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October 17, 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

Dear Superintendent Iuppa:

Enclosed for filing please find two hard copies of the following:

SUBMITTED BY: Christopher T. Roach
DATE: October 17, 2005
DOCUMENT TITLE: Anthem BCBS Response to Informational Requests of Dirigo
Health Agency Board
DOCUMENT TYPE: Response to Request for Information
CONFIDENTIAL: No

Thank you for your assistance in this matter.

Very truly yours,


Christopher T. Roach

cc: John Kelly
Thomas C. Sturtevant, Jr.

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

IN RE:)	
)	
REVIEW OF AGGREGATE)	
MEASURABLE COST SAVINGS)	ANTHEM HEALTH PLANS
DETERMINED BY DIRIGO HEALTH)	OF MAINE, INC. RESPONSE
FOR THE FIRST ASSESSMENT YEAR)	TO INFORMATION
)	REQUESTS OF BOARD OF
)	DIRECTORS OF DIRIGO
)	HEALTH
)	
)	
Docket No. INS-05-700)	

Pursuant to Maine Bureau of Insurance Rules chapter 350, section 10, Anthem Health Plans of Maine, Inc. d/b/a/ Anthem Blue Cross and Blue Shield (“Anthem BCBS”), by and through undersigned counsel, hereby respond to the Request for Information of the Board of Directors of Dirigo Health.

1. Please identify by name, address and business or professional affiliation every person or entity involved in the Anthem’s development of questions set forth in its Informational Request to the Board date October 7, 2005.

Response: Anthem BCBS objects to this request to the extent it seeks information protected from disclosure by the attorney client and work product privileges. Subject to and without waiving these objections, as set forth in Anthem BCBS’s designation of witnesses, Anthem BCBS expects to submit prefiled testimony on the relevant issues by Sharon Roberts, BCBS’s Director of Stakeholder Relations, Jack C. Keane, consultant for BCBS, Daniel McCormack, Executive Director of Provider Network Management for BCBS, William Whitmore, an Anthem BCBS actuary, and David Wakelin, an attorney who represents the Maine Education Association Benefits Trust.

2. Please identify, if not done so in response to Request No. 1, by name, address and business or professional affiliation every consultant or expert retained by Anthem with regard to the present proceeding.

Response: Jack Keane
Jack C. Keane Consulting
2305 Caves Road
Owings Mills, MD 21117

3. For each person or entity identified in response to Request No. 2, please provide a copy of the contract or other agreement pursuant to which services were retained.

Response: Mr. Keane is on retainer with the East Region of Anthem BCBS, and does not have a specific contract for the purposes of the adjudicatory hearing.

4. For each person or entity identified in response to Request No. 2, please state the rate of compensation and how much has been paid to date to each person.

Response: Mr. Keane is reimbursed at an hourly rate of \$250. Mr. Keane has worked a total of 54 hours on this project to date.

5. Please provide a copy of all reports prepared for this proceeding or related to the determination of aggregate measurable cost savings by each person identified in response to Request No. 2, whether or not such reports are to be introduced into evidence in this proceeding.

Response: Please see Attachment A.

6. If the Anthem intends to present an alternative methodology to the methodology adopted by the Board, please describe the alternative methodology in detail.

Response: Anthem BCBS does not intend to propose an alternate methodology for the Superintendent's approval. Anthem BCBS will in its testimony address the alternate methodology proposed by the payor group and included in the Dirigo filing as a means of highlighting flaws in the methodology proposed by the Dirigo Board.

7. If your response to Request No. 6 was "yes", please provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature related to the methodology and your determination of aggregate measurable cost savings.

Response: Please see Anthem BCBS's response to Request Number 6.

8. With regard to your response to Request No. 7, please identify the sources of all data used.

Response: Please see Anthem BCBS's response to Request Number 7.

9. If not already provided in response to Request No. 6 or question No. 5, please provide a copy of all reports prepared or related to the alternative methodology, whether or not such reports are to be introduced into evidence in this proceeding.

Response: Please see Anthem BCBS's response to Request Number 6.

