



**Consumers for  
AFFORDABLE  
Health Care  
COALITION**

39 Green Street  
Post Office Box 2490  
Augusta, ME 04338-2490

Tel: 207 / 622 – 7045

Fax: 207 / 622 – 7077

E: [consumerhealth@mainecahc.org](mailto:consumerhealth@mainecahc.org)

Web: [www.mainecahc.org](http://www.mainecahc.org)

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*Advocating the right to health care  
for every man, woman and child.*

August 21, 2007

**VIA Hand Delivery**

Eric A. Cioppa, Acting Superintendent of Insurance  
Attn: Vanessa J. Leon  
Docket No. INS 07-900  
Maine Bureau of Insurance  
124 Northern Avenue  
Gardiner, ME 04333-0034

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR  
THE THIRD ASSESSMENT YEAR (2008)

Dear Superintendent Cioppa:

Please find enclosed for filing in the above captioned matter, two (2) copies of the following document from Consumers for Affordable Health Care (CAHC):

**SUBMITTED BY:** Joseph P. Ditré  
Legal Counsel to Consumers for Affordable Health Care

**DATE:** Tuesday, August 21, 2007

**DOCUMENT TITLE:** Intervenor Brief

**DOCUMENT TYPE:** Brief

**CONFIDENTIAL:** No

Thank you for your attention in this matter.

Respectfully submitted,

/s/ Joseph P. Ditré

Joseph P. Ditré, Esq.  
Bar Number 3719

*Counsel to:*  
Consumers for Affordable Health Care  
P.O. Box 2490, 39 Green Street  
Augusta, Maine 04338-2490  
Ph: 207-622-7045  
Fx: 207-622-7077  
Email: [jditre@mainecahc.org](mailto:jditre@mainecahc.org)

Pc: Service List (by US Mail and electronically)

**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION  
BUREAU OF INSURANCE**

IN RE: REVIEW OF AGGREGATE	)	<b>Consumers for Affordable</b>
MEASURABLE COST SAVINGS	)	<b>Health Care</b>
DETERMINED BY DIRIGO HEALTH	)	
FOR THE THIRD ASSESSMENT YEAR (2008)	)	
	)	
Docket No. INS-07-900	)	<b>Intervenor Brief</b>
	)	
	)	

Now comes intervenor, Consumers for Affordable Health Care (“CAHC”), by and through its legal counsel, and hereby files its Intervenor Brief in accordance with the Superintendent’s August 7, 2007 Order on Intervention and Procedures, sections I and II.

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Introduction

An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs, commonly referred to as the Dirigo Health Act, P.L. 2003, Ch. 469, as amended by P.L. 2005, Ch. 400 (“the Act”), established the Dirigo Health Board to sponsor affordable, comprehensive health care for low-income Maine citizens and small businesses with subsidies coming from annual assessments on insurers and third party administrators based on savings determined by the Board from initiatives to reduce costs in the health care system. The Act provides for the subsidies to be established through three distinct administrative stages: *first*, the Board each year determines the “aggregate measurable cost savings” in the health care system attributable to Dirigo Initiatives; *second*, that determination is subject to review by the Superintendent as to whether the savings found by the Board are reasonably supported by the

evidence in the record; and *third*, the Board establishes a “savings offset payment” (“SOP”) to be assessed against insurers and third party administrators that may not exceed 4% of paid claims or the aggregate measurable cost savings as approved by the Superintendent. The SOP is then used to subsidize Dirigo insurance for income eligible enrollees. We are at the second stage of the process.

The Dirigo Health Agency (“DHA”) submitted its estimate and methodology for calculating the Aggregated Measurable Cost Savings (“AMCS”). DHA’s estimate totaled \$92.7 million. R. at P5357. DHA’s estimate was later amended to \$88.4 million. R. at P5358. The methodology used was conservative and applied the recommendations of the Superintendent of Insurance and the intervenors from the two previous year’s proceedings. DHA’s Year 3 AMCS includes three initiatives: (1) Hospital Savings Initiative (Case Mix Adjusted Discharges); (2) Uninsured/Underinsured Initiative (Bad Debt and Charity Care); and (3) Provider Fee Initiative (hospital Prospective Interim Payments (“PIPs”) and physician reimbursement). Moreover, in order to reduce any possibility of overlap between these initiatives, srHS calculated and reduced the estimated savings by \$4 million.

The Dirigo Health Agency Board of Directors determined the AMCS in the amount of \$78,143,400 for the 3<sup>rd</sup> assessment year. The components of the determinations were CMAD at \$70.6 million; Uninsured/Underinsured at \$6,343,400; and Health Care Provider Fee at \$5.2 million. The Board reduced the total savings by \$4.0 million as a result of overlap between CMAD and the Uninsured/Underinsured initiatives.

