

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

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO) FILING COVER SHEET
HEALTH FOR THE FOURTH)
ASSESSMENT YEAR)
)
)
Docket No. INS-08-900)

TO: Mila Kofman, Superintendent
Attn: Vanessa J. Leon
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, ME 04333-0034

Date Filed: September 2, 2008
Party: Dirigo Health
Document: Brief of Dirigo Health
Document Type: Brief
Confidentiality: None

/s/ Michael J. Colleran
Michael J. Colleran, Bar No. 9247
Assistant Attorney General
Office of Attorney General
6 State House Station
Augusta, ME 04333-0006
(207) 626-8834

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

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

DOCKET NO. INS-O8-900

INTRODUCTION

The Dirigo Health Board of Trustees (the “Board”) has determined that aggregate measurable cost savings for the fourth assessment year are \$149.6 million. (Board Decision at 10.) This matter now is before the Superintendent of Insurance pursuant to 24-A M.R.S.A. § 6913(1)(C), which provides for the Superintendent to review and approve the Board’s determination to the extent that it is reasonably supported by evidence in the record. Here, evidence in the record reasonably supports savings in an amount that equals or exceeds that determined by the Board. Accordingly, the Superintendent should approve the \$149.6 million aggregate measurable cost savings determination in full.

STANDARD OF REVIEW

The Dirigo Health Act sets forth the standard of review for this proceeding: “The [S]uperintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the Board are reasonably supported by the evidence in the record.” 24-A M.R.S.A. § 6913(1)(C). In a similar context, the Law Court has elaborated on the sufficiency of evidence standard as follows:

Our inquiry in a challenge to the sufficiency of the evidence in a civil matter is whether by any reasonable view of the evidence, including inferences to be drawn therefrom, taken in the light most favorable to the prevailing party, the [judgment] can be sustained. The existence of contrary evidence does not, in itself, require us to conclude that

insufficient evidence exists to support the judgment, however, because the fact-finder may believe some, all, or none of a witness's testimony. Rather, unless there is no record evidence to support the [determination], we will uphold the court's decision.

In re Cyr, 2005 ME 61, ¶16, 873 A.2d 355, 360-61 (internal quotation marks and cites omitted).

The review for reasonable evidentiary support should be performed with deference to the Board, and the Superintendent should not substitute her judgment for that of the Board. *Griswold v. Town of Denmark*, 2007 ME 93, ¶9, 927 A.2d 410, 414-15. "Further, the fact that the record before the Board is inconsistent or could support a different decision does not render the decision wrong; the Board's decision should be [disapproved] only if no competent evidence exists in the record to support it." *Id.*

The Superintendent's review is of the totality of evidence in the record, and not just portions in isolation. *In re Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Third Assessment Year*, No. INS-07-900, Decision & Order, at p. 2 (Sept. 17, 2007) (the "Year 3 Decision"). Additionally, "'reasonably supported' is not equivalent to a preponderance-of-the-evidence standard." *Id.* Dirigo does not have to prove that the Board's determination is the most reasonable, but instead only that the determination is reasonably supported by evidence in the record. *Id.*

The Superintendent does not have complete appellate jurisdiction over the Board's decision and the process used to reach it. Year 3 Decision at 5. Rather, the Superintendent's jurisdiction is limited to the sufficiency of the evidence supporting the Board's determination. *Id.*; 24-A M.R.S.A. § 6913(1)(C). The Superintendent does not have jurisdiction to review legal issues like the interpretation of the Dirigo Health Act, the constitutionality of the Act, or the due process rights of the Intervenors. Year 3 Decision at 5-6.

The meaning of the term "aggregate measurable cost savings" is a question of law for the Board to make based on its expertise, subject only to judicial review. *Maine Association of*

Health Plans v. Superintendent of Insurance, 2007 ME 69, ¶33, 923 A.2d 918, 927; Year 3 Decision at 6. In interpreting that term, it is proper for the Board to include all savings realized through the Dirigo Health Act, and not just those related to the DirigoChoice insurance program and MaineCare expansion. *Maine Association of Health Plans*, 2007 ME 69, ¶41, 923 A.2d at 929. Thus, the Board decides which initiatives may be included within the aggregate measureable cost savings determination, and the Superintendent does not have jurisdiction to review that legal decision. Year 3 Decision at 6.

