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January 7, 2005
Revised: June 24, 2005

Ms. Kristine M. Ossenfort
Senior Governmental Affairs Specialist
Maine State Chamber of Commerce
7 University Drive
Augusta, Maine 04330-9412

Re: Inquiry for Services Related to Maine's Dirigo Legislation

Dear Ms. Ossenfort;

At your request, we have revised our January 7, 2005 proposal to assist the Chamber and the Maine Association of Health Plans (MEAHP) in evaluating the savings estimation methodology under the Dirigo program, to include attending and assisting the newly formed Working Group. This includes the methods that will be used to set the savings offset payment (SOP) that will be levied on insurer and third party administrator (TPA) revenues under the Dirigo program.

The Dirigo Reform Act (hereafter referred to as the "Act") is a landmark piece of legislation enacted by the Maine legislature in June of 2003 designed to control health care costs, improve quality and expand access.[1] The program provides subsidies to lower-income people to purchase health insurance as savings are realized from reductions in uncompensated care and other cost containment initiatives under the Act.

There are several key issues in determining the SOP that are critically important to employers, who ultimately pay the SOP assessments in their premiums. These include:

- Assuring provider pass-back of uncompensated care savings;
- Assuring insurer pass-back of lower provider charges from uncompensated care savings and savings in administration;
- Accounting for possible spending increases for the newly-insured;
- Data quality issues and adequacy of projections methodologies; and
- Ambiguities in the Act and potential inequities in process.

[1] "An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs," Chapter 469, H.P. 1187 – L.D. 1611, Maine Legislature.

In the following sections, we describe the SOP process, discuss measurement issues and describe the tasks we would perform for the Chamber and the MEAHP.

Expansions in Coverage Under Dirigo

The centerpiece of the Act is the Dirigo Plan. In the first year of the program, firms with 50 or fewer workers, the self-employed and individuals are eligible to enroll. The plan provides premium discounts to enrollees living below 300 percent of the federal poverty level (FPL). Participating employers are required to pay 60 percent of the premium for eligible workers (employed 20 or more hours per week), but there is no contribution requirement for family coverage.

The Act also increases income eligibility levels under MaineCare (i.e., Medicaid) for parents from 150 percent of the FPL to 200 percent of the FPL, which is the current income eligibility level for children (Federal matching funds are available for this expansion). The income eligibility level for non-custodial adults (i.e., adults without custodial responsibilities for children) would be increased from 125 percent of the FPL to 150 percent of the FPL.

Dirigo Cost Containment

Under the Act, an assessment is to be imposed on health insurers and TPAs in Maine to recover savings under Dirigo, up to a maximum of 4 percent of revenues. The primary source of these savings would be reductions in provider uncompensated care, including bad debt and charity care, resulting from increased insurance coverage. However, the Act also requires the development of a state health plan and other provisions designed to slow cost growth.[2] Other potential sources of savings include:

- **State Health Plan:** A state health plan would be developed to identify strategies for addressing major cost drivers in the system. It would also serve as a guide for the certificate of need (CON) process;
- **Expand Certificate of Need (CON):** The current Maine CON process is extended to encompass ambulatory surgical centers and doctors' offices. A capital budget would be developed as part of the state health plan that would limit the amount of capital spending approved in the CON process;

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[2] Rosenthal, J., Pernice, C., "Dirigo Reform Act: Addressing Health Care Costs, Quality, and Access in Maine," (report to the Maine Governor's Office of Health Policy and Finance), The National Academy for State Health Policy (NASHP), June 2004.

- **Hospital Planning:** A commission is established to review Maine hospital finances, structure, roles, reimbursement, capital, technology, and staffing needs. The commission's report would include recommended legislation;
- **Public Price Disclosure:** The Act requires hospitals and physicians to disclose average charges for the 15 inpatient and 20 outpatient services most commonly performed to assist consumers in selecting providers;
- **Simplification of Administrative Functions:** The Act mandates the use of electronic claims submission, data exchange, and referral submission;
- **Enhanced Public Purchasing:** The Act requires the state to coordinate purchasing for public programs to reduce costs; and
- **Rate Review and Voluntary Limits:** Small group insurance rates would become subject to review, and insurers are asked to voluntarily limit their cost growth to 3.0 percent.

Estimating Savings

The state is required to estimate the savings resulting from the Dirigo program. Data and methods have been proposed by the Governor's office and Mathematica Policy Research, Inc. These methods would estimate Dirigo savings by estimating what spending would have been, beginning in 2003, in the absence of Dirigo, and subtracting estimates of the amount actually spent on health in Maine in that year. This is less difficult to do than attempting to estimate the savings from each of the individual sources of savings under Dirigo (listed above).

Information on spending in 2003 without Dirigo must be extrapolated from prior years based upon an analysis of historical spending growth data for the state. Also, because health spending data is not routinely compiled across all payers and all types of providers at the state level, statewide health spending for historical years must be assembled from several sources that span across differing time periods. Proposed data sources for estimating actual spending in Maine for 2003 include:

- Medicare spending for beneficiaries by state from the Centers for Medicare and Medicaid Services (CMS);
- MaineCare beneficiary spending;
- Maine Health Management Coalition for large employer and employee spending;
- Hospital spending data from public sources;
- The Northwest sample of the Medical Expenditures Panel Survey (MEPS); and

- Trends in spending growth derived from CMS data on health spending by state in 1993 through 1998.

Due to the diffused nature of the data available for this process and the uncertainty in estimating trends, it will be difficult to reliably estimate the level of spending with and without the Dirigo program. Beginning in 2005, the Maine Health Data Organization's (MHDO) state-wide all-payer database will become available, which will be based upon data compiled from public and private payers in the state. However, estimating what would have been spent in the absence of the Act will continue to be a challenge.[3]

Issues In Estimating Savings

There are several potential problems with the estimates currently under development, including those that you outlined in your letter to us dated September 30, 2004.

Isolating savings from Dirigo only: The proposed methods do not differentiate savings resulting from Dirigo from savings resulting from other employer efforts to reduce costs. These include employee wellness programs, disease management, drug formularies, co-payment incentives, strengthening of provider network and other cost control initiatives. Without accounting for these factors, the proposed methodologies will overstate savings attributable to Dirigo. While some of these savings may be reflected in the trend analyses used to project spending in 2003 without Dirigo, it will be important to assure that these effects are not confused with Dirigo savings.

Provider pass-back of uncompensated care savings: There are no assurances that the savings from reduced uncompensated care for providers would be passed on to employers and consumers in the form of reduced charges. The Act requires insurers to account for these reductions in provider costs when negotiating payment levels with providers. However, there appears to be no guarantee that these adjustments would occur, particularly in rural areas where there are few competing providers and thus little negotiating leverage.

Existing research on cost-shifting indicates that only about 40 percent of reductions in hospital uncompensated care and only about 20 percent of reductions in physician uncompensated care would be passed back to payers in

[3] "Maine's State Health Plan," Governor's Office of Health Policy and Finance, July 2004.

the form of lower charges.[4,5] The remainder would be retained by the providers as a windfall. Thus, to the extent that providers retain these savings, total health spending in the state could actually increase, and be passed on to employers in the form of premium increases, unless a mechanism is developed to fully recover these savings.

Spending could increase for newly-insured: The presumption that Dirigo will reduce spending may be flawed. Most research on the uninsured indicates that utilization of health services would, on average, increase for newly insured people. While increased access to primary care is likely to reduce avoidable emergency room visits and inpatient stays, these savings are expected to be more than offset by the cost of increased use of primary care and other services that are more elective in nature, such as prescription drugs, tonsillectomies and corrective orthopedic surgery.[6]

Our own analyses indicate that utilization of health services by currently uninsured people would, on average, increase by up to 70 percent once they have coverage.[7] This suggests that we need to be open to the possibility that health spending could actually increase under Dirigo. This is particularly true in the early years of the program where savings from capital budgeting and other Dirigo initiatives will be just beginning to materialize.

Data Quality: The data on health spending at the state level is notoriously poor. For example, the most recent estimates of state level health spending available from CMS are for 1993 through 1998. These data are inadequate for developing

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[4] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4 (Winter 1984); Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured." *Health Affairs*, Vol. 4 No. 3 (Fall 1985); Sheils, J., Claxton, G., "Potential Cost Shifting Under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), The Lewin Group, December 6, 1995.

