<pre>
 1   STATE OF MAINE
 2   DIRIGO HEALTH AGENCY
 3
 4
 5
 6   RE: DETERMINATION OF   )
 7   AGGREGATE MEASURABLE   )   PRE-FILED TESTIMONY OF
 8   COST SAVINGS FOR THE FOURTH   )   STEVEN P. SCHRAMM
 9   ASSESSMENT YEAR (2009)   )
10   )
11   )
12
13
</pre>

14   Q: Please state your name, company, and primary business location.

15   A: My name is Steven P. Schramm. I am a Managing Director for

16   **s**chramm▫**r**aleigh **H**ealth **S**trategy (**srHS**). My office is located at 7740

17   East Gelding, Suite 2, Scottsdale, Arizona, 85260.

18

19   Q: Please describe your educational and professional background.

20   A: My educational and professional background is set forth in my curriculum

21   vitae (CV) (DHA Exhibit 1 – Schramm CV). **srHS** is a consulting firm

22   dedicated to helping publicly-sponsored health and welfare programs

23   determine and implement strategies to become more efficient purchasers

24   of health care services. I have been involved in the design, development,

25   implementation, and evaluation of major statewide health care reform

26   initiatives in the states of Arizona, Connecticut, Kansas, Kentucky,

27   Louisiana, Massachusetts, Missouri, New Jersey, New Mexico,

28   Pennsylvania, Tennessee, and here in Maine.

29

30   Q: Please describe generally the work **srHS** did on behalf of the Dirigo Health

31   Agency (DHA).

32   A: We worked with the DHA to determine the initiatives to include in the Year

33   4 Aggregate Measurable Cost Savings (AMCS) report. We then

34   developed methodologies and calculated savings amounts for each of the

35   included initiatives. This process, the methodologies, and calculations are

36   described in the **srHS** Year 4 AMCS report, which is DHA Exhibit 2 – Year

37   4 AMCS Report.

38

39   Q: Have you also provided the supporting documentation for the Year 4

40   AMCS Report?

41   A: Yes. Those are all included in DHA Exhibit 3 – Year 4 AMCS Supporting

42   Documentation.

43

44   Q: Mr. Schramm, are there any changes in the **srHS** Year 4 AMCS Report

45   from what the DHA disclosed on June 2, 2008?

46   A: Yes, there were typographical errors in Appendices F, G, and I of the

47   original report, involving the description of the indicator variables and the

48   column references in the footnotes. Our labeling was inaccurate; for

49   example, we transposed the description of the 0,1 indicators used in the

50   calculations. Correcting the labeling and footnotes does not impact the

51   calculations. These typographical errors have been corrected in DHA

52   Exhibit 2.

53

54   Q: Can you describe **srHS**' overall approach to this project?

55   A: Yes. We followed a multi-step process in approaching the Year 4 AMCS.

56   First, we reviewed the Dirigo Health Reform Act, its amendments, and

57   products of the workgroups and committees created through these Public

58   Laws. We developed a list that included those items that impact the

59   health care marketplace. Section 2 of our report discusses several

60   initiatives that were considered and Appendix B summarizes the initiatives

61   noted in the Public Laws.

62

63   Second, we determined which initiatives should be included in the Year 4

64   AMCS by reviewing the progress of each initiative, whether data could be

65   collected to measure the impact, and whether results could be measured

66   at this time. For example, you'll notice there is quite a bit of detail on the

67   progress that the Maine Quality Forum (MQF) has made in Appendix D of

68   our report. At this time, the Year 4 AMCS does not include these efforts

69   due to a lack of data specific to quantifying the MQF's impact.

70

71   Third, we determined a methodology for each of the initiatives by

72   reviewing prior feedback, performing research to find the most suitable

73   methodologies given the initiative and available data, and consulting with

74   other experts.

75

76   Fourth, we calculated savings for each of the initiatives after collecting

77   data and using the chosen methodology.

78

79   Fifth, we summarized the process and calculations in the Year 4 AMCS

80   report.

