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VIA HAND DELIVERY AND ELECTRONIC MAIL

Mila Kofman, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-08-900
Bureau of Insurance
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FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: September 5, 2008
DOCUMENT TITLE: Pre-Hearing Reply Brief of Anthem Health Plans of Maine, Inc.
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Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

Christopher T. Roach

cc: Service List Attached

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

Docket No. INS-08-900

**IN RE: REVIEW OF AGGREGATE MEASURABLE
COST SAVINGS DETERMINED BY DIRIGO HEALTH
FOR THE FOURTH ASSESSMENT YEAR**

**PRE-HEARING REPLY BRIEF OF
ANTHEM HEALTH PLANS OF MAINE, INC.**

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After reading the Pre-Hearing Brief of the Board of Directors of the Dirigo Health Agency (“Dirigo Brief”), it becomes clear why the Board spent the first four pages attempting to minimize the review to be performed by the Superintendent. Running full speed away from the testimony of all of the experts—including those from the Dirigo Health Agency (“DHA” or “Agency”)—and indeed from the plain language of its own decision and deliberations, the Board in its brief (1) relies on circular logic to “support” its CMAD calculation while relegating to obsolescence the statistical principles upon which the savings are actually based; (2) ignores the fact that Board members selected the “pre-Dirigo Maine model” (for which no testimony was offered at hearing) for Bad Debt and Charity Care (“BD/CC”) savings solely to compromise on a number; and (3) actually touts as consistent the fact that the Medical Loss Ratio (“MLR”) “savings” are not recoverable, while ignoring the reality that if the MLR is approved, those with private insurance will pay \$6.6 million more than they possibly could have received in savings realized through the Dirigo Health Act. And they do so while arguing forcefully that the Superintendent has no authority to do anything about it. That has never been the case in any of the previous three assessment years and it is not so here. As any meaningful review reveals, the three initiatives approved by the Board simply do not provide valid aggregate measurable cost savings (“AMCS”) and must be rejected.

I. The Dirigo Brief Ignores The Board’s Own Findings: The Board Explicitly Rejected The Cluster Regression Models And Adopted The U.S. Hospital Regression Model.

After reminding the Superintendent that DHA produced three regression models, the Dirigo Brief remarkably invents a logic for the Board’s decision that is missing from the decision itself: “The amount of savings determined by the Board was based on a conservative decision to use the lowest results of the three models, the \$119.4 million from the U.S. model, without

blending.” (Dirigo Brief at 6-7.) The record and decision by the Board reflect that this simply did not occur.

The record instead reflects that the DHA witnesses themselves rejected the Cluster 2 regression’s projection of more than \$396 million in savings as unreliable and way beyond the bounds of reason. (*See* Schramm Hearing Testimony at 228:22-25 (AR Tab 2-60) (acknowledging that Cluster 2 was “discarded because it was so out of bounds with prior calculations”); Schramm Prefiled Testimony at 18 (AR Tab 1-16) (“Cluster 2 was accorded 0 percent credibility because the final savings estimate . . . was inconsistent with evidence presented in past AMCS proceedings.”).)

The Board was presented with extensive testimony concerning the Cluster 1 regression’s small number of observations, clustering bias and dissimilarities to Maine. (*See, e.g.*, Maffei Prefiled Testimony at 20 (AR Tab 1-27) (explaining that 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); Dobson Prefiled Testimony at 32 (AR Tab 1-35) (noting a “lack of ‘degrees of freedom’” (*i.e.*, not enough independent observations) in the Cluster 1 analysis).)¹ Apparently heeding this undisputed testimony, the Board explicitly rejected the Cluster 1 regression model because the states within the cluster were so dissimilar to Maine. (Year 4 Board Decision at 8 (“The Board is not persuaded that Cluster 1 tracks Maine”); *see also* Year 4 Board Deliberations at 29:24-30:3 (AR Tab 3-62) (Board member Beal: “I have real problems with the clusters because they are inherently selecting a sample smaller than

