subsequently, On May 20, 2008, the Board published an Order on Intervention and Procedures Notice ("Procedural Order").

Pursuant to the Notice and 5 M.R.S.A. §9054(1), the Chamber filed its application to intervene as a matter of right with full party status. The Board granted the Chamber's application on May 27, 2008.

A description of the DHA's proposed savings methodologies are contained in a June 2, 2008 report prepared by its consultants, schramm-raleigh Health Strategy ("srHS Report"). The DHA has apparently adopted each of its consultants' recommendations in full, and is

recommending that the Board adopt $190.2 million in AMCS, consisting of the following savings categories:

Issue	Proposed Yr. 4	Approved Year 3	Approved Year 2	Approved Year 1
CMAD	$147.9 mm	$ 25.0 mm	$ 14.5 mm	$ 33.7 mm
BD/CC	35.7 mm	6.3 mm	5.5 mm	2.7 mm
MLR	6.6 mm	n/a	n/a	n/a
Overlap	0.0 mm	0.0 mm	n/a	n/a
	$190.2 mm	$ 32.8 mm[1]	$ 34.3 mm[2]	$ 44.3 mm[3]

As illustrated in the table above, the proposed DHA Year 4 AMCS of $190.2 million is nearly six times the AMCS deemed reasonably supported last year, and represents approximately 172% of the AMCS approved by the Superintendent for DHA Years 1, 2 and 3 combined.

ARGUMENT

I. THE DHA HAS FAILED TO PROVE THAT THE RECOMMENDED CMAD SAVINGS ARE REASONABLE, ACCURATE, AND RECOVERED BY PURCHASERS OF HEALTH INSURANCE.

The DHA has proposed $147.9 million of savings for the CMAD Savings Initiative. This represents more than two times the amount of CMAD savings deemed reasonably support by the evidence for the First, Second, and Third Assessment Years combined ($73.2 million).

The srHS Report explains that the "CMAD savings attributable to Dirigo is calculated by comparing the CMAD in two scenarios -- an estimate of what the CMAD would have been in the absence of Dirigo and the actual CMAD experienced in the presence of Dirigo." srHS Report, p. 12. If the "actual CMAD is lower than the estimated CMAD," the srHS Report declares the

[1] The Board originally adopted $78.1 million of AMCS in Year 3. The Superintendent found $32.8 million to be reasonably supported by the evidence, and amount which included $1.5 million of Health Care Provider Fee Savings, a category not included in the srHS Report for Year 4.

[2] The Board originally adopted $41.8 million of AMCS in Year 2. The Superintendent found $34.3 million to be reasonably supported by the evidence, and amount which included $7.3 million of Health Care Provider Fee Savings, a category not included in the srHS Report for Year 4.

[3] The Board originally adopted $136.8 million of AMCS in Year 1. The Superintendent found $43.7 million to be reasonably supported by the evidence, and amount which included $14.3 million of Health Care Provider Fee Savings, a category not included in the srHS Report for Year 4.

difference to be savings "resulting from Dirigo." Id. The total savings is determined by multiplying the per CMAD difference by "the actual number of adjusted discharges (taking into account inpatient case-mix adjusted discharges, volume-adjusted outpatient discharges, and discharges associated with cost-based reimbursement." Id. The srHS Report theorizes that "[l]ower CMAD trends over time result in lower charges or lower premiums paid by the consumers, resulting in savings to the Maine health care system." Id.

However, the "Dirigo" variable used by srHS to derive its inflated savings figure does not refer to the Dirigo Health Act or the Dirigo Health Agency. Instead, it merely introduces a 2000-2003 versus 2004-2008 national time trend that does nothing to explain the cost per CMAD variation experienced nationwide. For this reason, and the reasons explained below, the DHA Board must reject the proposed CMAD savings as not reasonable.

A. The srHS CMAD Regression Analysis Is Flawed.

The Chamber contends that the srHS CMAD regression analysis is flawed because, first of all, it does not control for several important variables that drive hospital cost growth, and secondly, the data set used to perform the analyses contains numerous errors and questionable values.

