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July 18, 2008

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Dirigo Health Agency  
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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 18, 2008

DOCUMENT TITLE: Anthem Health Plans of Maine, Inc.'s Pre-Hearing Brief

DOCUMENT TYPE: Brief

CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

STATE OF MAINE  
DIRIGO HEALTH AGENCY

IN RE: )  
)  
DETERMINATION OF AGGREGATE ) **ANTHEM HEALTH PLANS**  
MEASURABLE COST SAVINGS FOR ) **OF MAINE, INC.’S PRE-**  
THE FOURTH ASSESSMENT YEAR ) **HEARING BRIEF**  
(2009) )  
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Intervenor Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield (“Anthem BCBS”), by and through its attorneys, files this Pre-Hearing Brief in support of its position in this matter pursuant to the Order on Intervention and Procedures issued by the Board of Directors of the Dirigo Health Agency (“Board”) on May 20, 2008.

For the fourth assessment year, the Dirigo Health Agency (“Agency”) and its consultants propose aggregate measurable cost savings (“AMCS”) from three initiatives: 1) \$147.9 million for cost per Case-Mix Adjusted Discharge (“CMAD”) savings; 2) \$35.7 million for Bad Debt and Charity Care (“BD/CC”) savings and 3) \$6.6 million for Medical Loss Ratio (“MLR”) savings. For reasons detailed herein, the methodologies advanced by the Agency for each of its three initiatives are fatally flawed, do not accurately calculate recoverable AMCS for the fourth assessment year, and thus are not supportable and should be rejected in their entirety.

**INTRODUCTION**

Anthem BCBS fully supports the goals of the Agency and the objectives of the Dirigo Health Act. However, in the interests of its group and individual members, Anthem BCBS is committed to ensuring that the amount of the savings offset payment (“SOP”) reflects no more than the AMCS as defined by the Dirigo Health Act. That is, every dollar of AMCS that is recoverable

by insurance carriers in their negotiations with providers may be fairly assessed to insured members and, as the name implies, “offset” by a dollar of SOP ultimately paid to the Agency. Requiring insurance carriers such as Anthem BCBS, and, in turn, those with private insurance, to pay a SOP that is inflated beyond the actual recoverable AMCS would impose an unfair burden on those with insurance.

## **DISCUSSION**

### **I. Initiative One—CMAD**

For the fourth assessment year, the Agency and its consultant, schramm raleigh Health Strategy (“srHS”), have produced a statistical regression analysis that purports to calculate AMCS. Regression analysis seeks to quantify the relationship of one variable (the dependent variable) to another variable(s) (the independent or explanatory variable(s)). (Allen Dobson, PhD Prefiled Testimony (“Dobson”) at 11.) It is a common tool for hypothesis testing, estimation, and forecasting. (Vincent Maffei Prefiled Testimony (“Maffei”) at 4.) The prefiled testimony of Chamber of Commerce expert Dr. Allen Dobson and Anthem BCBS expert Vincent Maffei provide a fulsome explanation of the purpose of statistical regression and the fundamental requirements for valid regression analysis. In short, however, a properly specified regression analysis will control for all other explanatory variables with the goal of isolating the targeted variable and establishing a statistically significant correlation. In this fundamental objective, the srHS regression methodology fails.

The precise nature of how the srHS CMAD regression analysis works is described in Dr. Dobson’s prefiled testimony at pages 12 and 13 and Chamber Exhibit 2. In summary, srHS undertook the following steps:

Step 1: srHS produced certain regression “coefficients,” which estimate the change in value of the dependent variable (cost per CMAD) in response to a one unit change in one of srHS’s chosen explanatory variables (*e.g.*, “Dirigo,” “Total.Beds,” “Interns.Beds.,” “Days.Medicare,” etc.).<sup>1</sup>

Step 2: Relying on its coefficient projections, srHS calculated a) the estimated cost per CMAD value in the Dirigo (post-SFY 2003) time period, and b) the estimated cost per CMAD value without the Dirigo time period.

Step 3: srHS subtracted the estimated cost per CMAD value with the Dirigo time period from the estimated cost per CMAD value without the Dirigo period to calculate CMAD “savings.”

srHS repeated these steps for three different sets of data, the first set using all fifty states in the U.S. on a hospital-by-hospital basis as the benchmark, and the other two using clusters of states that srHS determined most similar to Maine as the benchmark. For the U.S. hospital analysis, srHS determined savings at \$119.4 million. (srHS Report at 52.) For the clustering analyses, srHS’s projected savings were \$233.4 million for Cluster 1 and \$396.6 million for Cluster 2. (*Id.*) srHS then determined a final savings number of \$147.9 million based on a credibility weighted average of 75% applied to the U.S. hospital model and 25% for the Cluster 1 model. (*Id.* at 53; Steven Schramm Prefiled Testimony (“Schramm”) at 17-18.)

