



Christopher T. Roach

One Monument Square
Portland, ME 04101

207-791-1373 voice
207-791-1350 fax
croach@pierceatwood.com
pierceatwood.com

October 24, 2005

VIA HAND DELIVERY

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon
Docket No. INS-05-700
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

In Re: Review of Aggregate Measurable Cost Savings Determined By Dirigo Health
For The First Assessment Year

FILING COVERSHEET

Dear Superintendent Iuppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: October 24, 2005
DOCUMENT TITLE: Anthem BCBS Pre-Hearing Brief
DOCUMENT TYPE: Brief
CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,


Christopher T. Roach

cc: Thomas Sturtevant, Jr., Esq. (via hand delivery and electronic mail)
John Kelly (via electronic and U.S. mail)

NON-CONFIDENTIAL

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

IN RE:)
)
REVIEW OF AGGREGATE) ANTHEM BCBS PRE-HEARING
MEASURABLE COST SAVINGS) BRIEF
DETERMINED BY DIRIGO HEALTH)
FOR THE FIRST ASSESSMENT)
YEAR)
) October 24, 2005
Docket No. INS-05-700)
)
)

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Pursuant to the Superintendent’s Second Procedural Order dated October 11, 2005, Anthem Health Plans of Maine, Inc. d/b/a Anthem Blues Cross and Blue Shield (“Anthem BCBS”) submits this Pre-Hearing Brief. Anthem BCBS intervened in this proceeding not to advocate for a specific dollar amount of aggregate savings that should be found to have resulted from the operation of the Dirigo Health Act (“Dirigo Health” or the “Act”), but rather to ensure that whatever methodology is used to calculate that savings is (1) reasonable and credible; (2) designed to calculate those aggregate savings that are attributable to the operation of Dirigo Health; and (3) reflects savings to the end purchasers—consumers and employers.

Anthem BCBS had hoped that the methodology proposed by the Dirigo Board would reasonably satisfy these principles such that the savings offset payment (“SOP”) amount that will be charged to Anthem BCBS members (and all those with private medical coverage in Maine) is no larger than the savings actually accrued to those members as a result of the operation of Dirigo Health. The Board’s proposed methodology, however, does not meet this fundamental objective.

The intent of the Dirigo Act regarding the savings determination is clear: as the name implies, the savings offset payment is designed to offset savings as a result of the operation of Dirigo Health. Analysis of the cost drivers in the healthcare system is complex, but to the extent the proposed methodology results in a savings calculation that is greater than this rather simple formulation (*i.e.*, “SOP paid by those with private medical coverage \leq savings to members with private medical coverage”), the methodology is inaccurate and fundamentally contrary to the intention of the Dirigo Legislation.

It is no answer to suggest that all we need do in this proceeding is determine whether there are “savings to the healthcare system” and ignore whether those savings have actually resulted in a reduction in premiums paid for private medical coverage. The Superintendent is

charged with approving, denying or modifying a calculation that will result in real dollars being paid by Mainers with private medical coverage. Adopting a methodology that does not directly address this reality would be not only be unfair, but also unlawful and discriminatory.

Anthem BCBS has specific concerns with the Dirigo Board analysis, but more globally, the methodology fails to satisfy these fundamental principles because (1) it measures the wrong “thing” (*i.e.*, provider costs, without consideration of whether any reduction in those costs actually leads to a reduction in insurance costs and, ultimately, to a reduction in insurance premiums), and (2) even if it was designed to measure the right thing, the methodology overstates savings by exaggerating the cost savings and then by attributing them all to Dirigo without regard to the role of numerous other factors. Indeed, if approved without modification, the proposed methodology would turn the proper burden of proof in this proceeding on its head, *i.e.*, creating a presumption that 100% of any “savings” found are attributable to Dirigo unless proven otherwise.

Anthem BCBS strongly supports the goals of Dirigo Health and firmly believes that the best way to support those goals is to ensure that the aggregate measurable savings calculation does what it was designed to do and results in premium neutrality for those members paying the SOP. The methodology proposed by the Dirigo Board fails in this fundamental objective and should be modified to meet that goal.