1. The srHS CMAD Regression Analysis Fails to Control for Important Variables that Drive Hospital Cost Growth.

The Chamber contends that the srHS CMAD regression analysis produces misleading savings projections because the "Dirigo" variable relates to a national time trend (not the Dirigo Health Act), and it fails to control for important variables that drive hospital cost growth. As explained more fully in the pre-filed Testimony of Dr. Dobson, the srHS model fails to control for hospital competition, insurance competition, supply of physicians, CON and other types of regulations, hospital owner status, economic and employment variables, and hospital operating margins. **Chamber 1, p. 15.** As Dr. Dobson explained, the failure to include the correct

variables in a regression analysis may cause the Dirigo coefficients to reflect the impact of the omitted variables. This appears to have been the case here, as srHS admits that the variables in US Hospital model explain only "43% of the variance in cost per CMAD." **DHA 11.**

In addition to omitting key variables, the srHS model is unreliable because:

- srHS was not consistent in the use of variables among its regressions;
- srHS was not consistent in the use of hospital level / state level data among its regressions;
- srHS "credibility weights" are arbitrary, especially because they are being applied to unreasonable estimates;
- srHS failed to log CMAD (and other) variable(s) to determine if savings estimates are influenced by non-normality in CMAD data distribution;
- srHS failed to supplement its regression analysis with key informant interviews; and
- srHS failed to address or control for key concerns identified by past Superintendent Decisions.

Chamber 1, pp. 14 - 19.

2. <u>The srHS CMAD Data Lacks Credibility</u>.

In the prior years' proceedings, srHS provided paper copies of the relevant Medicare cost report worksheets as support for their calculations. This important step created an audit trail that could be reviewed to confirm the accuracy of the data underlying the calculations, as Mr. Mercier did when identifying tens of millions of dollars of errors in past proceedings. In contrast, srHS failed to provide an audit trail for this year's proceeding. Instead, srHS purchased raw text file data from the American Hospital Directory ("AHD"), "condensed" the data to include only certain fields, imported the data into a Microsoft Access database, and then adjusted the data, including the replacement of individual hospital names with a random numeric identifier (not the provider number used by CMS). srHS Report, pp. 43-44. There is no paper trail. Although srHS suggests that this information should be relied upon without any means of

independent verification, the Chamber believes that the CMAD regression model's results must be rejected unless verifiable, auditable source data is provided. Indeed, in the Year 3 Report, srHS stated that one of its "guiding principles" was to "use readily available, verifiable, and auditable data sources," and "make AMCS calculations transparent by presenting all data used in the calculation, the formulas used in the calculation, and the documentation relied on as best as possible in this report." Year 3 Report, p. 6. Auditable documentation and a transparent calculations are important because the AMCS determined at this proceeding will ultimately be translated into a tax on health insurance which will increase the costs to the Maine health care system and the ultimate purchasers of health insurance (Maine businesses, employers, employees and individuals).

There is significant evidence that the data relied upon by srHS is inaccurate. First, a comparison of the Maine "virtual hospital" cost per CMAD have materially changed from Year 3 to Year 4, as demonstrated by **Chamber 7**, and as summarized in the table below:

SFY Year	CMAD Year 2	CMAD Year 3	CMAD Year 4	DHA DS-18
2000	4868	4882	5001	5151
2001	5097	5109	5564	5747
2002	5613	5571	6080	6315
2003	5800	5739	6269	6511
2004	5912	5922	6588	6872
2005	6316*	6160	7011	7234
2006	--	6407*	7233	7492
2007	--	--	7470*	7757*

*srHS estimates based upon an incomplete data set.
Source: DHA Year 2 Report, Appendix; DHA Year 3 Report, p. 39; srHS Year 4 Report, p. 54; dha dataset_18.

Although there is a modest differential between the Year 2 and Year 3 CMAD figures, this differential was verified by auditable documentation as the effect of audit findings by the Medicare fiscal intermediary, or the replacement of srHS estimates with actual cost report data. However, srHS has provided no explanation for the material variances between the Year 3 and

Year 4 CMAD data. For example, the rate of cost growth between 2000/2001, which was 4.65% in Year 3, has nearly doubled to 11.26% for Year 4. This one change has the effect of raising the average cost growth in the pre-Dirigo period (2000-2003) from 5.54% (based upon the Year 3 audited figures) to 7.82% (based upon Year 4 un-audited figures). As Dr. Dobson has explained in his pre-filed testimony, the differential in average growth rates between the pre-Dirigo period (2000-2003) and the post-Dirigo period (2004-2007) figures prominently in the srHS CMAD regression analysis and its recommended savings. Interestingly, srHS fails to explain the significant variance in its Maine CMAD figures from Year 3 (audited) to Year 4 (unaudited). They simply ignored clear evidence that something is wrong with their Year 4 data, and now ask the Board to do the same.