To determine whether srHS’s methodology was a valid tool for calculating AMCS, Dr. Dobson (a PhD in economics with more than 20 years consulting experience in provider payment issues) replicated the methodology to demonstrate its inner workings, ran various tests using the data relied upon by srHS and performed several reality checks with respect to the srHS-recommended savings. (Dobson at 5.) Dr. Dobson’s analysis was reviewed by Mr. Maffei (a former econometrics and statistics professor employed since 1987 as a forecasting and health economics expert at WellPoint), and also Jack Burke (a principal and consulting actuary at

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<sup>1</sup> A full list and description of the explanatory variables chosen by srHS can be found in Mr. Maffei’s prefiled testimony at pages 11-15.

Milliman who testified on behalf of the Maine Association of Health Plans (“MEAHP”) in the Year 3 proceedings). Mr. Maffei and Mr. Burke, in addition to reviewing Dr. Dobson’s work, each examined the srHS model independently.

Based on their review of srHS’s CMAD methodology, Payor Intervenors’ three expert witnesses reached the conclusion, both individually and as a group, that the methodology (and thereby the associated \$147.9 million in CMAD savings) recommended by the Agency and its consultants are fatally flawed, not grounded in sound statistical principles, and must be disregarded. The individual points that make srHS’s methodology invalid are discussed below.<sup>2</sup>

**A. The srHS Methodology Does Not Attempt To Calculate AMCS As A Result Of The Dirigo Health Act.**

In its simplest form, srHS’s model attempts to estimate what the cost per CMAD for Maine hospitals would have been in the “absence” of the variable entitled “Dirigo.” If the estimated cost per CMAD with the Dirigo variable is lower than the estimate of cost per CMAD without the Dirigo variable, srHS asserts that the difference is attributable to the Board-recommended voluntary cost growth limits. It is important to note that despite srHS’s misleading naming convention, the Dirigo variable used in this equation is not the “Dirigo Health Act,” the “Dirigo Health Agency” or any cost limit imposed by the Board. Rather, “Dirigo” is a binary variable that separates the data into two time periods: the period up to and including SFY 2003 and the period after SFY 2003. (Dobson at 22; Maffei at 3; Jack Burke Report (“Burke”) at 2.)

Put differently, as used in the srHS regression analysis, “Dirigo” is simply a pre-Dirigo (SFY 2000-2003) / post-Dirigo (SFY 2004-2007) time trend that applies to all hospitals in the United States. This means that the Dirigo variable (and the critical interaction terms that include the

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<sup>2</sup> The fundamental flaws discussed herein are not inclusive of all the defects identified by Payor Intervenors’ experts which render the srHS CMAD methodology invalid. Additional and complimentary points are presented in the pre-hearing briefs of the other Payor Intervenors.

Dirigo variable) do not have a Maine-specific effect that produces Maine-specific savings as a result of the Dirigo Health Act. Instead, the srHS regression model has the potential to pick up any differences in cost between the two time periods and deem them “Dirigo-related savings” whether the results have anything to do with the Dirigo Health Act or not. (Dobson at 4; Maffei at 29-30.)

To demonstrate this, Dr. Dobson replicated the srHS CMAD regression analysis for all U.S. states other than Maine, using the srHS data and methodology, and found that 29 of 50 states show a “Dirigo savings effect,” with 15 of those states experiencing Dirigo savings similar to or greater than Maine’s. (Dobson at 28-29.) The fact that several states that are clearly not impacted by the Dirigo Health Act demonstrate savings implies that there were strong national forces pushing down cost per case growth in the post-Dirigo time period (2004-2007), and suggests that the savings srHS calculates for Maine as a result of the Dirigo Health Act are instead the result of that national trend and other non-Dirigo phenomena. (*Id.* at 29; Maffei at 29-30; Burke at 3.)

