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July 9, 2008

Dirigo Health Agency
Attn: Ruth.A.Burke@maine.gov
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Fourth Assessment Year (2009)

FILING COVERSHEET

Dear Ms. Burke:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	July 9, 2008
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of Vincent Liscomb Jr.
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 2
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE FOURTH ASSESSMENT YEAR	)	VINCENT LISCOMB JR.
(2009)	)	
	)	
Docket No.	)	July 9, 2008
	)	
	)	

NON-CONFIDENTIAL

Q. Please state your name and your position with Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is Vincent Liscomb Jr. and I am Executive Director of Provider Network Management.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

A. I have worked in the health care industry for nineteen years in a variety of positions, with a primary focus on hospital and physician contracting and provider network management. For the last four years, I have been employed by WellPoint, first as Regional Vice President of Network Development and Management at Blue Cross Blue Shield of Georgia, and more recently as Executive Director of Provider Network Management for Anthem BCBS.
Dan McCormack, Thomas Drottar and Amy Cheslock held this position in years past and provided testimony at previous hearings.

Q. Have you reveiwed the methodology that has been proposed by the Dirigo Health Agency ("DHA") for the fourth assessment year?

A. I have reviewed the report from DHA's consultant, schramm raleigh Health Strategy ("srHS"), summarizing the methodologies that srHS proposes should be used for calculation of aggregate measurable cost savings in the fourth assessment year (the "SrHS Report").

Q. **What is the purpose of your testimony?**

A. The purpose of my testimony is to explain: (1) the mechanics of hospital and physician contracting in Maine; (2) how our process at Anthem BCBS has changed since the implementation of the Dirigo legislation; (3) the extent to which we investigate whether our network of providers have experienced savings as a result of Dirigo, and (4)

the process by which hospitals often shift costs from governmental payors to the commercially insured population.

Q. Please explain the mechanics of hospital contracting.

A. Anthem BCBS's provider contracting department negotiates with hospitals and other providers to ensure that Anthem BCBS is getting the best possible rates for the services that the hospitals provide to our members. We generally begin contract discussions with providers several months in advance of a renewal. The process includes both an internal detailed review of relevant financial information and extensive external discussions with providers regarding their financial situation. The rate that the hospital is willing to negotiate is made up of many factors, one of which is the cost of the services the provider performs. If there are reductions in the provider's costs in any particular year, if all else is equal and the provider is willing and able to pass those cost reductions on in the form of a lower contract rate, Anthem BCBS's costs for that particular provider will also be reduced.

Provider Network Management has the same goal with respect to contracts today as we did before the Dirigo legislation passed. That goal is to secure the best possible rates for our members in each negotiation. In addition to working for the best possible rates, our negotiation protocol includes a requirement that hospitals and physician groups tell us the applicable group's bad debt and charity care costs, the extent of any savings as a result of the operation of Dirigo Health, and whether or not the hospital or provider group is passing on the full extent of those savings in the group's contract rates.

Q. Has the Superintendent determined that Anthem BCBS used best efforts to recover savings in prior assessment years?

A. Yes. The Superintendent has repeatedly found that Anthem BCBS used best efforts to recover the savings and that all savings attributable to Dirigo were embedded in the premium rates proposed and charged by Anthem BCBS. Accordingly, the Superintendent has authorized Anthem BCBS to include the full

savings offset payment ("SOP") amount in member rates. *See, e.g., In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Docket No. INS-05-820, Decision and Order issued December 19, 2005, p.10 ("[Mr. McCormack] testified that he was confident that the current contracts with health care providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore [Anthem BCBS's actuary] testified these savings attributable to Dirigo had been incorported into the filed rates. The Superintendent concludes that Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives.").

Q. Has there been any change in the fourth measuring period?

A. No. There has been no change in the contracting philosophy or practice in the fourth measuring period. Our team of negotiators continues to use best efforts to recover in contracted rates any cost savings as a result of the operation of Dirigo Health.