Before the Board and now in this proceeding, Intervenors have argued that aggregate measureable cost savings includes only those that are recoverable by payers of the savings offset payment (“SOP”) under the statutory scheme. This, again, is a question of the meaning of the term “aggregate measureable cost savings.” As a matter of statutory interpretation, and thus a question of law, the Board’s decision that recoverability is not a requirement is not subject to review by the Superintendent.¹ Year 3 Decision at 6.

The Intervenors inaccurately claim that the Superintendent’s Year 3 Decision set a precedent that savings must be recoverable. In fact, the Year 3 Decision merely noted that the Board was inconsistent in that year’s determination by considering recoverability for one initiative, when it had not done so for other initiatives or in prior years. Year 3 Decision at 10. The Superintendent simply was attempting to discern the Board’s legal interpretation of the statute – if the Board interpreted the statute to require recoverability, then that requirement should have been imposed across all initiatives. This year, the Board entertained argument from both sides on the recoverability issue, (*see* prehearing briefs before the Board), and consistently,

¹ In any event, the Board’s legal decision was well-founded. Recoverability is not mentioned in the part of the Dirigo statute that discusses the aggregate measureable cost savings determination. 24-A M.R.S.A. § 6913(1). Recoverability is a factor the Board considers later in the process when the Board determines the savings offset payment. 24-A M.R.S.A. § 6913(2).

across all initiatives, determined savings without requiring recoverability.² The Superintendent may not disturb that legal decision.

ARGUMENT

I. The CMAD Savings Determined by the Board Are Reasonably Supported.

The Board's determination of aggregate measureable cost savings included \$119.4 million that the Board attributed to the Hospital Savings Initiative ("CMAD"), a component of savings included in each prior year's determination and the inclusion of which has been affirmed by the Law Court. *Maine Association of Health Plans*, 2007 ME 69, ¶¶24, 33, 923 A.2d at 926, 928-29; Year 3 Decision at 9.

In the Year 3 Decision, the Superintendent recommended that the Dirigo Health Agency consider using a "multivariate statistical model which incorporates cost and other data from both Maine and from other states" to calculate CMAD savings in future years. Year 3 Decision at 14. The Superintendent was concerned that the methodology used in the first three years depended upon projections that were based on Maine pre-Dirigo data alone, which would become less reliable with the passage of time. *Id.* Dirigo Health followed that suggestion this year, and the Board made its determination after receiving evidence that included the results of multi-state, multivariate statistical models. (*E.g.*, AR 4-64.)

The Board's finding of \$119.4 million in CMAD savings is supported both by empirical evidence and statistical evidence in the record. First, there is a historical record of CMAD savings from years 1 through 3 with no evidence whatsoever suggesting a reason why there would not be savings in Year 4. Additionally, as previously noted by the Superintendent, savings from prior years continue to be reflected as savings in future years because the CMAD

² This is most starkly shown with respect to the MLR initiative, discussed below, where all parties agreed that the savings were not recoverable and where they were challenged by the Intervenors only on recoverability grounds. The Board rejected this challenge, and determined MLR savings in the amount proposed by the agency.

trend has been deflected downward. *In re Review of Aggregate Measureable Cost Savings Determined by Dirigo Health for the Second Assessment Year*, No. INS-06-0900, Decision & Order, at 8 (July 21, 2006) (“Year 2 Decision”). Second, hospitals report that they are complying with the Dirigo voluntary cost restraints and that their efforts have resulted in savings. (*See, e.g.*, AR 4-69; AR 2-60, at p. 33 Ins. 15-20; AR 5-95(H), at p.5.) Third, without doing any statistical analysis, the observed CMAD data clearly shows a dramatic reduction in CMAD growth rate from the pre-Dirigo to the post Dirigo period – a reduction that exceeds that of other states. (AR 2-60, at p. 32 ln. 15 – p. 33 ln. 6.; AR 4-72.) Indeed, a non-statistical analysis done by Intervenor’s own expert, Allen Dobson, shows this dramatic reduction in cost growth beyond any national trend. (AR 4-84, at p. 7 (Table 1); AR 2-60, at p. 34 ln. 8 – p. 35 ln. 4.)

