

October 24, 2005

VIA E-MAIL AND US MAIL

Alessandro A. Iuppa, Superintendent
ATTN: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional & Financial Regulation
34 State House Station
Augusta, ME 04333-0034

RE: In Re: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the First Assessment Year
Docket No. INS-05-700

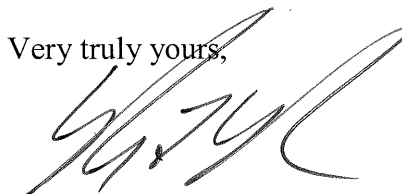
Dear Superintendent Iuppa:

Enclosed for filing in the above-referenced matter please find the original and one (1) copy of the following documents:

1. Filing Cover Sheet; and
2. Hearing Brief Of The Maine Automobile Dealers Association Insurance Trust And The Bankers Health Trust.

Thank you for your attention to this matter.

Very truly yours,



Roy T. Pierce

RTP:lm

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

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO)
HEALTH FOR THE FIRST) FILING COVER SHEET
ASSESSMENT YEAR)
)
)
DOCKET NO. INS-05-700)

TO: Alessandro Iuppa, Superintendent of Insurance
Attn: Vanessa J. Leon

Date Filed: October 24, 2005

Names of Parties: Maine Automobile Dealers Association Insurance Trust
and Bankers Health Trust

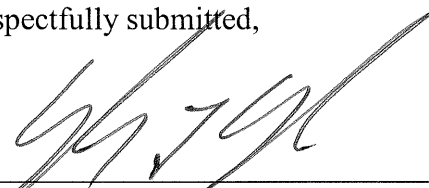
Document Title: Hearing Brief Of The Maine Automobile Dealers Association Insurance
Trust And The Bankers Health Trust

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Dated: October 24, 2005

Respectfully submitted,



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

IN RE: REVIEW OF AGGREGATE)	
MEASURABLE COST SAVINGS)	HEARING BRIEF OF THE MAINE
DETERMINED BY DIRIGO)	AUTOMOBILE DEALERS
HEALTH FOR THE FIRST)	ASSOCIATION INSURANCE TRUST
ASSESSMENT YEAR)	AND THE BANKERS HEALTH
)	TRUST
DOCKET NO. INS-05-700)	

NOW COME the Intervenors, the Maine Automobile Dealers Association Insurance Trust and the Bankers Health Trust (collectively, “the Trusts”), by and through their undersigned counsel, and, pursuant to the Superintendent’s Second Procedural Order dated October 11, 2005, submit the following hearing brief.

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INTRODUCTION

On September 19, 2005, the Dirigo Health Agency’s Board of Directors (the “Dirigo Board”) filed with the Superintendent its first annual determination of “aggregate measurable cost savings” pursuant to the Dirigo Health Act, P.L. 2003, ch. 469, as modified by P.L. 2005, ch. 400 (the “Act”). The Dirigo Board found aggregate measurable cost savings in the amount of \$136.8 million. In so finding, the Dirigo Board adopted the bulk of the methodology (the “Mercer Methodology”) advanced on behalf of the so-called “Dirigo Group” by Nancy M. Kane, DBA of the Harvard School of Public Health, and Mercer Government Human Services Consulting (“Mercer”), who were each retained by the Dirigo Health Agency (“DHA”).

As demonstrated below and in the hearing briefs of Anthem, the Maine State Chamber of Commerce, and the Maine Association of Health Plans, the Mercer Methodology is a purely results driven construct used to create an illusion of cost savings where none exist. It takes liberties with the statutory language, violates basic principles of economic and actuarial analysis, defies common sense, and is riddled with mathematical errors.

I. DHA Cannot Prove Aggregate Measurable Cost Savings To Any Reasonable Degree Of Certainty.

It is not the Intervenors’ burden to prove anything in this proceeding. Rather, it is DHA’s burden to prove the existence of aggregate measurable cost savings and to quantify them. To

that end, DHA hired Mercer to develop a methodology for determining cost savings and to do the necessary calculations and agreed to pay it \$975,000 to do so. However, to its credit, Mercer has been quite candid regarding its inability to segregate cost savings attributable to Dirigo Health from those that are not given the data and time constraints presented.¹

At a meeting of the Savings Offset Payment Working Group authorized by the Legislature, P.L. 2005; ch. 400, § B-1, held on August 2, 2005, Steven Schramm of Mercer fielded questions from members of the Working Group. Mr. Schramm's answers to the members' questions, as summarized by the Bureau, are revealing:

Q: How does one determine where savings come from?