81

82 Q: Can you summarize the results of your AMCS calculations for Year 4?

83 A: The results summarized in DHA Exhibit 4 – Year 4 AMCS Savings

84   Estimates are as follows:

85   CMAD Savings $147.9 million

86   BD/CC Savings $ 35.7 million

87   MLR Savings $ 6.6 million

88   Overlap $ 0.0 million

89   Total $190.2 million

90

91 Q: Can you briefly describe these four calculations?

92 A: There are three initiatives for which we calculated savings. The first is

93   Cost per Case-Mix Adjusted Discharge (CMAD) savings. CMAD savings

94   measures the hospital savings achieved due to Dirigo requesting that

95   hospitals limit their rates of cost growth. The second initiative is Bad Debt

96   and Charity Care (BD/CC) savings, which measures reductions achieved

97   as more people become insured due to Dirigo. The third and final initiative

98   is Medical Loss Ratio (MLR) savings, which measures insured member

99   savings achieved due to limits Dirigo placed on insurers' non-medical

100   expenses. In addition to calculating savings from these three initiatives,

101   we looked at whether an adjustment is appropriate for any overlap.

102   Overlap accounts for any double-counting between the three initiatives.

103

104   Q: Did you arrive at these calculations by applying the criteria you described

105   earlier?

106   A: Yes. We reviewed all of the initiatives and determined what stage

107   (developing, implementing, monitoring) the initiative was in, whether data

108   could be collected to measure the impact, and whether results could be

109   determined at this time. If the data were available, we recommend

110   including additional initiatives because Dirigo has had such a broad impact

111   on the health care marketplace in Maine. As data becomes available, we

112   will include additional initiatives in future AMCS determinations.

113

114   Q: Can you discuss the general methodology used for the calculations?

115   A: Yes. The savings associated with Dirigo is essentially the difference

116   between what health expenditures would have been in the absence of

117   Dirigo and what health care expenditures are in the presence of Dirigo.

118   DHA Exhibit 5 – Maine Health Care Expenditures Comparison

119   demonstrates this approach in graphical form.

120

121   Calculating the expenditures in the <u>absence</u> of Dirigo involves estimating

122   what the expenditures would have been if the Dirigo reforms were never

123   implemented. To do this, we relied on information from other states to

124   predict what the expenditures would have been. Statistical models that

125   utilize other states' information were used to predict Maine's trend in the

126   <u>absence</u> of Dirigo, since the states outside of Maine are now better

127   predictors of Maine's trends in the <u>absence</u> of Dirigo. This type of

128   modeling is a new approach for the CMAD and BD/CC calculations this

129   year. Calculating the expenditures in the <u>presence</u> of Dirigo involves

130   using the same statistical models to project expenditures in Maine. These

131   two expenditures, projected expenditures in the <u>absence</u> of Dirigo and in

132   <u>presence</u> of Dirigo, are then compared to determine whether there are

133   savings.

134

135   Q: Mr. Schramm, did you attempt to determine what part of the savings are

136   "recoverable" by the intervenors or what part is appropriate to include in

137   the Savings Offset Payment (SOP) assessment?

138   A: No. The savings figure does not represent the assessment amount as the

139   savings determination is only the first step in a multi-step process. The

140   savings figures provided here are reviewed separately by the Dirigo Board

141   of Trustees (Board) and the Superintendent of Insurance (Superintendent)

142   and once that process has concluded, the Board determines an

143   assessment figure in a separate proceeding. Comparing the savings

144   figure here to the SOP amount that has been assessed in past years is

145   comparing "apples and oranges" from both a methodological as well as a

146   process perspective.

147

148   Q: Mr. Schramm, focusing on the first initiative, can you describe the

149   methodology followed in this year's CMAD calculations?

150   A: The general methodology involved calculating the CMAD savings as the

151   difference between an estimate of what the CMAD would have been in the

152   <u>absence</u> of Dirigo and the CMAD experienced in the <u>presence</u> of Dirigo.

153   The SFY07 CMAD savings per discharge was then multiplied by SFY07

154   discharges to determine total CMAD savings for SFY07.

155

156   This general methodology was followed for each of the prior years' AMCS

157   calculations. The change for Year 4 focuses on the methodology to arrive

158   at the estimated CMAD in the <u>absence</u> of Dirigo. This estimate of what

159   the CMAD would have been in the <u>absence</u> of Dirigo was calculated by

160   trending the pre-Dirigo Maine CMAD by a benchmark trend developed

161   from a multiple regression of other states' CMADs that controls for the

162   impact of non-Dirigo factors on hospital costs. In other words, the

163   resulting savings represents those attributable to Dirigo since other factors

164   are accounted for in the calculation.

