

October 14, 2005

Via mail & email

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034
vanessa.j.leon@maine.gov

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

Dear Superintendent Iuppa:

Please find enclosed the following:

1. Filing Cover Sheet.
2. Two hard copies of Dirigo Health Response to First Information Request of the Superintendent.
3. Attachment A—List.
4. Attachment B—MHDO data.
5. Attachment C—CD of electronic documents.

Thank you for your assistance with this matter.

Yours very truly,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

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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) FILING COVER SHEET
HEALTH FOR THE FIRST)
ASSESSMENT YEAR)
)
)
Docket No. INS-05-700)

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

Date Filed: October 14, 2005

Name of Party: Dirigo Health Board of Directors

Document Title: Dirigo Health Response to First Information Request of the
Superintendent, w/Attachments A, B, and C

Document Type: Response to Information Request

Confidential: No

Dated: October 14, 2005

Respectfully submitted,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

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

IN RE: REVIEW OF AGGREGATE)	
MEASURABLE COST SAVINGS)	
DETERMINED BY DIRIGO)	DIRIGO HEALTH RESPONSE TO
HEALTH FOR THE FIRST)	FIRST INFORMATION REQUEST OF
ASSESSMENT YEAR)	THE SUPERINTENDENT
)	
DOCKET NO. INS-05-700)	

The Board of Directors of Dirigo Health responds to the First Information Request of the Superintendent of the State of Maine Bureau of Insurance dated October 5, 2005 as follows:

1. Please provide the following information electronically, in Excel or text file format, by hospital, for each hospital in Maine for the years 2000-2004:
 - a) Inpatient Gross Patient Services Revenues (Medicare, MaineCare, Other).

Response No. 1a: Information from MHDO for 1999-2003 is provided. See Electronic Documents **Payer Mix Inpatient 99-02.xls**; **OPCOSTLMTREV2.xls**. Information from 2004 has not been included. Dirigo does not have the data for 2004. (See Attachment A, List of Electronic Documents.)
 - b) Outpatient Gross Patient Service Revenues (Medicare, MaineCare, Other).

Response No. 1b: Information from MHDO for 1999-2002 is provided. See Electronic Documents **Payer Mix outpatient 2000.xls**; **Payer mix Outpatient 2001.xls**; **pmt2002 payer mix outpatient 2002.xls**; **OPCOSTLMTREV2.xls**
Dirigo does not have information for other years.
 - c) Inpatient Discharge total (including newborns) (Medicare, MaineCare, Other).

Response No. 1c: See Electronic Document **OPCOSTLMTREV2.xls**.
 - d) Case Mix Index based on all-payer claims using Medicare grouper (from MHDO as referenced in report).

Response No. 1d: See Electronic Documents **OPCOSTLMTREV2.xls**; **2001 All Payer CMI.xls**; **2004 Medicare CMI.xls**; **CMI Including NB Estimating Model.xls**.

e) Medicare Cost Report Worksheet C, Column 1.

Response No. 1e: Dirigo only has elements from Column 1 required in the MHA spreadsheet. See **Hardcopy, Attachment B; Electronic Document OPCOSTLMTREV2.xls**.

f) Hospital Operating Margin and components for calculation (operating revenue and operating expense and all detail required for any exclusions or adjustments).

Response No. 1f: See Electronic Document **Fiscal Year Adjusted Op Inc Limit hospital plus Sub.xls**.

g) Bad Debt/Charity Care. These should be provided in the fiscal year groupings native to their data sources, with those fiscal year periods indicated.

Response No. 1g: See Electronic Document **Bad Debt and Free Care 2000-2004.xls**.

2. Please provide the following work papers electronically, in Excel or text file format:

a) Spreadsheet provided by MHA to Dr. Kane.

Response No. 2a: See Electronic Document **CPAD data 2003-2004 from MHA.xls**.

b) State Provider Tax amounts by hospital.

Response No. 2b: See Electronic Documents **Explanation of Provider Tax Estimate used in CMAD.xls; Medicaid Provider Tax 4 qtr 2004.xls; Medicaid Provider tax paid later in 2004.xls**.

c) Source data and all calculations for HMBI statistics displayed in report.

Response No. 2c: See Electronic Document **HMBI Trend. PDF**.

d) All spreadsheets and calculations used to generate the estimates summarized in the CMAD and COM reports.