10. If Anthem contends that there have been increased costs in the health care system as a result of the operation of Dirigo Health, please:

- a. Identify each cost
- b. State the amount of each cost identified
- c. State how each cost identified is the result of the operation of Dirigo Health
- d. Provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature used in developing each cost identified

Response: Anthem BCBS does not contend one way or the other with respect to whether there have been increased costs as a result of the operation of Dirigo Health. Any methodology for calculation of the aggregate measurable savings attributable to the operation of Dirigo Health that includes only instances of “savings”, however, is fundamentally flawed.

11. If Anthem contends that there are savings in the health care system not the result of the operation of Dirigo Health, please:

- a. Identify each savings
- b. State the amount of each saving identified
- c. State how each savings identified was achieved
- d. Provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature used in developing each savings identified.

Response: Anthem BCBS does not contend one way or the other with respect to whether there have been savings in the health care system not the result of the operation of Dirigo Health. The methodology proposed by the Board for calculation of the savings attributable to Dirigo Health, however, would include numerous “savings” that are not directly attributable to the operation of Dirigo Health and, accordingly, overstate the savings. For example, when Lewin used the methodology proposed by the Board to calculate “savings attributable to the operations of Dirigo Health” using New Hampshire data, the methodology showed significant savings for New Hampshire. An accurate methodology would have produced no savings, since Dirigo Health is a Maine

initiative that affects Maine residents and thus had no impact on health care costs in New Hampshire. A more appropriate methodology would include a comparison of Maine's experience to regional and national trends to accurately differentiate the savings produced from Maine specific initiatives (i.e. Dirigo) from those that have occurred on a regional and/or national basis.

12. If Anthem contends that netting the amounts of cost avoided by hospitals that met Dirigo voluntary targets against the amounts of cost above target for hospitals that did not meet the voluntary targets, please describe how this addresses the objection that the Dirigo methodology will not capture the valid effort to respond to Dirigo targets by those hospitals that reduced their cost.

Response: Dirigo is supposed to be funded wholly through the aggregate measurable savings attributable to the operation of Dirigo. As such, premiums for insureds should be unaffected by Dirigo: if an insured's annual premium without Dirigo would be \$1,000, the insured's premium with Dirigo should be \$1,000 as well because a properly calculated savings offset payment amount should be offset entirely by the savings from the operation of Dirigo Health. That is why the Legislature embedded the strict standard that the savings offset payment can be no larger than the aggregate measurable savings as a result of the operation of Dirigo Health. If it were otherwise, the savings offset payment would be an additional cost burden on those who purchase insurance. If one were to count only hospitals that experienced cost reductions without aggregating the impact of hospitals that experienced increases in costs, as proposed by the Board, the purported savings are overstated. This necessarily results in a "savings" calculation far greater than the aggregate hospital costs which, together, form the basis for the insured's premium rates. This would be equivalent to one choosing to balance their checkbook by adding up only credits while ignoring debits. Including all hospital costs, *i.e.*, the aggregate costs as the statute directs, captures the aggregate impact on costs that drive premium rates and is the only reasonable methodology for calculating those aggregate costs.

13. Please describe how the private sector contracting process for health care services with hospitals works. Include in your answer:

- a. How far in advance of the first year of the operation of Dirigo health rates for services were negotiated
- b. The basis upon which the rates were negotiated
- c. Whether the rates negotiated for the first year of the operation of Dirigo health can be changed based on information about hospital costs and profits that is not known until the third year of the operation of Dirigo health
- d. How frequently private insurers negotiate charge reductions with hospitals rather than discounts off those charges

Response:

- a. Contract negotiations occur all year long and the timing is based largely on the start of the respective hospital's fiscal year. In addition to the hospital's fiscal year, how far in advance of the contract effective date negotiations begin depends on a number of factors that are tied to each hospital's contract. These factors include the duration of the contract being negotiated, the complexity of the contract terms and other prospective market changes that may affect reimbursement.
- b. The rates are negotiated based on what the hospitals indicate they need to remain financially viable, balanced against Anthem BCBS's need to ensure that our members receive the benefit of the lowest possible rates for services provided by the hospitals.
- c. The rates agreed upon by Anthem BCBS and hospitals in our contracts cannot be changed without the consent of both parties. In addition, it is not possible to change the rates paid to hospitals per the contract on a retroactive basis.
- d. Anthem BCBS does not negotiate charge reductions with hospitals because federal law requires that hospitals charge the same amount to all payers.

