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July 9, 2008

Dirigo Health Agency
Attn: Ruth.A.Burke@maine.gov
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53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Fourth Assessment Year (2009)

FILING COVERSHEET

Dear Ms. Burke:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	July 9, 2008
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of Sharon Roberts
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 1
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE FOURTH ASSESSMENT YEAR	)	SHARON ROBERTS
(2009)	)	
	)	
Docket No.	)	
	)	July 9, 2008
	)	

NON-CONFIDENTIAL

Q. Please state your name and your position with Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is Sharon Roberts. I am Director of Stakeholder Relations with Anthem BCBS in its Maine office.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

A. In addition to my 30 years of experience in the Maine insurance markets, I was appointed as a member of the working group formed pursuant to the Dirigo Health Act ("Dirigo Health" or the "Act") for the purpose of making recommendations for an appropriate methodology for calculating the "aggregate measureable cost savings . . . as a result of the operation of Dirigo Health." 24-A M.R.S.A. § 6913(1). I have also participated in prior years' assessment hearings.

Q. Please explain why Anthem BCBS intervened in this proceeding

A. Anthem BCBS is the largest health insurer in the State of Maine and also provides administrative services for a number of self-insured employers in Maine. By operation of the Dirigo Health Act, whatever savings are ultimately approved will determine one of the maximum limits for the savings offset payment ("SOP") to be paid by, among others, insurers like Anthem BCBS and then included in the premium rates and health claims that our members pay for their insurance. Anthem BCBS fully supports the goals of Dirigo Health and the objectives envisioned by the Act. In the interests of its group and individual members, however, Anthem BCBS is committed to ensuring that the amount of the SOP reflects only the aggregate measurable cost savings ("AMCS") permitted by the Act. The issues surrounding Dirigo Health are complex, but it is critical that the established methodology for calculating savings does not result in a savings offset

payment assessment beyond the true savings that resulted from the operation of Dirigo Health. Otherwise, the SOP is only serving to increase costs for Anthem BCBS's members.

Q. What is the purpose of your testimony?

A. Within the context of our reasons for intervening, there are several purposes to my testimony here today: (1) to explain how health care provider costs, and hence any potential savings, are built into Anthem BCBS's premium rates; (2) to explain the implications of the SOP on the cost of health insurance in Maine; and (3) to identify problems that Anthem BCBS perceives in the Dirigo Health Agency's ("DHA") proposed methodology for the fourth assessment year.

Q. What happens to actual cost savings that result from the operation of Dirigo Health?

A. Those savings are included in the calculation of the premium rates that our members pay.

Q. How do the savings pass through to your members?

A. To answer that, I need to start with a description of our provider network and how we contract with providers in that network.

Anthem BCBS has a very broad network of providers from which our members can choose to receive services. To ensure network stability, Anthem BCBS has contracts with those providers that define the nature of the contractual relationship as well as the rates at which Anthem BCBS will pay the providers for the services they render to Anthem BCBS's members. As such, it is in Anthem BCBS's best

interest, and in the best interest of our members, to secure from providers contract rates that are as low as possible, while maintaining a broad network in compliance with Maine law.

Anthem BCBS's provider contracting personnel negotiate with hospitals and other providers to ensure that Anthem BCBS is getting the best possible rates for the services that the hospitals provide to our members. The rate that the hospital is willing to negotiate to is made up of many factors, one of which is the cost of the services the provider performs. If there are reductions in the provider's costs in any particular year, if all else is equal and the provider is willing and able to pass those cost reductions on in the form of a lower contract rate, Anthem BCBS's costs for that particular service will also be reduced.