Q. Please explain the basic process whereby hospitals or other provider groups get paid for their services by Anthem BCBS?

A. Discount from charge is the most prevalent methodology of payment for hospitals. This payment mechanism involves the provider billing a dollar charge for a particular service on a claim. If the service is a covered service under the member's certificate of coverage, and the service was authorized as medically necessary, the claims system applies the negotiated discount from charge to the claim. The resulting amount is the "allowed" amount, which reflects the total amount the hospital expects to recoup for the service through payments by Anthem BCBS (and/or the member through cost sharing). The other primary arrangement is fixed pricing. Under this methodology, Anthem BCBS pays a fixed price for a service or bundle of services provided to our members. The fixed price, except for some outlier provisions, which are used to

compensate the hospitals for unusually costly cases, is the "allowed" price regardless of the charge.

Q. Are all hospital payments made by private payors, like private insurance companies?

A. No. There is a substantial portion of revenue at Maine hopsitals that is derived from governmental payors. At many rural hospitals, this amount may exceed 70% of total revenue.

Q. If a large percentage of hospital revenues are derived from governmental – as opposed to private payor – sources, does that fact have implications on the way in which the aggregate measurable cost savings calculation is used as one cap in the determination of the savings offset payment?

A. Yes, it has significant implications. Private payors and their members pay the savings offset payment, which is derived, in part, from the calculation of aggregate measurable savings. The SOP is supposed to be an offset to savings that have accrued to the benefit of those same private payors. If the aggregate measurable savings calculation calculates 100% of the "savings", but does not take into consideration that a significant portion of those "savings" go to governmental (not private) payors, the private payors will pay an amount of SOP that is greatly exaggerated relative to the calculated savings that actually could have accrued to the benefit of those private payers. This is obviously inequitable and results in private payors subsidizing the savings that have accrued to governmental payors.

Q. Since the arrival of Dirigo, has Anthem BCBS seen reductions in costs below Board-approved rates at hospitals?

A. We have seen reductions in costs at some hospitals for explicit periods of time. For the most part, however, we have not seen reductions but only some slowing of cost increases. In some instances—outpatient costs for example—costs in Maine are actually skyrocketing. For example, the Kaiser Family Foundation tracks outpatient utilization in all 50 states. Maine saw a 31% increase in outpatient utilization between 1999-2006, while the national average was 9% during the same period (www.statehealthfacts.org).

Q. Have hospitals stated that these cost reductions are the result of Dirigo?

A. There have been limited circumstances where hospitals have stated that a reduction in costs was the result of a commitment to manage to the stated cap on operating margin as detailed in the Dirigo legislation. However, in the aggregate, hospital costs have continued to increase during the fourth assessment year.

Q. Have hospitals and provider groups assured you that the full extent of Dirigo-related cost reductions, whatever they may be, are embedded in the negotiated contract rates?

A. Yes. Providers have assured us that, to the extent Dirigo led to any reduction in their costs, those cost reductions are included fully in the negotiated contract rates we pay. For the most part, however, those providers have been unable to give specific accountings of "savings" due to Dirigo.

Q. What has been happening to the rates paid to providers in Maine by Anthem BCBS?

A. The rates paid to providers continue to increase in absolute terms. The rate of increase (*i.e.*, the trend), however, while institution-specific, is about in line with the trend for previous years. Overall, health care costs in Maine remain very high, especially when compared to other states. For example, Anthem Blue Cross and Blue Shield's provider costs in Maine are approximately 10% higher than those in our neighboring state of New Hampshire, and 30% higher than those in Connecticut.

Q. Based on your negotiations with providers, can you identify and quantify the total amount of the reduction in trend that is the result of Dirigo?

A. No. As I stated previously, providers have been unable to give us accountings of the specific reductions in costs that are attributable to Dirigo. Like the providers, we cannot isolate Dirigo from other factors that influence the reduction in trend.

