October 18, 2005

Via mail & email

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

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

Dear Superintendent Iuppa:

Please find enclosed the following:

1. Filing Cover Sheet.
2. Two hard copies of Dirigo Health Response to Joint Information Requests of Anthem and MAHP to the Board of Directors of Dirigo Health.
3. Attachments A through D.

Thank you for your assistance with this matter.

Yours very truly,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

WHL/elf
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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

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

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

Date Filed: October 19, 2005

Name of Party: Dirigo Health Board of Directors

Document Title: Dirigo Health Response to Joint Information Requests of Anthem and MAHP to the Board of Directors of Dirigo Health, w/Attachments A through D.

Document Type: Response to Information Request

Confidential: No

Dated: October 19, 2005

Respectfully submitted,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

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

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

The Board of Directors of Dirigo Health responds to the Joint Information Requests of Anthem Health Plans of Maine, Inc. and MAHP as follows:

1. Please describe how the Board's methodology takes account of increases in costs to the Maine healthcare system. As part of your answer, but without limitation to it, please describe what increases in costs are captured by the Board's methodology.

Response No. 1: See response to Trusts' Request No. 1. The Board does not consider costs to the health care system to be savings. The Board's statutory responsibility was to determine savings from the operation of the Dirigo Health Plan.

2. Please describe what initiatives, required by the Act, the Board believes its methodology takes account of.

Response No. 2: See Attachment 11 to the Board filing of September 19, 2005.

3. Please describe what initiatives, required by the Act, are not taken account of by the Board's methodology.

Response No. 3: See response to Request No. 2. The voluntary limit for health care practitioners on growth of net revenue was not included in the Board's determination of aggregate measurable cost savings.

4. Please explain, from both an actuarial and financial perspective, how the methodology recommended by the Board will ensure that the savings calculated by that methodology reflects the cost savings as a result of the operation of Dirigo Health, and excludes cost savings resulting from factors external to the legislation. Please produce all documents related to this conclusion.

Response No. 4: As stated in the final report and presentations to the Board, calculations were derived from Dirigo authorizing language which was a result of interested parties negotiating how savings would be defined including specific targets for certain initiatives. The healthcare system is extremely complex with a myriad of variables moving at the same time. Since this is real life, we cannot perform a randomized controlled scientific trial where you can take one initiative and de-link it from all others. Forces other than Dirigo had a potential impact on the data used to perform the calculations. Mercer recognized this through the use of conservative assumptions when calculating savings.

5. Please explain all bases for the Board's recommendation that determination of "aggregate measurable cost savings," under 24-A M.R.S.A. § 6913(1), requires consideration only of those elements of Dirigo Health that result in avoided costs, and not a netting of annual savings and costs increases produced by Dirigo Health and other external factors. Please produce all documents related to this recommendation.

Response No. 5: See response to Trusts' Request No. 1 and 52.

6. Please explain in full all of the bases for the Board's conclusions that "the Dirigo Group methodology offers a more accurate approach to the measurement of cost savings and a more transparent response to the initiatives identified in the Act" than the Payor Group methodology. Please produce all documents related to this statement.

Response No. 6: This request was withdrawn.

7. Please explain the basis for certain Board members' concern that the Dirigo Group proposal may "create expectations of savings that may not be realized" and produce all documents related to this analysis. Include in your response concerns raised by Board members related to including projected, in addition to actual, cost savings, how those concerns were addressed by the Board, and produce all documents related to this analysis.

Response No. 7: This was a concern of one member of the Board and does not necessarily reflect the concerns of the Board. See response to Trusts' Request No. 1 and 52, Minutes of Board meetings.

8. Please produce the State and fiscal year 2005 year-end financials, as presented to the Board on October 5, 2005.

Response No. 8: Objection to request sustained.

9. Please produce your projections of enrollment in DirigoChoice for 2005 and 2006 by category of uninsured and underinsured as well as total projections.

Response No. 9: For calendar year 2005, the enrollment projection is 14,400; the Agency assumed that approximately 81% would be uninsured or underinsured. For

calendar year 2006, the enrollment projection is 26,300; the Agency assumed that approximately 76& would be uninsured or underinsured.

10. Please produce all documents provided by the Office of Health Policy and Finance and Department of Health and Human Services to the Joint Select Committee on Healthcare Reform.

Response No. 10: See Attachments A and B..

11. Please provide copies of all Board meeting minutes, memoranda, notes, correspondence, reports or communication of any kind from any of your consultants or staff stating, confirming or advising explicitly or to the effect that it was difficult or impossible to develop a methodology that could attribute savings to the Dirigo Health reform initatives, particularly in the time frame allowed.

Response No. 11: Objection to this request was sustained.