[5] Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

[6] To the extent this increased utilization encompasses need care that they are not receiving, this is arguably one of the key benefits of expanding coverage.

[7] "The Health Benefits Simulation Model (HBSM): Uniform Methodology and Assumptions," (report to the Robert Wood Johnson Foundation (RWJF) on the Covering America project), The Lewin Group, October 2003.

trend analyses capable of projecting health spending with a satisfactory degree of accuracy. While the spending growth rates in Maine may have been greater than the national average over the 1993 through 1998 period, we cannot assume this growth rate differential continues to hold five years later in 2003.[8]

For example, initial data from Mathematica indicate that health spending in Maine in 2002 is estimated to be about $7.0 billion, with an expected growth in spending of about 10 percent in 2003. However, if we have over-estimated the rate of growth in spending under current law by just 1.0 percentage point, we could overstate potential savings under Dirigo by about $70 million, which would probably result in the maximum assessment on insurance costs. Because estimation errors of this magnitude are routine for even the most respected health spending experts, it will be important to develop means of verifying the Dirigo estimates.

Ambiguities in Act: There are ambiguities in the legislation that would affect the way in which savings are determined and the SOP is calculated. These include the exclusions that apply to various types of insurers and the way in which the inclusion of insurers and TPAs in setting the rates. It will be important to review this process to assure that insurers and TPAs are treated equitably so that the incidence of costs across employers is also equitable.

Proposed Analysis

In this project, we would provide the Maine State Chamber of Commerce and the MEAHP with an independent assessment of the estimates used to set the Dirigo SOP. This would include a detailed review of the available information on methods used and our own review of the available data. We would benchmark the various estimates against other health spending growth estimates in neighboring states and from alternative surveys. We would also propose a refined methodology for measuring the impact of Dirigo on health care costs in Maine.

Based upon your letter, we propose the following tasks:

- Review and critique the proposed method of measuring savings from Dirigo;

- Benchmark health spending estimates against other sources of health spending data including:

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[8] Martin, A., et al,"Trends in State Health Care Expenditures and Funding: 1980-1998", *Health Care Financing Review*/Summer 2001/volume 22, number 4.

- — Medicaid, SCHIP and Medicare program data for Maine and neighboring states;
- — Cost data from Blue Cross/Blue Shield if available;
- — TRICARE/Military spending data;
- — Association health plans;
- — the MEPS employer data for the Northeast region; and
- — the survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET) (i.e., northwest region).

- Recommend changes to methodology to better measure savings attributed to only Dirigo; and

- Develop an alternative methodology for estimating the impact of Dirigo savings on the actual cost of purchasing health insurance coverage in Maine.

The project would result in a final report that presents our findings, recommendations and proposed alternative methodology. We would also provide two briefings over the course of the project in Augusta to consult with a Steerin Committee composed of employer and insurer representatives, and Chamber and MEAHP staff on our findings and ideas on how the process could be improved. We will also be available to have meetings via telephone.

Working Group Meetings

Recent legislation creates a 10-member working group to look at and advise the Dirigo Health Board of Directors on several different issues, assisted by an independent facilitator (P.L. 2005, c. 400). The issues to be addressed by the working group are:

1. The definition of "subsidy" within the Dirigo Health Program;
2. The definition of "paid claims" for the purpose of using paid claims as the base for savings offset payment assessments on health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers;
3. The process for implementing and invoicing savings offset payment assessments based on the recommended definition of paid claims;
4. The board's proposed methodology for calculating aggregate measurable cost savings. This recommendation must be made no later than September 20, 2005; and
5. A funding strategy to cover Dirigo Health's administrative expenses. This recommendation must be made no later than December 31, 2005.

In this project, we would Attend meetings of the working group related to the measurement of savings under Dirigo. We would attend and assist in the two adjudicatory hearings required in the law, including serving as expert witnesses and providing testimony.

Proposed Project Team

The project would be directed by John F. Sheils, who is nationally known for analyses of the cost and coverage impacts of proposals to reform the health care system. Mr. Sheils recently completed a comparative analysis of the Presidential candidates' proposals to expand insurance coverage which was widely reported in the press. He has also testified before Congress and various state legislative committees on the cost and coverage impacts of a wide range of health reform proposals. He has also prepared analyses of several health reform proposals for Vermont and other states ranging from Medicaid expansions, expansions in private insurance coverage, Health Savings Accounts and the single-payer model.

We also include Ms. Terry Savela, who would be responsible for designing a framework for critiquing proposed methods for estimating Dirigo savings and reviewing available data sources for Maine and neighboring states. Ms. Savela has developed an extensive knowledge of health spending data sources and analytic methods in developing and implementing methodologies for calculating capitation rates and projecting health care spending for public programs.

We include Mr. Grady Catterall, F.S.A, who is a Lewin Group health benefits actuary who has extensive experience specialized in estimation of savings from disease management, wellness programs and managed care. In addition, we include Mr. Keith Hearle who is a widely known expert in hospital finance and uncompensated care issues for public and private hospitals. Resumes for the proposed project team are included in ***Appendix B***.

Proposed Budget

The analysis would be completed over a period of approximately eight to twelve weeks at a firm fixed price of $94,149. This includes all labor, materials and travel costs under the project. Our normal business practice with a project of this size is to require payment of one-half of the contract price prior to beginning work with the remainder billed separately when work is completed. A draft of our standard terms and conditions is attached in ***Appendix A***.

As you know, our work for you is confidential. However, if any portion of our results become public, we reserve the right to release the report in its entirety. We reserve the right to review any press release concerning this study 72 hours in advance of release. Your signature below will suffice for a contract.

We look forward to working with you on this important project. Please call me at (703) 269-5610 if you have any questions.

Sincerely;

John F. Sheils
Vice President

ACCEPTANCE:

The terms of the above-stated proposal dated October 17, 2005, including the terms set forth in Appendix A, are hereby accepted and agreed to by Maine State Chamber of Commerce and the Maine Association of Health Plans, as witnessed by the signatures below of their authorized representatives. Upon signature by a the representatives, the proposal and acceptance shall form a Letter Agreement governing the Services, effective as of the date signed below. By signing below, the Chamber and the Maine Association of Health Plans agree that each will be responsible for one-half of the costs incurred under this Agreement.

For: Maine State Chamber of Commerce

____
Signature

Name:
Title:

____
Date

For: Maine Association of Health Plans

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Signature

Name: Katherine D. Pelletreau
Title: Executive Director

____
Date

APPENDIX A

These terms and conditions apply to the letter agreement dated December 20, 2004 ("Agreement") between The Lewin Group, Inc. ("The Lewin Group") and ("Client").

1. *PROPRIETARY INFORMATION.* Proprietary and/or confidential information ("Proprietary Information") developed or disclosed by either party under this Agreement shall be clearly labeled and identified as Proprietary Information, or with similar designation, by the disclosing party at the time of disclosure. When concurrent written identification of Proprietary Information is not feasible at the time of such disclosure, the disclosing party shall provide such identification in writing promptly thereafter. Oral communications pertaining to the Services shall be presumed to be Proprietary Information unless otherwise indicated by the disclosing party.

Proprietary Information shall not be disclosed, or permitted to be disclosed, to any other party except that disclosure can be made to those individuals who need access to such Proprietary Information to ensure proper performance of the Services.

Neither party shall be liable for disclosure or use of Proprietary Information which: (1) is generally available to the public without breach of this Agreement; (2) is disclosed with the prior written approval of the disclosing party; or (3) is required to be released by law or court order. When disclosure is required by law, such disclosure shall be made only after the receiving party has notified the disclosing party in writing and the disclosing party has been provided an opportunity to take appropriate action to protect its legal interest in the Proprietary Information.

Each party shall return all Proprietary Information relating to this Agreement to the disclosing party upon request of the disclosing party or upon termination of this Agreement, whichever occurs first. The Lewin Group shall have the right to retain one archival copy of the Deliverables and Proprietary Information for its records, and such archival copy of the Proprietary Information shall remain subject to the terms of this Section unless and until the Proprietary Information is returned to Client. This Section shall remain in effect during the term of this Agreement and for a period of three (3) years thereafter.