Beyond the empirical evidence, there was ample evidence from three multi-state, multivariate statistical models that show CMAD savings in at least the amount found by the Board for year 4. The Dirigo Health experts, who have decades of experience with this type of analysis, performed regression models based on the universe of U.S. hospitals (“the U.S. model”), on a cluster of states similar to Maine based on variables that impact the health care market overall (“Cluster 2”), and on a cluster of states similar to Maine based on variables that affect hospital cost growth (“Cluster 1”). They used these models, as suggested by the Superintendent in year 3, to predict what Maine’s CMAD experience would have been absent Dirigo without relying solely on Maine pre-Dirigo data. All three models produced savings equal to or greater than those found by the Board. Dirigo’s experts recommended to the Board a blending of the U.S. model and Cluster 1 results that would yield savings of \$147.9 million. They testified, based on their specialized knowledge, training, and experience, that this methodology and the savings amount it calculated were reasonable. (AR 4-83, at p. 5 Ins. 111-117.) 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. (Board's Decision at 8.)

As mentioned above, the Superintendent is required to review all of the evidence, not just part of the evidence in isolation. Thus, the Superintendent's review of evidence supporting the CMAD determination is not limited to the output of the U.S. model. Based on a review of all of the empirical and statistical evidence in the record, the Board's determination is reasonably supported by competent evidence.

A. Intervenor's Myriad Attacks on the CMAD Determination Are Meritless.

Consistent with their practice in prior years, when a different methodology was employed, Intervenor's have attacked the Board's determination on numerous grounds. As outlined below, none of these attacks undercut the reasonable evidentiary support for the Board's determination.³

1. The Savings Compared to Prior Years

It is true that \$119.4 million is a much larger number than that approved by the Superintendent in prior years, but the Superintendent's reviews in those years were based on different Board determinations and different records. Both year 2 and year 3 decisions were based on "rough justice" necessitated by Board or Superintendent dissatisfaction with the CMAD methodology presented to the Board. Year 3 Decision at 13-14. This also led to the Superintendent's suggestion that a new, multi-state multivariate analysis be incorporated this year, which has been done. *Id.* at 14. With this new, more accurate, methodology and an additional year of data, it is not surprising that the savings calculation is not directly comparable to the amounts approved in earlier years. As the Superintendent noted last year, each year's

³ In the interest of brevity, Dirigo Health will not directly address each of the attacks Intervenor's make on the savings determination (CMAD or otherwise). This does not suggest agreement with any of the attacks, all of which Dirigo Health disputes.

determination is reviewed against the record for that year; differing from prior year's determinations, where the reason for the difference is understood (here, a switch to a more accurate methodology), is not a basis for rejecting the determination. *Id.* at 8, 9 (“An amount approved by the Superintendent in a prior year that was judged to meet the standard of reasonable support is one among a range of estimates that could be reasonably supported, and in no sense should be judged as the best estimate analytically.”).

2. Board Reliance on U.S. Model

Intervenors argue that the Board relied solely on the U.S. model, allegedly ignoring testimony from Dirigo expert Steve Schramm that the U.S. model by itself is inconclusive. This argument is incorrect. As Mr. Schramm elaborated, he would not recommend that the Board rely on the U.S. model *alone, if there were no other evidence of savings*. (AR 2-60, at p. 239 lns. 4-12.) As discussed above, however, there was ample other empirical and statistical evidence of savings. Mr. Schramm, along with Kenneth Thorpe, PhD, would and did recommend that the Board find CMAD savings based on all of the evidence, including the U.S. model. (AR 2-60, at p. 91 ln. 4 – p. 93 ln. 15; AR 4-83, at p. 5 ln. 106 – p. 7 ln. 158; AR 2-60, at p. 27 ln. 18 – p. 29 ln. 12.) That is what the Board did, and the evidence in the record supports the Board's determination.