**B. The srHS Methodology Fails To Include Obvious Economic Factors As Explanatory Variables.**

Contrary to suggestions in the srHS Report and supporting prefiled testimony, a regression analysis cannot determine attribution or causal effect. (Dobson at 11; Maffei at 5.) Rather, a regression model can only establish a correlation or association between the dependent variable and the explanatory variable(s), and only then when the model is “properly specified.” (Dobson at 11; Maffei at 5; Burke at 3-4.) For a regression model to be properly specified, the model must include all factors or events that could have an impact on the dependent variable. (Maffei at 5.) Omission of a factor which has an appreciable impact on the dependent variable can lead to biased estimates of the coefficients of the included explanatory variables. (*Id.*) Put differently, if the regression analysis omits factors that are necessary to measure the dependent variable, the analysis will be inherently unreliable. (*Id.*; Dobson at 16.)

There are scores of drivers that can influence a particular state's rate of cost growth when measured on a cost per CMAD basis, including gross state product, employment growth levels, rate regulation, hospital competition, operating margins, insurance competition, hospital owner status, supply of physicians, managed care penetration and hospital physician relations. (Dobson at 8, 15; Maffei at 16-19; Burke at 2). The srHS model does not account for any of these potentially explanatory variables.

For example, employment growth affects cost per CMAD because when employment rates increase, more persons become commercially insured through their new employers, leading to increased hospital revenue and reimbursement at higher rates, as well as less pressure on hospitals to increase charges. (Maffei at 16-19.) The same holds true for operating margins: the higher a hospital's operating margin, the less pressure to increase charges and cost per case should slow. (*Id.* at 19.) As explained in Mr. Maffei's prefiled testimony, after a demonstrable economic downturn, Maine experienced employment growth and increases in hospital margins starting in the period after SFY 2003, which likely affected cost growth in Maine in the post-Dirigo period. (*Id.* at 16-19.) Because the srHS model does not control for these explanatory economic variables, their influences on cost growth are picked up as "Dirigo" savings when they clearly are not. (*Id.* at 19; Dobson at 15.)

srHS's failure to include appropriate economic and financial factors that influence hospital costs renders the CMAD methodology fundamentally flawed and unreliable.

**C. The Key Variables Driving srHS's U.S. Hospital Analysis Are Not Statistically Significant.**

The variables driving the "savings effect" in srHS's U.S. hospital analysis have no statistically significant association with the dependent variable (cost per CMAD). "Statistical significance" means that there is a high probability that the coefficient for a particular explanatory variable or interaction term (*i.e.*, the estimated value change in a dependent variable due to a change

in the explanatory variable) is not the result of random variation. (Maffei at 6.) Because the inherent randomness in numerical measures assures that there will always be at least some spurious correlation between any two variables, a fundamental tenet in regression analysis is to retain in the final model only explanatory variables that demonstrate statistical significance, and exclude variables that are statistically insignificant. (*Id.* at 10; Dobson at 24.) It is proper statistical practice to include an explanatory variable or interaction term in a regression model only if testing indicates that there is less than a 5% chance that the value of the coefficient could have been generated by random variation. If there is a 5% or greater chance that the value of the coefficient could have been generated by random variation, that explanatory variable is deemed to be statistically insignificant (*i.e.*, invalid as a factor that may explain change in the dependent variable), and must be omitted from the final model. (Maffei at 7; Dobson at 24).

In his review of srHS’s methodology, Dr. Dobson determined that the key “Dirigo” / “Maine” interaction terms in the U.S. hospital analysis—“M\*D” and “M\*D\*Y” (the only variables or interaction terms within the srHS model that can implicate savings)—were well below the 95% confidence level standard. (Dobson at 25.) Mr. Maffei confirmed these results, independent from Dr. Dobson. (Maffei at 14-16.) Even Mr. Schramm concedes that the U.S. hospital analysis “is inconclusive about whether the reduction in trend is attributable to Dirigo.” (Schramm at 19.)<sup>3</sup> The lack of statistical significance to the U.S. hospital model’s critical test terms renders the model invalid for purposes of determining AMCS. (*See* Dobson at 26 (“[A]ll of the Maine and Maine / Dirigo related variables have no statistical significance, and therefore, there is no statistically significant Dirigo Health Act impact for Maine.”); Maffei at 14, 15 (opining that the estimated

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<sup>3</sup> That Mr. Schramm agrees with Payor Intervenors’ experts is not surprising. The interpretation of “t statistics” and other standardized output from the regression that indicate statistical significance are not open to subjective judgment. (Maffei at 13.)



coefficients produced by the “M\*D” and “M\*Y\*D” interaction terms are “the result of random variation”).)