2. *DELIVERABLES, PUBLICATIONS AND PRESS RELEASES*. Upon payment in full for the Services, and unless otherwise stated herein, deliverables, analyses and reports first developed under this Agreement ("Deliverables") shall be the property of Client. Client shall be solely responsible for any disclosure of the Deliverables which may be required by law and agrees to indemnify and hold The Lewin Group harmless for any loss resulting from Client's failure to make such disclosure. Where applicable law requires immediate disclosure by The Lewin Group, The Lewin Group will make its best efforts to give prior notice to Client. At Client's request and expense, The Lewin Group will assist the Client in making such disclosures as may be required by law.

Notwithstanding the foregoing provisions of this Section, Client acknowledges that in the course of its performance under this Agreement, The Lewin Group may use its own products, materials and methodologies, and Client agrees that it shall have or obtain no rights in such proprietary products, materials and methodologies. In addition, Client agrees that Deliverables, as defined herein, do not include confidential background data collected by or communicated to The Lewin Group from third parties during the performance of this Agreement (including, but not limited to, confidential data collected during interviews of subjects such as interview notes, interviewee's internal reports and numerical data), even if such background data is used to develop the Deliverables ("Background Data"). The Background Data will not be provided to Client under the terms of this Agreement, unless the party providing the Background Data expressly agrees in writing to such disclosure, and Client shall have or obtain no rights in such Background Data, but rather, the Background Data will be retained by The Lewin Group.

The Client shall take the necessary actions to ensure that only accurate, complete versions of the report(s) and analyses developed by The Lewin Group under this Agreement are used by the Client and/or disclosed by the Client to others. Client shall indemnify The Lewin Group against any liability related to Deliverables that have been changed without The Lewin Group's written approval or have been used for a purpose not

expressly authorized by The Lewin Group in writing under this Agreement. In the event that Client uses the name of The Lewin Group and attributes any conclusions to The Lewin Group that misrepresents or misstates the conclusions or views expressed by The Lewin Group in the Deliverable, The Lewin Group reserves the right to itself go public with a correction, clarification, or release of the full text of the Deliverable.

Client agrees that when it is the intent of this Agreement to make a Deliverable public, The Lewin Group shall have the right to post information about the Deliverable on its website (www.lewin.com), up to and including posting of a final report.

3. ***ACCEPTANCE.*** Under the terms of this Agreement, certain Deliverables shall be provided to Client by The Lewin Group. Client shall have fourteen (14) days to accept or reject all or part of each Deliverable. Each Deliverable, to the extent not rejected in writing by Client, shall be deemed accepted. If Client determines that a Deliverable does not meet the requirements of this Agreement, Client shall notify The Lewin Group as such in writing before the end of the acceptance period. Such notice shall contain the specific reason(s) for Client's determination. The Lewin Group shall be given no less than fourteen (14) days to cure any deficiencies. Client shall not reject a Deliverable unless based on a substantial or material nonconformity.

4. ***PAYMENT.*** If any portion of an invoice is disputed, then Client shall pay the undisputed amounts and the parties shall use good faith efforts to reconcile the disputed amount as soon as practicable. Client shall pay Lewin interest in the amount of one percent (1%) per month, or the maximum lesser amount permitted by law, of all undisputed amounts owing hereunder and not paid within thirty (30) days of the date of the invoice. When applicable, Lewin reserves the right to submit, within ninety (90) days after Lewin has submitted the final invoice for Services rendered, an invoice for any outstanding out-of-pocket expenses incurred.

In the event that payment has not been made in accordance with the terms of this Agreement, in addition to any other remedy The Lewin Group may have under law or in equity, The Lewin Group may stop work and/or terminate this Agreement. Client shall reimburse The Lewin Group for all costs, including but not limited to attorney fees, which are incurred by The Lewin Group in attempting to obtain payment under this Agreement which are ninety (90) days or more past due.

5. ***CLIENT'S RESPONSIBILITIES.*** Client shall provide to The Lewin Group such resources as may be required by The Lewin Group to properly perform the Services. Client shall provide site access at such times as may reasonably be required by The Lewin Group and shall make timely payments in accordance with the terms of this Agreement.

6. ***LIMITATION OF LIABILITY.*** In no event shall either party be liable for any incidental, special or consequential damages whatsoever (including but not limited to lost profits or interruption of business) related in any way to this Agreement, even if advised in advance of the possibility of such damages. The maximum liability of The Lewin Group for any reason related to this Agreement shall be the amount paid by Client hereunder.

7. ***FREEDOM OF ACTION.*** Client acknowledges that The Lewin Group provides similar services for a broad range of other clients and agrees that The Lewin Group shall be free to work for other clients in matters that do not involve the use of any Proprietary Information that has been disclosed to The Lewin Group by Client under this Agreement.

8. ***RELATIONSHIP OF THE PARTIES.*** The Lewin Group is an independent contractor and shall not be deemed to be an employee or agent of Client. Neither party hereto is, by this Agreement or anything herein contained, constituted or appointed agent or representative of the other for any purpose whatsoever, nor shall anything in this Agreement be deemed or construed as granting either party any right or authority to assume or to create any obligation, warranty or responsibility, express or implied, for or in behalf of the other.

9. ***NON-SOLICITATION OF EMPLOYEES.*** Neither party shall knowingly solicit for employment or hire the employees of the other party involved in the performance of this Agreement during the term of this Agreement and for one (1) year thereafter.

10. ***INDEMNIFICATION*.** Each party shall indemnify and hold the other harmless against any loss or liability due to physical injury to persons or destruction or damage to property arising out of the performance of the indemnifying party under this Agreement, to the extent solely caused by the negligent acts, omissions or willful misconduct of the indemnifying party. Client shall indemnify, defend and hold harmless The Lewin Group and its affiliates, and its and their directors, officers, employees and agents (each, a "Lewin Indemnified Party"), from and against any and all losses, damages, liabilities, reasonable attorney fees, court costs, and expenses (collectively "Losses") resulting or arising from any third-party claims, actions, proceedings, investigations or litigation relating to or arising from or in connection with this Agreement, Proposal or the Services contemplated herein (including, without limitation, any Losses arising from or in connection with any study, test, device, product or potential product to which this Agreement or any Work Order relates), except to the extent such Losses are determined to have resulted solely from the negligence or intentional misconduct of the Lewin Indemnified Party seeking indemnity hereunder.

11. ***TERMINATION*.** Either party may terminate this Agreement upon written notice, in the event the other party shall be in default of a material provision of this Agreement and such default is not cured within fourteen (14) days of receipt of the notice of default. Notwithstanding any other provisions of this Agreement, either party may terminate this Agreement without cause by giving the other party at least thirty (30) days prior written notice. In the event either party terminates this Agreement pursuant to this Section, Client shall pay The Lewin Group for that portion of the Services performed and, in the case of termination for default, those accepted by Client, as well as approved expenses incurred, through the date of termination. Unless terminated earlier as provided herein, this Agreement shall expire automatically ninety (90) days following the later of a) the last date on which The Lewin Group performs Services for Client, or b) the date on which The Lewin Group receives complete payment for the Services specified under this Agreement.

12. ***WAIVER.*** No waiver of any provision in this Agreement shall be effective unless made in writing, signed by the party against whom such waiver is sought to be enforced. No waiver of any breach of this Agreement shall operate as a waiver of any similar subsequent breach or any breach of any other provision of this Agreement.

13. ***SEVERABILITY.*** If any provision of this Agreement is held invalid by a court of competent jurisdiction, such provision shall be severed from this Agreement and to the extent possible, this Agreement shall continue without affect to the remaining provisions.

14. ***ASSIGNMENT.*** Neither party shall assign, transfer or otherwise convey its rights, interests, duties and/or obligations under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld, and any attempt to do so without such consent shall be deemed void.

15. ***GOVERNING LAW.*** This Agreement shall be construed, governed, interpreted, and applied in accordance with the laws of the State of North Carolina, exclusive of its conflicts of laws provisions. The failure to enforce any right or provision herein shall not constitute a waiver of that right or provision. If any provisions herein are found to be unenforceable on the grounds that they are overly broad or in conflict with applicable laws, it is the intent of the parties that such provisions be replaced, reformed or narrowed so that their original business purpose can be accomplished to the extent permitted by law, and that the remaining provisions shall not in any way be affected or impaired thereby.