Q. You mentioned that the provider must be willing and "able" to pass on cost reductions. What do you mean by that?

A. As I explained earlier, hospital finance is very complex. Simply because a hospital's costs may be reduced does not necessarily mean that hospital is in sufficient financial health to pass along those cost reductions in the form of a reduction in its charges for services. For example, a hospital with a low operating margin is in no position to pass along cost reductions in its provider contracts with Anthem BCBS. Those cost reductions instead must be used to buoy the hospital's balance sheet to ensure its ongoing financial stability. My point is that it is not as simple as suggesting that any reduction in a hospital's costs necessarily is available for insurers to "take back" in the form of a contract reduction. In fact, the Acting Superintendent in last year's AMCS proceeding recognized the fact that cost reductions must be recoverable to be counted. *See In re Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Third Assessment Year*, Docket No. INS-07-900, Decision and Order issued September 17, 2007 ("It is reasonable to assume that hospitals with margins below 1% could not be expected to generate recoverable savings . . .") .

It is unrealistic to suggest that cost reductions at hospitals with meager operating margins can be recovered by insurers in the contracts with those hospitals.

In addition to the hospital's margin affecting its ability to pass along cost reductions, the source of the hospital's revenues also has an effect. For example, an increase in the number of Mainers covered by insurance likely will increase the utilization of services and, in the aggregate, hospital revenues.[1] However, there is a substantial portion of revenue at Maine hopsitals that is derived not from private payors, but rather from governmental payors. At many rural hospitals, this amount may exceed 70% of total revenue. Accordingly, to the extent the source of a hospital's increased revenues is from insureds covered by MaineCare (as opposed to coverage through private insurance), the financial result for the hospital, all else being equal, would be a net negative because MaineCare reimburses at less than 100% of the cost of the services provided by the hospital. Thus, while the aggregate revenue for the hospital may be greater, unless charges to private paying consumers are increased to cover the increased utilization from those newly covered by MaineCare, the hospital is in a worse (not better) position to pass along "savings" that purportedly result from those covered by MaineCare. When a hospital treats governmental payors (***e.g.***, those covered by MaineCare), there are only two choices for the hospital: (1) absorb the losses associated with providing services that are reimbursed at less than 100%; or (2) cost shift the difference to those covered by private insurance. Either way, the hospital does not experience actual cost savings associated with the increased revenue and, accordingly, does not have savings that are meaningfully recoverable.

[1] For recent research regarding coverage and utilization, see, ***e.g.***, the Health Affairs articles available at http://content.healthaffairs.org/cgi/reprint/27/3/646 and http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.250v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=hadley&author2=holahan&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&fdate=11/1/2002&resourcetype=HWCIT.

Q. What do you mean by "meaningfully recoverable"?

A. Well, if the hospital absorbs the difference between the actual cost of the services provided and the amount reimbursed by the governmental payor, the hospital did not achieve any savings that may be recovered through negotiations with that hospital in the provider contracting process. If instead the hospital cost-shifts the difference to the commercially insured population, the hospital will not "give back" that cost shift in its private-payor contracts because that would return the hospital to the position of absorbing the cost shift and, hence, not achieving any real savings from the increase in revenue.

Q. What about persons who were previously uninsured, but using services? Is the hospital better off financially with some level of reimbursement than with none?

A. Certainly if a person would use precisely the same services irrespective of their insured status, the hospital would be best off if the person were insured through private insurance or was uninsured but willing and able to pay the hospital's charges. However, if the person were uninsured and unwilling or unable to pay the full charge, a less than full reimbursement by a governmental program would be better than nothing. Your question, however, presumes that utilization remains constant irrespective of insured status. That is simply not the case. As recent research suggests, utilization among those with insurance is greater than for those without. That being the case, the premise of the question (*i.e.*, that utilization remains constant) is fundamentally flawed.

Q. You mentioned earlier that a large percentage of hospital revenues are derived from sources that are not subject to the SOP. Does that fact have implications other than limiting a hospital's ability to pass on cost reductions?