Second, a brief review of the data underlying the srHS CMAD regression analysis demonstrates that there are a significant problems with their data. **Chamber 6.** Some examples include:

- An implausible range of CMAD values from a low of 0.41513060 to 19,982.66541, and the hospitals at the higher end do not appear to be teaching hospitals;
- There were 740 observations of hospitals with the same CMAD value when expressed out to the 11th decimal (e.g. 7 hospitals had the exact value of 5403.28606406227). Given the number of variable that are contained in the CMAD formula used by srHS, it is highly unlikely that exact duplication is plausible;
- The were 21 observations of hospital beds exceeding the largest number of beds (1660 according to CMS data), including a bed size of 44491.82665 and 16299.17355;
- % Days Medicare included hospitals with percentages of 106.1728% and 4744.8276%.

These examples demonstrate significant problems with the srHS data cleaning process, and calls into question the reliability of the data underlying the srHS CMAD regression analysis. As explained by Dr. Dobson, this results in "garbage in, garbage out." Accordingly, the

Chamber believes that the DHA has failed to meet its burden of proof because it failed to provide auditable documentation, and the data provided contains a significant number of material errors.

B. <u>The Recommended CMAD Savings Result from a Misinterpretation of the CMAD Regression Analysis</u>.

In addition to the omitted variables and data cleaning problems identified above, the Chamber contends that the recommended savings of $147.9 million results from srHS' misinterpretation of the CMAD regression analysis. First, srHS mistakenly derives a significant amount of recommended savings from coefficients that are not related to the Dirigo Health Act. Second, the coefficients that are driving the srHS recommended savings are not statistically significant.

1. <u>The srHS CMAD Regression Analysis Savings Rely Upon Coefficients that Are Not Related to the Dirigo Health Act</u>.

According to srHS, the CMAD regression analysis suggests $439 of recommended savings (on a per CMAD basis). This recommended savings amount is derived from the following four variables: (1) Dirigo ($285.61); (2) Maine*Dirigo $65.45; Year*Dirigo $433.69; and Maine*Year*Dirigo $225.53. **Chamber 1, p. 22.** However, as explained by Dr. Dobson, the Dirigo variable does not refer to the Dirigo Health Act, but instead represents a pre-Dirigo (2000-2003) and post-Dirigo (2004-2007) time trend that applies to all hospitals in the nation.[4] That is why the "Dirigo" coefficient value is positive, and adds cost to the CMAD rather than decreasing costs. Similarly, the Year variable is not Maine-specific, but represents a seven year time trend with each year adding a specified amount of cost. Therefore, the interaction of the two variables does not describe the program effect of the Dirigo Health Act, but instead attributes a <u>national</u> pre-Dirigo (2000-2003) / post-Dirigo (2004-2007) time trend effect to Maine. Hospitals across the United States, including Maine, experienced a marked slowing in

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[4] A review of the underlying data shows that all US hospitals are assigned a "0" for the pre-Dirigo period (2000-2003) and a "1" for the post-Dirigo period (2004-2007). **DHA 3.**

the rate of cost growth; therefore, the Y:D interaction inappropriately credits the Dirigo Health Agency with the national trend of a slowing rate of growth. In other words, since all hospitals nationally experienced a marked slowing of the rate of cost growth as a result of forces other than the Dirigo Health Act, it is improper to assume that Maine's reduction was solely attributable to the Dirigo Health Act -- if at all. Because the srHS interpretation includes variables that are not specific to Maine, their interpretation is flawed.

In addition, the srHS interpretation disregards Dr. Dobson's descriptive statistics (created using srHS data and methodologies) that show that Maine's cost growth rates in the post-Dirigo period (2004-2007) have actually outpaced the national trend, notwithstanding the fact that Maine's growth rate for 2002/2003 (the year prior to the Dirigo Health Act) was below the national trend. **Chamber 1, p. 8.** These descriptive statistics indicate that the Dirigo Health Act has not produced CMAD savings, but rather the substantial fluctuations in cost growth are explained by other forces, including the expected regression to the mean.