Response No. 2d: See Electronic Documents **OPCOSTLMTREV2.xls;**
dfyadjhospital; Fiscal Year Adjusted Op Inc Limit Hospital Plus
Subsidies.xls.

3. Questions Related to Voluntary Underwriting Gain

- a) How does Dirigo differentiate between: (a) the normal increases and decreases in underwriting margin over time that are a characteristic of a highly cyclical industry, and (b) savings that are created by the actions of Dirigo?

Response No. 3a: The target limit of 3 percent underwriting gain less federal income taxes was set in the Dirigo statute. These targets were negotiated by the insurance carriers with full knowledge of the period for which savings would be measured and, thus, were negotiated to incorporate where insurers were within the underwriting cycle. Health insurance carriers were requested to comply with this voluntary limit; our measurement was done only for those carriers that responded affirmatively. The time period for this limited underwriting gain was set in the statute to be the carrier fiscal year ending June 30, 2004. Since insurance carriers use calendar years for their fiscal years, the measurement year was taken to be calendar year 2004. The base data period of the prior 4 years (calendar years 2000 through 2003) was selected to strike a balance between the potential variability of year-to-year underwriting gains and the use of readily available recent data.

- b) Should the true IBNR be substituted for the reported IBNR in determining the underwriting gain, since there is reporting of the adequacy of the December 2004 IBNR in each subsequent quarterly filing throughout 2005? Please explain.

Response No. 3b: Consideration was given to using the IBNR in the retrospective follow-up of the previous year's IBNR in place of the initially reported IBNR. In order to be consistent across all years, however, the retrospective 12/31/2004 IBNR with 12 months of run out would be needed. This amount will not be reported until the filing of the 12/31/2005 annual statement, which is due in March 2006. It should be noted that the annual financial statements are audited by independent auditors, but quarterly statements typically are not scrutinized to the same extent. Consistent data sources were used for both the 2000 through 2003 base period and the 2004 measurement period.

- c) How should the methodology deal with quota share reinsurance which has a significant impact on the premium and claim volumes that are reported in the Statement of Revenue and Expenses, but minimal impact on the underwriting gain (in dollars)?

Response No. 3c: The Dirigo statute does not directly address the issue of quota share reinsurance. Reported financial results in the selected source data do not necessarily isolate quota share reinsurance from non-proportional reinsurance, such as stop loss medical reinsurance. Accordingly, premiums net of reinsurance were used as the base from which to compare underwriting gain, without distinction between quota share reinsurance, non-proportional reinsurance, and no reinsurance.

- d) Which is a more meaningful measure of the impact of underwriting margin on the price paid by a policyholder:
- i. underwriting margin as a percent of direct (gross) premium revenue; or
 - ii. underwriting margin as a percent of a net (of ceded reinsurance) revenue?

Response No. 3d: Underwriting gain as a percentage of premiums net of reinsurance was used, the amount reported on line 1 of the Analysis of Operations by Lines of Business (Gain and Loss Exhibit) of the Health annual statement (the Orange Blank). The underwriting gain on this exhibit is also net of reinsurance recoveries, so the more meaningful measure is as a percentage of premiums net of reinsurance. Also, if both the ceding carrier and the reinsurance carrier were being considered as separate carriers in the calculation, use of gross premium revenue could result in double counting – first for the entire premium paid by the consumer to the ceding carrier, and second for that portion of premium ceded to the reinsurer.

- e) Why were the federal employees included in the calculations? Are they explicitly excluded by the same statute? Please explain.

Response No. 3e: The language in the statute PL 2003, c. 469 §F-1(1) (C) says “pricing of the products it sells in this State.” “Products” was interpreted to be those medical insurance products for which there is a connection to the Dirigo initiatives related to health care services, specifically to the lines of business for which fees negotiated between the carrier and the provider determine the eligible charge. This includes the Federal Employee Health Benefit Plan line of business, which is not excluded by the above mentioned statute.

- f) If the projected underwriting margin for the life of a multi-year contract is negative, it may be necessary to establish a premium deficiency reserve. Should the savings to policyholders, due to negative margins projected for the life of the contract be allocated over the entire period of the multi-year contract, or to the year in which the required premium deficiency reserve is established? Please explain.