12. Do you contend that as a result of the Dirigo Health reform initiatives, those who pay for health care, including health plans, carriers, employers and self-insured groups and multiple employer welfare arrangements, have experienced a reduction in what they would otherwise have paid for healthcare for the period July 1, 2004 through June 30, 2005, and if so by what amount? Please provide all bases for your response, including any work papers, studies, analyses or communications you relied in considering this point in developing your recommendation for aggregate measurable cost savings dated September 19, 2005.

Response No. 12: The Board has determined that there have been savings in the health care system as a result of the operation of Dirigo Health. It did not undertake to

determine whether these savings have been passed on to payors; it is the responsibililty of the market to ensure that these savings are realized by payors and consumers.

13. Do you contend that as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility, there was a reduction in the growth of the state's health care spending for the period July 1, 2004 through June 30, 2005, and if so by what amount? Please provide all bases for your response, including any work papers, studies, analyses or communications you relied in considering this point in developing your recommendation for aggregate measurable cost savings dated September 19, 2005.

Response No. 13: See response to Request No. 12.

14. Please explain all bases for your conclusion that all of the proposed savings in the September 19, 2005 report are the result of the operation of Dirigo Health . Please provide all documentation, reports, correspondence and any other information upon which you relied in forming this conclusion, and the names of any non-retained consultants or objective sources upon which you relied or with whom you consulted in reaching this conclusion.

Response No. 14: Please see response to Question #4. We have already provided Attachment 11 (Final Report) as well as additional data that went into the Request for Information by the Trusts (Question #7- VUG data, CON/CIF data, and budget initiatives).

Hospital Initiatives

15. In determining to use the hospital market basket inflation factor, please explain whether you reviewed alternative local measures of inflation as possible factors to be used in calculating CMAD for years 2001, 2002, and 2003. Please produce all documents related to this analysis.

Response No. 15: The hospital market basket inflation factor is a national index and is what was used in the calculation. Alternative local measures of inflation were not used in the calculation. See response to Superintendent's First Request for Information No. 2.d.

16. The cost per CMAD measures the rate of increase in a hospital's expenses. Please explain how the rate of increase in a hospital's costs directly impacts the rate of increase in the amounts that a hospital contracts to pay carriers and TPAs, and please explain all bases for your response and produce all documents related to your analysis.

Response No. 16: Data describing rates established in hospital contracts with carriers and TPAs is not in the public domain, so even if it were appropriate to do so, it would not be possible to relate changes in hospital costs to changes in the amounts carriers and TPA's contract to pay hospitals using publicly available data.

17. Please explain whether the Board, in calculating CMAD, assumes that each hospital in Maine will increase charges to every carrier at the same rate. Please produce all documents related to this analysis.

Response No. 17: In calculating CMAD, there is no assumption that each hospital in Maine will increase charges to every carrier at the same rate.

18. The CMAD savings methodology excludes all hospitals that did not meet the maximum 3.5% targeted rate of increase. Please explain whether the Board, the Office of Health, Policy and Finance, or anyone contracted by either, tested the CMAD methodology by looking at a prior year and setting a target rate of increase to determine if there would be measurable savings in a year when Dirigo did not exist. Please produce all documents related to this analysis.

Response No. 18: The underlying assumption in the CMAD methodology was that measurable cost savings found in Dirigo Year 1 (7/1/03-6/30/04) would be made known to payers once calculated. The data and methodology for calculating CMAD savings was not available until Dirigo Year 3 (7/1/05-6/30/06). The assumption was that payers would negotiate those savings into their Dirigo Year 3 (7/1/05-6/30/06) or 4 (7/1/06-6/30/07) rates, corresponding to the same timeframe that they would be assessed for such savings.

19. Please state whether there was a test of statistical significance applied to the COM or CMAD measures in the recommended methodology and, if so, please produce all documents related to the test(s).

Response No. 19: "Statistical significance" does not represent a reasonable standard for determining whether or not a specific hospital achieved a target CMAD cost increase. Either the hospital met the defined standard or it did not.

20. Please explain whether any of the "hospital costs" exclusions from measurement were considered for inclusion and subsequently removed, including without limitation the exclusion of hospital-owned physician practices, and if so, whether

exclusion of any of these items created greater savings based on the Board's chosen methodology. Please produce all documents related to this analysis.

Response No. 20: None of the hospital costs excluded from measurement were considered for inclusion and then subsequently excluded. The costs to be included and excluded in the numerator of CMAD were defined by the Maine Hospital Association in October, 2003, well before any information about whether a hospital met its target was known. Documents responsive to request No. 20 are appended as Attachment C. Also refer to response to the Superintendents First Information Request No. 1.c and No. 2.b

21. Please produce the actual fiscal year for each hospital used in the methodology recommended by the Board and how those years were adjusted in the recommended methodology.