14. Please explain how the methodology presented by the payor group to the Board, a methodology that uses hospital charges per adjusted discharge ("CPAD"), reflects the actual rates of payment that are negotiated.

Response: Discount off charge contracts, as reflected in the majority of the contracts Anthem BCBS has with hospitals, do not diminish or understate the savings calculated using the methodology presented by the payor group. Even though the discounts result in Anthem BCBS paying less than billed charges, the upward trend on hospital payments is still the same, so long as the discounts remain the same. The discounts included in hospital contracts do not change substantially from year to year. Because there is no material impact from changes in discounts, Anthem BCBS would see their hospital unit cost trends move in line with the charge increases enacted by the hospitals.

15. If Anthem contends that changes in volume account for increases or decreases in Cost per Case Mixed Adjusted Discharge (“CMAD”) please provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature relate to this contention.

Response: Anthem BCBS does not contend that changes in volume account for changes in the Cost per CMAD.

16. If Anthem contends that hospitals raise charges whenever the government announces cost containment initiatives, please provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature related to this contention.

Response: Anthem BCBS does not contend that “hospitals raise charges whenever the government announces cost containment initiatives.”

17. If Anthem contends that hospitals pass uncompensated care on to the private payors on the basis of cost of uncompensated care, and not on the basis of gross charges foregone, please

provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature relate to this contention.

Response: Anthem BCBS does not contend that hospitals pass uncompensated care to the private payors on the basis of cost. However, the value of uncompensated care should be counted at the cost level when it is being measured as a cost savings in the hospital system. The hospitals record their charges to all patients at the "full" or "gross" charge level. However, charges at hospitals routinely exceed the costs associated with the services that were provided. This "markup" varies substantially across hospitals. Therefore, in valuing the amount of charity care provided by a particular hospital, or by all hospitals, during any time period, and across time periods, it is most appropriate to state the amount of uncompensated care provided in terms of costs rather than charges.

18. Please provide for each Maine hospital the average percentage discount by payer and year for the period 2000 through 2005.

Response: Anthem BCBS objects to Requests 18 because it seeks highly confidential and proprietary business information, the production of which in this proceeding would be impracticable and disruptive to the hearing procedures outlined by the Superintendent in his procedural orders in this matter. The information sought by the Request—all relating to discounted pricing negotiated between Anthem BCBS and Maine hospitals for the years 2000 through 2005—is proprietary as to nearly every other party to the proceeding. Indeed, production of this information concerning Anthem BCBS's business negotiations and pricing schedules could have a significant impact on its ability to offer competitive insurance rates in Maine.

The proprietary nature of the information sought would also cause delays in the hearing process and thereby run contrary to the Superintendent's clear direction in the procedural orders issued in this case. More specifically, information designated by a party as confidential is typically only confidential as it relates to the public; the Superintendent simply goes into executive session when the confidential information is discussed. Here, by contrast, if the requested discount information were to be referenced at the hearing, all parties, witnesses, and attendees would have to be removed from the hearing, with the exception of the Bureau, the Dirigo Board, and the applicable health

plan each time the Superintendent or the Board wishes to use the information requested (*e.g.*, on cross-examination). Given the limited time for the hearing and the Superintendent's admonition that further time limits may be imposed, producing the information requested would at best be impracticable and, more likely, disrupt the flow of the hearing contemplated by the Superintendent's procedural orders and the Bureau Rules governing this proceeding. *See, e.g.*, Bureau Rules ch. 350, §2(B) (purpose of rules is "to secure a just, speedy and economic determination of all matters pending before the Superintendent or his staff.").

Subject to and without waiving the objections provided above, in an effort to provide meaningful information that actually can be produced under normal procedures for confidentiality and without the cumbersome prospects of clearing the room each time the information is referenced, Anthem BCBS proposes to produce hospital discount information in the aggregate reflecting the discount trend for the period 2002 through 2005. From 2002 through the present, there has been no more than a 1% aggregate change in hospital discounts.