STANDARD OF REVIEW

As stated in the Superintendent’s Second Procedural Order, the Dirigo Board, as the moving party, carries the burden of proof in this matter. As articulated in its Response to the Motion to Dismiss of the Maine Automobile Dealers’ Association Insurance Trust and in its Memorandum on Standard of Review, Anthem BCBS firmly believes that the Superintendent

should consider the evidence presented by the parties in this proceeding *de novo*, without any deference to the Dirigo Board's recommendations.

In the Second Procedural Order, the Superintendent did not address explicitly the question of deference, but ruled that the Dirigo Board is not required to prove by a preponderance of the evidence that its methodology is reasonable. To the extent this ruling gives deference to the Dirigo Board's recommended methodology, it is erroneous for the reasons set forth above and in Anthem BCBS's Response to Motion to Dismiss of the Maine Automobile Dealers' Association Insurance Trust and in its Memorandum on Standard of Review, both of which are incorporated herein by reference.

BACKGROUND

The Dirigo Health Act was enacted in 2003 to provide subsidized insurance coverage to Maine's uninsured population, to expand eligibility for MaineCare and to control the costs of health care in Maine. Reducing the number of Maine's insured and underinsured, it was believed, would cause hospitals to incur reduced costs for bad debt and charity care. It was also believed that these hospital cost reductions would ultimately pass through to private health insurers such as Anthem BCBS, thereby benefiting their insureds through correspondingly lower rates for health care insurance.

The Act creates a mechanism for capturing these cost reductions by requiring private insurers and third party administrators to pay a portion of those cost reductions in the form of a "savings offset payment", which would in turn be embedded in premium rates. The theory underlying the Act is that Anthem BCBS's insureds should be paying no more in premiums post-Dirigo than pre-Dirigo because the reduced bad debt and charity care costs would be passed through in the form of lower hospital and other provider costs, which in turn would lower insurance premiums in an amount that is no less than the savings offset payment.

To implement this funding mechanism, the Act required the Dirigo Board to make a determination of 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 aggregate measurable cost savings figure is then used to form one of the ceilings on the savings offset payment to be determined by the Dirigo Board. 24-A M.R.S.A. § 6913(2)(C). The savings offset payment is then calculated as the lesser of (1) the aggregate measurable savings, (2) 4.0% of certain annual paid claims, and (3) “the amount of funds necessary to provide subsidies pursuant to section 6912 and to support the Maine Quality Forum.” *Id.* §§ 6913(2)&(3)

It was never the intent of the Act to force Maine’s insured population to bear the financial burden of paying for the provision of Dirigo health insurance benefits to Maine’s uninsured or underinsured population. A private insured paying \$1000 in premium pre-Dirigo, should continue to have a \$1000 premium, including the new savings offset payment, post-Dirigo.

ARGUMENT

I. THE METHODOLOGY EMPLOYED BY THE DIRIGO BOARD TO DETERMINE AGGREGATE MEASURABLE COST SAVINGS MUST FURTHER THE UNDERLYING GOALS OF THE ACT

In order to remain true to the purpose of the Act and the statutory requirements of the SOP mechanism, it is vital that the SOP not become an added cost to the insured population (*i.e.*, a payment that is not offset by actual cost reductions for the end-purchasers resulting from Dirigo Health). If the aggregate measurable cost savings are not determined accurately, net premiums for private insurance holders will increase unjustly, which will result in more people being unable to afford private health insurance; a result that is directly contrary to the underlying

goals of the Act. Anthem BCBS submits that avoidance of this negative result is only possible if the aggregate measurable cost savings satisfy the following three criteria:

- A. The methodology used to determine the aggregate measurable cost savings must be *reasonable* and *credible*.
- B. The methodology must calculate only those avoided costs that are *attributable to the operation of Dirigo Health*, as required by the Act.
- C. The methodology must calculate only those avoided costs that are actually avoided *by the end-purchasers*: consumers and employers.

