

Dirigo Health Agency
Board of Directors
Minutes of Meeting - FINAL
August 29, 2005

The Dirigo Health Agency Board of Directors held a meeting on Monday, August 29, 2005. Dr. Robert McAfee, Chair, convened the meeting at approximately 1:15 PM in the Dirigo Health Agency Board Room, located at 211 Water Street in Augusta. Other Board members in attendance: Dana Connors, Mary Henderson, Commissioner Christine Bruenn, Commissioner Rebecca Wyke, Carl Leinonen and Trish Riley. Joining by telephone was Charlene Rydell. Also in attendance: Karynlee Harrington, Executive Director of Dirigo Health Agency and Kirsten Figueroa, Fiscal Operations Director.

Agenda: Meeting is dedicated to the Savings Offset Payment and the work of the SOP workgroup specific to the proposed methodology for calculating aggregate measurable costs savings.

Dr. McAfee opened the meeting and asked Commissioner Bruenn to introduce Ann Gosline. Ms. Gosline is the facilitator who was hired by the Bureau of Insurance to facilitate the SOP workgroup meetings.

Ms. Gosline distributed a hard copy of the Interim Report to the Board (refer to copy of report). Ms. Gosline walked the Board through the report and summarized the following:

- Charge to the Working Group
- Working Group Membership and Process
- Summary of Working Group Process to Date
- Recommended Definition of Paid Claims

Ms. Gosline stated that the workgroup has focused much of its time to date on the charge concerning paid claims and on the methodology for calculating the measurable aggregate cost savings. The workgroup is close to reaching consensus on the definition of paid claims with one outstanding issue specific to out of state claims which is described in the Interim Report. Unfortunately the workgroup did not reach consensus on the methodology for calculating the measurable aggregate cost savings. As such there will be two presentations regarding proposed methodologies for calculating the measurable aggregate cost savings, one from the Dirigo side and one from the Payor side of the workgroup.

Dr. McAfee asked the workgroup who was going to present first. The Dirigo side of the workgroup volunteered. Karynlee Harrington introduced herself as the Executive Director of the Dirigo Health Agency and as a member of the 10-member working group established under Chapter 400, a result of LD1577. Ms. Harrington presentation was on behalf of the Dirigo group. Ms. Harrington provided an overview of the process with the following key points:

- Working group has spent hours working through very complex issues. To date 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.
- 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.
- 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 our 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 Commonwealth 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.
- Workgroup has struggled with 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.
- 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.
- 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.
- 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.
- Savings associated with these voluntary measures 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.
- 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 propose using data that is currently available and 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.

Ms. Harrington distributed to the Board a hard copy of the SOP Methodology Matrix (see attached). She then proceeded to review the document with the Board. Board members asked Ms. Harrington clarification questions as she reviewed the Matrix.

Dr. McAfee asked the Payor side of the workgroup to present their methodology. Dan Roet, Director of Human Resource Services at Bath Iron Works and Frank McGinty, Executive Vice President and Treasurer of Maine Health made the presentation on behalf of the Payor group. Mr. Roet began the presentation with the following points:

- It was also our hope that we would be able to reach a consensus. 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.
- 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.
- 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.
- Payers will categorize their disbursements as a tax on health care payments they make on behalf of their employees. 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.

Mr. Roet turned the presentation over to Mr. McGinty who presented the Payor groups methodologies and the rationale behind the recommendations. Mr. Roet distributed to the Board a hard copy of the Draft Payor Caucus Report to Dirigo Health Board of Directors (refer to attached report). Mr. McGinty then proceeded to review the document with the Board. Board members asked Mr. McGinty clarification questions as he reviewed the Payor Report.

Dr. McAfee thanked the workgroup for their time and commitment to the process and all the information that was provided. Dr. McAfee requested that there be another meeting after Labor Day where both sides would present additional information and answer questions from the Board.

Dr. McAfee opened the meeting to the public. There were various comments and questions asked. The Board responded.

Ms. Harrington will provide for the Board via e-mail guidance from the AG's office regarding process and rules of the road pertaining to the Adjudicatory Hearing. Additionally, Ms. Harrington indicated that she was in the process of securing Mercer for the next Board Meeting and asked if the Payor Group would be able to secure their actuaries for the next meeting.

The next Board Meeting was scheduled for 9/6 at 1:30. In addition, the Board tentatively scheduled a Board Meeting for 9/14 at 11:15.

There were no other comments from the public. There were no other matters discussed. Dr. McAfee motioned, the Board seconded, to adjourn at 4:15PM.