Ans: After some review of the savings initiatives to see if the savings are connected to the Dirigo Health Act and after reviewing the savings offset payment process where the actual payment represents only a portion of the savings estimated, *Mercer chose an approach that did not separately identify savings associated with the Dirigo Health Act. Mercer indicated that if more data was forthcoming and if time permitted, then a more precise calculation could theoretically be made.*

...

Q: In regard to the CMAD - savings are identified as attributable to Dirigo, as are changes in the severity of illness. However, there are quality initiatives developed by carriers and others in the State. How can the changes in severity be attributed to Dirigo only?

Ans: It is not certain one can differentiate between CMAD changes already in the works versus new initiatives that may have been undertaken during the time period of the baseline. Further, *given the timing and the lack of baseline data, it is probably impossible to say whether CMAD improvement is as a result of initiatives before 2004 as opposed to 2004 and later.*

(Shiels Pre-Filed at Exh. 2 pp. 2-3).

¹ Other witnesses share Mr. Schramm's belief that it is not possible to segregate cost savings attributable to Dirigo Health from those attributable to other factors given the data and time restraints. (Shiels Pre-Filed at 14; Tobin Pre-Filed at 5; Keane Pre-Filed Testimony at 2). Indeed, David Tobin of CIGNA has testified that such segregation would be very difficult even with unlimited time and data. (Tobin Pre-Filed at 5-6).

Later, at the September 6, 2005 Dirigo Board Meeting, Mr. Schramm stated that it is not possible to determine the impact of any of the particular cost savings initiatives with the data and time available. (Transcript of 9/6/05 Dirigo Board Meeting at 56). Mr. Schramm elaborated:

[I]t is an unrealistic standard to try to say you have to be able to ascribe any one particular cost savings amount to a particular initiative. But what I can say very comfortably is, the Dirigo Health reform initiatives are the primary driver of change within the marketplace and we believe that our overall savings estimate, underestimates the amount of savings in the marketplace and so I'm comfortable saying if a savings is a number as high as this and we're only going to take a portion of it, I clearly recognize that Dirigo is not responsible for every portion of savings but I know we're responsible for a significant portion as the primary driver of reform in the marketplace.

(Id. at 57) (emphasis added).

DHA was asked in an information request propounded by Anthem and MAHP to explain how the Mercer methodology “will ensure that the savings calculated by that methodology reflects the cost savings as a result of the operation of Dirigo Health, and excludes cost savings resulting from factors external to the legislation.” DHA’s response was as follows:

The healthcare system is extremely complex with a myriad of variables moving at the same time. Since this is real life we cannot perform a randomized controlled scientific trial where you can take one initiative and de-link it from all others. Forces other than Dirigo had a potential impact on the data used to perform the calculations. Mercer recognized this through the use of conservative assumptions when calculating savings.

(Dirigo Health Response to Joint Information Requests of Anthem Health Plans of Maine, Inc. and MAHP to the Board of Directors of Dirigo Health at Response No. 4). Mr. Schramm has reaffirmed this point in his pre-filed testimony. (Schramm Pre-Filed at 8-9).

Despite repeatedly admitting that it cannot separate health care cost savings attributable to other factors it concedes were operating in the marketplace, Mercer calculated aggregate measurable cost savings of \$136.8 million as a result of Dirigo Health by simply attributing to

Dirigo 100% of the savings it claims have found.² Remarkably, the justification for this approach is nothing more than “the cost savings figure is smaller than it could have been because we were conservative on our assumptions.” However, the size of the number says nothing about the validity of the equation used to calculate it.

II. The Mercer Methodology Adopted By The Board Is Fundamentally Flawed.

A. A Valid Methodology Would Not Reveal Aggregate Measurable Cost Savings In States Other Than Maine Or For Periods Prior To The Act’s Passage.

Perhaps the most damning indictment of the Mercer Methodology is the fact that although it purports to quantify cost savings in Maine attributable to Dirigo Health, it is capable of demonstrating cost savings attributable to Dirigo Health in states other than Maine and for time periods prior to the Act’s passage. John Shiels of the Lewin Group has used the Mercer Methodology to demonstrate the existence of cost savings attributable to Dirigo in both Maine and New Hampshire in SFY 2003, the year *before* the Act’s passage. (Shiels Pre-Filed at 17-18, 19). According to Mr. Sheils, the Mercer Methodology is so flawed that it will *always* reveal the existence of cost savings attributable to Dirigo “anywhere, at any time.” (*Id.* at 17-18).