165

166   Q: Why wasn't last year's methodology followed?

167 A: As the base time period becomes further removed from the projection time

168   period, the use of Maine's pre-Dirigo trend in the <u>absence</u> of Dirigo

169   becomes less indicative of future trends in the <u>absence</u> of Dirigo. Instead,

170   the multi-state, multivariate approach captures concurrent health care

171   trends in the <u>absence</u> of Dirigo in states other than Maine and adjusts

172   them to reflect changes in non-Dirigo influences on Maine's health care

173   trend. It thus produces a Maine-specific health care benchmark trend in

174   the <u>absence</u> of Dirigo using data from a concurrent time period.

175

176   Multi-state, multivariate models are very powerful tools, but they must

177   have a strong theoretical basis or empirical support for their results to be

178   meaningful. In this instance, it has already been established, through past

179   evidence and rulings by the Board and Superintendent, that there is

180   empirical evidence that Maine hospitals have voluntarily restrained the

181   rate of growth in CMAD as a result of Dirigo. DHA Exhibit 6 – CMAD

182   Comparison shows an example of the deflection in CMAD that the

183   Superintendent confirmed in approving savings in Years 1, 2, and 3. And

184   DHA Exhibit 7 – Maine Medical Center CMAD Reduction is a quote from a

185   representative of Maine Medical Center (MMC), one of the largest

186   hospitals in Maine (MMC represents approximately 20% of hospital

187   discharges in Maine in 2007), describing how much money their voluntary

188   compliance with the CMAD limits has saved the Maine health care

189   system. Thus, the regression models being developed to calculate the

190   benchmark trend in the <u>absence</u> of Dirigo are supported by this evidence.

191

192   If grounded in theory or empirical evidence, regression models become

193   very powerful tools because of their predictive power and the explanatory

194   power. As each regression model can vary, the relative predictive and

195   explanatory powers will vary as well. For CMAD, predictive power can be

196   thought of as the model's overall ability to accurately project CMAD

197   expenditures and explanatory power can be thought of as any one given

198   variable's ability to impact the CMAD value itself. A model that is strong in

199   predictive power may not be as strong in explanatory power and vice

200   versa. This is where a firm grounding in theory or existing evidence

201   becomes essential to help the user to effectively interpret the models'

202   results.

203

204   The Superintendent recommended Dirigo consider a multi-state,

205   multivariate analysis for Year 4 for many of the above stated reasons.

206   After much discussion, research, and review, it was concluded that the

207   multivariate statistical modeling approach was well suited for the SFY07

208   CMAD savings analysis.

209

210 Q: Mr. Schramm, do you know what the savings from the CMAD calculation

211   would have been if last year's methodology was used?

212   A: No. We did not recalculate the CMAD using last year's methodology. We

213   focused our efforts on the new methodology.

214

215   Q: Are the CMAD savings calculated for this year comparable to the savings

216   approved by the Superintendent in prior years?

217   A: No. Fundamentally, the methodology for estimating the benchmark trend

218   has changed. Past years' savings approved by the Superintendent were

219   conservative, proxy estimates as a result of multiple adjustments at the

220   Board and Superintendent level to try to determine savings attributable to

221   Dirigo. This year's methodology allows us to count savings directly

222   attributable to Dirigo, by using regression models that isolate Dirigo's

223   impact, and are not subject to some of the adjustments required in past

224   years' calculations.

225

226   To put this year's savings estimate in perspective, the savings generated

227   by CMAD is a large number; however, it represents less than 1.5 percent

228   of the total statewide health care expenditures. DHA Exhibit 8 – Maine

229   Personal Health Care Expenditures, using 2004 data (the most recent

230   available) trended forward, illustrates this relationship.

231

232   Q: Mr. Schramm, please explain how this new methodology was developed

233   for Year 4 CMAD savings.

234   A: **srHS** assembled a team of experts to assist it and the Dirigo Health

235   Agency develop the methodology to determine if SFY07 CMAD savings

236   existed and if so, how much. As noted in the report, Dr. Ken Thorpe and

237   Sunstone Consulting assisted **srHS** in the design, development, and

238   review of the CMAD methodology. Dr. Thorpe was also engaged to

239   develop the BD/CC methodology.