Q. If you know, what factors might affect a provider's costs in any given year?

A. Anthem witnesses Sharon Roberts and Vincent Maffei testified concerning the affects of employment growth and hospital operating margins. In addition to these factors, in my experience, hospital costs fluctuate annually due in part to volume changes. Changes in volume affect unit costs to an extent that is related to the size of the volume changes. Maine has many relatively small hospitals and so is particularly susceptible to changes in volume. Also, changes in the type of care provided (*i.e.*, utilization trends, acuity or mix of services) by a hospital will affect costs. Changes in the supplies or technology needed to deliver care are another cost driver. Should a new treatment require costly technology to administer, hospitals will experience significant changes in their cost structures. This is also true for changes in supplies, pharmaceuticals or overhead. Cost shifting by hospitals from governmental payors to commercial payors, discussed more fully below, can also affect costs.

Q. Does srHS's CMAD methodology for the fourth assessment year adequately control for these non-Dirigo factors that affect cost growth in Maine?

A. Mr. Maffei explains the details in his testimony, but in short, srHS's methodology does not reasonably measure cost savings that are attributable to Dirigo in part because it does not take into consideration several non-Dirigo factors that drive hopsital costs in Maine.

Q. Does cost shifting influence the difference between a hospital's cost increases and their charge increases?

A. Yes. Cost shifting is one of the leading drivers for rate increases in our negotiations with hospitals and physicians. While MaineCare enrollment has increased in

recent years, the overall number of uninsured Mainers has remained relatively constant. For hospitals, it is reasonable to infer that even though the number of uninsured has not changed, their net payments may be reduced to the extent they are trading higher commercial payment rates for lower MaineCare reimbursement. Maine hospitals derive a substantial portion of revenue from governmental payors. This so-called payor-mix adds additional pressure on the remaining commercially insured population as hospitals must cost shift more to offset the reduction in net payments. That is, providers increase the rates they charge to private payors in order to make up for the smaller payments they receive from governmental payors which do not cover the full cost of the services provided.

Q. Has Maine's hospitals' need to cost shift increased as a result of reductions in MaineCare reimbursement?

A. Absolutely. MaineCare and other governmental programs reimburse at less than 100% of the cost of the services provided by the hospital. Accordingly, when a hospital treats governmental payors (*e.g.*, those covered by MaineCare), there are only two choices for the hospital: (1) absorb the losses associated with providing services that are reimbursed at less than 100%; or (2) cost shift the difference to those covered by private insurance. As explained more fully in Ms. Roberts's testimony, either of these options can place the hospital in a worse (not better) position to pass along "savings" that purportedly result from increased revenue from those covered by MaineCare. In fact, in last year's proceeding, the Acting Superintendent determined DHA's and its consultants' failure to account for MaineCare reimbursement cuts to be a significant factor in his decision to trim the $70.6 million in CMAD savings approved by the Board to $25 million. *In re Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Third Assessment Year*, Docket No. INS-07-900, Decision and Order issued September 17, 2007.

Q. **Does srHS's CMAD methodology for the fourth assessment year account for cost shifting from governmental to private payors?**

A. No. In fact, srHS states in its Report that no cost shift occurred during the fourth assessment year or any other Dirigo time period, and thus no adjustment to the CMAD savings figure was necessary. srHS Report at 14-15.

Q. Does this suggestion—that no cost shift occurred—make sense?

A. No, this suggestion makes no sense mathematically. MaineCare's reduced reimbursement shifts costs from governmental payors to the commercially insured population in absolute terms. That is, providers increase rates they charge to private payors in order to make up for the smaller payments they receive from governmental payors which do not cover the full cost of services provided.

Q. Does this conclude your testimony?

A. Yes.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of Vincent Liscomb Jr. was served this day upon the following parties via Electronic Mail.

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Dated: July 9, 2008

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