STATE OF MAINE

DIRIGO HEALTH AGENCY

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE FOURTH ASSESSMENT YEAR (2009)	)))))	DIRIGO HEALTH AGENCY'S PRE-HEARING BRIEF

INTRODUCTION

The Dirigo Health Agency ("DHA") submits that the Dirigo initiatives have resulted in aggregate measurable cost savings totaling $190.2 million for the fourth assessment year. (Dirigo Ex. 4.)

This year, DHA's submission is limited to three cost saving initiatives: (1) The Hospital Savings Initiative (also called "CMAD" because it is based on limiting the growth of hospital cost per Case Mix Adjusted Discharge); (2) The Uninsured/Underinsured Initiative (sometimes referred to as Bad Debt and Charity Care); and (3) The Insurer Oversight Initiative. The first two of these initiatives were included in the savings found by the Board and approved by the Superintendent of Insurance in each of the previous three years. The Insurer Oversight Initiative is included for the first time this year because its structure required a three-year review period before results were produced.

The inclusion of just these three initiatives does not suggest that they are the only Dirigo initiatives affecting health care in Maine. As explained in detail in the report of DHA's consultant, schramm-raleigh Health Strategy ("srHS"), Dirigo has made sweeping changes in the Maine health care system to improve cost, quality, and access. (DHA Ex.

2 at 3-9.) DHA's submission is limited to the three initiatives where progress reasonably could be measured based on existing data.

For both the Hospital Savings and Uninsured/Underinsured Initiatives, DHA uses a new statistical methodology this year as suggested in the Superintendent's Year 3 decision. The new methodology is a multi-state, multivariate approach using data from other states, and controlling for non-Dirigo differences between Maine and those other states, to predict what Maine's experience would have been in the absence of Dirigo. This prediction is then compared to Maine's experience with Dirigo to measure savings.

The amount of savings calculated for these two initiatives far exceeds the savings approved in previous years. This reflects the facts that previous determinations understated savings and that Dirigo's effects are continuing to grow as its initiatives advance.

DISCUSSION

I. The Legal Standard Governing this Proceeding

Under the Dirigo Health law, the Board is required to determine not later than August 1 of each year:

> aggregate measurable cost savings, 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 of MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A). This is just the beginning of a process that later results in the determination of a savings offset payment ("SOP") to be paid by insurance carriers and 3rd-party administrators to fund aspects of the Dirigo initiatives. 24-A M.R.S.A. § 6913.

At this early stage in the process, the Board is determining the aggregate measurable cost savings to the health care system. The Board is not determining whether and to what extent the SOP payers have or will recover the savings from health care providers. In other words, the Board is not determining to what extent savings are recoverable. In fact, there is no mention of recoverability in the part of the Dirigo statute that discusses the aggregate measureable cost savings determination. 24-A M.RS.A. § 6913(1). Recoverability is a factor the Board considers later in the statutory process, along with the amount of aggregate measurable cost savings and other factors, when the Board determines the SOP. 24-A M.R.S.A. § 6913(2). Now, the Board is only assessing and quantifying the success of the Dirigo initiatives; it is not determining the implications of that success.

It is well established that aggregate measurable cost savings encompass all savings that are realized through the Dirigo Health law, and not just the savings due to the reduction of bad debt and charity care that are expressly mentioned in § 6913(1)(A). *Maine Ass'n of Health Plans v. Superintendent of Insurance*, 2007 ME 69, ¶ 59. For example, the Law Court has affirmed the Board's previous determination that aggregate measurable cost savings include savings resulting from voluntary reduction in cost increases by hospitals in response to the Dirigo Health law's request for this reduction. *Maine Ass'n of Health Plans*, 2007 ME 69, ¶¶ 8, 24, 58, 59.

The Board's determination of aggregate measureable cost savings is subject to review by the Superintendent of Insurance. 24-A M.R.S.A. § 6913(1)(C). The Superintendent is required to uphold the Board's determination to the extent that it is reasonably supported by evidence in the record. *Id.*; *In re Review of Aggregate*

Measureable Cost Savings Determined by Dirigo Health for the Third Assessment Year, No. INS-07-900, at 1 (BOI, September 17, 2007) ("The Superintendent's Year 3 Decision"). The Superintendent does not have jurisdiction to review questions of law or to interpret the Dirigo Health law. The Superintendent's Year 3 Decision at 5-6. Those determinations are to be made by the Board, subject to judicial review. *Id.*

II. The Savings Initiatives

A. Hospital Savings Initiative (CMAD)

The Dirigo Health law requests hospitals to voluntarily reduce cost increases to meet certain targets. P.L. 2005, Ch. 394, § 4(1)(B). The law specifies that the costs to be restrained are costs "per casemix-adjusted inpatient and volume-adjusted outpatient discharge," also known as CMAD. *Id.* Using CMAD was the product of negotiations with Maine hospitals to find an appropriate benchmark for hospital cost containment. Commission to Study Maine's Hospitals, Report to the Legislature, at 85-87, 100-01 (Feb. 2005). Since the Dirigo Health law was enacted, Maine hospitals have succeeded in reducing cost growth as a direct result of the restraint request. This is not just DHA's contention – the Superintendent concluded in each of the prior years that DHA had established millions of dollars in CMAD savings. *See, e.g.*, The Superintendent's Year 3 Decision at 5. Moreover, Maine hospitals have confirmed that their efforts to comply with the Dirigo targets have reduced cost growth. (DHA Ex. 7.) *See also* Letter to Editor of Steven R. Michaud, President, Maine Hospital Association, Bangor Daily News, 7/5/08, at A10.