16. ***NOTICE***. Any notice given by either party to the other party shall be in writing. Such notices shall be deemed given upon the earlier of three (3) days after being deposited in the United States mail, postage prepaid, or by actual delivery to the other party. Notice will be sent to the following, or to such addresses as the parties may designate in writing:

To Client:
Ms. Kristine M. Ossenfort
Senior Governmental Affairs Specialist
Maine Chamber of Commerce
7 University Drive
Augusta, Maine 04330-9412
Main Phone: (207) 623-4568
Main Fax: (207) 622-7723

To The Lewin Group:
The Lewin Group, Inc.
Attn: John Sheils, VP
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
Main phone: (703) 269-5500
Main fax: (703) 269-5501

17. *ENTIRE AGREEMENT.* The parties acknowledge that they have read this Agreement, understand it and agree to be bound by its terms. This Agreement supersedes all prior agreements, whether written or oral, relating to the subject matter hereof. No modification to this Agreement shall be binding unless such modification is made in writing, signed by an authorized representative of each party.

18. *FORCE MAJEURE*. Neither party shall be liable to the other under this Agreement for any loss or damage due to delay in delivery or other performance failures resulting from any cause beyond such party's reasonable control. Such causes shall include, but are not limited to, compliance with regulations, orders, acts, or instructions of any government or department or agency thereof, civil or military authority, acts of God, earthquakes, acts or omissions of the other party which resulted in the delay, electrical power surges or fluctuations, lightning, fires, floods, strikes, lockouts, embargoes, wars, hurricanes or other debilitating severe weather, fuel shortages, riots, insurrections, default or delay of suppliers, delays in transportation and loss or damage of goods in transit.

The estimated timeline and budget stated in this Agreement are based on the assumptions specified herein. The estimated timeline and budget do not account for events not caused by The Lewin Group which fall outside of its control, including but not limited to the causes set forth in the preceding paragraph. The occurrence of such events may require an extension of the estimated timeline and may entail additional costs. In the event that such an extension and/or increase in costs becomes necessary, The Lewin Group will provide Client with a revised timeline and/or budget. The Lewin Group's continued performance will be contingent upon Client's acceptance of The Lewin Group's revised timeline and/or budget in the form of a signed modification to this Agreement.

19. *ARBITRATION*. Any controversy or claim arising out of or relating to this Agreement or the breach thereof shall be settled by arbitration administered by the American Arbitration Association ("AAA") under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator shall be binding and may be entered in any court having jurisdiction thereof. Such arbitration shall be filed and conducted in English by one arbitrator mutually acceptable to the parties selected in accordance with AAA Rules. The arbitrator shall not have the power to award any punitive damages or any damages excluded by this Agreement.

Appendix B
Resumes

JOHN F. SHEILS
VICE PRESIDENT

EDUCATION

1980 MS, with Honors, Public Policy, School of Urban and Public Affairs, Carnegie-Mellon University

1977 BS, *summa cum laude*, Political Science, State University of New York at Brockport

EXPERIENCE

Mr. Sheils is joined the Lewin Group in 1980 and is now a Vice President . He is a nationally recognized expert on designing and evaluating health coverage expansion proposals. He is the architect of the Lewin Group Health Benefits Simulation Model (HBSM), which provides actuarial and economic analyses of proposals to expand public and private coverage. Mr. Sheils has testified before Congressional committees and is often quoted in national news media. His experience at the Lewin Group includes:

- **Policy options under State Planning Grants (SPG)**: The Lewin Group assisted five states in conducting their HRSA funded SPG studies of options to expand insurance coverage, including California, Iowa, South Dakota, Vermont and West Virginia.
- **A Single-Payer Program for Georgia:** Projected the cost of implementing a single-payer program for Georgia, included benefits costs under a specified benefits package, savings in administrative costs, tax rates required to fund the program and impacts on employers, families and providers.
- **Alternative Options for Expanding Health Coverage in Maryland:** Estimated the cost of three models for achieving universal coverage including an employer pay-or-play proposal, single-payer model and a multi-payer alternative.
- **State of Connecticut, Analyses for Connecticut Blue Ribbon Commission on Health Care:** The Lewin Group assisted the state of Connecticut in the development of options for extending coverage to the uninsured.
- **Comparative Analysis of Health Reform Proposals for The Robert Wood Johnson Foundation (RWJF):** Directed study of cost and coverage impacts of 18 health reform proposals introduced in the Health Coverage 2000 Conference in January 2000, and Covering America project I 2003.
- **Indiana Legislative commission in SCHIP:** Assisted a legislative commission in evaluating alternative ways of structuring the State Children's Health Insurance Program (SCHIP).
- **District of Columbia SCHIP Program:** Assisted the District of Columbia in designing its SCHIP program and other n designing various coverage expansions, and developed a waiver application to expand coverage for non-custodial adults.
- **Medicare Reform Policy Papers:** Developed a series of widely distributed papers on major issues concerning Medicare reform including: premium support models; medical savings accounts; health spending budgets; cost shifting and quality of care.

- **Coverage Expansions in St. Louis:** Assisted ST. Louis health care coalition with proposal to extend coverage to low-income people and potentials cost offsets to current indigent care programs.
- **Analysis of the Impact of Insurance Reforms on the Small Group Market:** Developed a micro-simulation model of health benefits and premiums under alternative health insurance reforms.
- **Analysis of President Clinton's Health Reform Proposal:** Developed estimates of the impact of the President's health reform proposals on health spending by major payers for care including employers, households and governments.
- **Financial Impacts Analysis of an Illustrative Universal Health Coverage Plan:** For the Bipartisan Congressional Commission on Comprehensive Health Care, estimated the cost and coverage effects of a proposed universal health coverage proposal.
- **Development of Health Reform Program for New Mexico:** Worked with the New Mexico Health Policy Commission to develop a health care financing system for the state which assures universal health insurance coverage and cost containment.
- **Evaluation of Alternative Health Care Financing Options for North Carolina:** Worked with the North Carolina Health Planning Commission to evaluate the financial implications of alternative health reform proposals for that state

From 1977 to 1998, Mr. Sheils was an Assistant Analyst, for the Congressional Budget Office (CBO), where he specialized in micro-analytic simulation of public assistance and Medicaid eligibility. Following that, Mr. Sheils was an Analyst at the Department of Labor, Office of the Assistant Secretary for Planning, Evaluation, and Research, and served as a consultant the State of Pennsylvania Office of Family Assistance through 1980.

TERRY SAVELA
SENIOR CONSULTANT

EDUCATION

B.A., Economics and Political Science, Wellesley College

EXPERIENCE

Ms. Savela is a Senior Consultant who has worked for The Lewin Group since 1985. Ms. Savela served as a Vice President between 1994 and 2000, worked as an independent contractor to The Lewin Group from 2000 to 2002, and rejoined the firm in 2002 as a Senior Consultant.

Ms. Savela's career has focused on managed care program development, implementation, administration and evaluation for public payers, cost-effectiveness analyses, rate setting and reimbursement model design, and research on the impact of managed care on safety net providers. For state projects involving Medicaid, children's health insurance, and health benefits for public employees, Ms. Savela has worked with public agencies, legislators, and stakeholder representatives to assist them in introducing new delivery system models. Ms. Savela has also worked for the Bureau of Primary Health Care in HRSA on projects relating to the managed care readiness and viability of community health centers. In addition, Ms. Savela worked with Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and the Department of Defense on a series of projects which involved designing and implementing new health care delivery programs (e.g., the CHAMPUS Reform Initiative and later, the Tricare program) and evaluated programs for increasing the productivity and effectiveness of military hospitals and clinics. Through her work, Ms. Savela has gained much experience working with policy makers and balancing the objectives of different agencies, elected officials, the provider communities, and consumer advocates, and working within the federal and state regulatory parameters. Specific examples of Ms. Savela's experience are provided below.

Medicaid Managed Care

- Directed a project for the New York State Office of Mental Health to assist in the design, procurement, and implementation of special needs plans for Medicaid recipients with serious mental illness. This project included assisting with the development of all specifications for the program, including designing and facilitating conferences with multi-agency representatives to achieve consensus on program objectives, design elements, and implementation timelines. In addition to significant project management activities relating to the consulting activities, the project involved developing a series of workplans to assist the State in organizing and prioritizing its own efforts for completion of the program development and plan procurement activities. In addition, we advised the State on changes needed for effective State administration of the managed care program.