3. Attacks on the Models

a. Statistical Significance

A failure to meet customary standards of statistical significance does not mean that the U.S. model output must be rejected. First, statistical significance is an arbitrary concept developed 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 a 95% level of certainty. The Board need only have been convinced that it is

more likely than not that the savings exist, and the Superintendent need only find that the Board's determination, viewed in the light most favorable to the Board, is supported by evidence in the record.

Second, statistical significance is relevant as to whether the "null hypothesis" can be rejected. Here, the "null hypothesis" is that there are no CMAD savings due to Dirigo – that the savings shown by the statistical models are the product of randomness. Intervenors in essence are arguing that the lack of customary statistical significance means that there are no CMAD savings. This argument, however, ignores the empirical evidence of CMAD savings discussed above. The hypothesis that there are no savings can be rejected because the empirical evidence shows that there are savings, regardless of the output of any statistical hypothesis testing. There is no question that CMAD cost growth in Maine has been reduced as a result of the Dirigo voluntary restraints.

Third, the U.S. model is not based on a sample of hospitals. (AR 3-61, at p. 268 lns. 8-16.) It is based on essentially the entire population of U.S. hospitals. (*Id.*) As Dr. Thorpe testified, statistical significance is not an issue in this context. (*Id.*) "The US hospital model is not based on a sample. It uses the complete universe of hospital experience in the US during the time periods in question (approximately 40,000 observations) and so will have excellent predictive power for CMAD trend in the absence of Dirigo." (AR 4-83, at p. 6 lns. 138-141.)

Fourth, contrary to how it has been described in these proceedings, including, unfortunately, in Dirigo filings,⁴ the "M:D:Y" variable in the U.S. model does not have a p-value indicating a 45% chance that the null hypothesis can be rejected. Rather, the p-value of .45 indicates a 55% likelihood that the null hypothesis can be rejected – or 1 minus the p-value. (*See*

⁴ Mr. Schramm's pre-filed testimony incorrectly characterizes the p-value of .45 as corresponding to a 45% chance that the effect is due to Dirigo. (AR 4-82, at p. 19 lns. 421-424; *see also* AR 4-73.) The correct characterization is that there is a 55% chance that the effect is due to Dirigo.

AR 4-82, at p. 16 lns. 356-361, p. 19 lns. 431-434 (probability that null hypothesis is false is 1-p-value).) Thus, even absent the empirical evidence and even if statistical significance were relevant here, it would be more likely than not that the results are real and not the product of random variation.

Finally, even Intervenor's expert, Dr. Dobson, reports, relies upon, and draws conclusions from regression analysis output that fails to meet the statistical significance custom if other evidence shows him that he can reject the null hypothesis. (AR 3-61, at p. 67 ln. 20 – p. 71 ln. 14.) Again, in our case, there is ample evidence outside the U.S. model that supports rejecting the null hypothesis.

b. Additional Variables

Intervenor's argue at length that the regression models used by the Dirigo Health experts should be rejected because Intervenor's believe additional variables should have been used, including employment growth, hospital competition and operating margin, insurance competition, physician supply, existence of certificate of need and other government regulations, hospital owner status, and the effects of the "cost cycle." (*See, e.g.*, MEAHP Br. at 20; Chamber Br. at 22; 11.) Tellingly, none of the Intervenor's did their own regression analysis, despite the facts that they knew since last year that the Superintendent had recommended this type of analysis, the outcome of these proceedings is obviously very important to the Intervenor's, and their experts are capable of performing a regression analysis. While Intervenor's will correctly say that they do not have the burden of producing any evidence, the fact that they did not perform a regression analysis using the variables they claim should have been used undercuts the credibility of their attacks. If they were confident of the outcome, they surely would have performed the analysis.

One of the additional variables that Intervenors put great emphasis on is employment growth. Intervenors' expert Vincent Maffei explained at length that it was important to include employment growth because it affects the percentage of the population that is uninsured. (AR 5-106, at p. 16 ln. 21 – p. 18 ln. 12.) However, Mr. Maffei apparently was unaware that one of the variables used by Dirigo Health was the percentage uninsured, (AR 4-64, at p. 49), so that using employment growth as a proxy for insurance coverage was completely unnecessary.