These principles emanate from the language of the Act itself, which provides:

the Board shall determine *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.

24-A M.R.S.A. § 6913(1) (emphasis added). This provision reflects the Legislature’s intent that the cost savings must be “aggregate” (as opposed to partial) and “measurable” (as opposed to theoretical) and must arise “as a result of the *operation of Dirigo Health* and any increased MaineCare enrollment.” *Id.* The Legislature clearly intended a measurement of the actual aggregate cost savings from the operation of Dirigo Health and not mere speculation or projection of possible future reductions that may or may not be realized.

II. THE METHODOLOGY PROPOSED BY THE DIRIGO BOARD TO MEASURE COST SAVINGS AT THE HOSPITAL LEVEL FAILS TO SATISFY THE REQUIREMENTS OF THE DIRIGO HEALTH ACT

The methodology adopted by the Board to determine aggregate measurable cost savings at the hospital level fails to comply with the principles outlined in the preceding section and with the statute itself. The Dirigo Board proposed two methods that endeavor to measure costs savings at Maine hospitals. These methods attempt to isolate savings resulting from voluntary reductions in the State hospitals’ consolidated operating margins (“COM”) and reductions in cost per case-mix adjusted discharge (“CMAD”). As will be explained in more detail below, both

the COM and CMAD measures are fundamentally flawed and their use has produced inflated and unreliable cost savings figures that do not measure costs actually avoided by the end-purchasers of health care. Specifically, the Board-proposed methodology employed to calculate savings ignores hospital charges, and thus fails to reflect the actual cost trends of hospitals as they were passed along by the hospitals to private insurers, and ultimately consumers. In effect, the methodology measures the wrong statistic to ensure compliance with the Act. Moreover, even if the Board’s methodology measured the right statistic, the methodology greatly overstates savings because it attributes 100% of these “savings” to the operation of Dirigo Health.

A. THE METHODOLOGY PROPOSED BY THE BOARD TO DETERMINE SAVINGS ATTRIBUTABLE TO HOSPITAL COST REDUCTION MEASURES THE WRONG STATISTIC TO ENSURE COMPLIANCE WITH THE ACT

The measure proposed by the Board to determine savings attributable to hospital cost reduction uses the wrong statistic to ensure compliance with the Act. Indeed, there is no direct linkage between cost per CMAD and actual savings by private payers that can be captured through savings offset payments. This is because hospitals in Maine, in the vast majority of cases, are reimbursed based on a percentage of their *charges*, and not on the basis of the hospital’s own costs.¹ Changes in a hospital’s *costs* and changes in a hospital’s *charges* differ because hospital charges are influenced by a variety of other factors unrelated to changes in underlying costs of service.²

¹ In cases where Anthem BCBS does not reimburse hospitals based on a percentage of charges, the reimbursement is made based on a negotiated schedule of fixed fees. When fixed fees are negotiated, especially when they are negotiated over the term of a multi-year contract, there is limited opportunity for a payor to have savings attributed to either the reduced COM or the reduced cost per CMAD measure. The rates are simply fixed and do not fluctuate based on cost savings measures.

² These factors include, among other things, changes in enrollment and reimbursement levels by Medicare and Medicaid, volume, changes in investment income and other non-operating revenues, changes in bad debt and free care levels, changes in hospital goals for operating margins, and other factors.

Because the proposed CMAD measure accounts only for hospital costs, without any consideration of whether any reduction in those costs leads to a reduction in insurance costs, the measure fails to ensure that the calculated savings are actually costs avoided by private payers, and thus fails to meet the goals of the Dirigo Act.

B. THE METHODOLOGY PROPOSED BY THE BOARD TO DETERMINE SAVINGS ATTRIBUTABLE TO HOSPITAL COST REDUCTION OVERSTATES ANY POTENTIAL SAVINGS CAUSED BY THE OPERATION OF THE ACT

Even if the Board’s proposed methodology to determine savings attributable to hospital cost-reduction measures the correct statistic, the methodology still violates both the letter and the purpose of the Act because it overstates any potential savings resulting from the operation of Dirigo Health.