- Directed a multi-year project for the State of New Mexico to design and implement a statewide mandatory managed care program for the Medicaid population. This project included assisting the State in refining the program parameters; assisting with the development of the waiver application, provider RFP, and provider contract; developing the upper payment limits and evaluating capitation rate bids; identifying and facilitating administrative changes; assisting with the evaluation of and negotiation with offerors; identifying administrative changes necessary for program operation and oversight; and developing and reviewing program monitoring techniques once the program is implemented.

- Assisted the State of West Virginia in the design and implementation of a physical health 1915(b) waiver program for the Medicaid population. Since the program's inception in 1996, Ms. Savela has continued to develop the capitation rates for the program, and has assisted with other aspects of the program administration and assessment as well.

- Directed a project for the Montana Department of Social and Rehabilitative Services in the design of a managed care program for Montana's AFDC population for general medical/surgical services. The project included developing the recommended services, geographic areas, and eligibility categories for inclusion in the program, and developing the capitation rates. Ms. Savela was also responsible for development of provider contracts, QA/UR requirements, and the tools for monitoring plan performance. Subsequently directed a multi-year rate-setting project for the state of Montana involving both the physical health HMO program and the mental health program.

- Directed a project for the State of Montana in support of the state's managed mental health care §1115 waiver application. Ms. Savela's primary responsibilities included the analysis of the cost and utilization of mental health services provided by Medicaid-funded providers, the State Hospital, and community mental health centers; the development and implementation of a rate setting methodology; and the development of the waiver application's cost-effectiveness analysis.

- Developed capitation rates each year for two Medicaid managed care programs in the State of Iowa: the HMO program for medical and surgical services for the AFDC population, and the statewide mental health program for AFDC and SSI populations. Ms. Savela also supplied those financial-related materials needed for the waiver application for the mental health program.

- Directing a multi-year contract for the State of Kansas for calculation of capitation rates for the Kansas 1915(b) managed care program.

Children's Health Insurance

- Directed a project to assist the Indiana Governor's Advisory Panel on Children's Health Insurance to develop a blueprint for the State's Title XXI program. This

blueprint described the proposed design for the children's health insurance program and provided estimates of enrollment and program costs.

Program and Provider Evaluation

- Co-directed a focus group study for the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services examining the experiences of managed behavioral healthcare organizations (MBHOs) with public payer programs. The study synthesized the experiences of the MBHOs with public sector managed care carve-out programs and their recommendations with regard to program design, financial requirements, reimbursement, procurement processes, and administration of managed behaviorial health carve-out programs.

- Case study of seven community health centers participating in managed care arrangements for the Bureau of Primary Health Care in HRSA. Ms. Savela managed all aspects of this study which involved analyzing the performance of community health centers as participants in HMO networks and assessing the impact of managed care on the CHCs. Through detailed sets of interviews with the CHCs and the HMOs with which they contracted, examination of available documents including HMO contracts, grant applications, and other materials, and comparison of utilization statistics for CHC patients and other primary care provider patients within the same HMO networks, the study assessed CHCs' strategic planning and administrative practices, delivery of care and quality assurance, financial management, and management information systems. Ms. Savela recently completed a similar follow-on study for the Bureau with seven new CHCs.

- Evaluation of a Home Health Care/Case Management demonstration project implemented by the Department of Defense. Ms. Savela developed the analytic plan for the evaluation and was responsible for refining the methodology and directing the analysis, developing the contractor and beneficiary interview guides and administering the interviews, and supervising the various components of the evaluation. The evaluation included a cost-effectiveness analysis, a review of the operational and administrative functions of the program, a beneficiary impact assessment, and the development of a detailed set of recommendations for program modification.

- Evaluation of the military services' PRIMUS/NAVCARE program, designed to expand MHSS beneficiaries' access to primary care services in a cost-effective manner by providing care on a fixed unit cost basis. Ms. Savela participated in the analysis of the cost-effectiveness of the program as well as undertaking a review of the operational aspects of PRIMUS/NAVCARE. As part of the study, Ms. Savela interviewed MTF staff and PRIMUS/NAVCARE contractors' staff to evaluate administrative procedures and quality control mechanisms.

- Evaluation of DoD's Partnership program, a program augmenting military hospital staff with civilian providers who provide CHAMPUS services on a

discounted fee-for-service basis. Ms. Savela examined the impacts on costs and workload, and interviewed staff at several MTFs to identify how MTF staff identify their resource needs, how they measure the cost-effectiveness of different arrangements, and how they monitor Partnership providers once agreements are in place.

- An assessment of a Department of Defense demonstration project known as CHAMPUS Choice involving the use of prepaid health plans for CHAMPUS beneficiaries. This included a review of the rate setting procedures, marketing and enrollment procedures, covered benefits, utilization experience, and cost effectiveness of the program. In addition, profiles of the HMOs involved in the demonstration were developed and compared to other local HMOs. Ms. Savela assisted in reviewing the program's objectives, interviewing the HMOs involved in the demonstration, and measuring the cost effectiveness overall.

- A study of the alternatives available to the military for redesigning DoD's civilian health care system and for implementing proposed changes. Ms. Savela participated in the research and analysis of various at-risk contracting models as they apply to CHAMPUS. This study included detailed analyses of mechanisms to protect the government and any potential contractors against excessive financial risks, to promote efficient use of military facilities, to improve the scope and quality of CHAMPUS benefits, and to improve military readiness.

- For various CHAMPUS managed care procurements, Ms. Savela evaluated cost proposals submitted and analyzed the offerors' pricing models including the methodologies, assumptions made, and problem areas. She also developed the models used by the Government for projecting base case costs and utilization in the demonstration regions in lieu of the fixed price contract, and for projecting the impact of improved claims processing procedures, utilization review mechanisms, provider discounts, and other cost containment features to be included under the fixed price contract on these base case costs.

Benefit Studies

- Participated in a review of the CHAMPUS mental health benefit. This study examined the scope of mental health benefits available through CHAMPUS, the type of utilization management imposed upon the benefit, and the payment mechanisms affecting CHAMPUS mental health providers. The study examined the "best practices" found in the civilian sector and makes recommendations for changes in the mental health benefit. Ms. Savela was responsible for the review of the scope of CHAMPUS benefits and the review of private sector initiatives in the area of mental health. In addition, she participated in the development of the chapters on utilization management, reimbursement, and recommendations.

- A study of substance abuse benefits and treatment patterns for CHAMPUS beneficiaries. For this study, Ms. Savela interviewed commercial insurers, private companies, and managed care vendors to examine the initiatives being taken in the private sector to reduce substance abuse. The benefits covered by

Medicare, commercial insurers, and private employers were compared to the current CHAMPUS benefit structure for alcohol and drug abuse coverage.

- A survey of firms for the U.S. Small Business Administration to determine the extent of pension coverage across firm size and industry. The survey covered plan types, participation requirements, vesting schedules, administrative costs, and other issues which affect the comprehensiveness of retirement benefits and the employer's costs.

- An analysis for OCHAMPUS of the extent of disability in the CHAMPUS population and the potential costs associated with expanding coverage for custodial care for this population. Ms. Savela supervised this effort, which included an extensive review of findings from national surveys including the National Medical Expenditure Survey, the National Health Interview Survey, the Survey of Income and Program Participation, and the National Nursing Home Survey to identify the size and characteristics of the population in need of custodial care services. Prevalence rates for disabilities in the CHAMPUS population were developed based upon the survey findings, and potential custodial care costs were estimated using a range of custodial care benefit specifications.

Managed Care Business Development and Strategy

- Directed a project to design and implement a statewide managed care program for the Public Employees Insurance Agency of West Virginia. Ms. Savela made several presentations throughout the program development to the PEIA Advisory Council, which was comprised of legislators, the directors of state provider organizations, state agency representatives, and other stakeholder representatives, and also met with the Governor and key legislators to keep them apprised of the project. As part of the assessment and design planning phase, Ms. Savela traveled throughout the state meeting with and presenting to hospital and health plan executives to evaluate the feasibility of different program options. Ms. Savela was responsible for designing the benefit package, specifying the plan qualifications, developing an incentive arrangement for non-capitated plans, drafting the Request for Proposals, evaluating the proposals submitted, and performing on-site inspections and interviews with each of the offerors. Ms. Savela also assisted the client in identifying those operational changes needed to administer the program efficiently and with issues related to implementation and oversight of the contracted plans

- Identified and evaluated revenue enhancement opportunities for a federally qualified health center. For this project, Ms. Savela analyzed market opportunities, evaluated the capabilities of the organization, and developed options for consideration by the FQHC executive staff and board of directors to increase their short-term and long-term revenue prospects through a combination of market expansion and new product development activities.