With respect to employment growth and the other variables put forth by Intervenors, Dr. Thorpe credibly testified as to the reason why each variable was appropriately excluded from the regressions. (AR 2-60, at p. 58 ln. 8 – p. p. 66 ln. 12.) The Board could reasonably rely upon his expert testimony and reject Intervenors' unsupported claims that these additional variables should have been used.

c. Issues from Prior Superintendent's Decisions

Intervenors also attack the models on the grounds that they allegedly fail to address four issues discussed in prior decisions: (1) hospitals with low or negative consolidated operating margins ("COM"); (2) MaineCare reimbursement cuts; (3) cost-based reimbursement; and (4) outpatient utilization. All of these issues were considered and dealt with in a reasonable manner.

The COM issue is one of recoverability. In year 3, faced with a Board decision that was inconsistent on whether recoverability of savings should be considered, the Superintendent reduced the amount of savings approved to account for the SOP payers' inability to recoup savings from unprofitable hospitals. Year 3 Decision at 10, 14. This year, however, as discussed above, the Board was clear in its legal determination that recoverability is not an issue at this stage of the statutory process. Accordingly, no adjustment for COM was necessary.

With respect to MaineCare reimbursement, Mr. Schramm testified in detail that MaineCare reimbursement cuts do not have a determinate effect on CMAD. (AR 2-60, at p. 46

ln. 17 – p. 53 ln. 25.) In any event, there is no credible evidence in the record that there have been overall MaineCare reimbursement cuts, and in fact the evidence shows an increase in reimbursement. (AR 4-64, at pp. 14-15.) As they have done in the past, Intervenors offered hearsay evidence regarding a legislative proposal to cut certain types of reimbursement, but the witness testifying about this hearsay had no knowledge as to its accuracy or as to whether the legislative proposal was ever enacted. (AR 3-61, at p. 169 ln. 18 – p. 24.) Moreover, the witness’s pre-filed testimony bore a striking resemblance to the pre-filed testimony of another witness, (AR 3-61, at p. 175 ln. 22 – p. 177 ln. 11), further undermining the witness’s credibility. The Board quite properly could have rejected his testimony.

As for cost-based reimbursement, Intervenors acknowledge Mr. Schramm’s testimony that an adjustment was made for cost-based reimbursement, but claim that Mr. Schramm’s report does not set forth the adjustment. (Chamber Br. at 11.) In fact, an appropriate adjustment was made, and the report clearly sets forth the adjustment. (AR 4-64 at pp. 12-13.)

The final issue, outpatient utilization, is similar to the MaineCare reimbursement issue in that the effect of increased outpatient utilization on CMAD is indeterminate and in that there is no evidence that changes in outpatient utilization have caused a reduction in CMAD. (AR 2-60, at p. 54 ln. 1 – p. 57 ln. 17.)

d. Difference between Fitted Prediction and Observed

Intervenors claim that the U.S. model is invalid because the predicted CMAD values differ from actual observed. (MEAHP Br. at 17; *see* AR 4-64, at 54.) This is a misinterpretation of what is shown in the table cited by Intervenors. Columns III and IV of the table are not showing an apples-to-apples comparison of actual and predicted CMAD. (AR 3-61, at p. 251 lns. 6-20.) Rather, Column IV shows fitted values that were derived by using Maine-specific characteristics from the “virtual hospital” as predictors that the model uses to extrapolate a

CMAD value. (*Id.*) If instead of the “virtual hospital” characteristics used to generate Column IV, average hospital values are used for total beds and interns/beds, the predicted values closely track the actual observed CMAD and result in the same savings:

		Fitted Using Regression Model		
		Hospital-Level Input		State-Level Input
Actual Maine				
		Hospital Level	US-Hospital Level	US-Hospital Level
Cost per CMAD				
	2000	\$5,001	\$5,097	\$8,313
	2001	\$5,564	\$5,491	\$8,412
	2002	\$6,080	\$5,926	\$8,829
	2003	\$6,269	\$6,394	\$9,317
	2004	\$6,588	\$6,582	\$9,521
	2005	\$7,011	\$6,990	\$9,941
	2006	\$7,233	\$7,291	\$10,217
	2007	\$7,470	\$7,439	\$10,293
Annual Growth Pre-Dirigo		1.078	1.078	1.039
Post-Dirigo		1.045	1.039	1.025
2000-2006		1.059	1.055	1.031
Cost per CMAD				
	Estimated 2007 (using Annual Growth Pre-Dirigo)	\$ 8,474	\$ 7,878	\$ 10,732
	Estimated 2007-Actual 2007 = Savings per CMAD	\$ 1,004	\$ 439	\$ 439
Adjusted Discharges		272,041	272,041	272,041
2007 Savings		\$ 273,100,000	\$ 119,400,000	\$ 119,400,000

(*Id.*; AR 4-65, dha_dataset_20.mdb, CMAD_Fitted Values.xls.)

e. Savings in Other States

Intervenors claim that the Dirigo Health analysis must be rejected because it shows savings in other states that do not have Dirigo. This is a faulty argument that Intervenors raise each year, regardless of the methodology used. As Dr. Thorpe explained, since the analysis here looked at national averages, there will be some states with higher cost growth rates, and some

with lower. (AR 2-60, at p. 89 ln. 21 – p. 91 ln. 3.) Without further research and analysis, which no one has done here, we do not know why a particular state (other than Maine) may have had lower cost growth in the post-Dirigo period. As Intervenors’ experts conceded, health care reform in some of the states may be a possible explanation for declining costs. (AR 3-61, at p. 162 lns. 4-7; AR 3-61, at p. 77 ln. 20 – p. 78 ln. 9.) In Maine, no other significant factor other than Dirigo explains the cost growth reductions. (AR 3-61, at p. 247 ln. 24 – p. 250 ln. 18.)⁵

4. CMAD Formula

Contrary to Intervenors’ arguments, there is nothing improper with the formula used by Dirigo Health for CMAD. Although some of the formula’s terms vary from those in the statute, it is the same formula used by Dirigo in prior years (which resulted in CMAD savings approved by the Superintendent) and it is the formula used by the hospitals in voluntarily restraining their costs. (AR 2-60, at p. 112 lns. 2-5.) In any event, whether it is appropriate to include CMAD savings using the formula used here is a question of legal interpretation and thus not subject to the Superintendent’s review.

5. Data Issues

Medicare Cost Reports are not perfect. Given the amount of reports involved here, it is inevitable that some reports will contain errors. (AR 2-60, at p. 44 ln. 3 – p. 45 ln. 11; AR 3-61, at p. 23 lns. 3-6.) There is no inherent bias in these errors, and so there is no reason to believe that they materially impacted the CMAD calculations. (AR 2-60, at p. 44 ln. 3 – p. 45 ln. 11.) Dirigo Health’s expert made adjustments for data errors identified by Intervenors, and those adjustments resulted in only approximately 1% variance (an increase) in savings. (*Id.*; AR 4-81.)

⁵ The cited testimony also explains why “reversion to the mean” as advocated by Intervenor expert Jack Burke is a faulty explanation for the reduction in CMAD cost growth post Dirigo. Moreover, even under the reversion to the mean theory, one of the factors that would cause this reversion is government intervention (e.g., the Dirigo reforms). (AR 3-61, at 63 lns. 2-10.)

II. The Bad Debt and Charity Care Savings Are Reasonably Supported.

The Board's determination of aggregate measureable cost savings also included \$23.6 million that the Board attributed to the Uninsured and Underinsured Initiative, also known as Bad Debt and Charity Care ("BD/CC"), a component of savings included in each prior year's determination. Year 3 Decision at 15.