Response No. 3f: The information in the annual statement does not provide details on the length of time for which the deficiency reserve is established. However, the vast majority of medical insurance is written with contracts that permit premium rates to be changed no less frequently than every 12 months. Therefore, any premium deficiency reserves at the end of a year would be expected to be for losses emerging in the next several months, not extended multi-year periods

- g) Why did Dirigo take only the fractional portion of the year 2000 and ignore the results for BDBSME in the first five months? Please explain.

Response No. 3g: Mercer's calculation included only financial results from those carriers which affirmatively responded to the request from the Bureau of Insurance to limit their underwriting gain less federal taxes to 3 percent. Among those that responded affirmatively was Anthem Health Plan of Maine (Anthem), so Mercer included their results for years 2000 through 2003 in the base calculation. Mercer did not include partial year 2000 financial results for Blue Cross Blue Shield of Maine, the predecessor organization to Anthem. Blue Cross Blue Shield was a not-for-profit carrier; Anthem is a for-profit carrier. In Mercer's opinion, the baseline underwriting gain calculation for a for-profit carrier is better made using for-profit data than including data from a time period when a predecessor organization operated as a not-for-profit.

- h) Please explain the basis for the statement in Mercer's Final Report that in the Blue (Life and Health) and Yellow (Property and Casualty) Blanks, individual health insurance would be recorded as Collectively Renewable. Is this consistent with the NAIC Annual Statement Instructions? Please explain.

Response No. 3h: The splits on Schedule H of the NAIC Annual Statement are for (1) Group Accident and Health, (2) Credit Accident & Health (Group and Individual), (3) Collectively Renewable, (4) Non-Cancelable, (5) Guaranteed Renewable, (6) Non-Renewable for Stated Reasons Only, (7) Other Accident Only, and (8) All Other. The splits for the individual (non-group and non-credits) contracts are based on the renewability provisions of the contracts, not on a type of coverage that would permit the isolation of medical insurance to the exclusion of other forms of health insurance. The decision concerning which categories to include and which to exclude in the calculation was based on which categories would be most likely to include the financial results of those medical insurance products for which there is a connection to the Dirigo initiatives related to health care services. Group comprehensive major medical coverage sold to employers would be in Group Accident and Health. As detailed in the NAIC Instructions for Schedule H, the Collectively Renewable category includes non-group medical coverage sold to members of associations and other affiliated groups. (Mercer's report used the term

“individual” to refer to such non-group coverage, although this is not the only category in which individual coverage would appear.) Neither the Group A&H nor the Collectively Renewable category is exclusively medical coverage — dental, vision, and disability income coverage could be included in them. The other categories typically include such products as disability income, accident only, and scheduled medical indemnity coverage. Some individually underwritten major medical coverage would appear in the Non-Renewable for Stated Reasons Only category; however, Mercer elected not to include this category due to expected significant amounts of other non-medical coverages in the category.

Dated: October 14, 2005

Respectfully submitted,

/s/William H. Laubenstein, III
William H. Laubenstein, III
Assistant Attorney General

ATTACHMENT A
CD Document List
10/14/05

1. 2001 all payer CMI including newborns from MHA.xls	Response 1d
2. 2004 Medicare CMI.xls	Response 1d
3. Bad debt and free care 2000-2004.xls	Response 1g
4. CMI incl NB estimating model.xls	Response 1d
5. CPAD data 2003-2004 from MHA.xls	Response 2a
6. dyfadj hospital entity only.xls	Response 2d
7. explanation of provider tax estimate used in cmad.xls	Response 2b
8. fiscal year adjusted op inc limit hosp plus subs.xls	Responses 1f, 2d
9. HMBI Trend.pdf	Response 2c
10. Medicaid Provider Tax 4 qtr 2004.xls	Response 2b
11. Medicaid Provider Tax paid later in 2004.xls	Response 2b
12. OPCOSTLMTREV2.xls (updated 10-13-05, 3PM)	Responses 1a, 1c, 1d, 1e, 2d
13. payer mix inpatient 99-02.xls	Response 1a
14. payer mix outpatient 2000.xls	Response 1b
15. payor mix outpatient 2001.xls	Response 1b
16. pmt2002payer mix outpatient 2002.xls	Response 1b