¹ Even DHA’s experts were concerned that the results of Cluster 1 may be unreliable due to “clustering bias.” (Schramm Hearing Testimony at 231:5-10 (AR Tab 2-60) (“Dr. Thorpe recommended that we do the U.S. hospital analysis because . . . there is a phenomenon known as clustering bias, and the concern is that by picking a particular subset of states, you are not necessarily getting a good match.”); Schramm Prefiled Testimony at 11 (AR Tab 1-16) (“Upon review of the dataset developed based on the . . . clustering analysis, Dr. Thorpe also recommended we develop a regression dataset for . . . the United States (US), thus eliminating some of the concerns associated with any clustering bias.”).)

the totality.”.) Thus, contrary to the Dirigo Brief, the Board did not find that DHA presented three valid models from which the Board then simply selected the one with the lowest (*i.e.*, most conservative) calculation of CMAD savings, but rather (1) affirmatively rejected the Cluster 1 and Cluster 2 regression models, and (2) affirmatively adopted the U.S. hospital regression model alone. (*See* Year 4 Board Deliberations at 55:17-23 (AR Tab 3-62) (Board member David noting for the record that the Board’s determination of \$119.4 million in CMAD savings was based on “adopting the United States [model] . . . as opposed to just a number”).) In an effort to support the U.S. hospital regression (which DHA’s own experts admit is “inconclusive” and unreliable), it is perhaps understandable why the Board’s counsel attempts to revive the cluster models. The plain fact, however, is that the Board rejected both clustering analyses, and also determined any “blending” of the three regression models to be “arbitrary and not supported by the evidence.” (Year 4 Board Decision at 8.) It is thus clear that the Board did not rely on either cluster regression, and any suggestion otherwise is simply a *post hoc* attempt to rewrite the record now before the Superintendent.

We turn next to the non-statistical “evidence” the Dirigo Brief trumpets as corroborative of the Board’s CMAD determination, which may be summarized as follows: (1) there must be CMAD savings because the Superintendent found such savings in the past (Dirigo Brief at 5); (2) there exists anecdotal evidence that one hospital reduced its COM during the Dirigo period (*id.* at 6); and (3) “the observed CMAD data clearly shows a dramatic reduction in CMAD growth rate from the pre-Dirigo to the post Dirigo period” (*Id.*) Each is discussed in turn.

First, suggesting that there must be CMAD savings this year because such savings were approved in the past is at best circular, but even less convincing when juxtaposed with the Board’s refusal to acknowledge that the Superintendent’s prior determinations provide a

reasonableness or “sanity” check on the results. Put differently, suggesting that prior years’ CMAD determinations are conclusive that CMAD savings exist in Year 4, but are wholly invalid as a sanity check is, at best, inconsistent.

Second, relying on an anecdotal report from one hospital that purportedly reduced its COM due to Dirigo hardly supports the \$119.4 million in CMAD savings produced by the U.S. hospital regression analysis and adopted by the DHA Board. The sum and substance of this “evidence” consists of Maine Medical Center’s claim that it saved \$40 million over three years due to a reduction in operating margin, a Dirigo initiative that none of DHA’s methodologies have even attempted to measure in Year 4. (*See* AR Tab 4-69.) In fact, it is telling that no other hospital came forward to proclaim “us too” following this announcement. Mr. Schramm acknowledged that they conducted no interviews or surveys of any hospitals, nor did they attempt to contact any Maine provider to determine whether any experienced savings related in any way to the Dirigo Health Reform Act, and if so in what amount, or even to determine the order of magnitude of the “savings.” (*See* Schramm Hearing Testimony at 143:6-11 (AR Tab 2-60).)