A. Yes, it has significant implications on the way in which the aggregate measurable cost savings calculation is used as one cap in the determination of the savings offset payment. Private payors and their members pay the savings offset

payment, which is derived, in part, from the calculation of aggregate measurable savings. The SOP is supposed to be an offset to savings that have accrued to the benefit of those same private payors. If the aggregate measurable savings calculation calculates 100% of the "savings", but does not take into consideration that a significant portion of those "savings" go to governmental (not private) payors and others who do not pay an SOP, the private payors will pay an amount of SOP that is greatly exaggerated relative to the calculated savings that actually could have accrued to the benefit of those private payers. This is obviously inequitable and results in private payors subsidizing the savings that have accrued to governmental payors and others who do not pay an SOP. Put differently, the savings that accrue to governmental payors simply are not recoverable by private insurance carriers, which means they cannot be passed on to those with private insurance who pay the SOP.

Q. To the extent cost reductions are recoverable – that is, from those hospitals with healthy operating margins – that explains how Anthem BCBS's costs would be reduced, but how do those provider cost reductions end up reducing premium rates?

A. Premium rates charged to all members for a given period are calculated by Anthem BCBS's actuaries and underwriters based on projected claims (***i.e.***, the amount that Anthem BCBS expects to pay health care providers for the applicable period for the services providers perform for Anthem BCBS members). The total of all provider contracts, including any reductions in provider contract rates, are used to develop those claim projections. This means that any impact from the operation of Dirigo Health that truly reduces health care provider charges (***i.e.***, cost reductions that are truly recoverable) would be reflected in Anthem BCBS's claim projections and, accordingly, the premium rates that our members pay for insurance.

Q. Will the cost savings flow to all of Anthem BCBS's customers, including self insured large groups, fully insured large groups, small groups, and individuals?

A. Yes, any recoverable cost savings will flow to all of our members. In fact, despite the perceived differences in these types of risk, the rating process is nearly identical. I believe that a more detailed explanation here will be useful in understanding how the savings are passed on.

First, let me begin with the example of a self insured group. Self insured groups, or administrative services only ("ASO") groups, contract with Anthem BCBS to administer their health plan, but not underwrite the risk of the claims. This means that Anthem BCBS provides all adminstrative services, including paying claims for the ASO group, but is later reimbursed for the claims. Accordingly, Anthem BCBS has no risk for the group's actual claim experience, and the product is priced to reflect that.

In the typical ASO arrangement, Anthem BCBS will project an estimate of the ASO group's future claims for the group's budgeting purposes. This projection is based on using the group's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future health care cost and utilization changes.

Q. So, in essence, Anthem BCBS works as an intermediary for the self insured group by paying providers for the the group's claims and the group reimburses Anthem BCBS dollar for dollar for those claims?

A. Yes, that is correct. In this arrangement Anthem BCBS is selling only its services to the group. One of these services is the negotiated discounts that Anthem BCBS receives from providers. The group benefits directly from Anthem BCBS's ability to negotiate lower fees with providers. If these

negotiated amounts are lower due to the operation of Dirigo Health (or any other reason), then the group benefits directly.

Q. In this type of arrangement, where Anthem BCBS pays claims and is then reimbursed, how could Anthem BCBS retain any discounts, or savings, from providers?

A. It would be impossible for Anthem BCBS to keep any discounts or savings that come through as part of the payments to providers because the actual claim costs ultimately are paid by the group, not by Anthem BCBS.

Q. That explains the self insured large groups. What happens with fully insured large groups?

A. The process is nearly identical. For large fully insured groups, Anthem BCBS will project an estimate of the group's future claims in order to set the claim portion of the group's total premium. As with self insured groups, this projection is based on using the group's own actual paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future health care cost and utilization changes. The only difference from a self insured group is that Anthem BCBS is at risk for the claim payment to be made from the premium received from the group.

Q. How can this rating process work for a small group? How could a group of three people, for instance, have enough claims to be considered reliable as the basis for predicting future claims?

A. It is quite possible for a group of three people to have no claims during any given year. Therefore it is not possible to use a small group's claim experience as a basis for predicting future claims.