19. With regard to your response to Request No. 18, please provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature related to your response.

Response: Anthem BCBS incorporates by reference its objections and response to Request 18.

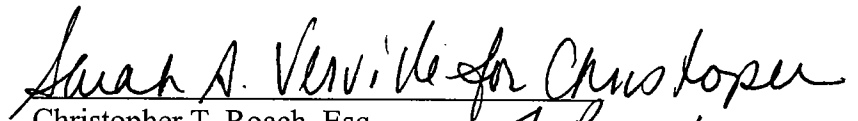
20. For each Maine health insurance carrier, please provide the average percentage discount by hospital and associated contract terms for the period 2000 through 2005.

Response: Anthem BCBS incorporates by reference its objections and response to Request 18.

21. With regard to your response to Request No. 22, please provide all data, calculations, information, work papers, documents and other materials of whatever kind and nature related to your response.

Response: Anthem BCBS assumes the Dirigo Board intended to reference Request 20. Under that assumption, Anthem BCBS incorporates by reference its objections and response to Request 18.

DATED: October 17, 2005


Christopher T. Roach, Esq.
PIERCE ATWOOD LLP
One Monument Square
Portland, ME 04101
(207) 791-1100
Attorney for
Anthem Health Plans of Maine, Inc.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on October 17, 2005, a copy Anthem Health Plans of Maine, Inc.'s Response to Request for Information from The Board of Directors of Dirigo Health was served via electronic and US mail on each of the persons listed below:

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

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Attn: John Kelly
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Portland, Maine 04101

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

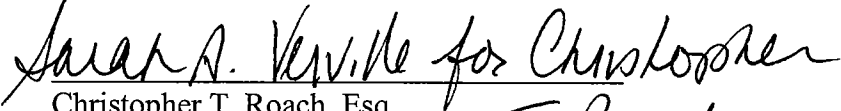

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DATED: October 17, 2005


Christopher T. Roach, Esq. 

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

Attorney for Anthem Health Plans of Maine, Inc.

MEMORANDUM

To: Sharon Roberts
From: Jack Keane
Subj: Dirigo Health Savings Offset Payments
Date: July 19, 2005
cc: E. Hoeflinger, D. McCormack

I am providing the following preliminary comments regarding the Dirigo Health Savings Offset Payments based on the slide presentation presented by Dirigo Health for discussion purposes as of April 15, 2005. I will review the additional Dirigo documents that you sent me yesterday and get back to you with more comments if they affect my assessment in a material way.

A. The Voluntary Hospital Targets

In the Dirigo Act, several voluntary “targets” were established as a basis for determining health cost “savings” that could be used to provide subsidies under the Dirigo Health Insurance program and to fund the activities of the Maine Quality Forum. Two of the tests relate to hospital performance and one relates to insurance company performance. I will address the hospital targets in this section and with the insurance company target in Section B.

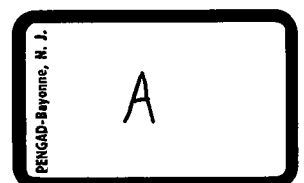
The hospital targets are:

- o Consolidated Operating Margins: Hospitals have been asked to hold these margins to 3% or less for their fiscal year beginning on July 1, 2005 and to continue meeting this target through the end of the fiscal year beginning on or after July 1, 2007.
- o Expense per Casemix-Adjusted Discharge and Volume-Adjusted Outpatient Discharge: Hospitals have been asked to hold the trend in this amount to 3.5% per year for the time period defined by the fiscal year beginning on July 1, 2005 and extending through the close of the fiscal year beginning on or after July 1, 2007.

If these voluntary targets are achieved, the associated “cost savings” are to be computed and made available to subsidize payments for eligible persons enrolled under Dirigo Health Insurance and to fund the Maine Quality Forum.