- Assisting managed care organizations in developing bid strategies and writing proposals in response to Medicaid and Medicare RFPs. Ms. Savela has assisted plans with developing their strategies for these lines of business as well as with designing benefit packages, developing and/or assessing capitation rates, evaluating network adequacy, describing proposed practices with regard to QA, UM, marketing, and enrollment activities, and all other aspects of proposal preparation.

- Conducted a feasibility study and developed a business plan for the Florida Association of Community Health Centers to assist the member CHCs to form a prepaid health plan. The feasibility study examined other managed care options available to the CHCs and provided detailed recommendations. The business plan set forth the proposed organizational structure and discussed governance issues, capitalization requirements, revenue projections, business relationships, the nature and distribution of operational responsibilities, and other critical factors.

- Performed on-site assessments of HMOs in New England and the mid-west that responded to an RFP released by United Technologies seeking health care services for United Technologies' active and retired beneficiary population. Ms. Savela participated under a contract with Value Health Management, a Lewin-VHI sister company. The on-site assessments measured the degree to which the plans were capable of complying with performance standards developed for United Technologies to assure that only cost-effective, high quality HMOs were offered to beneficiaries.

- Assisted the Office of the Assistant Secretary of Defense (Health Affairs) in several major managed care procurements for CHAMPUS, developing rate setting methodologies and assessing rates proposed by potential contractors. Ms. Savela participated in the development and refinement of the financial aspects of the CHAMPUS Reform Initiative and later, the Tricare program.

Provider Network Development

- Assisted the Office of the Assistant Secretary of Defense (Health Affairs) to design a managed care program for a group of former Public Health Service hospitals providing care to beneficiaries of the military health services system. The design included structuring the enrollment procedures, developing a reimbursement and reinsurance system, designing a program evaluation methodology, and determining the benefit package, utilization management and quality assurance, and data reporting requirements. Ms. Savela participated in all aspects of the development of the managed care model and negotiations with the providers and was responsible for rate development. She has provided policy support for this program since 1989.

PUBLICATIONS AND PRESENTATIONS

"Contracting for Public Mental Health Services: Opinions of Managed Care Behavioral Health Care Organizations. Co-authored with Gail Robinson and Sarah Crow. (DHHS Publication No. [SMA] 00-3438). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000.

"Continuous Eligibility for Children Under Medi-Cal," (co-authored with Joel Menges and Lisa Chimento), prepared for the Medi-Cal Policy Institute, March 25, 1999.

"The Performance of Community/Migrant Health Centers Under Managed Care: Findings from Seven Case Studies", presented to The National Association of Community Health Centers Annual Conference, Marcy 16, 1999.

"Medicaid Capitation Rate Setting Methodology: Montana's Mental Health Access Program," prepared for the Montana Department of Public Health and Human Services, November 6, 1998.

"Technical Documentation for Capitation Rate Development for the Montana Medicaid HMO Program, SFY2000 – SFY2001", prepared for the Montana Department of Public Health and Human Services, March 16, 1999.

"Financing Behavioral Health Care: What Plans Should Know about Approaches for Managed Medicaid," News and Strategies for Managed Medicare & Medicaid, vol. 4, no. 34, September 21, 1998.

"Financing Behavioral Health Care: What Health Plans Should Know about State Agencies' Approaches to Program Financing," Managed Behavioral Health News, vol. 4, no. 31, August 27, 1998.

"The Performance of C/MHCs Under Managed Care: Case Studies of Seven C/MHCs and their Lessons Learned," co-authored with Lisa Chimento and Nathan Stacy, prepared for the Health Resources and Services Administration, Bureau of Primary Health Care, August 21, 1998.

"Derivation of 1998 (Revised) and 1999 Capitation Rates: Final Report," (co-authored with Ellen Englert and Nathan Stacy), presented to the Kansas Department of Social and Rehabilitation Services, March 6, 1998.

"Derivation of SFY98 Capitation Rates: Mountain Health Trust," (co-authored with Ellen Englert), presented to the West Virginia Division of Human Services, February 25, 1998.

"Financing Care: Rates, Risks & Incentives," presented at the Annual State Health Policy Conference organized by the National Academy for State Health Policy and Brandeis University Institute for Health Policy, Portland, Maine, August 1997.

"Issues and Options for Financing Managed Behavioral Health Care Programs," paper prepared for seminar on "Behavioral Health in Medicaid Managed Care: A 'How To' For

State Policymakers," National Academy for State Health Policy and Brandeis University Institute for Health Policy, August 1997.

"Final Interim Report on Medicaid Managed Care," (co-authored with Robert Atlas and Colette Desmarais), presented to the New Mexico Human Services Department, January 1996.

"Medicaid Capitation and Rate Setting Strategies for Medicaid Managed Care," presented at the GHAA Conference "Medicaid: Managed Care at the Crossroads" in Baltimore, MD, September 22, 1995.

"Setting Capitation Rates for a Medicaid Managed Care Program" and "HCFA's Approach to Capitation in Medicare Risk Contracts," a two-hour tutorial to be presented at the Infoline Conference "Rate Setting for Government Contracts: Medicaid, Medicare, & CHAMPUS" in Baltimore, MD, September 6, 1995.

"Performance of Community Health Centers Under Managed Care" (co-authored with Margaret Thomas Trinity and Marilyn Falik), The Journal of Ambulatory Care Management, vol. 18, no 3, July 1995, pp. 77-88.

"Public/Private Partnerships Part III: Performance of Community Health Centers Under Managed Care", presented with Margaret Thomas Trinity at the Group Health Institute Conference, San Diego, June 20, 1995.

"Quality Assurance and Compliance Review Guide for Managed Health Care Plans" (co-authored with Margaret Thomas Trinity), presented to the West Virginia Public Employees Insurance Agency, April 1995.

"Montana Medicaid Managed Care Quality Assurance Monitoring and Coordination" (co-authored with Melinda Beeuwkes, Moira Forbes, and Dennis Hodges), presented to the Montana Department of Social and Rehabilitation Services, March 13, 1995.

"Recommendations Regarding the Inclusion of Medicaid Eligible Groups and Covered Services" (co-authored with Melinda Beeuwkes), presented to the Montana Department of Social and Rehabilitation Services, December 6, 1994.

"Potential Integration of Medical Savings Accounts into the West Virginia Public Employees Insurance Agency Coverage Options" (co-authored with Robert Mechanic, Jeffrey Blend, and Moira Forbes), presented to the West Virginia Public Employees Insurance Agency, November 4, 1994.

"Montana Medicaid Managed Care Project: Research of Federal and State Requirements" (co-authored with Melinda Beeuwkes and Annie Elizabeth Van Dusen)), presented to the Montana Department of Social and Rehabilitation Services, October 31, 1994.

"Community Health Centers' Performance Under Managed Care" (report co-authored with Margaret Thomas of Lewin-VHI and Marilyn Falik of MDS Associates; presentation co-authored and co-delivered with Margaret Thomas), presented to the Bureau of Primary Health Care, Health Resources and Services Administration, October, 1994.

"Medicaid Payment Methodology Under Managed Care", presented at the GHAA Annual Medicaid Conference in Baltimore, Maryland, September 22, 1994.

"Evaluation of the CHAMPUS Home Health Care - Case Management Program" (co-authored with Amy Chasanov, Robin Mahoney, and Nancy Melvin), presented to the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) and OCHAMPUS, June 1992.

"Retirement Plan Coverage in Small and Large Firms" (co-authored with Arnold T. Brooks and David L. Kennell), presented to the Office of Advocacy, U.S. Small Business Administration, June 1992.

"Report on the PRIMUS/NAVCARE Programs" (co-authored with David Kennell of Lewin-VHI and Charles Roehrig and Ron Mitchell of Vector Research, Inc.), submitted to the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA), May 1991.

"Cost and Impact of Federal Regulation on Small Versus Large Business Retirement Plans:", (co-authored with Arnold T. Brooks and David L. Kennell of Lewin-VHI, John Trutko of James Bell Associates, and John Gibson), presented under James Bell Associates contract to the Office of Advocacy, U.S. Small Business Administration, June 1992.

"Feasibility and Advisability of Uniformed Services Treatment Facility-Operated Satellite Facilities" (co-authored with Robert F. Atlas and Amy Chasanov), presented to the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA), August 14, 1990.