Q. But you noted earlier that the premium for a small group is derived in the same way that the premium for a large group is derived?

A. It is, but not for each and every small group standing alone. In Maine, it is required that the small group market, defined as groups with fifty or fewer employees, be rated on a "community" basis. What this means is that all small groups are combined together in order to create one large community, or "group of groups." The size of the community makes it possible to use the claims for the entire community as a predictor of future claims. Anthem BCBS will project an estimate of the community's future claims in order to set the claim portion of the small group community's total premium. As with all large groups, this projection is based on using the community's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future health care cost and utilization changes.

Q. That leaves individuals who purchase their own health insurance because they do not have insurance through an employer. How is the premium determined for an individual?

A. It is the same as with small group, except rather than aggregating all small groups in one community for rating purposes, all individuals are combined together in order to create one large group of individuals. Again, the size of the group of individuals makes it possible to use the claims for the entire group as a predictor of future claims. Anthem BCBS will project an estimate of the group of individual's future claims in order to set the claim portion of the individual total premium. As with all large and small groups, this projection is based on using the

group of individual's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future health care cost and utilization changes.

Q. So for all members, all cost savings are included in premiums, whether or not those cost savings are as a result of the operation of Dirigo Health?

A. Yes. Because we use actual claims data and project forward taking into account our provider contracts, any reduction in costs or cost growth is included in our claims experience and, hence, the premium rates we charge our members. Further, Anthem BCBS is regulated by the Maine Bureau of Insurance – the same Bureau of Insurance that reviews the DHA Board's recommended calculation of the aggregate measurable cost savings as a result of the operation of Dirigo Health. As part of the regulatory process, the Bureau of Insurance regularly reviews Anthem BCBS's finances and, whenever Anthem BCBS seeks a rate modification for its individual products (*e.g.*, HealthChoice), the Bureau of Insurance examines every component of the proposed premium rates, including the projected claim trends and profit margins, to ensure that they are reasonable. The Superintendent routinely examines these components and has determined that all cost savings, including those that result from the operation of Dirigo Health, are reflected in the premium rates proposed and charged by Anthem BCBS. *See, e.g., In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Docket No. INS-05-820, Decision and Order issued December 19, 2005, p.10 ("[Mr. McCormack] testified that he was confident that the current contracts with health care providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore [Anthem BCBS's actuary] testified these savings attributable to Dirigo had been incorported into the filed rates. The Superintendent concludes that Anthem has

made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives.").

Q. Has Anthem BCBS followed this same premium development process that you have described since the effective date of the Dirigo legislation?

A. Yes. The process has remained the same both before and after the effective date of the Dirigo legislation. Anthem BCBS still attempts to negotiate the lowest possible rate with each provider. The only difference is that we now request each hospital's bad debt and charity care costs and probe each hospital specifically to ensure that the negotiated rate includes any cost savings as a result of the operation of Dirigo Health.

Q. If health insurance carriers, including Anthem BCBS, are reimbursed for the savings offset payments by consumers because the payments will be embedded in premium rates, why is Anthem BCBS concerned with the amount of the savings offset payments?

A. Anthem BCBS is concerned that the methodology proposed by the DHA for the fourth assessment, like that from prior years, is flawed and tends to overstate cost savings. Anthem BCBS works diligently to keep insurance costs for its members as low as possible. Anthem BCBS's members ultimately pay the SOP and that payment should not exceed the actual measurable aggregate cost savings as a result of the operation of Dirigo Health that are recoverable in provider contracts. That is the only way to ensure that existing insurance purchasers are not being unduly burdened by a new cost to subsidize Dirigo Health insurance coverage and that there will continue to be broad-based support for the ongoing operations of Dirigo Health and the subsidies for the health insurance coverage provided through the Dirigo Health Agency.