240

241   The team initially decided upon using a sample of comparison states to

242   develop the benchmark trend. To assist **srHS** in gathering the regression

243   dataset for the comparison states, Dr. Thorpe provided **srHS** with an initial

244   set of recommended regression variables. Dr. Thorpe also provided **srHS**

245   with the type of variables to be used for a clustering analysis to determine

246   the comparison states to be used in developing the benchmark trend.

247

248   Upon review of the dataset developed based on the initial regression

249   variables and the limited number of observations associated with a

250   clustering analysis, Dr. Thorpe also recommended we develop a

251   regression dataset for the entire universe of hospitals in the United States

252   (US), thus eliminating some of the concerns associated with any clustering

253   bias. Comparing the US hospitals and the clusters to Maine for Pre- &

254   Post-Dirigo trends illustrates that Maine's trend reduction was greater

255   (DHA Exhibit 9 – CMAD Pre- v. Post-Dirigo Trend Comparison).

256

257 Q: What do you mean by clustering bias?

258 A: In any regression modeling, there are a series of decision points about the

259   structure of your model and the assumptions within your model. Each of

260   these decision points involves trade-offs that are meant to balance the

261   regression model's predictive capabilities in aggregate with the predictive

262   capabilities attributable to any particular independent variable. In the

263   example of clustering, there are multiple reasonable approaches to

264   clustering that could drive different comparison state clusters. To avoid

265   any appearance of bias, appropriate approaches to clustering must justify

266   the clustering variables chosen and their relationship to the dependent

267   variable in question in order to be valid. In fact, **srHS** developed two

268   cluster analyses using this approach; Cluster 1 is a hierarchical clustering

269   approach using the relationship of states along the initial regression

270   variables, and Cluster 2 is a clustering approach that uses the relationship

271   of states along the initial regression variables as well as some key

272   indicators of the states' health care marketplace. For Cluster 1, we

273   essentially looked at the value of the regression variables, variable-by-

274   variable, and identified the cluster of states that consistently had similar

275   values to Maine. Cluster 2 used a similar approach but also included

276   some higher level comparison variables from the entire health care

277   marketplace in each state. The use of clustering is not without tradeoffs,

278   however, including substantially reducing the number of observations and

279   the possibility of differing clusters. Thus, Dr. Thorpe recommended we

12

280   also complete a regression model based on the universe of hospitals in

281   the US.

282

283 Q: So you used multiple approaches to determine the savings estimates in

284   Appendix G?

285 A: Most certainly, because as I've mentioned previously, there are multiple

286   approaches to any regression modeling. We've chosen a combination of

287   approaches that are reasonable in terms of the development of the

288   methodology, each model's predictive capability, and their explanatory

289   capabilities.

290

291 Q: I would like to direct your attention to DHA Exhibit 10 – Year 4 AMCS

292   Summary of CMAD Calculations. Please describe what this Exhibit is and

293   what it shows.

294 A: This is a table that summarizes our CMAD calculation results. It is

295   contained in Appendix G of our report. Columns I, II, and III in the Exhibit

296   are simple tabulations to determine if savings do exist using the baseline

297   data compiled for the US, Northeast, and Maine. These simple

298   tabulations do not involve any sophisticated modeling techniques and are

299   used to determine if the data warrants further, more sophisticated

300   regression analysis. The first two columns (I and II) express savings using

301   an adjusted historical control method. Using the US and Northeast as

302   control groups, we adjusted for the relationship between their and Maine's

303 pre-Dirigo time period trends and used that as a benchmark for what the

304 trend would have been in Maine in the <u>absence</u> of Dirigo for the post-

305 Dirigo time period. Column III expresses savings using the historical

306 control method. That is, Maine's pre-Dirigo trend is used as a benchmark

307 for what the trend would have been in Maine in the <u>absence</u> of Dirigo in

308 the post-Dirigo time period. The results of the tabulation do show that

309 Maine's post-Dirigo trend reduction is greater than that for the US or the

310 Northeast.

311

312 The last three columns use the more sophisticated multi-state, multivariate

313 regression models that can control for differences among states and have

314 much more accurate predictive and explanatory power in developing the

315 benchmark trend in the <u>absence</u> of Dirigo. Column IV uses US hospital

316 level data to fit a regression model using the independent variables

317 described in the report, which, because it represents the universe of

318 hospital experience in the US, the model will have good predictive power.