2. The srHS CMAD Regression Analysis Coefficients that Drive the Recommended Savings Are Not Statistically Significant.

As discussed above, four coefficients (D, M:D, Y:D, M:Y:D) combine to produce the srHS recommended savings. Although Y:D reaches statistical significance, this interaction must be rejected as a savings measure because it merely introduces a national pre 2003 / post 2004 time trend that is in no way related to the Dirigo Health Act or Maine. The other variables that produce savings (M:D, M:Y and M:Y:D) admittedly do not achieve statistical significance, and therefore very well may be the result of random statistical variability. As illustrated by **DHA 11**, srHS expressly concedes that the M:Y:D intersection is not statistically significant and that "the effect of the presence of Dirigo is inconclusive on the CMAD." The M:D intersection is even less statistically significant than M:Y:D. Interestingly, srHS concedes that all three of the remaining variables that drive the recommended CMAD savings lack statistical significance.

Nevertheless, it asks the Board to ignore the results of this well accepted and important test, and instead look to the R-squared measure "as an indicator of the model's predictive powers." However, this argument too must fail. Indeed, srHS admits that its model only "explains 43% of the variance in cost per CMAD." **DHA 11.** Although srHS suggests that this low threshold should be enough to satisfy the Board, the Chamber believes that a more conclusive finding is required in the context of a proceeding that will ultimately determine a substantial health insurance tax. This is especially true where, as here, the variables that drive the recommended savings (M:Y:D and M:D) do not contribute to the R-squared so-called predictive powers. Indeed, if the srHS model is re-run without these variables, the R-squared result remains exactly the same out to three decimals -- .428. In other words, the variables that drive the savings do not influence the R-squared result. Therefore, these variables cannot contribute to the model's alleged predictive power. **Chamber 1, p. 26.**

Furthermore, using the srHS CMAD regression model and data, Dr. Dobson demonstrated that a majority of states (29 of 50) showed a Dirigo variable "saving" effect, and 15 states showed a per-CMAD "savings" figure that was similar or greater than Maine's.[5] Certainly, the "savings" identified by the srHS model in other states cannot be attributable to the Dirigo Health Act. This is additional proof that the srHS CMAD regression analysis does not take into account significant drivers of rates of cost growth, but instead confuses them with "savings" attributable to the Dirigo Health Act.

As explained above, the key variables that produce the recommended savings pursuant to the srHS US Hospital CMAD regression analysis have been misinterpreted and lack statistical

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[5] A similar result was found when Dr. Dobson replicated for all 50 states the Column III analysis set forth on page 54 of the srHS Report. This analysis is similar to the Years 1, 2 and 3 comparison of projected historical growth rates to actual CMAD. 39 of 50 states showed some "savings," while 20 state (including Maine) has "savings" of $150 million or more. This is additional evidence of a general nationwide slowing of the rates of cost growth that is unrelated to the Dirigo Health Act. As demonstrated by Dr. Dobson (again using srHS data and methods), the rate of cost growth began slowing in Maine long before the Dirigo Health Act was proposed and enacted. **Chamber 1, p. 8.**

significance. As Dr. Dobson explained in his pre-filed testimony, the Cluster 1 CMAD regression analysis suffers the same fate. Indeed, the coefficients have a similar lack of statistical significance, except that not even the Dirigo coefficient is significant in Cluster 1. As a result, the Cluster 1 analysis is even less meaningful than the US Hospital level analysis. Although the DHA argues in its pre-hearing brief that one of the savings producing variables (M:Y:D) is almost statistically significant, this argument must fail. The srHS CMAD models seek to prove their "savings" theory exclusively through the use of statistics, which requires adherence to the principles of mathematics. Moultrie v. Martin, 690 F.2d 1078, 1082 (4th Cir. 1982). As a result, srHS cannot on the one hand argue that its math should be conclusive when, on the other hand, it seeks to free itself from the objective process of hypothesis testing using even the lowest (.10) significance level as a threshold standard (as opposed to the commonly used .05 or .01 standards).

No less an authority than the United States Supreme Court has relied upon the 95 percent confidence criterion in evaluating statistical significance. *Castaneda v. Partida*, 430 U.S. 482, 497 n. 17 (1977), *Hazelwood Sch. Dist. v. U.S.*, 433 U.S. 299, 309 n. 14 (1977) (stating that, in general, two to three standards of deviation are appropriate in large samples). First Circuit courts also rely upon a 95 percent or higher confidence criterion. *E.E.O.C. v. McCarthy*, 768 F.2d 1 (1st Cir. 1985) (upholding district court decision, 578 F. Supp. 45 (1983), to rely on data with probability due to chance between 0.5 and 0.01 percent rather than data with lesser statistical significance); *Fudge v. City of Providence Fire Dep't.*, 766 F.2d 650, 657-58 (1st Cir. 1985) (stating that data should be attributed statistical and judicial significance only when probability of result being due to chance is low); *Hilton v. Wyman-Gordon Co.*, 624 F.2d 379 (1st Cir.1980) (upholding district court decision to adopt 0.05 level of significance) (concurring opinion finding statistical significance of 3.2 percent "well below" statistically significant) (Breyer, C.J.,