Q. What is wrong with those who can afford private health insurance subsidizing those with lower incomes?

A. Health care costs in Maine are already high. Each year during the regulatory process associated with examination of rate modifications for Anthem BCBS's HealthChoice products, the Superintendent hears from many Mainers who report their frustration with the continued rise in the cost of health care and health insurance in Maine and their need to make decisions whether they can afford to maintain insurance coverage. Requiring those with private insurance to pay an SOP that is inflated beyond the actual savings as a result of the operation of Dirigo Health is an unfair burden and promises only to result in more Mainers dropping their coverage. As I have previoulsy testified in proceedings before the Bureau of Insurance to review the Board's recommended calculation of aggregate measurable savings for prior assessment years, research shows that for every 1% increase in health insurance costs, 300,000 people lose coverage nationwide. That represents a significant number of Maine people who could drop coverage due to increased cost. If the savings offset payment represents new spending by purchasers that is not offset by tangible savings to them, the net impact to the system will result in more Mainers losing coverage because of the added cost rather than meeting Dirigo Health's intended goal of expanding coverage.

Q. How should the Dirigo Board calculate the aggregate measurable savings?

A. The Board should include only those savings that are within the language of the Act iself. The Act directs that the calculation should be limited to "the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1).

Q. Have you reveiwed the methodology that has been proposed by DHA for the fourth assessment year?

A. I have reviewed the report from DHA's consultant, schramm raleigh Health Strategy ("srHS"), summarizing the methodologies that srHS proposes should be used for calculation of aggregate measurable cost savings in the fourth assessment year (the "SrHS Report").

Q. Do you have any comments based on the cost per case mix adjusted discharge ("CMAD") methodology summarized in the srHS Report?

A. Yes. It appears that DHA will depart from the CMAD methodology it has employed in past years and rely heavily on a statistical regression analysis for the fourth year assessment. I have only a high-level understanding of statistical regression, and thus defer to Anthem BCBS witness Vincent Maffei to more fully explain the mechanics and purpose of such analysis, as well as comment specifically on srHS's modeling. In short, however, srHS's regression model—which srHS calls a multi-state, multivariate approach—includes a review of health care and other data from various states in addition to Maine, and, according to srHS, is intended to control for various non-Dirigo influences on Maine's health care expenditures, such as changes in demographcis, supply of health care, and other socio-economic factors.

Q. Does the srHS CMAD methodology reasonably control for non-Dirigo cost drivers in determining aggregate measurable cost savings for the fourth assessment year?

A. No. As explained in Mr. Maffei's testimony, srHS's methodology does not reasonably measure cost savings that are attributable to Dirigo in part because

it does not take into consideration several non-Dirigo factors that drive hopsital costs in Maine.

Q. Can you provide examples of the non-Dirigo factors that drive hospital costs in Maine that were not considered by srHS in its CMAD methodology?

Certainly. Mr. Maffei's testimony explains these non-Dirigo cost drivers that affect the cost per CMAD in detail, but some of the larger factors that srHS fails to consider include employment growth in Maine, hospital profit margins (or operating margins) and changes in utilization.

Q. First, please explain how statewide employment growth rate can affect hospital costs and its specific implications to Maine.

A. Since the majority of commercial subscribers receive their medical insurance through employers, changes in the employment rate affect the percent of the population with medical insurance and thereby the level of medical spending. As employment levels grow, so too do those who have insurance. In a growing economy, employers who offer insurance will hire more employees, some employers who had not previously offered insurance to their employees will be able to afford to do so, and, as per capita income grows, more employees will be able to afford their insurance co-shares, co-pays and deductibles. Not only does the number of insured lives increase, utilization rates for the commercially insured increase as well. As a result, hospital revenue growth accelerates, and as revenues grow, the financial need for increases in reimbursement rates (*i.e.*, the average cost of a discharge or outpatient visit) eases. The growth in CMAD average cost should also slow. By contrast, as employment levels decline, hospital revenues shrink and the cost per case mix increases.