319 Columns V and VI use state level aggregated hospital data for two cluster

320 groups of states to fit regression models using the independent variables

321 stated in the report, which, because these states will have been similar to

322 Maine pre-Dirigo, the model will have strong explanatory power. For each

323 of these three columns, savings are calculated by the difference between

324 the fitted values for SFY07 CMAD in the <u>absence</u> of Dirigo versus in the

325 <u>presence</u> of Dirigo.

14

326

327 Q: Mr. Schramm, how were the variables selected to use in the regression

328 analysis for CMAD?

329 A: Dr. Thorpe recommended we use the following variables that are

330 commonly used in hospital cost analyses: teaching intensity, case mix,

331 wage index, number of hospital beds, urban/rural location, mix between

332 types of payors, as well as demographic adjusters. For each of the three

333 regression models, we use the unique combination of these variables that

334 has the greatest predictive and explanatory power as measured by their

335 regression statistics. Again, as each model uses different approaches and

336 datasets, each model will have a slightly different variable set that has the

337 greatest predictive power or explanatory power for that particular

338 approach and dataset.

339

340 Q: Mr. Schramm, what do you mean by predictive power versus explanatory

341 power?

342 A: Health economists use a variety of statistics generated by regression

343 modeling to analyze the strength of the model in establishing the overall

344 predicted relationship between the independent variables and dependent

345 variables and the relative explanatory power of any one independent

346 variable. There are several key statistics to be considered when

347 examining the predictive power of any given regression model:

348   R-squared – Also known as the coefficient of determination, the R-

349   squared statistic measures the proportion of variability in the

350   dependent variable (CMAD) that is explained by the fitted

351   regression model.

352   t-statistic – The t-statistic measures how far from zero the estimated

353   coefficient of an independent variable is. The larger in absolute

354   magnitude the t-statistic is, the stronger the relationship between its

355   associated independent variable and the dependent variable.

356   p-value – The p-value associated with the estimated coefficient of an

357   independent variable is the probability of obtaining a value at least

358   as extreme as the t-statistic that was actually observed, given that

359   the null hypothesis is true. The lower the p-value, the likelier that

360   the null hypothesis (that the true value of the coefficient is non-

361   negative) is false.

362   F-statistic – The F-statistic is used to decide whether the regression model

363   as a whole has statistically significant predictive capability. That is,

364   whether the proportion of variation in the dependent variable is big

365   enough, considering the number of independent variables needed

366   to achieve it.

367

368   We looked at the output from each of the models for these statistics and

369   reviewed each one them and what they told us individually and collectively

370   about each model's predictive and explanatory powers.

371

372   Thus, no single statistic can be used in isolation when considering the

373   results of a regression model, nor can one ignore the impact that the

374   structure of the model itself has on the predictive or explanatory power.

375   As mentioned earlier, the results must be interpreted using existing, sound

376   theories on the relationships being examined or other known facts or

377   considerations; otherwise the results have little or no meaning. In this

378   instance, it has already been established through past proceedings of the

379   Board and Superintendent that Maine hospitals have voluntarily restrained

380   the rate of growth in CMAD as a result of Dirigo. As a result, the

381   regression models being developed to calculate the benchmark trend in

382   the <u>absence</u> of Dirigo are supported by this empirical evidence.

383

384 Q: So what did your regression models, supported by the evidence presented

385   in past AMCS proceedings, determine for CMAD savings for SFY07?

386 A: The savings estimate for SFY07 for CMAD is $147.9 million.

387

388 Q: Mr. Schramm, you've testified that you developed three regression models

389   during your analysis. How were the results of these models combined to

390   determine a single final savings amount for CMAD for SFY07?