The Hospital Savings Initiative for Year 4 has resulted in savings totaling $147.9 million. This figure is arrived at using a different methodology than was used in previous

years. Similar to earlier years, DHA uses a methodology that compares hospital costs under the Dirigo Health law with what those costs would have been absent Dirigo. In past years, DHA calculated what the costs would have been by looking at pre-Dirigo costs and projecting them forward to the year under consideration. The Superintendent approved savings based on this methodology, but cautioned that projections based on pre-Dirigo data alone would become less reliable with the passage of time. The Superintendent's Year 3 Decision at 14. The Superintendent recommended instead a multivariate multi-state analysis, *id.*, which is the methodology DHA uses this year to calculate what costs would have been absent Dirigo.

In this context, a multivariate multi-state analysis involves using statistical modeling techniques – here, multiple regression – to predict what would have happened in Maine by looking at what occurred in other states and then controlling for factors other than Dirigo that distinguish Maine from those states. (Thorpe Pre-Filed Testimony at 2-3.) This type of analysis is often used by health economists to predict what would have happened in one state by modeling from the experience of other states. (DHA Ex. 2 at 11.)

DHA's consultant, srHS, retained renowned health economist Kenneth Thorpe, Ph.D., to work with srHS in developing the statistical models. Dr. Thorpe has three decades of experience with statistical modeling, and his research in this area has been widely published. (Thorpe Pre-Filed Testimony at 1.)

Performing a regression analysis is part science and part art. As Dr. Thorpe notes in his pre-filed testimony, there is no single way to conduct a regression analysis.

(Thorpe Pre-filed Testimony at 5.) For a particular situation, there may be many models that could be used to produce reasonable and reasonably supported results.

In developing a particular model, one of the decisions made by an economist or statistician is the choice of variables. Here, this means the choice of factors affecting cost to include in the model (and control for) so that we can calculate the Dirigo impact. Dr. Thorpe, based on his knowledge and experience, has selected variables that are commonly used by health economists for this type of analysis, such as wages, uninsurance level, payer mix, and demographics. (Thorpe Pre-Filed Testimony at 3.)

Another decision is the selection of states to use for comparison. Modelers might use a national approach, using all 50 states, or might use a clustering approach – selecting a cluster of states based on their similarity to the state under consideration. Both national and cluster approaches have strengths and weaknesses. (Thorpe Pre-Filed Testimony at 4.) Because it contains more observations, a national approach has greater predictive power. (*Id.*) This means that a national approach in our case is better at predicting what costs would have been in Maine. Because it looks at states with similar variables, a clustering approach has greater explanatory power. (*Id.*) Here, that means that a clustering approach better explains the connection between Dirigo and reduced cost growth. DHA's consultants use both approaches, a national approach and an approach using a cluster of states selected because of their similarity to Maine in key factors that influence hospital costs. (*Id.* at 3.) The results then are blended together to take advantage of the benefits of each approach. (*Id*. at 5.)

As they have done in past years, the Intervenors in their pre-filed testimony have made various criticisms of DHA's methodology without offering an alternative

methodology.[1] In a complex analytical area like statistical modeling, particularly one where there are many different reasonable ways to conduct an analysis, it is easy but not particularly constructive to assert that different choices should have been made. It is much more difficult to conduct your own analysis and have the results of those choices open for scrutiny.

After reviewing the critiques of Intervenors' witnesses, DHA's consultants have re-confirmed the reasonableness of DHA's methodology and the accuracy of its savings calculations. Through their oral testimony at the hearing, Dr. Thorpe and Mr. Schramm will rebut the Intervenors' criticisms.

One of the Intervenors' arguments, however, merits discussion at this point. Certain of the Intervenors' witnesses claim that DHA's results should be rejected because they do not meet the customary test for statistical significance used by peer-reviewed journals – a 95% confidence level in the results. (*See* Maffei Pre-Filed Testimony at 7; Dobson Pre-Filed Testimony at 24.) As Mr. Maffei's choice of words reflects, the 95% confidence criterion is a *custom*. It was arbitrarily determined for a context far different from an adjudicatory proceeding. *Kadas v. MCI Systemhouse Corp.*, 255 F.3d 359, 362 (7th Cir. 2001). The standard of proof in this proceeding does not require the Board to find that there is a 95% likelihood that the savings exist in the amount claimed. The Board need only be convinced that it is more likely than not that the savings exist. Thus, it would be quite appropriate for the Board to rely on evidence that has a confidence level of less than 95% as long as the Board finds that the evidence is persuasive. *See id.* at 362. This is particularly true if the evidence is supported by other evidence, as in this

[1] Although not actually proposing an alternative methodology, Maine Association of Health Plans witness Jack Burke does suggest a "rough justice" approach of taking the Superintendent's savings figure from Year 3 and adjusting it slightly for what Mr. Burke asserts is the difference between Years 3 and 4.

case where the hospitals have confirmed the existence of savings and savings have been proven to the satisfaction of the Superintendent in each of the prior years.