B. The Mercer Methodology Is Contrary To The Act’s Plain Language.

At the core of this proceeding is the following statutory language:

[T]he [Dirigo] Board shall determine annually ... 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

² In an attempt at damage control, CAHC contends that Mercer’s admitted inability to segregate cost savings attributable to Dirigo Health from those attributable to other factors is not fatal because none of the Intervenor has made a “convincing case that there are any such factors in play.” (CAHC Brief at 5). However, as noted above, the Intervenor are under no obligation to prove anything—the burden of proof rests squarely on DHA. Therefore, DHA cannot, as CAHC suggests, simply assume that all cost savings are attributable to Dirigo until shown otherwise—DHA must affirmatively prove that the cost savings are the 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)(A); see also P.L. 2005, ch. 400, § B-2(2)(A). The Act, therefore, clearly and unambiguously provides that there are but two sources of “aggregate measurable cost savings”—cost savings as a result of (1) “the operation of Dirigo Health” and (2) increased MaineCare enrollment due to expansions in eligibility. However, most of the so-called “Cost Savings Initiatives” on which the Mercer Methodology is based, representing the overwhelming majority of the aggregate measurable cost savings found by the Dirigo Board, fall outside the cost savings categories identified in the Act.

1. *The Mercer Methodology Includes Categories Of Supposed Cost Savings Having Nothing To Do With “The Operation Of Dirigo Health.”*

Throughout this process, Mercer has repeatedly asserted that aggregate measurable cost savings includes all savings “as a result of the Dirigo Health Reform Act and its related initiatives.” (Mercer Final Report at 5, 9, 26, 27, 28; Dirigo Health Savings Offset Methodologies at 25). Following up on this theme, in his Pre-Filed Testimony, Steven Schramm identifies Mercer’s “approach to this project” as follows:

Mercer’s approach was to use the Dirigo enabling statute as our guide. The statute lays out the framework and time frames for estimating the impact of the Dirigo program in reducing the rate of growth in the health care system. The Dirigo program is composed of various initiatives and decisions made by the Dirigo Health Agency, the Hospital Commission, and other entities associated with, related to, or a result of, Dirigo. These programs and decisions impact multiple time frames and populations. Thus, the approach to estimating the impact of Dirigo must include multiple initiatives to be consistent with the statute and capture the full impact of Dirigo.

(Schramm Pre-Filed at 3). In short, it is Mercer’s belief, and the foundation on which the Mercer Methodology rests, that any cost savings having any relation to the Act is appropriately considered in determining aggregate measurable cost savings.³

As noted above, however, the Act requires that in order to be included in the calculation of aggregate measurable cost savings must be “as a result of the operation of Dirigo Health.” Under the Act, “Dirigo Health” is “an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents and individuals on a voluntary basis.” 24-A M.R.S.A. § 6902. Thus, as used in the Act, “Dirigo Health” refers to the *agency* created by the Act, *i.e.*, DHA, not to the Act. In the calculation of aggregate measurable cost savings, therefore, the focus must be on the agency alone, not the Act itself.

Moreover, it is not enough for a measure of cost savings to be related to the DHA to be considered in the calculation of aggregate measurable cost savings; rather to be included in the calculation, an item of cost savings must be related to the *operation* of DHA. A central tenet of statutory construction is that statutes must be interpreted in accordance with the plain meaning of the language used. See In re Wage Payment Litig., 2000 ME 162, ¶ 4, 759 A.2d 217, 220-21. The plain meaning of “operation” is the state of being functional. See THE NEW WEBSTER’S ENCYCLOPEDIA OF THE ENGLISH LANGUAGE at 467-68 (1997). Therefore, in order to be properly included in the measure of aggregate measurable cost savings, a cost savings must be attributable to the functioning of DHA. DHA, however, was established to provide comprehensive and affordable health coverage to those eligible and to monitor and improve the quality of health care in Maine. See 24-A M.R.S.A. §§ 6902 and 6908.

³ DHA has endorsed this position. (Dirigo Brief at 4-5).

The Mercer Methodology includes a variety of purported cost savings having nothing to do with the operation of DHA.

a. VOLUNTARY LIMITS ON CONSOLIDATED OPERATION MARGINS, CASE MIX ADJUSTED DISCHARGE, AND UNDERWRITING GAIN.