#### Statutory Authority and Legal Standards

P.L. 2003, Ch. 469, as amended by P.L. 2007, Ch. 240 and P.L. 2007, Ch. 447, provides the Dirigo Health Agency Board of Trustees with the authority to determine the aggregate measurable costs savings.

**Determination of cost savings.** The following are the procedures for determining cost savings. A. After an opportunity for a hearing conducted pursuant to Title 5, chapter 375,

subchapter 4, the board shall determine annually not later than August 1st the 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 in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. §6913(1)

The Board's determination of AMCS is reviewed by the Superintendent of Insurance. 24-A M.R.S.A. § 6913(1)(C). The Superintendent will uphold the Board's determination as long as it is reasonably supported by evidence in the record. *Id.*; *In re Review of AMCS Determined by Dirigo Health for the Second Assessment Year*, No. INS-06-900, at 2 (Bureau of Insurance, July 21, 2006) ("Superintendent's Year 2 Decision"). In the Superintendent's Year 2 decision, he stated:

"The Superintendent has interpreted "reasonably supported by the evidence" to refer to the totality of the evidence and not to any part of the evidence taken out of context. Second Procedural Order. "Reasonably supported" is not a preponderance-of-the-evidence standard. *Id.* **If more than one alternative for determining aggregate measurable cost savings could be reasonably supported by the evidence, Dirigo does not have to prove that its chosen alternative is more reasonable or better supported than another alternative.** The Superintendent's statutory responsibility in this proceeding is limited to determining whether the "aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record." P.L. 2005, ch. 400, § B-2(2)(B); 24-A M.R.S.A. § 6913(1)(C). In making his decision, the Superintendent has the authority to "issue an order approving, in whole or in part, or disapproving the filing." *Id.* (Bold added)

As the Superintendent said, if there is more than one alternative for determining the savings, Dirigo does not have to prove that its chosen alternative is more reasonable or better supported than another alternative. For example, despite the fact that a calculation error was made regarding Franklin Memorial Hospital expenses, which were categorized as ER activities instead of health clinic activities, and therefore corrected during the hearing process, it does not mean that a different or alternative methodology is needed.

### Discussion

#### **A. Hospital Savings Initiative (CMAD)**

P.L. 2005, Ch. 394, §4 established voluntary restraints to control the rate of growth of hospital costs in Maine.

- 1. Voluntary restraint.** To control the rate of growth of the costs of hospital services, the Legislature requests that each hospital licensed under the Maine Revised Statutes, Title 22, chapter 405 voluntarily restrain cost increases and consolidated operating margins in accordance with this section. The targets and methodology apply to each hospital's fiscal year beginning on or after July 1, 2005 and remain in effect through the end of each hospital's fiscal year beginning on or after July 1, 2007.

The Hospital Savings Initiative captures savings resulting from the hospitals' voluntary reduction of cost increases in response to recommendations made by the Commission to Study Maine's Hospitals, a commission created by the original Dirigo Health Act, and reflected in LD 1673 (An Act To Implement Certain Recommendations of the Commission To Study Maine's Community Hospitals) and enacted as P.L. 2005, Ch. 394. This initiative was included in DHA's estimates and methodologies, accepted by the Board, and approved by the Superintendent in both Years 1 and 2.

The Hospital Savings Initiative for Year 3 produced measurable savings totaling \$70.6 million. The Board reduced the DHA calculation of \$74.9 million to \$70.6 million to correct the error mentioned above regarding the Franklin Memorial Hospital expenses. The Year 3 methodology was revised to address concerns by the Board in Year 2 and by applying recommendations from Superintendent's Year 2 Decision. But for the Board's choice of the median in Year 2 rather than the preferred geometric mean, the Year 3 savings totaling \$70.6 million figure are in line with those that were calculated by Mercer in Year 2. As noted by the Superintendent in his Year 2 decision, the median is a poor measure of central tendency. As provided in Draft Payor Caucus Report to Dirigo Health Board of Directors Re: the Measurement of Savings under the Dirigo Health Initiatives (08-24-05 Draft), the Payor Group (representing many intervenors in the immediate proceeding) stated a clear preference for the geometric mean. R. at 5677.