1. CMAD METHODOLOGY

The CMAD method exaggerates the aggregate savings in the hospital system by including in the analysis only those hospitals that showed a decrease in costs per CMAD, while ignoring those hospitals that experienced increases in costs per CMAD.³ This method fails to produce “aggregate” measurable cost savings as required by section 6913(1) of the Act. If the Legislature had wished to include cost savings data from only those hospitals that experienced a reduction in costs, it would not have used the term “aggregate” in the Act. Because hospitals with increased costs per CMAD over the benchmark level were excluded from the analysis, it is quite possible that the statewide cost per CMAD may have actually increased during the same time period when the Board’s analysis produced a \$64.2 million purported savings.

³ Of 36 hospitals whose cost growth was measured by Dirigo, 22 showed cost savings while 14 showed dissavings (*i.e.*, rates of increase in cost per CMAD that exceeded the 3.5% target).

Hospital costs fluctuate naturally year to year based on a wide variety of factors, which in turn leads to a bandwidth of expected costs. There will be a mean within that bandwidth, but if only those hospitals that produce costs below the mean are included in the analysis, there will be “savings” in any year, irrespective of the operation of Dirigo Health. To reduce the effects of this self-fulfilling prophecy (*i.e.*, counting as “savings” all those who fall below the mean in the naturally-occurring bandwidth), either all of the hospital results must be considered, or those falling within an expected bandwidth of costs should be removed from the analysis.

In sum, excluding data from hospitals that did not experience a decline in costs results is an inaccurate measure of statewide savings, and is illogical. *See, e.g., Wood v. Superintendent of Insurance*, 638 A.2d 67, 70 (Me. 1994) (“when interpreting statutes, we seek to discern from the plain language the real purpose of the legislation, avoiding results that are absurd, inconsistent, unreasonable, or illogical”).

Another fundamental problem with the cost per CMAD methodology is the assumption that all cost savings experienced by hospitals are attributable to the operation of Dirigo Health. Obviously, many other factors besides Dirigo contribute to changes in hospital costs. The Dirigo Board conceded in its discovery response that it made no effort to limit its methodology so that only those savings resulting from the operation of Dirigo Health would be counted. This failure violates section 6913(1) both because the statute requires the Board to determine only those savings resulting from the operation of Dirigo Health and because it would lead to a SOP that is larger than the savings to those who will pay the SOP.

2. COM MEASUREMENTS

For many of the same reasons, the methodology used to determine the COM measure also overstates savings attributable to the operation of Dirigo Health. The COM measure compares the actual COM for each Maine hospital in 2004 to its expected COM for that year.

Some hospitals reduced their expected COM in 2004, but a number of other hospitals failed to do so. Although section 6913(1) requires that cost savings be measured in the “aggregate,” the Dirigo Board excluded hospitals that showed no reduction in expected COM for 2004. By excluding hospitals that showed a higher than expected COM, the COM measure produced an inflated cost savings figure and failed to determine the “aggregate measurable cost savings.” Similar to the flaws in the CMAD methodology, the COM methodology is mathematically guaranteed to produce cost savings (even if there are no cost savings in the aggregate). The Legislature presumably did not intend such illogical results. *See Wood v. Superintendent, supra.* The proposed methodology also ignores the Legislature’s use of the term “aggregate” as used in the statute.