Third, the Dirigo Brief’s steadfast reliance on the pre-Dirigo versus post-Dirigo cost growth is puzzling. The Board did not include this as support for adopting the U.S. hospital regression output, perhaps because the whole purpose of attempting to develop the multivariate multi-state regression was to address the Superintendent’s concerns about the lack of reliability/credibility of using the pre-Dirigo cost growth as a projection methodology from which AMCS may be calculated. The Superintendent’s clear admonitions apparently bear repeating:

the passage of time makes the failure to control for other factors affecting costs increasingly problematic for the method, and at the same time makes other methods

which control for these factors, such as multi-variate multi-state analyses, more feasible. The cost per CMAD method will soon reach the point at which its drawbacks prevent it from producing reasonably supported findings. While small random fluctuations in cost will occur in any year, the more serious threats to the persuasive power of this method would be raised by specific, additional credible explanations for the pattern of slower cost growth post-Dirigo.

(AMCS Year 3 Decision and Order dated September 17, 2007, Docket No. INS-07-900, at 12; *see also id.* at 9 (“Time both diminishes the relevance of the available pre-Dirigo historical data and assigns an increasingly disproportionate dollar value to small variations in the trend rate chosen to project forward from 2003.”).) Indeed, Board Chairman McAfee acknowledged in the Board’s deliberations that the “reason [the regression approach] was suggested in the first place was that to continue the old methodology gets quite far away from the base years we were using to identify savings.” (Year 4 Board Deliberations at 20:10-13 (AR Tab 3-62).)

In summary, the DHA Board very clearly (1) determined to use a regression analysis to support CMAD savings in this Year 4 proceeding; (2) affirmatively rejected the Cluster 1 and Cluster 2 regression models; (3) concluded that any blending of the three regression models was arbitrary and not supported by the record; and (4) adopted the U.S. hospital regression model as the sole regression model supporting Year 4 CMAD savings. No amount of backtracking at this point can change the fact that the Board has relied upon a single regression model that all of the experts agreed cannot be relied upon to calculate CMAD savings accurately.

II. The Dirigo Brief Ignores The Fact That The U.S. Hospital Regression Relies On A Comparison Of Pre-Dirigo And Post-Dirigo Cost Growth.

Each of the intervenors pointed out in their principal briefs that one of the flaws in the DHA regressions is their continued reliance on pre-Dirigo cost growth as indicative of post-Dirigo cost growth in the absence of Dirigo. (*See, e.g.*, Anthem BCBS Pre-Hearing Brief at 10; Chamber Pre-Hearing Brief at 22-24.) Indeed, the national data reflect that the Superintendent’s concerns with the use of this old data to project future cost per CMAD growth were well-

founded. (*See, e.g.*, srHS Report at 54, Table A (AR Tab 1-10 (CD)) (demonstrating significant cost growth reductions post-2003 all across the nation and cost growth in Maine post-Dirigo exceeding cost growth for the Northeast and the U.S. overall); *see also* Thorpe Hearing Testimony at 263:23-264:13 (AR Tab 2-60) (conceding that the srHS data reflects higher post-Dirigo cost growth in Maine (4.5%) than it does in the United States as a whole (3.9%).) It is clear from the record testimony that the DHA regression models would pick up these national cost growth reductions and treat them as “Dirigo” savings. (*See, e.g.*, Maffei Prefiled Testimony at 29 (AR Tab 1-27); Dobson Prefiled Testimony at 22 (AR Tab 1-35); Burke Prefiled Testimony (Report) at 3-4 (AR Tab 1-29).) The Superintendent indeed advised DHA to develop a multivariate, multi-state regression model; the problem is that the models put forth by DHA and the one ultimately adopted by the Board continue to suffer from the fundamental flaw that necessitated the change in the first place.

III. The Board Does Nothing To Rebut The Unanimous Testimony That The U.S. Hospital Regression Model Is Inconclusive/Statistically Insignificant And Cannot Be Relied Upon To Calculate AMCS.

The Board in its brief next tries to rehabilitate Mr. Schramm’s concessions concerning the reliability (or lack thereof) of the U.S. hospital regression model. This is wishful thinking.

The Board first suggests that Mr. Schramm “elaborated” on his testimony making clear that the Board could not rely on the U.S. model alone “if there were no other evidence of savings.” (Dirigo Brief at 8.) It is telling that the Board offers no direct quote from Mr. Schramm and, instead, attempts to dilute the import of Mr. Schramm’s testimony with the suggestion that somehow the inconclusive U.S. hospital regression can effectively be blended with non-regressed data and the one hospital anecdote to create statistical significance where none otherwise exists.