391 A: We applied a 75 percent credibility factor to the US-Hospital Level

392   analysis (column IV on DHA Exhibit 10) and a 25 percent credibility factor

393   to the Cluster 1 – State Level analysis (column V on DHA Exhibit 10) and

394 a 0 percent credibility to the Cluster 2 – State Level analysis (column VI on

395 DHA Exhibit 10). The credibility factors reflect the relative strengths and

396 weaknesses of the three models. The US-Hospital Level analysis was

397 accorded 75 percent credibility as it is based on the complete universe of

398 hospital experience and so is not subject to sampling bias. It has strong

399 overall predictive value. The Cluster 1 analysis is accorded 25 percent

400 credibility because while it is derived from the regression variables and

401 thus identifies the comparison states by those that were similar to Maine,

402 (these states should then be excellent indicators of the trend in Maine in

403 the <u>absence</u> of Dirigo for the post-Dirigo time period) it could be

404 considered to be subject to clustering bias. Cluster 2 was accorded 0

405 percent credibility because the final savings estimate, while the highest,

406 was inconsistent with evidence presented in past AMCS proceedings.

407

408 Q: Help us put that in perspective. Can you give us some indication of the

409 relative predictive and explanatory power of your three models?

410 A: Let's look at DHA Exhibit 11 – US Hospital Regression Output. The US-

411 Hospital Level analysis (column IV) has an R-squared of 43 percent.

412 Typical social sciences models with R-squared values above 20 percent

413 are described as having good predictive power, so our US hospital model

414 has good predictive power about what the trend would be in the <u>absence</u>

415 of Dirigo. The t-statistic corresponding to Dirigo is -0.14. Since our

416 hypothesis is that Dirigo has a negative impact on cost per CMAD, for the

417		associated one-tailed t-test, t-statistics less than approximately -1.6 are
418		considered statistically significant at a 5 percent significance level. This
419		means that this model is inconclusive about whether the reduction in trend
420		is attributable to Dirigo, so it is inconclusive in its explanatory power. The
421		p-value attributable to Dirigo is 0.45 (.8916/2 for a one-tailed test). This
422		means that there is a 45 percent chance that the savings attributable to
423		Dirigo are positive and the estimate from the model for savings is \$119.4
424		million.
425		
426		Now let's look at DHA Exhibit 12 – Cluster 1 Regression Output. Cluster 1
427		– State Level analysis (column V) has an R-squared of 98 percent. The t-
428		statistic attributable to Dirigo is -1.64. This means that this model is
429		conclusive – the reduction in trend is attributable to Dirigo and therefore
430		the model has very strong explanatory power in telling us what has
431		impacted CMAD. The p-value attributable to Dirigo is .055 (.1097/2 for a
432		one-tailed test). This means that there is a 95 percent chance that the
433		savings are attributable to Dirigo and the model estimates the savings to
434		be \$233.4 million.
435		
436	Q:	Mr. Schramm, turning now to the second initiative, BD/CC savings, can
437		you describe the basic methodology for calculating the BD/CC savings for
438		Year 4?

439 A: The BD/CC savings reflects the health care expenditures that are no

440   longer "uncompensated" due to the additional people now insured in

441   Maine due to Dirigo. The approach compares the rate of uninsurance in

442   the <u>absence</u> of Dirigo to the rate of uninsurance in the <u>presence</u> of Dirigo.

443   The difference between these rates represents those people now insured

444   due to Dirigo. All of the Dirigo initiatives have contributed to more people

445   being insured now due to the multiple impacts of the reforms. The rate of

446   uninsurance in the <u>absence</u> of Dirigo is estimated several ways in Dr.

447   Thorpe's report (Appendix I of the **srHS** report, DHA Exhibit 2).

448

449 Q: Can you explain why this methodology for calculating BD/CC is different

450   than what was followed in the Year 3 AMCS Report?

451 A: After consulting with Dr. Thorpe and reviewing the research he has done

452   in this area, we decided that the best approach to estimate the

453   uninsurance rate in the <u>absence</u> of Dirigo, was to use a multi-state,

454   multivariate statistical model. As with the CMAD calculation, too many

455   years have gone by since Dirigo was enacted to be able to use pre-Dirigo

456   trends to predict what the uninsurance rate would currently be in Maine in

457   the <u>absence</u> of Dirigo.