For example, in 2003, employment growth throughout the United States declined and, as a result, hospital cost growth exceeded historical levels. The declining

employment growth rates throughout the United States contributed to the growing rates of uninsured, which in turn put downward pressure on hospital profit margins. These declining profit margins in turn pressured hospitals to push for higher prices (*i.e.*, cost per discharge and cost per outpatient visit). When employment growth rates turned positive in 2004, the resulting increase in the insured population allowed hospitals to ease up their demands for higher per discharge/visit cost increases. In short, when employment growth returned to more historical levels in 2004, hospital cost per case mix growth likewise returned to historical levels.

While a similar cycle occurred in Maine, the cost growth fluctuation was exacerbated because Maine experienced a longer recession in employment growth than the rest of the United States (including three years of zero growth from 2001 to 2003). The length and depth of the recession in Maine placed more financial pressure on Maine hospitals to increase reimbursement rates (*i.e.*, cost growth) than it did on U.S. hospitals in general. When employment growth turned positive in 2004, the financial pressure on Maine's hospital eased for the first time in three years, and Maine's hospital cost growth returned to its more historical levels.

Q. You indicate that Maine's more lengthy employment growth recession exacerbated cost growth fluctuation. Why?

A. Because the pre-2004 (*i.e.*, pre-Dirigo) cost growth level was artificially high from multiple years of employment growth decline, the return to historically normal levels in 2004 and after produces artificially exaggerated "savings" that the srHS model simply attributes to Dirigo.

Q. You also suggested that hospital operating margins can affect cost trends. How?

A. My experience is that hospital operating margins can also have a significant effect on health care costs. Hospitals with slim or negative operating margins are under pressure to increase revenues and that leads to increased costs per case mix. By contrast, when hospital operating margins are more robust, the pressure to increase revenues is diminished and there is consequently less cost growth pressure. The data provided by srHS reflects that hospital operating margins in Maine improved in 2004 and after, which for the reasons stated above, eased the need for hospitals to increase their costs per case mix.

Among other reasons, all of which are fully discussed in Mr. Maffei's testimony, the existence of declining employment growth and increasing hospital margins makes it all the more dubious to attribute the post-2004 decline in hospital cost growth to Dirigo. The fact that the srHS model does not control for two well-known factors affecting hospital costs (*i.e.*, increasing employment growth and operating margins) demonstrates that the model is fundamentally flawed and cannot be relied upon to produce reasonable results that truly measures AMCS.

Do you have any comments based on the bad debt and charity care ("BD/CC") methodology summarized in the srHS Report?

Yes. In Maine, reduction in BD/CC can be directly measured by determining how many individuals DirigoChoice and the MaineCare Parents Expansions are newly insuring. Indeed, DHA has utilized, and the Superintendent has approved savings based upon, variations of this direct measurement in the previous three assessment years. However, for the fourth assessment year, it appears that DHA suggests departing from its previous BD/CC methodology to use an approach that measures BD/CC only indirectly by comparing the actual uninsurance rates in Maine to those that were purportedly expected based on a multi-state regression analysis. For reasons more fully explained in the testimony of Mr. Maffei and Mr. Burke, DHA's use of a regression analysis in the BD/CC calculation when there exists a proven, direct method of measurement (*i.e.*,

determining how many individuals DirigoChoice and the MaineCare Parents Expansions are newly insuring) makes no sense.

Q. Do you have any concluding comments for the Board regarding the srHS Report?

A. As I have previously said, Anthem BCBS is fully supportive of the goals of Dirigo Health and wants the program to succeed. The funding of the program, however, must be done responsibly and in a way that does not result in an additional burden on those who already pay a high price for health care insurance. The flawed methodology proposed by DHA in the srHS Report fails to meet either of those goals and also undermines the public's acceptance of Dirigo.

Q. Does this conclude your testimony?

A. Yes.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of Sharon Roberts was served this day upon the following parties via Electronic Mail.

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Dated: July 9, 2008

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