The Board's determination of Bad Debt and Charity Care savings is reasonably supported by empirical and statistical evidence in the record. First, there is the historical evidence of approved savings in each of the prior years. *E.g.*, Year 3 Decision at 18. Second, there is the dramatic drop in Maine's uninsurance rate as compared to other states. (AR 4-77; AR 2-60, at p. 269 ln. 12 – p. 270 ln. 20.) Third, there are the results of three regression analyses performed by Dr. Thorpe, which show savings ranging from approximately \$17 million to \$42 million. The savings determined by the Board correspond to the regression analysis that produced results in the middle of the three analyses, "the Maine model." (AR 4-80.) This was arrived at as a conservative compromise in order to reach unanimity among the five Board members, which was required to make a determination. (AR 4-62, at pp. 6-19, 55-99.)

As discussed above in the context of CMAD savings, the Superintendent is required to review all of the evidence, not just part of it in isolation. Thus, the Superintendent's review of evidence supporting the Bad Debt and Charity Care determination is not limited to the output of the Maine model. Based on a review of all of the empirical and statistical evidence in the record, the Board's determination is reasonably supported by competent evidence.

A. Intervenor Attacks on the BD/CC Savings Determination Must Fail.

Although they are not as prolific as they were with CMAD, Intervenors make several attacks on the Bad Debt and Charity Care determination. As highlighted below, none of these attacks has merit, and the Board's determination should be approved in full.

1. The Savings Exceed Those Approved in Prior Years.

As addressed above with respect to a similar attack on the CMAD determination, exceeding the amount of savings approved by the Superintendent in prior years is not a sufficient reason to disapprove the savings determination, particularly where the reason for the difference is understood. Year 3 Decision at 8, 9. The methodology this year captures the total reduction in uninsurance due to Dirigo, including the reduction caused by the effect the Dirigo initiatives have had in lowering the rate of increase in private health insurance premiums. (AR 4-82, at p. 20 ln. 439 – p. 21 ln. 479.) It is not surprising or in any way improper then that the amount of savings determined by the Board has increased.

2. The Maine Model Was Not Recommended by Dirigo Experts.

Dr. Thorpe performed three regression analyses using the same methodology but using three different models – one with national data, one with data from a cluster of northeastern states, and one based on Maine pre-Dirigo data only. (AR 4-83, at p. 8 ln. 168 – p. 9 ln. 204; AR 4-64, at pp. 70, 71, 77.) Although, consistent with the CMAD approach, Dirigo Health experts recommended that the Board adopt savings derived from a blending of the national and cluster models, nowhere do Dirigo Health’s experts say that there is anything wrong or unreliable about the Maine model. Also, as was true with CMAD, the model that produced the savings figure adopted by the Board is not the only evidence of savings and should not be viewed in isolation. The totality of the empirical and statistical evidence (from all three models) reasonably supports savings in the amount determined by the Board.

3. The Results Do Not Seem Right to Intervenors’ Expert.

Intervenors’ expert Jack Burke advances several arguments about the Bad Debt and Charity Care determination, including that he would not expect the uninsurance rate to continue to decline now that major Dirigo Health initiatives have taken effect, that he would not expect

savings to increase if the Dirigo start date were moved from 2003 to 2005, and that he did not think that such large savings should be attributed to Dirigo. (MEAHP Br. at 36-42.) These are just naked assertions by Mr. Burke about what he would expect. Mr. Burke did not do his own regression analysis, and the Board was free to discredit his unsupported critiques. Dr. Thorpe fully explained why it was reasonable to expect Dirigo Health to continue to positively impact the rate of insurance coverage after 2006 and why the change of base year did not significantly impact savings. (AR 4-61, at p. 273 ln. 14 – p. 274 ln. 4, p. 276 ln. 2 – p. 277 ln. 7.)

4. Regression Analysis Output Was Not Provided.

Finally, Intervenors complain that the Bad Debt and Charity Care regression output was not produced to them and is not in the record. (Chamber Br. at 35.) This assertion is incorrect. DHA Exhibit 3, admitted into evidence at the hearing, contains the output of the Bad Debt and Charity Care regressions. (AR 4-65, dha_document_53.pdf.) This file was produced to Intervenors on June 2, 2008. (AR 1-10.) Dirigo Health subsequently made its experts available to answer pre-hearing questions from Intervenors' experts about, among other things, where files of interest to Intervenors were located in the disclosures. (AR 3-61, at p. 272 ln. 22 – p. 273 ln. 10.) No Bad Debt and Charity Care questions were left unanswered. (*Id.*) Like Intervenors' other attacks on the savings determination, this one is baseless.