1. The Consolidated Operating Margins Test

Hospital margins (profits) change for any and all of the following reasons:



- Changes in expenses
- Changes in revenue
- Changes in accounting practices and estimates

The last item encompasses the first two and is a significant factor that is largely under the control of the hospitals. Estimates are involved in many accounts that affect the reported income level. For example, hospitals estimate the proportion of gross revenue recorded in any year that will not be received because it is associated with contractual adjustments. Contractual adjustments are the amount of revenue that is not received by the hospital because the payment arrangements it has in place with various payers (e.g., Medicare, Medicaid, private health plans, etc.) generate payments that are less than the hospital's full charges. The amount of contractual adjustments to be expected for any given year is an estimate rather than an exact amount. Higher (lower) estimates have the effect of reducing (increasing) reported margins. Similarly, the amount of revenue foregone in any given year for services to charity patients is also an estimate. Like contractual adjustments, higher (lower) estimates reduce (increase) reported margins. Finally, bad debts are reported as expenses. The amount of revenue lost for any given year because of bad debts is also an estimate. Higher (lower) bad debt expenses reduce (increase) reported margins.

The suggestion that hospitals can and do employ discretionary accounting estimates to manage their reported margins has been corroborated by academic and other work. Therefore, the use of the consolidated operating margin as a voluntary performance target gives the hospitals some ability to adjust their reported results to ensure that they pass the test. This flexibility makes it imperative for the Dirigo staff to employ an expert with extensive expertise in hospital financial analysis (e.g., Nancy Kane from HSPH) to review the financial statements submitted by the hospitals. However, even expert review will not entirely remove the element of judgment in the reporting of the relevant accounting items. In regard to the margin test, the hospitals will have the incentive to bias the estimates in whatever direction is needed to meet the Dirigo Health margin test without violating bond covenants or reducing the hospital's financial rating for borrowing purposes.

2. The 3.5% Target for Growth in Expenses per Casemix-Adjusted Discharge and Volume-Adjusted Outpatient Case

This test is also problematic. First, the private carriers in Maine generally do not pay on the basis of hospital costs or expenses—they generally pay for care on a “percentage of charges” (POC) or “discount” basis. Therefore, it is the annual growth in charges, rather than the growth in expenses, that affects private sector payment levels. If hospital expense growth is moderated, it does not necessarily translate into cost savings for the private carriers. A cost offset based on lower expense growth ignores the fact that it is the growth in charges, rather than the growth in expenses, that drives private sector hospital expenditures. Lower cost growth does not produce savings for the private sector unless it is translated into lower charge increases.

Second, as noted above, the hospitals in Maine are paid by most private carriers on a “percentage of charges” (POC) or “discount” basis for inpatient services. Accordingly, they have had weak incentives to fully code their inpatient records to ensure that private patients are

classified into the highest weighted DRGs. Higher weights produce higher casemix-adjusted discharge totals because the Casemix-Adjusted Discharges (CMADs) statistic is computed by multiplying the number of discharges by the associated weights. The establishment of the weighted expense growth test gives the hospitals an incentive to more fully code their discharge records. If the number of CMADs used in the denominator of the expense target is increased by more thorough coding practices, the effect will be to artificially increase the denominator in the calculation and to reduce the calculated rate of expense growth for the given time period.

Third, the weighted measure of outpatient volume that is added to the number of CMADs to produce an overall weighted volume level for the hospital is computed by dividing the average gross revenue per CMAD by the average gross revenue per outpatient discharge. But gross revenues are under the control of the hospitals because they are able to change their charge masters (which contain their unit prices) with few constraints. Hospitals can raise the level of “weighted” outpatient activity—and thereby artificially raise the denominator in the expense target calculation—simply by raising their charges. An artificially increased denominator will artificially depress the measured rate of expense growth. Thus, the expense target could be met not by real cost control but rather by charge master adjustments. To the extent that raising outpatient charges might cause the hospitals to fail the margins test, they could voluntarily increase the discounts given to the private carriers to ensure that the gross revenue increase would not generate excessive additional net revenues. This relationship between the tests is contradictory to some degree because the volume measure used in the expense growth test encourages hospitals to raise outpatient charges and thereby undermines the aim of the margin limits (and increases the likelihood of margin management through accounting estimates).