The record reveals that in the context of cross-examination focused on testing the validity of the two regression models that DHA's experts suggested ought to be blended, Mr. Schramm made clear – repeatedly – that (1) the U.S. hospital regression model was “inconclusive” for savings; (2) this was based on the fact that none of the critical variables and interaction terms in the U.S. hospital regression come close to statistical significance; and, accordingly, (3) the Board could not rely on the U.S. hospital model if that had been the only regression model offered by DHA. Given the Board counsel's attempt to revise history on these points, excerpted below is the relevant colloquy between Mr. Schramm and intervenors' counsel in its entirety:

MR. ROACH: Okay. So the only testimony that the Board has in front of it talks about 5 percent statistical significance, is that right?

MR. SCHRAMM: The only testimony from my pre-filed?

MR. ROACH: Or from Dr. Thorpe. Have you read Dr. Thorpe's testimony?

MR. SCHRAMM: I have.

MR. ROACH: And did you see where he talked about the traditional statistical significance in all the social sciences is 5 percent?

MR. SCHRAMM: He does.

MR. ROACH: And there wasn't any other figure put forth in either your testimony or Dr. Thorpe's, right?

MR. SCHRAMM: I don't believe there is.

MR. ROACH: And based on that, you determined that the U.S. regression model had statistically insignificant results, right?

MR. SCHRAMM: We say it's inconclusive about whether the reduction in trend is attributable to Dirigo.

MR. ROACH: And that followed your determination that none of the results that had to do with savings under your regression model were statistically significant, right?

MR. SCHRAMM: At a 5 percent significant level.

(Schramm Hearing Testimony at 227:11-228:3 (AR Tab 2-60).)

MR. ROACH: Yes. When we look at the U.S. regression, Maine cross Dirigo and Maine cross Dirigo cross year, which are the critical interaction terms do not have statistically significant results to a 5 percent statistical significance level?

MR. SCHRAMM: The four variables that impact savings as I've testified previously in the formula are Dirigo, Maine/Dirigo, Dirigo/year and Maine/year/Dirigo. Your point is accurate if I look at the Maine/Dirigo interaction and the Maine/year/Dirigo interaction.

MR. ROACH: Okay. So in other words, we don't have – what you're relying on when you're talking about a slight distinction between a 5 percent significance level and something less than that, you're talking about the cluster, the cluster one T statistic, right?

MR. SCHRAMM: What I'm talking about the slight distinction, yes.

MR. ROACH: Right, okay. In fact, putting aside our expert's testimony, you agree the U.S. regression is inconclusive for savings, right?

MR. SCHRAMM: Yes, we've said that.

MR. ROACH: That's what you testified to?

MR. SCHRAMM: Yes.

MR. ROACH: Okay. So the Board couldn't rely on that alone?

MR. SCHRAMM: Correct.

MR. ROACH: Okay. So then what we're left with is we're left with the clustering analysis, right?

MR. SCHRAMM: No, I think you just said the Board could not rely on that alone.

MR. ROACH: I said the Board couldn't rely on the U.S. regression analysis alone because you said it was inconclusive.

MR. SCHRAMM: Correct.

MR. ROACH: So then we're left with the Board relying on the clustering analysis, right?

MR. SCHRAMM: No, you said rely on it alone. So that means they would have to rely on it as well as other information.

MR. ROACH: . . . If all you presented was a U.S. regression model, you, yourself, say that's inconclusive, right?

MR. SCHRAMM: Correct.

MR. ROACH: So they couldn't rely on that alone?

MR. SCHRAMM: Correct.

MR. ROACH: Now, let's look at the clustering analysis, the clustering analysis that has only six states and that when Dr. Thorpe saw the results, Dr. Thorpe said you should run a U.S. regression as well, right?

MR. SCHRAMM: Correct

MR. ROACH: Okay. Now, when faced with the U.S. regression, you weighted the U.S. regression 75 percent, right?