concurring). Other circuit courts have also adopted a 95 percent confidence criterion. *Palmer v. Shiltz*, 815 F.2d 84 (D.C. Cir. 1987) (adopting the 5 percent probability of error level and refusing to accept an error level of 8 percent in order to establish a prima facie case of employment discrimination); *F.T.C. v. Swedish Match*, 131 F. Supp. 2d 151, 161-61 (D.D.C. 2000) (refusing to rely on 85 percent statistical significance level, acknowledging 95 percent significance level as "more typically accepted"); *Proctor & Gamble Co. v. Chesebrough-Pond's Inc.*, 588 F. Supp. 1082, 1083 (S.D.N.Y. 1984) (accepting 95 percent confidence level as statistically significant). There is authority for applying a stricter than 5 percent confidence criterion. *E.E.O.C. v. Sears, Roebuck & Co.*, 839 F.2d 302, 362 n. 1 (7th Cir. 1988) (citing authority for courts applying stricter than 5 percent confidence criterion, finding no *per se* rule against disparities of less than three standard deviations).

Stated differently, if a 95% confidence level is required for simply to publish an article in a peer review journal, this level of confidence should be the minimum required for consideration of an estimate used to assess a tax. Indeed, courts apply this minimum even in cases addressing alleged discrimination (which the law prohibits).

But there is additional evidence that not even srHS has faith in the Cluster 1 results. Despite praising its "conclusive"[6] nature, srHS affirmatively elected not to give much weight (only 25% overall) to the credibility of the Cluster 1 analysis. It is telling that srHS so substantially discounted the results of its own analysis, especially because it claims that the "Cluster 1 model shows a high degree of both predictive and explanatory power for Dirigo," and that the R-squared indicates that "98% of the change in cost per CMAD can be explained through changes in the variables in the model." **DHA 12.** As explained below, srHS apparently realized that the R-squared measure was inflated, and therefore was not a reliable indicator.

[6] Schramm Pre-Filed, p. 19, ln 426-434.

C. The Promotion of the Cluster CMAD Regression Analysis Results by srHS is Overly Aggressive because the R-Squared Measures Are Inflated for Technical Reasons.

With respect to Cluster 1, srHS states that the "Cluster 1 model shows a high degree of both predictive and explanatory power for Dirigo. In other words, the model shows that Maine saved money and Dirigo was the reason." **DHA 12.** As explained above, srHS clearly does not have faith in the Cluster 1 model, as it substantially discounted the savings attributable to it by applying a "credibility" weighting of only 25%. As Dr. Dobson explained, there is good reason that srHS avoided placing great emphasis on the Cluster 1 model. First, Dr. Dobson explained that the high R-squared measures are irrelevant because "the only coefficients that drive their savings estimates are statistically insignificant." Furthermore, Dr. Dobson explained that the R-squared measure is artificially high "because there are so few observations," and lack "degrees of freedom." **Chamber 1, p. 32.**

D. An Alternative Interpretation of the srHS CMAD Regression Analysis Data Suggests Zero Dirigo Health Act Savings.

In light of the significant savings recommended by srHS, Dr. Dobson performed several "reasonableness checks" to determine whether the recommended savings reflected reality. First, he incorporated the srHS data and regressions into an efficiency model. As Dr. Dobson explained, "one would expect a model that shows such dramatic savings would likewise show increased efficiency." **Chamber 1, p. 34.** However, the efficiency model proved just the opposite. Instead of increased efficiency (as compared to all other states), the efficiency model showed that Maine has not controlled costs as well as other states. Id. This finding provides additional support for the descriptive statistics Dr. Dobson developed using srHS data. Taken together, this evidence indicates that the Dirigo Health Act has not produced any savings.

Second, the Chamber argues that evidence of a reduction in the rate of CMAD cost growth (even assuming that it is properly calculation) is insufficient to prove AMCS. Indeed, the

voluntary CMAD limit has a companion COM limit of 3%. Taken together, the voluntary CMAD limit encourages hospitals to restrain cost growth, and if they are successful, the companion COM limit encourages the hospitals to pass along any savings, but only to the extent that the reduced cost growth would cause the hospitals to exceed the voluntary 3% COM limit.