In the Act, the Legislature asked various participants in Maine's healthcare market to adhere to certain voluntary limits on their businesses for SFY 2004. Those voluntary limits included requests that (1) hospitals limit their consolidated operating margins ("COM") to no more than 3%; (2) that hospitals limit their cost increases to no more than 3.5% as measured by expenses per case mix adjusted discharge ("CMAD"); and (3) that insurance carriers limit the pricing of products sold in Maine to a level of that supported no more than a 3% underwriting gain, less federal taxes ("VUG"). See P.L. 2003, ch. 469, § F-1(B)-(C). Any cost savings arising from adherence to the voluntary limits established by the Legislature are not the result of the operation of DHA.

First, in contrast to reduction in bad debt and charity care, the Act does not identify adherence to the voluntary COM, CMAD, or VUG limits as potential bases for cost savings to be included in the calculation of aggregate measurable cost savings.

Second, there is not one mention of DHA in the part of the Act in which compliance with the voluntary COM, CMAD, and VUG limits was requested. By contrast, there are several references to other state agencies and private organizations, including the Maine Hospital Association, the Governor's Office of Health Policy and Finance, the Department of Human Services, the Commission to Study Maine's Community Hospitals, and the State Planning Office. See P.L. 2003, ch. 469, Pt. F.

Third, DHA did not start functioning until long after SFY 2004 began on July 1, 2003. The Governor did not nominate the Dirigo Board until September 5, 2003; DHA did not release

an RFP to carriers regarding the administration of the Dirigo Health Plan until May 7, 2004; DHA's contract Anthem to serve as the Plan's administrator was not announced until August 23, 2004; DHA did not begin selling to its first eligible participants until October 4, 2004; and coverage for the first participants did not begin until January 1, 2005.⁴ The COM and CMAD targets on which Mercer relied were in place only through June 30, 2004, and the VUG target was in place only through December 31, 2004. See P.L. 2003, ch. 469, § F-1; Bureau of Insurance Bulletin 322 dated October 22, 2003.⁵ It is simply impossible for any cost savings resulting from adherence to the voluntary COM, CMAD, and VUG limits to be the result of the functioning of an agency that was neither in existence at the time the limits were established, nor actually providing coverage until after the voluntary limits expired.

b. CON/CIF SAVINGS

Mercer included \$9.8 million in Certificate of Need and Capital Investment Fund ("CON/CIF") savings in its calculation of aggregate measurable cost savings. (Mercer Final Report at 23-25). Such savings are not attributable to the operation of DHA. Indeed, as the statutory basis for including CON/CIF in aggregate measurable cost savings, Mercer cites not to the Act or even to another part of the Insurance Code, but to two provisions of the Certificate of Need Act of 2002 (22 M.R.S.A. §§ 327(1) and 335(1)(E)), and the Moratorium imposed on spending for new buildings and equipment in 2003.

⁴ See <http://www.dirigohealth.maine.gov/dhsp02f.html>,
<http://www.dirigohealth.maine.gov/dhsp01c.html>,
http://www.me.gov/governor/baldaccihealthpolicy/news/8_23_04.html,
<http://www.maine.gov/tools/whatsnew/index.php?topic=gov+news&id=675&v=article>,
<http://www.maine.gov/tools/whatsnew/index.php?topic=gov+news&id=2333&v=article>.

⁵ New and different voluntary COM and CMAD targets apply to fiscal years beginning on or after July 1, 2005, and remain in effect through the end of fiscal years beginning on or after July 1, 2007. See P.L. 2005, ch. 394, § 4. No new voluntary VUG targets have been established.

However, the Certificate of Need Act is administered by the Department of Human Services, and was passed a year prior to the Act's passage. See P.L. 2001, ch. 664. Similarly, the Moratorium was issued on May 5, 2003, a month before the Act's passage. Cost savings initiatives resulting from legislation and administrative rules enacted prior to the statute to which DHA owes its very creation was passed cannot be the result of DHA's operation.

c. BUDGET INITIATIVES

The Mercer Methodology attributes to so-called "Budget Initiatives," savings representing: (1) the time value of money stemming from hospitals' receipt of payments paid by the State to settle the hospitals' Medicaid reimbursement claims (the "historical settlement payments") and increased Prospective Interim Payments ("PIP") three years "early"; and (2) increases in Medicaid payments to be paid to physicians during SFY 2006 and the first half of SFY 2007. Neither of these purported categories of cost savings is the result of DHA's operations.