"Analysis of CHAMPUS Mental Health Policies" (co-authored with David Kennell, Peter McCanna, and Joyce West), presented to the OASD/HA, June 7, 1990.

"Initial Report on the Cost-Effectiveness of the Partnership Program", presented to the OASD/HA, September 8, 1989.

"Treatment and Coverage of Substance Abuse Services" (co-authored with Katherine Jones, Karen Monborne, and Michele McNally), presented to the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), DoD, July 1989.

"Evaluation of the CHAMPUS Choice Demonstration Project" (co-authored with Scott Honiberg and Peter McCanna), presented to the OASD/HA and the OCHAMPUS, June 15, 1988.

"Increases in Health Insurance Coverage Among Small Firms, 1986-1988", presented to the National Association for the Self-Employed, June 7, 1988.

"Health Care Coverage and Costs in Small and Large Businesses" (co-authored with David Kennell), presented to the Office of Advocacy, U.S. Small Business Administration, April 15, 1987.

"HMOs, Finance, and the Hereafter" (co-authored with Donald W. Moran), Health Affairs, Spring 1986, pp. 51-65.

EMPLOYMENT HISTORY

The Lewin Group	Senior Consultant	2002 to present
Independent consultant		2000 – 2002
The Lewin Group	Vice President Project Manager Senior Associate Associate Analyst Research Assistant	1994 – 2000 1991 – 1994 1989 – 1991 1987 – 1989 1986 - 1987 1985 – 1986
Marshall Bartlett, Inc. (economic consulting firm)	Research Assistant	1982 – 1984

GRADY CATTERALL, FSA, MAAA
ACTUARY AND SENIOR MANAGER

EDUCATION

2001	M.P.H., Johns Hopkins University, Bloomberg School of Public Health 615 N. Wolfe St., Baltimore, MD 21205-2179 Years Attended: 1999 - 2001
1985	A.B., Applied Mathematics, Harvard University University Hall, Cambridge, MA 02138 Years Attended: 1981 - 1985

EXPERIENCE

Mr. Catterall joined The Lewin Group in 2002. Prior to joining The Lewin Group, he was an independent consultant and actuary and was often retained by The Lewin Group as a subcontractor. He also has held positions with several large consulting firms, and he has 19 years of experience in the health care, employee benefits, and financial services fields. His work has focused on the design, implementation, and analysis of managed health care and pharmacy benefit programs. He specializes in data and trend analysis, benefit pricing, cost projection, financial liability evaluation, and risk adjustment analysis. He also has expertise in vendor selection, contract negotiation (including the development and monitoring of performance incentives and risk-based financial arrangements) and arbitration.

Mr. Catterall's experience includes:

Actuarial / Financial / Risk Analysis: ***Medicaid and SCHIP***

- 2002 - present: Reviewed methodology used to develop capitation rates for Medicaid managed care programs in two states, in order to ensure compliance with Actuarial Standards of Practice and other generally accepted actuarial principles. Worked with managed care vendors to address actuarial, data, and reporting issues that arose during the rate-setting process. Analyzed programs' historical utilization trends and developed projections of future trends, incorporating fee schedule data from the states and cost and enrollment data for Medicaid programs nationwide compiled by the Centers for Medicare and Medicaid Services (CMS). Developed methodology for identifying and redistributing outlier claims and for smoothing rate changes across age/sex cohorts. For each year and each state, prepared Statement of Actuarial Opinion to comply with Medicaid managed care regulations promulgated by CMS in June 2002.

- 2002: Evaluated the cost effectiveness of a Medicaid managed care program by developing hypothetical cost of discontinued fee-for-service program in order to demonstrate cost savings under the managed care program.

- 1999: Prepared the Actuarial Opinion Memorandum for a State Children's Health Insurance Program (SCHIP). Determined the actuarial value for all basic

and additional services to be offered under the proposed plan. Verified compliance with the actuarial requirements of Title XXI of the Social Security Act.

Actuarial / Financial / Risk Analysis: ***Coverage Expansion Programs***

- 2003 - 2004: For a state government: Developed estimates of per-member per-month (PMPM) net benefit costs and gross premiums for a proposed health insurance program aimed at currently uninsured persons. Developed premiums by age, sex, and coverage tier for basic and expanded benefit packages, and produced cost factors for other benefit changes under consideration. Analyzed state benefit mandates and rate restrictions in order to quantify the effect of a possible waiver. Determined the impact of various reinsurance arrangements on plan premiums and state costs. Developed sliding-scale deductible based on family income, and showed likely enrollment scenario and projected costs based on distribution of state population by income and coverage status. Prepared report detailing results, methods, assumptions, and sources to be presented to legislative committee.

- 2003: For a university-based policy institute working with a State Planning Grant (SPG) from the federal government: Developed PMPM cost estimates for a variety of benefit packages intended to be offered to low-income individuals and to small employers. Designed reinsurance alternatives to meet program cost and coverage goals. Presented results during conference calls with the benefits and finance subcommittees of the SPG Steering Committee.

- 2002 - 2003: For a state government: Developed PMPM cost estimates for a health insurance voucher program. Derived probability distribution for gross claims per member based on statistical characteristics and principal cost components of the state's current program for low-income residents. Projected program enrollment under various contribution requirements, reflecting the price elasticity of health insurance and the observed enrollment patterns for Medicaid programs and individual insurance products, and quantified the cost effect of the resulting adverse selection. Determined the effect of proposed limits on beneficiary cost-sharing, taking into account both average claims and expected volatility. Projected enrollment and costs over a five-year period. Produced detailed write-up of the analysis for the client.

- 2002: For a private foundation: Designed an administrative cost model for a statewide health insurance purchasing cooperative (HIPC). Described the administrative functions that the HIPC would perform under different program designs, and estimated the percentage of premium that would be available to cover the associated costs. Determined the break-even enrollment needed for the HIPC to become self-supporting, and estimated the net start-up costs.

- 2001: For a state hospital association, in cooperation with the state Department of Health: Developed estimates of net benefit costs for a proposed program to

provide health insurance coverage to low-income residents, based on historical Medicaid costs and premium quotes for low-cost commercial plans. Presented step-by-step explanation of premium projection process to state officials and HMO representatives.

Actuarial / Financial / Risk Analysis: ***Public Employee Programs***

- 1997 - 2000: Performed risk assessments, trend analyses, and cost projections for the health care program sponsored by a suburban county school system. Performed initial risk assessment and cost projection for a self-insurance feasibility study. Annually performed cost and trend analyses in order to develop the employer contribution rates used in the school system's budget forecasts. Periodically presented the results of these studies to the Superintendent and/or the School Board.

- 1998 - 1999: Developed and implemented a risk adjustment methodology for the health care program sponsored by a statewide public employee retirement system. Redesigned the risk adjustment methodology used in setting the employer and employee contribution rates for the program's two PPOs. Worked with the retirement system's health data vendor to develop new risk adjusters to be incorporated into the rate-setting process. Developed a new report to explain the risk adjustment and rate-setting process to the retirement system's staff. Annually presented the results to the Board of Trustees.

- 1998 - 1999: Tracked historical costs, forecasted future costs, and developed employer and employee contribution rates for the health care program sponsored by a statewide school employee retirement system. Redesigned the quarterly financial report used for tracking and forecasting health care costs. Annually presented financial results and proposed rates to the Board of Trustees.

- 1998 - 1999: Performed health care cost analyses and projections for a large urban school system. Analysis included estimates of the cost impact of proposed benefit changes. Presented the results to the Superintendent and the School Board.

Actuarial / Financial / Risk Analysis: ***Miscellaneous***

- 1988 - present: Performed miscellaneous financial analyses in response to special client requests. Example: Performed detailed analysis and critique of software developed by a client in the financial services industry. (Software was used for determining simplified repayment schedules for multiple-loan portfolios.)

- 1988 - 2000: Advised various employers on the funding and financial reporting issues associated with their employee benefit plans. Performed and/or

supervised actuarial valuations of retiree health and pension plans. Developed automated process for generating client reports.

- 1995: Developed cost projections and actuarial values to be used by attorneys in litigation and financial negotiations.

- 1992 - 1993: Developed pricing and reserve bases for life and health products to be offered by a commercial insurance company. Results used to prepare rate and form filings for state insurance departments.