Dr. Dobson aggregated hospital consolidated operating margin data from the Year 1, 2 and 3 proceedings, as well as information from the Maine Hospital Association. This information, summarized below, proves that the amount of savings recommended by srHS cannot be accurate.

Year	COM	Percent	Source
2001	$ 30,298,000	1.44%	DHA Yr. 1
2002	$ 2,011,000	.009%	DHA Yr. 1
2003	$ 13,729,000	0.53%	DHA Yr. 1
2004	$ 52,291,000	1.84%	DHA Yr. 1
2005	$ 92,369,164	2.90%	MHA
2006	$ 89,562,692	2.60%	MHA

Source: DHA Yr. 1 Calculation by Dr. Kane (2001-2004) and MHA Data. Individual hospital data grouped by calendar year in which hospital fiscal year ended. **Chamber 9.**

Indeed, Maine hospitals have increased the aggregate the operating margin from .009% in 2002 to 2.6% in 2006, but never exceeded the 3.0% COM limit. More importantly, the recommended CMAD savings of $147.9 million dwarfs the consolidated operating margin for all Maine hospitals for 2006, and this <u>one year</u> of alleged savings represents more than 50% of <u>six years</u> worth of consolidated operating margin. There is simply not enough recent or historical operating margin to entertain an inference that operating margins would have been approximately $237.5 million for 2007 ($147.9 million + $89.6 million) in the absence of Dirigo. Significantly, the consolidated operating margin for the "virtual hospital" has generally increased between 2000 and 2006, but has at all times remained below the voluntary 3.0% COM limit

created by the Dirigo Health Act. The Chamber contends that the DHA must demonstrate that the alleged CMAD savings would force the virtual hospital to rise above the 3.0% COM limit (and thus require a reduction of hospital charges) before any reductions in per CMAD cost growth may be considered "savings." Indeed, one without the other does not represent savings to the Maine health care system. The DHA has failed to meet its burden of proof in this regard.

E. The CMAD Variable Itself is Critically Flawed from a Savings Perspective.

The Chamber has consistently argued that the voluntary CMAD limit was never intended as a measure of "savings," and at the very least must be read in tandem with the voluntary COM limit to have real meaning. As explained by Dr. Dobson, the CMAD variable itself is critically flawed as a measure of savings because it merely represents a per unit cost of hospital services, and does not take into account total expenditures, which is the product of price and quantity. This is important because a per unit cost may be influenced by a relative increase in volume. Although the per unit price may be lower, more units are purchased leading to similar or greater total expenditures. Therefore, volume increases generally mean higher expenditures from the payer's perspective. However, according to the srHS CMAD model, as the volume increases, CMAD savings increase, because the differential is multiplied by the number of discharges. Thus, the srHS model is plainly inconsistent with the traditional health care industry approach of focusing on total expenditures, rather than the misleading per unit cost that disregards the impact of volume.

II. THE DHA HAS FAILED TO PROVE THAT THE RECOMMENDED BD/CC SAVINGS ARE REASONABLE, ACCURATE, AND RECOVERED BY PURCHASERS OF HEALTH INSURANCE.

In the pre-filed testimony of Dr. Dobson, the Chamber has demonstrated that the new srHS BD/CC methodology should be rejected. First, the methodology produces six times the savings determined to be reasonable by the Superintendent in the Year 3 proceeding. As the

Superintendent explained in the Year 3 Decision, "[o]ne final test of the overall reasonableness of this result is that it is not inconsistent with the $5.5 million found reasonably supporting in Year Two, when adjusted for growth in enrollment during the intervening year and for the addition of a new category of savings within this initiative." Year 3 Decision, p. 18. Mr. Schramm has indicated agreement with this type of analysis, noting in his pre-filed testimony that he afforded the CMAD Cluster 2 <u>zero</u> credibility "because the final savings estimate, while the highest, was inconsistent with evidence presented in past AMCS proceedings." Year 4 Pre-Filed Testimony of Mr. Schramm, p. 18, ln 404-406. Like Year 3, srHS has now proposed a whole new methodology for determining BD/CC savings. Unlike Year 3, however, enrollment in Dirigo Choice for the current year has substantially <u>declined</u> when compared to the prior year. Yet, srHS suggests that the Board should <u>increase</u> savings six fold. The Chamber suggests this fact alone requires rejection of the recommended BD/CC savings.