IV. Medical Loss Ratio Savings Are Supported By Undisputed Evidence.

The final initiative for which the Board found savings is new this year. The Board found savings for the Medical Loss Ratio initiative in the amount of \$6.6 million. Intervenors dispute this determination only on the grounds of recoverability. This argument goes to a legal determination to be made by the Board without review by the Superintendent. There is no dispute that the evidence shows that the amount of savings for this initiative is \$6.6 million. (AR 3-61, at p. 363 ln. 12 – p. 366 ln. 13.)

V. There is No Basis for Reducing the Savings Amount for Overlap.

Intervenors speculate that there may be overlap between the initiatives, but provide no evidence or analysis that overlap in fact exists. The Board reasonably could rely on the testimony of Dirigo's experts that the methodologies employed this year did not require any adjustments for overlap. (AR 3-61, at p. 270 ln. 21 – p. 271 ln. 10, p. 364 lns. 10-12; AR 4-82, at p. 23 ln. 519 – p. 24 ln. 537.)

CONCLUSION

For the foregoing reasons, Dirigo Health requests that the Superintendent find that aggregate measureable cost savings in the amount of \$149.6 million is reasonably supported by the evidence in the record.

Respectfully Submitted,

Dated: September 2, 2008

/s/ Michael J. Colleran
Michael J. Colleran, Bar No. 9247
Assistant Attorney General
Office of Attorney General
6 State House Station
Augusta, ME 04333-0006
(207) 626-8834

Counsel for the Dirigo Health

CERTIFICATE OF SERVICE

I, Michael J. Colleran, counsel for the Dirigo Health, do hereby certify that on this date the foregoing document was served via U.S. first class mail, postage prepaid, and electronic mail as follows:

1. The original and two (2) hard copies via U.S. Mail addressed to:

Mila Kofman, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-08-900
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034

2. One (1) hard copy via U.S. Mail addressed to the Superintendent's consultant at:

Compass Health Analytics, Inc.
Attn: James P. Highland, PhD
477 Congress St., 7th Fl.
Portland, ME 04101

3. One (1) hard copy via hand delivery to the Superintendent's legal counsel at:

Thomas C. Sturtevant, Jr., AAG
Office of the Attorney General
6 State House Station
Augusta, ME 04333-0006

4. One (1) identical electronic copy addressed to the following:

Vanessa J. Leon	vanessa.j.leon@maine.gov
Thomas C. Sturtevant, Jr., AAG	tom.sturtevant@maine.gov
James P. Highland, PhD	jh@compass-inc.com

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

Mia S. Poliquin Pross, Esq.
Consumers for Affordable Health Care
39 Green St.
P.O. Box 2490
Augusta, ME 04338-2490
mpross@mainecahc.org

D. Michael Frink, Esq.
Curtis Thaxter Stevens Broder & Micoleau
LLC
One Canal Plaza, Suite 1000
P.O. Box 7320
Portland, ME 04112-7320
mfrink@curtisthaxter.com

Roy T. Pierce, Esq.
Preti, Flaherty, Beliveau & Pachios, LLP
45 Memorial Circle
P.O. Box 1058
Augusta, ME 04332-1058
rpierce@preti.com

William H. Stiles, Esq.
Verrill Dana, LLP
One Portland Square
P.O. Box 586
Portland, ME 04112-0586
wstiles@verrilldana.com

Christopher T. Roach, Esq.
Pierce Atwood LLP
One Monument Square
Portland, ME 04101
croach@pierceatwood.com

Dated: September 2, 2008

/s/ Michael J. Colleran
Michael J. Colleran, Bar No. 9247
Assistant Attorney General
Office of Attorney General
6 State House Station
Augusta, ME 04333-0006
(207) 626-8834