Response No. 21: See response to Chamber Request No. 51. Actual fiscal year for leach hospital is provided in response to Superintendent's First Information Request No. 2.a.

22. Please explain how the Board's recommended methodology takes account of differing hospital fiscal years and contract cycles. Please produce all documents related to this analysis.

Response No. 22: Withdrawn.

23. In Table 2 of Attachment 12A to the Board Filing, some of the individual hospitals exhibit baseline compound growth rates that are out of line with the majority of Maine hospitals (*e.g.*, Mount Desert—41.72 %; Penobscot Valley—19.11%; Stevens—15.88%). Please explain whether any additional analysis was completed for these outlier

hospitals in an attempt to determine why their historical baseline trends were so high and, if so, produce all documents related to this analysis.

Response No. 23: No additional analysis was completed for these hospitals.

24. Please provide hospital market basket indices for 2000 through 2005.

Response No. 24: : HMBI using federal fiscal year (beginning10/1) :

2001: 4.1%; 2002: 2.9%; 2003: 3.5%; 2004 3.4%.

HMBI after adjusting federal fiscalyear to match Dirigo Fiscal Year:

2001: 4.2%; 2002: 3.1%; 2003: 3.5%; 2004: 3.8%

25. Do you agree that it is possible for a hospital's consolidated operating margin to decrease and for its charges and the prices paid for services rendered to its patients to actually increase? Please explain all bases for your response and provide copies of any work papers, memoranda, studies or correspondence you relied on in analyzing this point in establishing the figure for alleged savings attributable to hospitals' voluntary restraint on consolidated operating margins.

Response No. 25: : The COM calculation did not include an analysis as to the possibility of a hospitals consolidated operating margin decreasing and its charges and the prices paid for services rendered to its patients increasing.

26. Do you contend that the proposed methodology for the alleged savings attributable to a reduction in costs per case mix adjusted discharge reflects changes in reimbursement by public payors such as MaineCare and Medicare from 2003 through July 1, 2005? Please provide all bases for your response, and provide copies of all reports, analyses, memoranda and any other communications you relied on in analyzing

this point in establishing the figure for alleged savings attributable to hospitals' changes in costs per case mix adjusted discharge.

Response No. 26: The savings attributable to reductions in the rate of growth in CMAD do not reflect changes in reimbursement by public payers. CMAD reflects only costs, not in payments.

27. Do you agree that it is possible for a hospital's CMAD to decrease while the charges and prices paid by its patients and their insurance plans actually increase? Please provide all bases for your response, and provide copies of all reports, analyses, memoranda and any other communications you relied on in analyzing this point in establishing the figure for alleged savings attributable to hospitals' changes in costs per case mix adjusted discharge.

Response No. 27: The CMAD calculation did not include an analysis as to the possibility of a hospitals CMAD decreasing and prices paid by its patients and their insurance plans increase.

Voluntary Restraints – Underwriting Gains

28. Please provide a list of each insurer you determined realized a savings as a result of voluntary restraining its underwriting gain to 3% during the period June 30, 2004 to July 1, 2005, and for each one please provide:

Response No. 28:

a. premium and related revenue by line of business for 2000 through 2004;

Response No. 28.a.:

b. health benefits and administrative expenses by line of business for 2000 through 2004

Response No. 28.b.:

c. underwriting gains figures used for 2000 through 2004; and

Response No. 28.c.:

d. federal taxes.

Response No. 28.d.:

e. All work papers, analyses and spreadsheets showing how the three average underwriting gain for the period 2000 through 2003 was calculated for each carrier in preparing the September 19, 2005 report to the Superintendent, and any similar data you have obtained or generated on these four-year averages since issuing this report, including without limitation, such three-year average for Anthem Blue Cross and Blue Shield.

Response 28: (a) to (d) Please see response to Superintendent's Request for Information #1, Question #3.

(e) The calculation for Anthem includes partial year of 2000 (Anthem portion only, not Blue Cross) as well as full years for 2001-2003.

Uninsured/Underinsured Initiatives

29. Please describe how the Board's methodology takes account of reductions or avoidance of bad debt and charity care costs to all types of health care providers in Maine, as a result of the operation of Dirigo Health.

Response No. 29: Please review report in Appendix I of Attachment 11 which states how the bad debt and charity care amounts are determined. Generally, these are hospital only amounts and may include other entities that are consolidated into hospital system financial statements.

30. Please describe how the Board's methodology takes account of increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

Response No. 30: The enrollees in the MaineCare expansions that occurred after 6/30/04 were included.

31. Please explain all bases for the Board's definition of "uninsured" and "under-insured" as it relates to the calculation of aggregate measurable savings. Please produce all documents related to the development of these definitions.