C. OTHER METHODOLOGICAL FLAWS INHERENT TO THE BOARD-PROPOSED HOSPITAL COST-REDUCTION INITIATIVES

1. THE COM AND CMAD MEASURES ARE CONTRADICTORY

An additional flaw in the methodology proposed by the Board is that the COM measure actually contradicts the CMAD measure. If a hospital’s cost per CMAD increased by more than the prescribed 3.5% benchmark, the hospital was deemed by Dirigo to have failed the cost per CMAD test and was excluded from the analysis because it was deemed not to have contributed any reduced costs to the system. At the same time, if that same hospital’s COM falls below its historical level relative to its costs, Dirigo counted the reduction in COM as a cost savings. Thus, a hospital that experienced increased costs and contributed negative cost savings to the system, can be deemed to have generated cost savings by reducing its COM. Indeed, it is quite possible for a hospital to fail the cost per CMAD test of 3.5%, experience an increase in its

absolute profits, and yet be considered to have passed the COM test and to have contributed to net cost savings for the system.⁴

2. FISCAL YEAR MISMATCH LEADS TO ADDITIONAL INACCURACIES

Dirigo's proposed savings calculation uses portions of the hospital's fiscal years that align with the respective State fiscal year for both the base and measurement time periods. However, the voluntary caps that the hospitals were asked to comply with are based on the hospitals' fiscal years that began on or after July 1, 2003. The result is that unless a hospital's fiscal year happens to align identically with the State's fiscal year, the proposed measurement cannot accurately calculate the true base year costs or the measuring year costs. As a result, the formula necessarily miscalculates the true difference between those costs and produces figures that are inaccurate. Further underscoring the inaccuracy of Dirigo's methodology on this point, a portion of the measurement period used in the calculation for certain hospitals was before the time that hospitals were even asked to comply with the voluntary caps.

3. THE MEASURES ARE CAPABLE OF MANIPULATION

One technical problem, which will be explained in detail by Anthem BCBS's witnesses, is that the CMAD methodology employed by Dirigo includes a factor for outpatient volume. Outpatient charge levels are not regulated. Hospitals are completely free to establish their outpatient charges at whatever levels they deem to be most advantageous for their institutions. Under the formula used by Dirigo, the higher the hospital sets its outpatient charges, the lower will be its measured increase in cost per CMAD. This flexibility would permit hospital

⁴ Consider the following example. Assume that in 2003 a hospital had net revenues of \$42,800,000, expenses of \$40,000,000, a margin percentage of 7% and a net margin of \$2,996,000. In 2004, the same hospital's expenses increased by 4% to \$41,600,000, its net revenue increased by 4.21% to \$44,600,000 and that its margin percentage thereby decreased to 6.7% even though its net profit increased to \$3,000,000. In this example, the hospital would have failed the cost per CMAD test of 3.5%, and increased its absolute profits, yet would have been considered to have passed the COM test and have thereby generated net cost savings for the system.

administrators to raise or lower their cost per CMAD simply by adjusting their outpatient charge levels, and without necessarily having any actual reductions in cost per CMAD. Because it is susceptible to such manipulation, the cost per CMAD methodology is inherently unreliable.

Another major flaw is that the Board's CMAD analysis necessarily incorporated changes in utilization rates. Utilization rates fluctuate from year to year for many reasons that have nothing to do with actions taken by Dirigo Health. By multiplying by weighted discharges, Dirigo's methodology incorporates the effect of those utilization changes.

In addition, the COM test is also susceptible to subjective accounting judgments that can be manipulated to meet the requirements of the test. It is therefore an inherently unreliable measure of cost savings.

III. ADDITIONAL OBJECTIONS OF ANTHEM BCBS TO THE BOARD'S PROPOSED METHODOLOGY TO DETERMINE AGGREGATE MEASURABLE COST SAVINGS

A. MEDICAID INCREASES

Dirigo has also proposed to include increased Medicaid payments to physicians in the calculation of the savings offset payment. The methodology used is faulty because it misunderstands the payment arrangements in place between private insurers and physicians. First, Anthem BCBS pays physicians according to a fixed fee schedule that is updated annually. Under the assumption that increased Medicaid reimbursement is likely to reduce bad debt and charity care for physicians and then have a corresponding impact to reduce physician charges, there would still be no impact to Anthem BCBS because Anthem BCBS reimburses physicians based on a fixed fee schedule that is not based on the physicians' charges. Thus, any increased savings flowing out of this initiative are illusory.