MR. SCHRAMM: Correct.

MR. ROACH: Even though that was inconclusive?

MR. SCHRAMM: As I testified to earlier, we used the higher credibility because of our desire to have a conservative estimate for the savings, and as I said earlier, it's not a statement on the statistical validity necessarily of the U.S. hospital versus the cluster. It was an attempt to balance the information that we've presented to the Board and provide them with a conservative estimate so that they could say within the range of potential savings we have picked a number more heavily weighted towards the low end of the savings estimates that have been provided.

(Schramm Hearing Testimony at 237:19-240:20 (AR Tab 2-60).)

The above encompasses the entirety of Mr. Schramm's testimony on the discussed issues. There was no redirect from DHA's counsel. As you can see, Mr. Schramm did not provide any caveats or disclaimers regarding the U.S hospital model; rather, he stated, clearly and repeatedly, that the model was inconclusive and could not be relied on to calculate AMCS.

DHA's experts apparently assumed that they were "safe" in conceding these undisputed points because they were attempting to support the inconclusive U.S. hospital model by blending it with Cluster 1. They did not count on the Board actually rejecting Cluster 1 as well as the concept of blending the biased Cluster 1 with the inconclusive U.S. hospital regression. Yet that

is precisely what the Board did. (Year 4 Board Decision at 8 (“The Board is not persuaded that Cluster 1 tracks Maine and finds the weighting of the U.S. hospital model with Cluster 1 to be arbitrary and not supported by the evidence.”).) Having rejected the cluster regression models, the only regression model remaining – and the one the Board explicitly adopted – was the U.S. hospital regression model. The record clearly demonstrates that this model does not produce supportable CMAD savings.

IV. The Board Has Confused The Concept Of Statistical Significance With Its Burden Of Proof.

Tacitly conceding that none of the variables critical to the CMAD savings calculation come close to approaching statistical significance, the Board instead suggests that all it need find is one variable within the U.S. hospital regression that reaches 51% statistical significance, as that would meet a “more likely than not” standard. (Dirigo Brief at 8-10.) This standard would reduce to obsolescence the very statistics upon which the Board based its \$119.4 million CMAD savings.

Even the experts for DHA agreed that statistical significance has a particular meaning in the science of econometrics. (*See* Schramm Hearing Testimony at 223:17-225:18 (AR Tab 2-60).) It does not, as the Board now seems to infer, simply mean “significant” in layman’s terms. Rather, the only testimony before the Board – by any of the experts – speaks in terms of reliable results achieving a 5% significance level, meaning there is a 95% probability that the results of the statistical regression model were not due to random variation. (*See, e.g.*, Anthem BCBS’s Pre-Hearing Brief at 12-13 and testimony cited therein.) Statistical significance is not akin to a burden of proof; it is instead a measure within the science of econometrics that is designed to determine whether the results of the analysis are valid and thus can be considered as reliable evidence of anything, irrespective of the ultimate burden of proof. By way of example, a DNA

test must satisfy certain parameters and guidelines before those in the medical field deem it to be valid. A less than valid DNA test is not admitted into evidence in a civil trial, where the burden of proof is by a preponderance of the evidence, but excluded in a criminal trial simply because the burden of proof is to the higher degree of beyond a reasonable doubt. Rather, the DNA test that does not satisfy the validity testing within the medical field cannot be used in any proceeding because its results are unreliable, or as in this case, “inconclusive.”

Though the intervenors’ experts certainly made this point clear, Mr. Schramm also clearly testified that his determination that the U.S. hospital regression model is inconclusive for savings and cannot be relied upon was based on the fact that none of the variables within that regression model even approached statistical significance.² The Board cannot rely upon a statistical regression model for CMAD savings, but then ignore both the statistical principles upon which the regression analysis was based and the testimony from DHA’s own experts.

V. The Board Misconstrued The Undisputed Testimony Of The Implications That DHA’s Regression Models Produced Savings In States Outside Of Maine.