The Dirigo Board specifically considered this issue and cited it as an important consideration in reducing the CMAD-related savings estimate. The \$14.5 million savings estimate adopted by the Board resulted from a calculation that replaced the actual observed growth over the baseline period, annualized by taking the geometric mean, as proposed by Mercer, with the median annual rate of growth over the same period. This reduced the growth rate used from 6.9% to 4.7%. Dirigo attributed this decision to consideration of the baseline rate of growth that results when the 2002 growth rate is left in the base, and to other

issues that were raised about the CMAD estimate. The use of the median as a measure of central tendency is sometimes desirable when data contains outlier values, such as those in 2002. However, the median may be a poorer measure of central tendency when measured from only three data points. In this instance, evidence in the record supports the conclusion that use of the median likely represents a conservatively low choice for the calculation. As noted by the Board in its deliberations and discussed here, the choice of the median rather than the mean produces a lower number, and this conservatism offsets (and was intended by the Board to offset) several other issues raised by the intervenors.

Superintendent's Year 2 Decision, R. at P2981.

During the Board's deliberation on July 26, 2007, Dr. McAfee stated:

The whole matter of the mean, the median you have heard. IT was an issue before us last year and we chose the median. It was interpreted as rough justice, but I think it was made because of the realization that there was a substantial presentation made to us indicating the vast changes that occur when one uses one or the other. On the other hand this year, we have heard testimony from a variety of sources that the mean –including the superintendent, that the mean is a far more accurate term and that it might be the preferred method as we look at that methodology.” R. at P567.

The issues that concerned the Board in Year 2 were addressed and eliminated in Year 3, so there was no need for the Board to apply an inaccurate projection measurement that would have resulted in an artificially low savings calculation. srHS has accounted for the effects of the hospital tax and cost-based reimbursement in the Year 3 savings calculation. As srHS's analysis shows, the cost growth in 2002 was not anomalous. Costs rose after the 2002 and ignoring 2002 would have resulted in an inaccurate trend projection.

#### **B. Uninsured/Underinsured Initiative**

The Uninsured/Underinsured Initiative used a new methodology in Year 3 based on the one unanimous recommendation of the BDCC Working Group – use actual claim data. Using actual claims experience of those insured by Dirigo or through the MaineCare expansion, DHA captured the savings for bad debt and charity care by measuring the new money that is paid into the health

care system for what would otherwise be bad debt or charity care. Although there was and is disagreement over details, claim used was preferred to that used in Years 1 and 2. DHA's consultant has calculated savings for this initiative at \$10.3 million for those now insured by Dirigo and \$3.7 million for those now in MaineCare through the parents expansion, for a total of \$14 million. The Board reduced the \$14 million by \$7.7 million, a 55% reduction, to \$6.3 million. The Board did not provide a calculation that explained how they arrived at such a huge reduction. While the Board identified concerns with pharmacy costs, utilization, corporate pharmacies, and more physicians working for hospitals as reasons behind the reduction, they did not quantify those reductions in any way.

### **C. Provider Fee Initiative**

The Provider Fee Initiative produced savings due to the State increasing MaineCare hospital PIPs and physician reimbursement. The Commission to Study Maine's Hospitals, established by the Dirigo Health law, recommended earlier reimbursement to hospitals and increased reimbursement to physicians. By receiving reimbursement three years prior to when they otherwise would have, hospitals benefit from the time value of the money. The Board reduced the savings calculated by srHS for Year 3 down from \$3.7 million for PIPs and \$4.1 million for physician fee increases, for a total of \$7.8 million to \$3.7 million for PIPs and \$1.5 million for physician fee increases, for a total of \$5.2 million.

### **D. Overlap**

SrHS reduced the total cost savings of by \$4.0 million to reflect overlap between the CMAD initiative and the uninsured and underinsured initiative. The \$4.0 million figure was based on a series of calculations that reflected the number of discharges of DirigoChoice enrollees on an inpatient and outpatient basis multiplied by the adjusted charge per discharge. R. at P3301 – P3302. In order to *increase* the overlap value, in other words increase the amount by which the overall savings were reduced, srHS used the low end of the range for charge per discharge for DirigoChoice

enrollees, which was derived by taking the mean charge per discharge and subtracting two standard deviations from the mean. R at P3302. This process produced a reduction in the overall savings that was four times higher than if srHS has simply used the mean. Had srHS used the mean charge per discharge (\$6,410) rather than the charge per discharge two standard deviations from the mean (\$6,419) the reduction (i.e., the overlap) would have been \$1,003,797 rather than \$3,970,089. R. at P3323.

The Board disagreed with the uninsured and underinsured savings amount. They reduced it from \$14 million to \$6.3 million. However, the board failed to reduce the overlap (\$4 million) associated with the higher \$14 million uninsured/underinsured calculation to proportionately reflect their 55% reduction down to \$6.3 million. If the reduction in uninsured and underinsured resulted in a dollar-for-dollar effect on the overlap, the overlap, that solely reflected the overlap between the CMAD and uninsured/underinsured initiatives, should have been reduced by 55% or \$2.2 million. In other words, the savings should be increased by \$2.2 million to reflect a total savings of \$80,343,400.