Plan Design and Related Services for Health Care and Other Benefit Programs

- 1990 - 2000: Advised various clients regarding initial vendor selection, contract negotiation, and renewals, for health insurance, managed care, Medicare+Choice, pharmacy benefit management, and stop-loss insurance vendors for the clients' benefit programs.

- 1999: Designed premium subsidies for the dental and vision programs offered by a statewide public employee retirement system. Presented study results to the Board of Trustees.

- 1996 - 1999: Advised statewide public employee retirement systems regarding financial risk sharing arrangements and year-end settlements with health insurers and PBMs.

- 1988 - 1996: Designed and produced benefit statements to be distributed to plan members.

- 1995: Analyzed the claims experience of a large health plan for federal government employees, using sampling techniques based on DRG and CPT codes. Re-priced claims based on various PPO vendor proposals.

- 1990 - 1995: Assisted clients' counsel in drafting plan amendments.

- 1988 - 1995: Developed new benefit formulas for various plan sponsors in order to meet benefit goals and cost objectives, and to satisfy regulatory requirements.

Negotiation and Arbitration

- 2000 - 2001: Arbitrated a contract dispute between a Pharmacy Benefit Manager (PBM) and an HMO involving a financial risk sharing arrangement. Retained by counsel for the PBM to serve as a party-appointed arbitrator and as a consultant to the PBM. As a member of the arbitration panel, worked with the other arbitrators to manage the arbitration process and resolve disputes between the parties regarding discovery and other process-related issues. As consultant to the PBM, assisted the PBM and its counsel in developing and critiquing its case before counsel presented it to the neutral arbitrator. Also challenged the case presented by the HMO's counsel and its party-appointed arbitrator.

- 1988 - 2000: For a suburban county school system, served as the technical advisor to a joint labor-management committee charged with recommending changes to the health care program that would produce the cost savings that were agreed to during previous labor negotiations. Developed cost projections showing the expected financial impact of a number of individual benefit changes and various combinations of these changes. Helped draft a comprehensive report on the process and its results, and presented a summary to the Superintendent and the School Board.

- 1992 - 1995: Advised the administrators of a large health plan for federal government employees on premium negotiations with the federal government. Developed an automated process for analyzing the financial impact of alternative pricing strategies.

SELECTED PRESENTATIONS

"Pharmacy Cost Increases: Causes, Projections, and Strategies," presented at the 2002 Society of Actuaries Spring Meeting, San Francisco, California.

"Public Databases and Other Resources for Health Actuaries," presented at the 2002 Society of Actuaries Spring Meeting, San Francisco, California.

"Prescription Drug Cost Projections," presented at the 2001 Society of Actuaries Spring Meeting, Dallas, Texas.

"Medical Technology and Research Update: Current Priorities and Future Horizons," presented at the 2001 Society of Actuaries Spring Meeting, Dallas, Texas.

"Managed Care Organizations: The Purchaser's View," presented at the 1997 Society of Actuaries Annual Meeting, Washington, D.C.

EMPLOYMENT HISTORY

The Lewin Group	Senior Manager	2002 – present
Independent Consultant	- - - - -	2000 – 2001
Gabriel, Roeder, Smith & Company	Consultant & Actuary	1996 – 2000
Independent Consultant	- - - - -	1995 – 1996
Watson Wyatt Worldwide	Consulting Actuary	1990 – 1995
	Associate Actuary	1990 – 1993
Towers Perrin	Associate	1988 - 1990
Equitable Life	Actuarial Assistant	1985 - 1988

KEITH W. HEARLE, AB, MBA
VICE PRESIDENT

EDUCATION

MBA, finance, Vanderbilt University

AB, economics, Davidson College, *cum laude*

Mr. Hearle has over 20 years of consulting, policy analysis, and management experience. He began his career in the hospital finance consulting practice of KPMG Peat Marwick, then was Vice President at The Lewin Group until 1995. Prior to rejoining The Lewin Group in 1999, Mr. Hearle was a Senior Research Analyst for a California-based investment company where he evaluated pharmaceutical, medical device, and healthcare services companies for equity investment. Between 1995 and 1997, he was the Chief Financial and Operations Officer for the Public Health Division in the San Francisco Department of Health.

Mr. Hearle specializes in strategy development, program planning, financial analysis, public policy analysis (particularly regarding hospital performance, provider reimbursement, government pharmacy benefits, and indigent care), and market and investment analysis for the healthcare field.

Strategic and Business Planning

Mr. Hearle has extensive experience in providing strategic and business planning to a wide variety of organizations. He has worked extensively with academic medical centers, providers, insurers and others providing assessing and developing effective plans.

- Assisted the Peninsula Health District with an assessment of Sutter Health's plans to rebuild Mills-Peninsula Medical Center.
- Directed an assessment of the case for developing a new geographically-separate medical school campus in Northern Virginia.
- Directed development of a strategic plan for the New York Hospital Medical Center of Queens. Coordinated the work of seven task forces recommending initiatives for physician alliances, information systems, relationship-building with other New York Hospital affiliates, program development, marketing, customer services, and facilities master planning.
- Developed a business plan for a start-up medical device company. The business plan was used to help the company attract new capital for ongoing project research and development.
- Developed a successful Certificate of Need for open heart surgery and angioplasty services.
- Developed a financial analysis for the introduction of a new health insurance product for the Blue Cross Blue Shield Association of America.

- Conducted 15 financial feasibility studies to support bond issues and new program development.
- Developed financial models for strategic planning clients to demonstrate financial consequences of strategies and to establish targets for long-range financial policy.

Public Hospitals and Safety-Net Systems of Care

Mr. Hearle has worked extensively with public hospitals and communities, providing strategic planning, safety-net design analysis, financial analysis, and evaluations.

- Conducted strategic planning projects for MetroHealth Medical Center, a 1,000-bed public teaching hospital in Cleveland, Ohio, and for Grady Hospital in Atlanta, Georgia. Provided financial analysis and business planning input for a recently completed strategic plan for Jackson Health System in Miami, Florida.
- Directed two studies of local safety-net systems of care in Louisiana communities. Analyzed policy context, developed financial models, and facilitated interviews and meetings to examine alternative models for the organization and financing of services for low-income consumers.
- Served as an Expert witness for litigation regarding local tax funds appropriated by Hamilton County (Ohio) to the principal safety-net hospitals operating in Cincinnati.
- Directed evaluations of plans to replace or renovate the county hospitals in San Mateo, San Francisco, Contra Costa, Santa Clara, Los Angeles, Yolo, and Tuolumne Counties (all in California). These projects assessed a full range of alternatives to correct facility deficiencies and to take advantage of new State funds (S.B. 1732/2665) available to assist with debt service repayment. For San Francisco, projected program volumes for SFGH and facilitated discussions with a community task force, internal groups, and the Health Commission regarding the future role of the hospital and the resultant size of a replacement facility.
- Directed a study that documented the community benefits provided by the Broward Hospital Districts (Florida).
- Developed a model of Los Angeles County's supply and demand of hospital services. The model clarified the need for inpatient beds, emergency room and trauma services, particularly those provided by Los Angeles County + USC Medical Center.

Public Policy Analysis and Consulting

Mr. Hearle has extensive experience in the arena of public policy analysis and consulting.

- Evaluated the implications of price controls on the financial performance of the pharmaceutical industry. Developed financial model to evaluate impacts on company revenues, investments in research and development, and the introduction of future pharmaceutical products.

- For Pfizer, developed a user-friendly, state-level model to assess the impacts of alternative Medicaid rebate levels and pharmacy assistance programs.
- Evaluated Disease Management programs provided by Pfizer in the State of Florida.
- Directed two studies for the Blue Cross Blue Shield Association of the United States on drivers of healthcare cost growth in the U.S.
- Directed a study of the financial performance of hospitals in the State of Connecticut for the Office of Health Care Access. Identified variables affecting performance and recommended policy initiatives to assure access to high quality hospital services in the State.
- Evaluated the equity of hospital Medicaid reimbursement in the states of Connecticut, Oregon, Illinois, and Massachusetts.
- Directed a study for the Washington State Legislature of the costs and effectiveness of hospital health and safety regulation.
- Co-authored the Catholic Health Association's Social Accountability Budget, a guide to help non-profit hospitals demonstrate their community benefits and protect tax exemptions.
- Evaluated the economic impact of California legislation to regulate resident work hours.