**D. The srHS Methodology Fails To Test And Correct For Well-Known Pitfalls Inherent To The Type Of Data Used.**

The srHS regression relies on pooled time series data, as well as cross-sectional data. Autocorrelation (where the error term in one time period influences the error term in the ensuing period) is a common problem in time series data, and researchers using time series data must test for and correct autocorrelation to avoid biased results. (Maffei at 3.) Similarly, heteroskedasticity (where the variance of the error term is typically proportional to the value of the dependant or some explanatory variable) is a common problem in cross-sectional data, which must be tested for and corrected. (*Id.*) It appears that srHS did not test for or make any adjustments to correct autocorrelation or heteroskedasticity. This failure to test for and correct well-known problems inherent to the specific data used casts further doubt over srHS’s methods and renders its conclusions highly speculative.

**E. The srHS Methodology Inappropriately Relies On Non-Random Clustering Data From States With Demographics Not Properly Comparable To Maine.**

The Cluster 1 sample is unusually small with only six states, and those states have significantly disparate socio-economic characteristics that make them an inappropriate benchmark for Maine. (Maffei at 20.) For example, certain of the Cluster 1 states had employment growth that was multiple times higher than Maine during the relevant period (*e.g.*, Utah, Colorado, New Mexico). (*Id.* at 21.) Others differ greatly from Maine in median age (*e.g.*, Maine’s median age is 41; Utah’s is 28). (*Id.* at 21.) The ethnic disparities of the Cluster 1 states also make comparison to Maine inappropriate (Maine is 96% White/Caucasian, while many of the Cluster 1 states have significant minority populations). (*Id.* at 21.) Further, three of the states—one half of the total

sample—are economically and sociologically related, adjacent states in the Southwest (Colorado, New Mexico, Utah). (*Id.* at 21.)

Differences in demographics affect how different states will react to events that generally tend to decrease uninsured rates. For example, insurance rates among minorities are much lower than they are for White/Caucasian populations. (*Id.* at 22.) Additionally, insurance rates among younger age groups are much lower than they are for the older groupings. (*Id.* at 22.) Accordingly, it is likely that Maine (an older, highly White/Caucasian state) would have different responses to socio-economic changes that could affect insured status or commercial insurance costs than states with greater concentrations of minorities and/or younger populations. (*Id.* at 22.) These demographic disparities—which srHS did not control for in its CMAD methodology—make it virtually impossible to determine what role, if any, the Dirigo Health Act played in any cost growth estimate using Cluster 1.

In addition, Cluster 1 was not randomly selected. We are told that srHS chose states where the coefficients of some of the explanatory variables are similar to those in Maine. For a regression to be appropriate for an analysis, the random component (*i.e.*, the error terms) must be “independently and identically distributed.” (*Id.* at 3.) Because srHS selected observations that are similar, the resulting error terms are not independent, making any conclusions about Maine drawn from the Cluster 1 sample unreliable. (*Id.* at 3, 4; Dobson at 32 (noting a “lack of ‘degrees of freedom’” (*i.e.*, not enough independent observations) in the Cluster 1 analysis).)

In its brief, the Agency argues that because a single interaction term in the Cluster 1 analysis (“M\*D\*Y”) is almost statistically significant, the Cluster 1 model is conclusive in establishing that the projected savings are attributable to the Dirigo Health Act. (Agency Br. at 7-8; *see also* Schramm at 19.) What the Agency fails to recognize, however, is that the Cluster 1 sample is invalid as a benchmark not only because of lack of statistical significance but for multiple reasons,

including its mis-specification, the striking demographic differences between Maine and the other cluster states, and the model's failure to include obvious economic factors as explanatory variables. With such a small, biased sample, Cluster 1 is invalid as a benchmark and, as such, the statistics resulting from this biased sample are irrelevant.

The Agency seemingly merges the science of statistics with the burden of proof in this proceeding, stating that the Board is not required to find a 95% likelihood that savings exist in the amount claimed, but rather "the Board need only be convinced that it is more likely than not that the savings exist." (Agency Br. at 7.) Whatever this means, it cannot mean that "savings" that statistically have only a 51% chance of being attributable to the Dirigo Health Act and a 49% chance of being due to random variation are properly included in the Board's AMCS determination. The Board must base its decision on reliable information. To be reliable, statistical and econometric parameters dictate that for this type of regression analysis, the probability that the results were generated by random variation must be no greater than 5%. The Agency's effort to merge these two very different principles (that is, the burden of proof and the standard for a reliable statistical regression) is no more legitimate than its attempt to cure the flaws in its model by blending the results of its invalid U.S. hospital regression with the invalid and biased results of Cluster 1.