Second, physicians have been advocating for many years for this increase in Medicaid fees. Physicians are not about to simply give back that long sought after increase by lowering the fees they charge to private insurance carriers.

Finally, the \$12.3 million figure represents payments for an 18-month period. The savings offset payment is calculated for a 12-month period. Even if one assumes that the Medicaid fee increase received by physicians ought to be reduced by commercial payor fee schedule reductions, which in Anthem BCBS's view is an unreasonable expectation; only an equivalent amount of 12 months of Medicaid physician fee increases should be included.

B. DIRIGO'S METHODOLOGY IGNORED OTHER MAJOR COST-DRIVERS

The methodology adopted by the Dirigo Board excludes several other major health cost-drivers, including: hospital-owned physician practices, subsidiaries of hospitals and behavioral health facilities.

Hospital-owned physician practices have contributed significantly to increased costs in the hospital setting. The exclusion of these claims leaves out a significant component of cost *increases* and inflates the cost savings resulting from the operation of Dirigo Health.

The exclusion of hospital subsidiaries leaves out the Maine Heart Center. Hospital spending related to cardiac care has been a primary driver of hospital spending over the past few years and exclusion of the Maine Heart Center yields an incomplete picture of hospital cost increases. In contrast, the Central Maine Medical Heart Center is included in the analysis because it is part of the hospital rather than a subsidiary. Excluding one heart center while including another is, once again, illogical.

Similarly, the exclusion of the Spring Harbor and Acadia behavioral health facilities ignores another major contributor to hospital cost increases, especially since the regulated expansion of behavioral health covered services in the fall of 2003.

C. DIRIGO FAILED TO TEST ITS RESULTS

In order for a methodology to produce reasonable and credible results, the conclusions should be verified through statistical significance testing, cross-correlation to reduce the inclusion of impacts from factors extraneous to the operation of Dirigo Health, review and reconciliation of anomalous results, testing to reduce the potential for manipulation of results, and should employ methodologies for updating outdated studies relied upon in the calculation. According to its discovery response, the Dirigo Board performed none of this analysis and its conclusions are, therefore, neither reasonable nor credible.

For example, the Dirigo Board concedes that:

- It made no effort to de-link the various extraneous factors that could have contributed to a rise or fall in healthcare costs. *See* Dirigo Board Response to Anthem BCBS and MAHP Joint Requests, Response number 4.
- It performed no statistical significance testing to determine whether its COM or CMAD methodologies produced statistically significant results. *Id.*; Response number 19.
- It did not conduct analysis to explain why certain hospitals exhibited extremely high baseline growth rates relative to the norm; *Id.*; Response number 23.

The failure to perform these analyses reinforces the lack of credibility and reasonableness exhibited in the Board's methodologies.

D. THE INCLUSION OF SAVINGS BASED ON THE TIME VALUE OF MONEY FOR HOSPITAL SETTLEMENTS AND PIP INCREASES IS INAPPROPRIATE

Anthem BCBS believes that the inclusion of savings based on the time value of money for hospital settlements and PIP increases is inappropriate. Both of these items are longstanding issues that Maine hospitals have worked to fix. In fact, the settlements were the subject of litigation before the Hospital Study Commission ever considered this issue.

The PIP payments to the hospitals are adjusted each year. It is reasonable to assume that the State would have made increases to the PIP payments after MaineCare enrollment was increased. These increases were driven by the MaineCare expansion and were not the result of Dirigo.

Moreover, even with these increased payments, the hospitals still have significant settlements due to them for prior periods. The 2005 PIP rates are based on 2002 data and therefore do not reflect the full impact of increased claims for higher utilization rates by MaineCare members. Including the increased PIP rates assumes that hospitals receiving PIP payments that remain less than the cost of services provided will thereafter lower the charges to be paid by insurance carriers. That is illogical on its face and, at least with respect to Anthem BCBS, did not happen.

The argument that the time value of money for the settlements should be included in the savings calculation is also unreasonable. If the lawsuit surrounding this issue had proceeded to court and a judgment was awarded, the prevailing party would have been entitled to interest. That is, there is no net change to a party's financial position whether the party receives "X" dollars today, or "X" dollars a year from now, but with one year's worth of interest.