While Board member Ed David identified his concern with taking the full \$4 million in overlap without proportionately reducing it to reflect the reductions made in physician fee and PIP payments, which were not part of the overlap calculation, he had the right idea. Dr. David said:

If, in the overlap, there were these designations regarding the PIP and the physician payment and if we had adopted a lower number in part based on the reasoning which appears to go into that, should the overlap number be diminished reflecting that so that it's no longer four but say three. I can't do the arithmetic, but that's a question I have of my three fellow board members.

R. at P611.

In essence, the board committed error of law by failing to proportionately reduce the overlap calculation (\$4 million) that had been based on a higher uninsured/underinsured savings amount (\$14 million) once they had reduced the uninsured/underinsured savings (\$6.3 million).

## CONCLUSION

The estimate and methodology determined by DHA Board were reasonable except for their failure to proportionately reduce the overlap to reflect the lower savings amount of the uninsured/underinsured initiative. CAHC respectfully requests that the Superintendent determine that AMCS for Year 3 totals \$80,343,400.

Dated: August 21, 2007

Respectfully submitted,

/s/ Joseph P. Ditré

Joseph P. Ditré, Esq.  
Counsel for  
Consumers for Affordable Health Care

**CERTIFICATE OF SERVICE**

**Docket No. INS-07-900**

I, Joseph P. Ditré, counsel for Consumers for Affordable Health Care, hereby certify that on this date I caused to be served via U.S. Mail and electronic mail, as noted below, a copy of the foregoing **“Consumers for Affordable Health Care Intervenor Brief”** in the REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE THIRD ASSESSMENT YEAR (2008) as follows:

**Two (2) hard copies via hand delivery and one identical electronic copy addressed to:**

Eric A. Cioppa, Acting Superintendent of Insurance  
Attn: Vanessa Leon, Docket No. INS-07-900  
Bureau of Insurance  
124 Northern Avenue  
Gardiner, Maine 04333-0034  
Email address: [Vanessa.J.Leon@maine.gov](mailto:Vanessa.J.Leon@maine.gov)

**One (1) hard copy via U.S.Mail and one identical electronic copy addressed to:**

Thomas C. Sturtevant, Jr.  
Assistant Attorney General  
#6 State House Station  
Augusta, Maine 04333-0006  
Email address: [Tom.Sturtevant@maine.gov](mailto:Tom.Sturtevant@maine.gov) and [Jennifer.Willis@maine.gov](mailto:Jennifer.Willis@maine.gov)  
And [William.Laubenstein@maine.gov](mailto:William.Laubenstein@maine.gov)

**One (1) hard copy via U.S.Mail and one identical electronic copy addressed to:**

Compass Health Analytics, Inc.  
Attn: John Kelly  
477 Congress Street, 7<sup>th</sup> Floor  
Portland, Maine 04101  
Email address: [jck@compass-inc.com](mailto:jck@compass-inc.com) and [jh@compass-inc.com](mailto:jh@compass-inc.com)

**One (1) hard copy via U.S.Mail and one identical electronic copy addressed to each of the following parties to the proceeding:**

**Counsel for Dirigo Health Agency**

Michael J. Colleran, Assistant Attorney General  
Office of the Attorney General  
6 State House Station  
Augusta, Maine 04333-0006  
Email address: [michael.colleran@maine.gov](mailto:michael.colleran@maine.gov)

**Counsel for the Maine Automobile Dealers Association Insurance Trust**

Roy T. Pierce  
Preti Flaherty, Beliveau & Pachios, LLP  
45 Memorial Circle PO Box 1058  
Augusta, Maine 04332-1058  
Email address: [rpierce@preti.com](mailto:rpierce@preti.com)

**Counsel for the Maine State Chamber of Commerce**

William H. Stiles, Esq.  
Verrill Dana LLP  
P.O. Box 586 One Portland Square  
Portland, Maine 04112-0586  
Email address: [wstiles@verrilldana.com](mailto:wstiles@verrilldana.com)

**Counsel to the Maine Association of Health Plans**

D. Michael Frink, Esq.  
Curtis, Thaxter, Stevens, Broder & Micoleau, LLC  
One Canal Plaza P.O. Box 7320  
Portland, Maine 04112-7320  
Email address: [mfrink@curtisthaxter.com](mailto:mfrink@curtisthaxter.com)

Dated: August 21, 2007

Respectfully submitted,

/s/ Joseph P. Ditre  
Joseph P. Ditré, Esq.

*Counsel for*  
Consumers for Affordable Health Care  
P.O. Box 2490  
Augusta, Maine 04338-2490  
Ph: 207-622-7045  
Fx: 207-622-7077  
Email: [jditre@mainecahc.org](mailto:jditre@mainecahc.org)