**F. srHS's Attempt To Blend The U.S. Hospital And Cluster 1 Analyses Is Inappropriate And Does Not Cure The Analyses' Individual Flaws.**

Cluster 1 cannot be blended with the U.S. hospital sample to create a valid savings calculation. As an initial matter, blending results from two different models is highly unusual. If a researcher has a properly specified model, the results from the larger sample should be used because smaller samples are more prone to biased results. (Maffei at 27.) The U.S. hospital analysis and the Cluster 1 analysis are not data sets where one corrects the flaws in the other, thereby making the blended results stronger than the initial outputs. To the contrary, even if it were appropriate statistical technique to blend two analyses in an attempt to correct deficiencies (which it is not),

rather than offsetting opposite deficiencies, the two analyses are embedded with the same flaws. (*Id.*)

As explained above, both the U.S. hospital analysis and the Cluster 1 analysis failed to remove variables that demonstrate no statistical significance, including the only variables in the srHS regression model that can conceivably measure Dirigo savings (“M\*D\*Y” and “M\*D”). Further, both models failed to include economic variables that are important drivers of health care costs, including employment growth and hospital operating margin. The results srHS produced from blending and weighting the U.S. hospital analysis and the Cluster 1 analysis are no more explanatory or predictive than the fundamentally flawed results those two models exhibited on their own. (*Id.*; Dobson at 17 (“This weighting appears to be arbitrary. Neither of the two models’ key variables related to Dirigo Health Act’s impact in Maine reach statistical significance, and srHS arbitrarily picked a weighting method.”).)

## **II. Initiative Two—BD/CC**

In Maine, reduction in BD/CC can be directly measured by determining how many individuals Dirigo Choice and the Dirigo-related MaineCare expansions are newly insuring. The Agency has utilized, and the Superintendent has approved savings based upon, variations of this direct measurement in the previous assessment years. For this year, however, the Agency and its consultants depart from previous BD/CC methodology to use an approach that measures BD/CC only indirectly by comparing the actual uninsurance rates in Maine to those that were purportedly expected based on a multi-state regression analysis. This new model produces a savings estimate of \$30.3 million, more than six times the amount of savings deemed reasonable last year.

The Agency’s use of a regression analysis in the BD/CC calculation when there exists a proven, direct method of measurement (*i.e.*, determining how many individuals Dirigo Choice and the MaineCare expansions are newly insuring) is nonsensical, and serves only to complicate the

issue and make the Agency's consultants' methods less transparent. Further, the new methodology does not accurately calculate recoverable cost savings due to reductions in bad debt.

For example, the methodology inappropriately includes 2003 in the post-Dirigo time period (in contrast to the CMAD methodology, which uses SFY 2003 in the pre-Dirigo period). This is unreasonable given that the Agency did not begin issuing Dirigo Choice insurance coverage, and the Dirigo Health Act did not authorize the MaineCare expansion, until 2005. (Burke at 7-8; Dobson at 39.) As explained by Mr. Burke, if the srHS methodology was used but with CY 2003 as pre-Dirigo, the savings would drop by approximately 75%, from \$30.2 million to \$7.2 million, consistent with the level of last year's determination. (Burke at 7-8.)

Further, srHS projects the estimate of uninsurance to come down from 10.7% to 9.65% in 2008 by taking the historical rate of decline (from 2003) and assuming it will continue. However, the decrease in trend during that period can be directly explained. The total reduction in Maine's uninsured is 23,924 since 1999 and 16,954 since 2002, with the two big drops coming in 2003 (-12,712) and 2006 (-7,837). (Burke at 8-9.) As explained in Dr. Dobson and Mr. Burke's prefiled testimony, those reductions can be more than accounted for by 1) the MaineCare expansion to cover non-categorical adults (effective October 2002); 2) the MaineCare expansion to parents of children in 2005; and 3) the Dirigo Choice program. (Burke at 8-9; *see also* Dobson at 40.) There has been no significant increase in MaineCare enrollees from 2007 to 2008 and enrollment in Dirigo Choice has actually declined during the measuring period. (Dobson at 40.) Accordingly, srHS's projection of a continued decrease in uninsurance is unwarranted and invalid.