Intervenors presented unrebutted testimony that DHA’s regression models produce “Dirigo” savings outside of Maine. The Board in its brief dismissed this undisputed evidence, summarily suggesting that “[t]his is a faulty argument that Intervenors raise each year, regardless of the methodology used.” (Dirigo Brief at 13.) In so doing, however, the Board ignored the implications of the record evidence.

² MR. ROACH: And based on that, you determined that the U.S. regression model had statistically insignificant results, right?

MR. SCHRAMM: We say it’s inconclusive about whether the reduction in trend is attributable to Dirigo.

MR. ROACH: And that followed your determination that none of the results that had to do with savings under your regression model were statistically significant, right?

MR. SCHRAMM: At a 5 percent significant level.
(Schramm Hearing Testimony at 228:2-13 (AR Tab 2-60).)

The point of using a multivariate multi-state regression was to isolate for the effects of the Dirigo Health Reform Act. (*See* Schramm Hearing Testimony at 99:20-23, 210:3-8 (AR Tab 2-60).) This “new, more accurate, methodology” (Dirigo Brief at 7) was designed to control for all other explanations for changes in the cost per CMAD other than the Dirigo Act and in that way, produce only those savings that were really associated with the Dirigo Act. As reported in our initial brief, Mr. Schramm explained the implications of using an accurate regression model to measure Dirigo Act savings:

MR. ROACH: . . . What I mean is that if you were actually able to develop a regression analysis that truly isolated for only the effects of Dirigo, if you ran that regression in any other state that did not have Dirigo, it would not produce any savings?

MR. SCHRAMM: In the hypothetical construct, yes.

(Schramm Hearing Testimony at 217:22-218:5 (AR Tab 2-60); *see also* Dobson Hearing Testimony at 42:13-15 (AR Tab 3-61) (“You shouldn’t see savings for all of the other states when you use a model that purports to show Dirigo savings.”).) In addition to this concession, the undisputed evidence in the record reflects that DHA’s regression models in fact do produce significant savings in states outside of Maine, which means the models are picking up as “Dirigo” savings the effects of variables unrelated to the Dirigo Act. (*See* Dobson Prefiled Testimony at 28-29 (AR Tab 1-35) and discussion of that testimony in Anthem BCBS’s Pre-Hearing Brief at 9-10, 19-21.)

Thus, this is not the “same old argument” summarily dismissed by the Board. To his credit, Mr. Schramm conceded what a properly specified regression model would produce for results. The fact that the model relied upon by the Board does not satisfy Mr. Schramm’s basic test of validity demonstrates that the calculated CMAD savings must be rejected.

VI. The Board Had No Authority To Ignore The Statutory Formula For Calculating Cost Per CMAD.

The Board concedes (as it must) that the CMAD formula upon which the CMAD savings is based does not follow the formula set forth in the applicable statute. (Dirigo Brief at 14.) They argue, however, that the Superintendent is barred from requiring the Board to adhere to that formula because that is “a question of legal interpretation.” (*Id.*) Following this logic, if the Board determines next year that the difference in the price of gasoline pre-Dirigo versus post-Dirigo becomes the Board’s measure of AMCS, the Superintendent would be powerless to review that interpretation against the clear statutory requirements, and instead would be limited to determining whether DHA accurately calculated the change in gas prices. Put differently, if the Legislature plainly outlines a formula for the calculation of CMAD, and DHA plainly does not follow that formula, how can the Superintendent find that the record reasonably supports the Board’s determination of CMAD savings generated by that invalid formula?