First, the time value of money is not related to the operation of DHA. The historical settlement payments themselves have nothing to do with DHA's functioning as a state agency. Those payments are for reimbursements the State was required to make to hospitals for Medicaid expenses incurred during several fiscal years before the Act was even proposed, let alone before DHA was functioning. Moreover, not even Mercer, with its broad view of the cost savings properly included in the calculation of aggregate measurable cost savings, asserted that the PIP payments had any relationship to the operation of DHA. The time value of money has nothing more to do with the operation of DHA than do the payments on which they were based, unless of course DHA is now responsible for interest and inflation.

Second, an increase in Medicaid payments to physicians has nothing to do with DHA, much less its operations. Indeed, Mercer tacitly recognizes as much in its statement of the

statutory authorization for this initiative. According to Mercer, the increase in physician payments is attributable to the recommendations of the Commission to Study Maine's Community Hospitals, which was created by the Act, specifically P.L. 2003, ch. 469, § F-3(1). (Mercer Final Report at 28). The Commission to Study Maine's Community Hospitals, however, is independent from DHA, and, in fact, DHA is not even referenced in Part F of Chapter 469. Aggregate measurable cost savings does not include items simply because they are related in some fashion to the Act.

2. *Mercer Ignores The Act's Express Limitation On The Use Of Increased MaineCare Enrollment In The Calculation Of Aggregate Measurable Cost Savings.*

As one of its so-called "Uninsured Savings Initiatives," Mercer attributes \$3 million in cost savings to the "woodwork effect" of MaineCare members who were previously uninsured or underinsured coming "out of the woodwork" to enroll in MaineCare "through the Dirigo single-point-of-entry enrollment process." Mercer calculated these alleged MaineCare Woodwork savings by multiplying the increase in MaineCare enrollment since June 30, 2004 "assumed attributable to Dirigo" by a per member per month cost figure. (Mercer Final Report at Appendix L).⁶ Once again, Mercer is taking liberties with the statutory language.

As noted above, one permissible element of cost savings for inclusion in the Dirigo Board's determination of aggregate measurable cost savings consists of cost savings attributable to "any increased MaineCare enrollment *due to an expansion in MaineCare eligibility* occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A) (emphasis added); see also P.L. 2005, ch.

⁶ Mercer assumed that 50% of the 7,763 person increase in MaineCare enrollment was attributable to Dirigo. (Mercer Final Report at Appendix L). Such an assumption is not reasonable given the fact that MaineCare enrollment increased by 2.5% in SFY 2005, well below the average of recent years. (Shiels Pre-Filed at 30-31).

400, § B-2(2)(A). Mercer, however, bases its MaineCare Woodwork savings on the increase in the number of persons enrolled in MaineCare since June 30, 2004, that it assumes is due to “*publicity surrounding Dirigo*” (Dirigo Health Revised Response to Second Information Request of the Superintendent at Response No. 9), rather than on the increase in MaineCare enrollment attributable to an expansion of MaineCare eligibility as required by the express language of the Act. In so doing, Mercer impermissibly reads the limitation “due to an expansion in MaineCare eligibility” out of the Act, in contravention of the long-standing rule of statutory construction that meaning must be given to every word, term, and phrase in a statute. See Handyman Equip. Rental Co., Inc. v. City of Portland, 1999 ME 20, ¶ 9, 724 A.2d 605, 607-608.

C. Mercer Ignores The Meaning Of The Word “Aggregate”.

Assuming *arguendo* that savings resulting from hospital adherence to the voluntary COM and CMAD limits can properly be considered in calculating aggregate measurable cost savings, the COM and CMAD savings determined by Mercer are so fundamentally flawed that they cannot be considered here.

The Act requires that cost savings be measured in the *aggregate*. As commonly understood, an “aggregate” figure represents the whole resulting from the amalgamation of all constituent parts. See THE NEW WEBSTER’S ENCYCLOPEDIA OF THE ENGLISH LANGUAGE at 14 (1997). However, rather than including in its savings calculations the COM and CMAD data from *all* Maine hospitals, Mercer includes the COM and CMAD data only from those hospitals showing reductions in COM and CMAD; *i.e.*, those showing the desired savings. Thus, under Mercer’s reasoning, a corporation is profitable if one of its operating divisions shows a profit of \$1 million, notwithstanding the fact that each of its other three operating divisions shows a \$2 million loss. Mercer’s findings with respect to COM and CMAD are

particularly important since together they represent over \$70 million of the cost savings found by the Dirigo Board.⁷

D. There Is No Consistency In The Time Periods For Which Savings Attributed To The Various Cost Savings Initiatives Are Calculated.