Looking at the analysis comparing Maine to the Cluster 1 states, which is the analysis with the most explanatory power, the p-value of the Dirigo variable is .055, just missing the customary level of .050 for statistical significance used for peer-reviewed journals. (Schramm Pre-Filed Testimony at 19.) This means that there is a 94.5% level of confidence[2] that the Dirigo CMAD savings are real, rather than the result of a random coincidence. (*Id.*) It would be absurd for the Board to reject this evidence merely because it has a 94.5% confidence level, rather than 95.0%. *See* Kaye, *Is Proof of Statistical Significance Relevant?*, 61 Wash. L. Rev. 1333, 1345 (Oct. 1986) (explaining that courts should weigh actual magnitudes of p-values in considering evidence instead of rejecting evidence merely because it does not meet the arbitrary statistical significance level).

The Dirigo Hospital Savings Initiative has produced savings, and those savings for Year 4 are reasonably calculated to be $147.9 million.

B. Uninsured/Underinsured Initiative

Savings from reducing costs for which hospitals and other providers are not compensated, either because the hospital or provider offers care out of charity or because the patient fails to pay for care, are savings expressly mentioned in the Dirigo Health law as part of aggregate measureable cost savings. 24-A M.RS.A. § 6913(1)(A). Dirigo generates savings in bad debt and charity care by reducing the ranks of the uninsured and undersinsured through various reforms, including by providing subsidized health insurance through the DirigoChoice product and by expanding MaineCare eligibility.

[2] 1-.055=.945, meaning 94.5%.

For the Uninsured/Underinsured Initiative in Year 4, DHA uses the same sort of multivariate multi-state methodology used for the Hospital Savings Initiative and arrives at a savings amount of $35.7 million. Because of the similarities between the methodologies used for the two initiatives, much of the discussion above applies here as well. Additionally, it should be noted that the Uninsured/Underinsured Initiative savings in Year 4 include savings related not just to those previously uninsured or underinsured who are now covered by DirigoChoice or MaineCare, but also to those who have obtained private insurance coverage because it is more affordable than it would have been without the Dirigo reforms. As noted by srHS, the various Dirigo initiatives have resulted in decreased insurance premium trends and a corresponding increase in the rate of those insured. (Schramm Pre-Filed Testimony at 20-21.)

C. Insurer Oversight Initiative

The final initiative is new this year because this is the first year in which it has produced savings. As part of the Dirigo reforms, the Legislature required increased regulatory oversight over health care premiums and mandated that insurance companies return excess profits to their policyholders. P.L. 2003, Ch. 469, Part E, § E-16. As implicated here, an insurer in the small group market must pay out in claims at least 78% of the premiums the insurer collects measured over a three-year period. 24-A M.R.S.A. § 2808-B(2-C) (setting forth one of two tests insurers may choose). If its claims experience is lower than anticipated, the insurer must refund premiums to its policyholders to bring the ratio of claims-paid to premiums – the Medical Loss Ratio ("MLR") – up to 78%. *Id.* The insurer is not permitted to keep as profit the excess premiums.

Compliance with the MLR restriction is measured over a three-year period. *Id.* Under the Dirigo Health law, the first refunds were required earlier this calendar year when the Aetna Life Insurance Company refunded $6.6 million. (DHA Ex. 2 at 83.)

It is appropriate to include this $6.6 million amount in aggregate measureable cost savings. As the Board has previously found, and as the Law Court has affirmed, all savings resulting from the Dirigo Health law are appropriately included within aggregate measureable cost savings. *Maine Ass'n of Health Plans*, 2007 ME 69, ¶59.

The savings obviously are not recoverable by Aetna. However, as mentioned above, lack of recoverability is not a reason to exclude savings from aggregate measureable cost savings. At this stage, the Board is considering and determining the success of the Dirigo initiatives in causing savings. The premium refund from Aetna is a clear success caused by Dirigo and should be included. Recoverability is an issue for a later proceeding.

D. Overlap Between the Initiatives

As in Year 3, DHA has reviewed the savings calculations to determine whether an adjustment is appropriate to eliminate savings from different initiatives that overlap. Because of the changes in the methodology used this year, there is no overlap and no adjustment is required. (Schramm Pre-Filed Testimony at 23-24.)

CONCLUSION

For the fourth assessment year, the various Dirigo initiatives have resulted in aggregate measurable cost savings of $190.2 million. This figure is arrived at using categories of savings that are appropriately included within aggregate measureable cost savings and using a sound methodology.

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