Fourth, the expense target is mostly irrelevant for the Medicare program. The Medicare program does not save any money per unit of service if the expenses incurred by Maine hospitals grow by smaller amounts. Medicare pays on the basis of prospectively-computed fixed rates for inpatient and outpatient services. There is very little connection between actual expenses in Maine hospitals and their payments from Medicare. The Maine hospitals will be paid virtually the same amounts by Medicare regardless of their expense levels. Thus, any “savings” associated with Medicare patients covered by Medicare should be removed on a weighted basis from the computation of system savings computed by Dirigo Health. Depending on the payment methodology used by the Medicaid program in Maine, this same criticism may apply and may provide a basis on which to argue that at least the federal share of any Medicaid patient activity should be excluded from the savings offset calculation.

Finally, the use of an outpatient volume statistic that would be less vulnerable to manipulation—such as an APC equivalent statistic—and the use of a revenue-based “cost” statistic for the private sector would be desirable if this Dirigo Health test is to be used as a hospital performance measure.

3. The Issue of Double Counting

It is not clear to me that the margin test and the expense growth test do not involve some degree of double counting of savings. According to Dirigo Health, the health care system saves money when hospital margins are lower. Hospital margins could fall because hospital expenses

rise faster than hospital revenues. If so, the hospital industry might pass the margin test, and the decline in the margin would be counted as “savings” to the system, even though it would have been driven by higher, not lower, expenses. If the growth in expenses per weighted volume unit were to exceed the 3.5% target, the hospital industry would fail the expense test, but the “savings” computed in the margin test would still be treated as real money available to fund Dirigo Health Insurance subsidies and the Main Quality Forum. This savings computation approach does not appear sensible to me.

B. The Voluntary Insurance Cap on Underwriting Gains

Dirigo Health’s savings offset calculations contend that the health system will save money if the underwriting gains of private insurers are held to 3% or less—i.e., to levels below their recent experience. But it is the private carriers, who will thereby have less money to contribute to initiatives like broadening insurance coverage, that are being asked to make payments to Dirigo Health to subsidize coverage for the uninsured (and the activities of the Health Quality Forum). If health insurance premiums are lowered, it is the insured accounts, not the insurers, who will save money and who might thereby be in a better position to subsidize care for the uninsured. Arguably, the private insurers would be in a better position to provide such subsidies if their underwriting gains were to increase, rather than decline, against historical levels.

C. Reductions in Cost Shifting from Insuring the Uninsured

The Dirigo Health slide presentation estimated the cost of medical care for the uninsured at approximately \$87.00 PMPM. This translates to \$1,044 if a person is uninsured for an entire twelve month period. My understanding is that the Dirigo Health Insurance program currently includes about 2,800 people who were previously uninsured for a full year. Assuming that the entire cost of this care was previously shifted to the private sector, the “savings” would amount to approximately \$2.9 million. This amount is not very large. It is probably exceeded by the savings associated with the fact that previously uninsured persons who turn 65 years of age in any given year obtain Medicare coverage. The aging of the population increases the share of the total population in Maine that has Medicare coverage over time. This trend has the effect of reducing the number of uninsured persons in Maine and it has nothing to do with Dirigo Health’s efforts.

The fact that the total savings that could be computed as a result of insuring the 2,800 persons identified above is far below the \$50 million in savings that Dirigo Health estimates is needed to implement their program makes the calculation of system savings, as measured by the performance tests discussed above, the key drivers in the determination of whether or not the savings to support the program are being generated.

D. Summary

The three tests proposed by Dirigo Health as measures of system cost offsets that could be used to fund an expansion of coverage for the uninsured, and to pay for the activities of the Maine Quality Forum, are flawed in both technical and conceptual respects. The only real

sources of additional money to pay for these purposes in Maine are the state government, which could afford to contribute to such an effort if Medicaid costs are reduced, or if lower health costs attract more businesses and raise tax revenues; and the individuals and employers who pay for health insurance coverage. The payments made by this latter group could be reduced if health costs are moderated and premium increases follow the expense trend. These savings would increase the ability of this group to contribute to the expansion of health insurance coverage or health quality improvement efforts through taxes or other assessments. The system cost offsets proposed by Dirigo Health reflect measurements that do not capture real savings in the Maine health system.

* * * * *