458

459   In addition, our approach in last year's report strictly analyzed the

460   expenditures for people now enrolled in the DirigoChoice program or the

461   MaineCare Expansion program. This year, we take a much more global

462		approach because the Dirigo reforms touched all market segments
463		(individual, small, and large group insurance) and decreased the premium
464		trends statewide, making insurance more affordable and therefore, raising
465		the rate of those insured. Refer to DHA Exhibit 13 – Health Insurance
466		Premiums Comparison of Maine and the US, Appendix C in our report,
467		which graphically shows a reduction in the rate of increase of the Maine
468		premiums since Dirigo.
469		
470	Q:	Does that explain why the savings number is so much larger this year,
471		than in prior years?
472	A:	Absolutely. The reason is linked back to the approach and the
473		methodology. We are taking a much more global view in Year 4 by
474		incorporating all of the impacts that Dirigo has had on the marketplace in
475		Maine, since Dirigo has driven down the rate of growth of health care
476		expenditures in Maine. You can see in reviewing Section 2 and
477		Appendices B through D of our report that Dirigo impacted all insurance
478		markets, not just the DirigoChoice and MaineCare Expansion Parents
479		populations.
480		
481	Q:	Mr. Schramm, please explain how this new methodology is a reasonable
482		methodology for Year 4 BD/CC savings.
483	A:	This new methodology calculates the reduction in BD/CC in the total
484		Maine health care marketplace. It uses a multi-state approach that allows

485   us to calculate a Maine uninsurance rate in the <u>absence</u> of Dirigo based

486   on other states. Additionally, using a multivariate model allows us to

487   control for non-Dirigo related changes that may have an impact on the rate

488   of uninsurance. The savings is calculated by using the estimated amount

489   of BD/CC incurred if the additional people insured would have stayed

490   uninsured.

491

492   Q: Is it appropriate to use last year's methodology?

493   A: No. It does not truly reflect the total impact Dirigo has had on the Maine

494   health insurance marketplace. This year's approach is straight-forward

495   and reflects all of the additional people insured in the total Maine health

496   care market due to the multiple efforts of Dirigo. Reducing the number of

497   uninsured in Maine reduces the need for cost-shifting due to BD/CC and

498   results in savings available to the system. Using last year's approach

499   understates the impact of Dirigo on the total health care marketplace and

500   therefore underestimated the total savings available to the system.

501

502   Q: Turning now to the third and final initiative, did your firm calculate the

503   savings associated with the MLR initiative?

504   A: No. The MLR calculation is done by the insurer and submitted to Maine's

505   Bureau of Insurance. The methodology for this calculation involves a

506   comparison of the ratio of medical expenditures over premiums to MLR

507   targets outlined in the Dirigo laws. If the ratio is less than the target,

508   money is paid back (i.e., refunds) to the insured members because the

509   insurer made too much money according to the target.

510

511 Q: Can you explain why the MLR savings were included this year?

512 A: Certainly. The first year that refunds were awarded to insured members

513   due to Dirigo was 2008. These refunds would not have existed if Dirigo

514   was never signed into law because it is the Dirigo Public Law 2003,

515   Chapter 469 (E) that required the insurers to submit this information, the

516   Bureau of Insurance to review it, and the insurers to provide refunds when

517   the targets are not met.

518

519 Q: Mr. Schramm, you mentioned earlier that you looked for overlap between

520   the initiatives. Did you make any adjustments to the savings you

521   calculated for the three initiatives because of overlap?

522 A: No. We determined that no adjustment is needed to account for overlap

523   of the above calculations.

524

525 Q: Last year you recommended an adjustment for overlap. Why did you not

526   make one this year?

527 A: Overlap is directly linked to the methodologies employed by each of the

528   AMCS calculations; if the AMCS methodologies change, the overlap

529   methodology changes.

530

531   Last year's overlap was between CMAD and BD/CC. This year there is no

532   overlap because the BD/CC savings in the Year 4 analysis includes only

533   those costs, charges, and discharges that would have existed in the

534   absence of Dirigo as well as in the presence of Dirigo. Last year's overlap

535   was based on the additional expenditures expected when someone

536   becomes insured – these have not been included in the CY08 BD/CC

537   calculation, so there is no overlap.

538   Q: Do you adopt as part of your testimony the Exhibits you discussed, DHA

539   Exhibits 1 through 13?

540   A: Yes. I do.