Since the Dirigo Board is charged with making a determination of aggregate measurable cost savings “annually,” one would reasonably assume that the Mercer Methodology adopted by the Dirigo Board measures each element of cost savings included within that determination for the same 12-month period. That, however, is not the case. Instead, the Mercer Methodology uses a hodge-podge of different time periods to calculate the savings attributable to the various individual Cost Savings Initiatives by Mercer the sum of which constitutes what Mercer believes are the aggregate measurable cost savings for the first assessment year.

In response to an information request by the Superintendent, DHA identified the time period in which savings occurred for each of the Mercer Cost Savings Incentives as follows:

SAVINGS INITIATIVE	TIME PERIOD IN WHICH SAVINGS OCCURRED
COM	SFY 2004
CMAD	SFY 2004
VUG	CY 2004
Un- and Underinsured	CY 2005
MaineCare Woodwork	SFY 2005
CON/CIF	SFY 2004 and SFY 2005
Hospital and Physician Fee Initiatives	SFY 2006 and 1 st half of SFY 2007

⁷ Dr. Kane originally calculated \$75 million in CMAD savings. She now acknowledges that her original calculation was overstated due to a “spreadsheet error noted by a peer review done by Mercer,” which “had the effect of reducing the SOP estimate from roughly \$75 million to \$64.2 million.” (Kane Pre-Filed at Exh. C). What is truly disconcerting is not so much the error, but the fact that Mercer, with its nearly \$1 million contact with DHA and its nine people working on the project (including three peer reviewers) did not discover it until *after* its Final Report was submitted to the Dirigo Board. Even more disconcerting is the fact that Mercer did not discover the additional \$26 million error discovered by Roland Mercier of Baker, Newman & Noyes. (Mercier Pre-Filed at 12).

(Dirigo Health Revised Response to Second Information Request of the Superintendent at Response No. 1). Thus, Mercer calculates cost savings based on *five* different time periods between July 1, 2003 (when SFY 2004 began) and December 31, 2006 (when the first half of SFY 2007 ends).

Most remarkably of all, Mercer applies the alleged savings for each of the initiatives to the *same* Dirigo Program Year, *i.e.*, September 1, 2003 - June 30, 2004. (Id.) However, not one of the time periods used to calculate savings from the various initiatives corresponds directly to the Dirigo Program Year to which they are applied:

1. For COM and CMAD, the period of July 1, 200 through August 31, 2004 is *before* the Dirigo Program Year;
2. For VUG, the period of July 1, 2004 through December 31, 2004 is *after* the Dirigo Program Year; and
3. For Uninsured and Underinsured, MaineCare Woodwork, CON/CIF, and Hospital and Physician Fee Initiatives, the entire period for which savings were calculated is *after* the Dirigo Program Year.

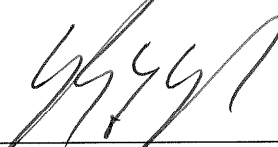
Indeed, the only alleged savings that actually fall within the Dirigo Program Year to which they are being applied are COM and CMAD savings between September 1, 2003 through June 30, 2004, and those VUG savings between July 1, 2004 and June 30, 2004. DHA's only explanation for why it believes it appropriate to apply to a Dirigo program year of September 1, 2003 through June 30, 2004, cost savings occurring in time periods falling outside that Dirigo Program Year, is to cite to the various "authorizing language" statements in Mercer's Final Report (DHA Revised Response at Response No. 1). There is, however, nothing in the statutory language cited by Mercer that in any way suggests that it is appropriate to apply cost savings to time periods other than those in which they occur, particularly savings realized, if at all, two years after the Dirigo Program Year.

CONCLUSION

For all of the foregoing reasons, the Superintendent should disallow the Dirigo Board's filing in its entirety.

Dated: October 24, 2005

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on this date the foregoing document was served on all counsel of record via electronic mail as follows:

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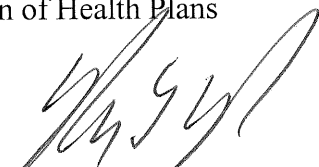
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