Second, the BD/CC methodology utilizes a pre-Dirigo time period (1999-2002) that is inconsistent with the CMAD methodology (2000-2003). Whether intentional or not, the selected pre-Dirigo time period captures the effect of a large MaineCare expansion that was authorized in 2002, long before the Dirigo Health Act was enacted (and before the current administration was elected). Moreover, the attempt to capture bad debt and charity care costs resulting from this time period directly contradicts the plain language of 24-A M.R.S.A. § 6913(1)(A), which specifies that such savings "occurring after June 30, 2004." Finally, there is no evidence in the record that the items identified by srHS as being related to the Dirigo Health Act (Section 2 and Appendices B-D of the srHS Report) were effective and had an impact during calendar year 2003. As the Board well knows, Dirigo Choice and the Dirigo related MaineCare expansion did not begin coverage until 2005.

Third, the srHS estimates of the number of previously uninsured who are now covered by insurance as a result of the Dirigo Health Act (up to 55,000) simply does not match up with Maine's historical and actual experience. In fact, using srHS's own percent uninsured and population figures from p. 70 of the srHS Report, the total number of uninsured persons decreased by only 16,933 from 2003 (before Dirigo) to 2008. Furthermore, as explained in the pre-Filed Testimony of MEAHP witness Mr. Burke, srHS improperly projected the uninsured rates by assuming that growth in the Dirigo Choice product and the Dirigo related MaineCare expansion would continue. However, enrollment in Dirigo Choice has actually declined from 2007 to 2008.

Fourth, the srHS BD/CC regression model lacks transparency. As Dr. Dobson explained, "[s]tatistical programs were written that included instructions to delete interim datasets that were key to the analysis, output needed to evaluate results from the regression analysis was missing, and the process used to 'un-log' regression results were not detailed." **Chamber 1, p. 40, ln 13-17.** Interestingly, Mr. Schramm and Dr. Thorpe spend a significant amount of time explaining the statistical significance of the CMAD regression analysis output, and the DHA pre-hearing brief suggests that the "DHA uses the same sort of multivariate multi-state methodology" for BD/CC. However, neither Mr. Schramm nor Dr. Thorpe (or the DHA Brief) bothers to discuss the statistical significance of the BD/CC regression analysis -- or even provide the regression analysis output for review. Without these significance measures, there are no means to evaluate the degree to which BD/CC variables occurred by chance, nor are there means to assess if any of the calculated BD/CC "savings" are attributable to the Dirigo Health Act.

Finally, the DHA BD/CC model apparently assumes that <u>everyone</u> who is newly insured in the period 2004 - 2008[7] owes their insurance to the Dirigo Health Act. This assumption is

[7] On July 17, 2008, the DHA extended the pre-Dirigo period to include 2003.

contrary to Maine's actual pre-Dirigo uninsured rate data which shows that the rate of uninsured fell from 13.25% in 1999 to 11.79% in 2003. srHS Report, p. 70. However, in order to improperly inflate BD/CC savings, the DHA asks the Board to assume that the uninsured rate would have increased from 2004 to 2008 if the Dirigo Health Act had not been enacted.

III. THE DHA HAS FAILED TO PROVE THAT THE RECOMMENDED MLR SAVINGS ARE REASONABLE, ACCURATE, AND RECOVERED BY PURCHASERS OF HEALTH INSURANCE.

Throughout the srHS report and the DHA pre-filed testimony, AMCS is referred to as "savings to the Maine health care system." The basis for this savings initiative, however, is a refund made by Aetna to certain policyholders as a result of the medical loss ratio ("MLR") imposed by the Dirigo Health Act. Because this refund represents savings to individual policyholders, it cannot credibly be considered savings to the Maine health care system. Therefore, it cannot be considered AMCS. Indeed, the DHA admits in its pre-hearing brief that this savings of $6.6 million is "obviously not recoverable by Aetna." As such, it is certainly not recoverable by other health insurance carriers or third party administrators who must pay the SOP.