### **III. Initiative Three--MLR**

For the reasons set forth in MEAHP witness Dr. Daniel Fishbein's prefiled testimony, the Board should reject the purported savings related to the Medical Loss Ratio. The premium amounts refunded to certain Aetna policyholders are not savings to the healthcare system and, in any event,

cannot be recovered in Anthem BCBS's contracts with hospitals or physicians because those hospitals and physicians have not experienced any cost decrease as a result of those refunds. Rather, the only individuals affected by the premium refunds are the recipients. Including this amount as part of AMCS ignores the fact that it cannot be recovered and passed through to those who ultimately will pay the SOP.

#### **IV. Recoverability**

Recoverability is not an issue unique to the MLR initiative. Rather, the failure to maintain any link between the calculated AMCS and the amount of cost savings that are actually recoverable permeates all three of the Agency's proposed measures. The Agency goes so far as to suggest that whether and to what extent private payors can recover savings from health care providers is not part of the AMCS hearing process. (Agency Br. at 3.) This is clearly at odds with past precedent and defies logic. In last year's AMCS hearing, the Board adopted Mr. Burke's Uninsured/Underinsured methodology and reduced the savings figure proposed by the Agency because it was "unreasonable to assume that all savings were available to be recovered." (Year 3 Board Decision at 7.) The Superintendent also recognized the fact that cost reductions must be recoverable to be counted. (*See, e.g.*, Year 3 Superintendent Decision ("It is reasonable to assume that hospitals with margins below 1% could not be expected to generate recoverable savings."))

What was true last year is also true this year: simply because a hospital's costs may be reduced does not necessarily mean that hospital is in sufficient financial health to pass along those cost reductions in the form of a reduction in its charges for services. For example, a hospital with a low operating margin is in no position to pass along cost reductions in its provider contracts with carriers. Those cost reductions instead must be used to buoy the hospital's balance sheet to ensure its ongoing financial stability. (*See, e.g.*, Sharon Roberts Prefiled Testimony ("Roberts") at 3-5.)

In addition to the hospital's margin affecting its ability to pass along cost reductions, the source of the hospital's revenues also has an effect. A substantial portion of revenue at Maine hospitals is derived not from private payors, but rather from governmental payors. At many rural hospitals, this amount may exceed 70% of total revenue. (*Id.* at 4.) 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. (*Id.*) As explained more fully in Anthem BCBS witness Sharon Roberts' prefiled 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. (*Id.*) In fact, in last year's proceeding, the Superintendent determined the Agency and its consultants' failure to account for MaineCare reimbursement reductions to be a significant factor in his decision to trim the \$70.6 million in CMAD savings approved by the Board to \$25 million. (*See* Year 3 Superintendent Decision.)

Despite the Board and Superintendent's recognition that not all "savings" are recoverable, none of the Agency's proposed methodologies for Year 4 take recoverability into account. Rather, they simply attempt to measure hospital cost savings; assume that all of those "savings" result in corresponding reductions in the charges paid by private payors; and then attribute all of those "savings" to the operation of Dirigo Health. This is unreasonable, contrary to last year's determinations by the Board and Superintendent, and results in an inaccurate calculation of the actual "savings" to the Maine system.

## V. Overlap

Mr. Schramm suggests that due to changes in this year's methodologies, there is no overlap between the initiatives and therefore no adjustment is necessary. (Schramm at 23-24.) This simply ignores the nature of the CMAD and BD/CC measurements. Any reduction in a hospital's bad debt would in theory reduce the pressure on the cost per case for the remaining, paying customers, and thus is reflected in the CMAD calculation. (Burke at 10.) According to the sources used in the Agency's proposed BD/CC calculation, 66% of uncompensated care is hospital care (the remainder is physicians and community health clinics). (*Id.*) Thus, contrary to Mr. Schramm's suggestion, there is substantial overlap between the CMAD and BD/CC initiatives that srHS does not account for. (*See* Dobson at 44 ("Because the costs, charges and discharges related to the newly insured . . . would necessarily be in the CMAD calculation, the two savings measures are duplicative."); Maffei at 30-31.)

## CONCLUSION

For reasons detailed herein, the methodologies advanced by the Agency for each of its three initiatives are fatally flawed and do not yield an accurate calculation of AMCS for the fourth assessment year. Accordingly, the Board should reject DHA's proposed AMCS in its entirety.

DATED: July 18, 2008

/s/ Christopher T. Roach

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**Certificate of Service**

I, Christopher T. Roach, Esq. certify that the foregoing Anthem Health Plans of Maine, Inc.'s Pre-Hearing Brief was served this day upon the following parties via Electronic Mail.

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