VII. The Superintendent Should Not Condone The Board’s Ever-Changing Interpretation Of AMCS.

The Board recognized that prior determinations of AMCS were reduced based on the lack of recoverability of the alleged savings, but maintains that the Superintendent must not do so here simply because the Board refused to include that concept in this year’s proceeding. (Dirigo Brief at 11.)³ This ever-changing landscape of what is, and is not, AMCS significantly undercuts the legitimacy of the Board’s determinations. In a decision that can only be interpreted as “AMCS means whatever we say it means,” the Board has ignored its own previous

³ The Board’s failure to adjust for recoverability is curious given its past decisions and Board Chairman McAfee’s comments in this year’s deliberations concerning the potential effects on Maine’s insured if non-recoverable savings are included in the SOP: “[T]he concept of recoverability must be understood. The industry has felt that the savings that have been assessed will be added on to subscriber’s premiums [and] [t]hat the whole process adds to the individual cost of insurance because of that. So the higher one picks a numbers, the adverse effect may occur in the marketplace.” (Year 4 Board Deliberations at 31:16-23 (AR Tab 3-62).)

determinations and those of the Superintendent simply because doing otherwise, and bringing at least some consistency to this process, would reduce the AMCS. That is an invalid approach that should be rejected by the Superintendent.

VIII. The Board Adopted A Bad Debt And Charity Care Savings Figure That Is Not Reasonably Supported By The Record Evidence.

The Board tries—in vain—to develop some logic for having selected the pre-Dirigo Maine regression model for the BD/CC savings calculation, but the truth behind the selection of this model is reflected most clearly in the transcripts of the Board’s deliberations: the Board was tired and wanted to compromise on a number. (*See, e.g.*, Year 4 Board Deliberations (AR Tab 3-62) at 80:13-15 (Board member David: “I happen to believe in the other [*i.e.*, Burke] methodology. But like I said, I’m not going to sit here all weekend.”) and 78:3-5 (Board member Beal: “We need to have a number which is unanimously supported otherwise we will be here through the weekend . . .”).)

In a year during which enrollment in DirigoChoice declined by double digits and there was no MaineCare expansion, the BD/CC regression model approved by the Board suggests four times the amount of BD/CC savings as approved in the last proceeding. These results are demonstrably unreasonable and should be rejected. Intervenors’ less “prolific” response to DHA’s BD/CC analysis (Dirigo Brief at 15) is reflective only of the fact that the suggested savings simply have no basis in reality.

The only BD/CC AMCS that is reasonably supported by the evidence in the record is that offered by Jack Burke.

IX. The Medical Loss Ratio Does Not Represent Savings That Should Be Included As Part Of AMCS.

It is undisputed that the \$6.6 million in MLR can never be recovered by any provider. That means that no insurance carrier can recover that \$6.6 million in its contract with a provider

and, accordingly, insurance premiums will not, and cannot, be reduced to reflect that \$6.6 million refund. As such, if this amount is included as part of AMCS, there will be no constraint on the Board from including that \$6.6 million in the SOP. That would defeat the purpose of the Superintendent's review.

X. No AMCS Are Reasonably Supported By The Evidence In The Record, But If The Superintendent Is Inclined To Find Savings, The Three Initiatives Clearly Overlap.

Any change in a hospital's BD/CC cost is reflected in the hospital's cost per CMAD.

The Superintendent in prior proceedings has corrected for this overlap, but in the present proceeding, the Board ignored this and found no overlap. This decision is particularly striking when considering that the Board attempts to justify its materially larger BD/CC result by suggesting that "[t]he methodology this year captures the total reduction in uninsurance due to Dirigo It is not surprising or in any way improper then that the amount of savings determined by the Board has increased." (Dirigo Brief at 16.) Put differently, to support higher savings, the Board suggests that the BD/CC regression is broader than in years past, but ignores that purportedly expanded scope when finding no overlap. The only commonality in those two decisions is that both result in increased AMCS.

For the reasons set forth above and in the initial briefs of Anthem BCBS, the Chamber, the Maine Auto Dealers Trust and MEAHP, the Board's determination of AMCS is not reasonably supported by the evidence in the record and, accordingly, must be rejected.

DATED: September 5, 2008

/s/ Christopher T. Roach

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CERTIFICATE OF SERVICE

I hereby certify that on September 5, 2008, a copy of Anthem Health Plans of Maine Inc.'s Pre-Hearing Reply Brief was served on each of the persons listed below via hand delivery and electronic mail in the manner described in the Superintendent's Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures dated August 18, 2008:

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