Notwithstanding its concession, the DHA urges the Board to include this amount in AMCS, suggesting that this hearing is meant to take place in a vacuum, and the sole purpose of this hearing is to measure any savings that may have inured to anyone in the State of Maine, without regard for whether the particular "savings" has -- or even can -- inure to the benefit of the Maine health care system. The MLR has not, and cannot, inure to the benefit of the Maine health care system. The refunds are paid to certain existing policy holders of Aetna, not spread out generally to make future policies more affordable for all. Since Aetna will have already issued the refunds, including this amount in the SOP will result in Aetna paying out some portion of the $6.6 million twice -- with the rest paid by other health insurance carriers and third party

administrators subject to the SOP. Because the sole purpose of determining AMCS is to set a ceiling on the SOP, the consideration of any savings initiative that cannot possibly form the basis of the SOP is illogical.

IV. THE srHS REPORT SIGNIFICANTLY OVERSTATES SAVINGS BY IGNORING CLEAR OVERLAP BETWEEN THE CMAD, BD/CC AND MLR SAVINGS INITIATIVES.

In his pre-filed testimony, Mr. Schramm attempts to explain the six fold increase in BD/CC savings as follows: "We are taking a much more global view in Year 4 by incorporating all of the impacts that Dirigo has had on the marketplace in Maine, since Dirigo has driven down the rate of cost growth of health care expenditures in Maine." Schramm, p. 21. He explains that the rate of cost growth has been driven down by the various initiatives detailed in Section 2 and Appendix B through D of the srHS Report. According to the cited sections of the srHS Report, the scope of the new "global approach" admittedly swallows the CMAD and MLR initiatives. This is demonstrated by the fact that the $35.7 million of recommended savings to the "Maine health care marketplace" is consistent with the Superintendent's total approved savings of $43.7 million, $34.3 million and $32.8 million for Years 1, 2 and 3, respectively.

According to the srHS Report, "the Year 4 analysis for BD/CC includes only those costs, charges and discharges that would have existed in the absence of Dirigo as well as in the presence of Dirigo." srHS Report, p. 20. The national BD/CC model apparently assumes 46,924 newly insured ($41,903,000 / $893). Since the costs, charges and discharges associated with this significant number of people is admittedly incorporated in the CMAD regression analyses, there is significant overlap between the CMAD and BD/CC savings calculations. Again, srHS specifically cites the voluntary limits as one of the Dirigo initiatives that has made health insurance more affordable. Likewise, srHS appears to be attempting to capture the MLR a second time -- once individually and again in the BD/CC savings because the MLR is specified

as one of the contributing factors for more affordable health insurance. Although there is clearly overlap between the three savings initiatives, the DHA urges the Board to ignore it.

V. THE DHA'S INCONSISTENT AND OVERLAPPING SAVINGS MEASURES PROVE THAT THE STATUTE IS UNCONSTITUTIONALLY VAGUE AND AMBIGUOUS AND RESULTS IN AN IMPROPER DELEGATION OF LEGISLATIVE AUTHORITY TO THE EXECUTIVE.

The concern expressed by Justice Alexander in his dissenting opinion has materialized. Maine Ass'n of Health Plans v. Superintendent of Ins., 2007 ME 69, 923 A.2d 918, 935 - 938 ("MEAHP"). In Year 4, the DHA simply cannot decide how to define AMCS consistently. Sometimes it is defined as refunds to select individual citizens (MLR refunds). At other times, it is defined as savings to the Maine health care system as a whole (BD/CC / more affordable insurance premiums for all). And yet other times, it is defined as a subset of the Maine health care marketplace (hospital CMAD) without regard to whether a projected reduction in the rate of CMAD cost growth by a mythical "virtual" hospital was -- or even could be -- passed on to the purchasers of health insurance policies (thus justifying the imposition of an SOP on health insurance carriers). The DHA's shifting and inconsistent definition of the term AMCS has led to an increase in the cost of health insurance for most Mainers. MEAHP, 2007 ME 69 at ¶ 68.

For the reasons specified by Justice Alexander in his dissent (and acknowledged without opinion by the majority), the Chamber contends that 24-A M.R.S.A. § 6913 is void for vagueness and therefore the Legislature has unconstitutionally delegated its taxing and spending authority. MEAHP, 2007 ME 69 at ¶ 58, fn 14, ¶¶ 61 - 75.

Dated: July 18, 2008.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on July 18, 2008, pursuant to the paragraph 3(a) of the May 20th Order, I caused to be filed electronically the foregoing document by emailing a true copy to:

Board of Directors, Dirigo Health Agency at Ruth.A.Burke@maine.gov

I further certify that on July 18, 2008, pursuant to paragraph 3(b) of the May 20th Order, I caused to be served by sending an identical electronic copy of the foregoing document to:

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