E. THE DIRIGO BOARD'S PROPOSED CON AND CIF DETERMINATIONS ARE ALSO FLAWED.

Although the Dirigo Board has provided very little information to support these proposed savings, it appears that the savings are overstated in any event. Dirigo has proposed savings for both SY04 and SY05. However, Dirigo's changes to the CON process did not produce any new denials of applications and once the one-year moratorium ended, projects that were delayed could be submitted for consideration.

Mercer's calculation of savings assumes that the significant drop in proposed projects by providers in SY04 and corresponding "savings" of \$5.7 million calculated by Mercer was due to Dirigo, as opposed to a normal fluctuation in project applications. There is simply no evidence

in the record to support such an assumption. To the contrary, the fact that no applications were denied and the full amount allocated to the CIF was not used suggests that the decline in projects was due to a normal fluctuation in project applications. Under these circumstances and without any supporting evidence, it is unreasonable to include the \$5.7 million as savings attributable to the operation of Dirigo Health.

IV. THE FLAWS IN DIRIGO'S METHODOLOGY ARE DEMONSTRATED THROUGH ANTHEM'S EMPIRICAL DATA

Anthem BCBS's empirical data presented in the testimony of William Whitmore shows that unit costs of healthcare have continued to climb substantially since the inception of Dirigo Health. What has decreased in Maine is the rate of utilization of health care. The empirical data underscores the fact that no reliable linkage has been proven between the operations of Dirigo Health and a decrease in the cost of healthcare in Maine. Anthem's empirical data shows just the opposite.

The purported savings calculated under the Board's methodology should have resulted in a 6.4% reduction in Anthem's unit cost trends. In order for the Superintendent to accept Dirigo's methodology as reasonable, he would have to find that, in the absence of Dirigo, the inpatient unit cost trends for calendar year 2004 would have been nearly 18% and 22.4% for the 12 month period ending March 2005. Such cost trends would be unprecedented in Maine and analysis of data from neighboring New Hampshire further supports the premise that it is unreasonable to assume this level of trend would have occurred in the absence of the operation of Dirigo Health. *See* Whitmore testimony at 7-8.

CONCLUSION

For the reasons described above and through the evidence to be presented by Anthem BCBS, the methodologies adopted by the Dirigo Board fail to accurately determine aggregate measurable cost savings resulting from the operation of Dirigo Health and, accordingly, the

evidence in the record does not reasonably support the Dirigo Board's calculation of aggregate measurable savings.

DATED: October 24, 2005

A handwritten signature in black ink, appearing to read "Christopher T. Roach", written over a horizontal line.

Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
(207) 791-1100

Attorney for Anthem BCBS

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on October 24, 2005, a copy of Anthem BCBS's Pre-Hearing Brief was served on each of the persons listed below and in the manner indicated.

Thomas C. Sturtevant, Jr.
Assistant Attorney General
Department of the Attorney General
6 State House Station
Augusta, Maine 04333-0006

Compass Health Analytics, Inc.
Attn: John Kelly
465 Congress Street, 7th Floor
Portland, Maine 04101

Roy T. Pierce, Esquire
PretiFlaherty
One City Center
P. O. Box 9546
Portland, ME 04112-9546

William H. Laubenstein, III, Esquire
Office of The Attorney General
6 State House Station
Augusta, Maine 04333-0006

William H. Stiles, Esquire
Verill Dana, LLP
One Portland Square
Portland, ME 04101

Rufus E. Brown, Esquire
Brown & Burke
85 Exchange Street, Suite 201
P.O. Box 7530
Portland, ME 04112

D. Michael Frink, Esquire
Curtis, Thaxter, Stevens, Broder
& Micoleau, LLC
One Canal Plaza
P.O. Box 7320
Portland, ME 04112-7320

DATED October 24, 2005



Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
(207) 791-1100
Attorney for Anthem BCBS