Response No. 31: Please refer to final report (Attachment 11) and responses to other Information Requests.

32. Please explain the bases for assuming that those "underinsured", as that term is defined in the Board methodology, contributes significantly to bad debt and charity care costs. Please produce all documents related to this analysis.

Response No. 32: Please refer to Section 5 and Appendix H of Attachment 11 for review of underinsured calculation methodology.

33. Please identify the financial basis for the bad debt and charity care amounts reported and utilized in the Board's recommended methodology.

Response No. 33: See response to Trusts' Request No. 1 and particularly Attachment 11 to the Board filing.

34. Mercer assumes savings of $3 million based upon increased MaineCare enrollment that has resulted from publicity around Dirigo Health. Please provide data to show how many new MaineCare enrollees were uninsured at the time of enrollment.

Response No. 34: Please refer to Appendix L of Attachment 11 for the calculation. Also see response to Question #9 to the Superintendent's Request for Information #2.

35. Mercer estimates that 50% of new MaineCare enrollment is a product of Dirigo initiatives. Please explain all bases for that assumption and produce all documents related to that assumption.

Response No. 35: Withdrawn.

36. Please produce documents reflecting the number of uninsureds in Maine since December 31, 2002.

Response No. 36: See response the Chamber Request No.37; Trusts' Request No. 1; and Attachment 11 to the Board filing.

37. In determining the savings that have resulted from the uninsured enrolling in DirigoChoice, Mercer uses the figure of 136,000 as taken from the HRSA survey conducted by the Muskie School in 2003. Please describe in detail the steps Mercer used to update that survey and calculate the total member months used in its calculation of the SOP. Please produce all documents related to this analysis.

Response No. 37: Mercer did not update the Muskie survey. The survey was provided in Attachment 11, Appendix J to the Dirigo filing.

38. Please explain all bases for Mercer's assumption that 25% of those enrolled in DirigoChoice who were previously insured at the time of enrollment met the proposed definition of underinsured. Please produce all documents related to this analysis.

Response No. 38: Please see response to Chamber's Request for Information, Question #40.

39. Please identify how the HMBI trend was used and how long it was applied to arrive at an estimate of bad debt and charity care costs for 2005. Please produce all documents related to this analysis.

Response No. 39: As stated in the calculation in Appendix H of Attachment 11, the HMBI was used to trend bad debt and charity care amounts from 2003 hospital fiscal years to 2005. This was done by calculating the rate of increase between the 4 quarters ending 4th quarter 2005 over the 4 quarters ending 3rd quarter 2004. The choice of 4 quarters ending 4th quarter 2004 is in recognition of the vast majority of hosp bad debt and charity care data being from that time or earlier. The 4 quarters ending 4th quarter 2005 recognizes the first 12 month period of DirigoChoice operations.

40. Please explain in detail the data and methodologies used by Mercer to calculate a bad debt and charity care per member per month figure from the estimated 2005 bad debt and charity costs and the estimated total of uninsured and underinsured member months. Please produce all documents related to this analysis, including without limitation the date, methodology and calculation in an electronic file in Excel format.

Response No. 40: Please see Section 5 and Appendix H in Attachment 11 for the calculation and description.

41. Please provide the claim probability distribution tables for hospital-based services used by Mercer to determine the bad debt and charity care per member per month figure.

Response No. 41: Please see Appendices D& H of Attachment 11 for claims probability distribution table, which is for all medical services. The data supporting the development of the table is taken from Mercer's proprietary database. The results are applied to hospital and other providers (non-hospital).

42. Please produce the actual questions and responses to (a) the 2002 HRSA study, and (b) the 2005 member survey conducted on behalf of DHA. Please include in your response the actual results of the first quarter 2005 member survey and results for the second quarter survey.

Response No. 42: (a) Please refer to Attachment 11, Appendix J and (b) Attachment 11, Appendix K.

43. Please explain all bases for using hospital charges to reflect the cost of bad debt and charity care to the hospital, and produce all documents related to your analysis.

Response No. 43: Please see response to Superintendent's Request for Information #2, Question 6.

44. Please describe the "Dirigo single point of entry enrollment process" and produce all documents related to the proposition that all Medicaid enrollees who are being counted in the "woodwork" calculation were enrolled in MaineCare through the Dirigo single point of entry enrollment process.

Response No. 44: See Revised Response to Superintendent's Second Request for Information, Request No. 9. See response to Revised Response to Superintendent's First Information Request, No. 1.g.

45. Please provide hospital bad debt and charity care amounts for 2002 through 2004.Please provide all supporting documentation for the assumptions used on Line F of Appendix H to the Final Mercer report.

Response No. 45: Please refer Attachment 11, Appendix H which shows the detailed calculation of line F.

46. Please provide the Maine Hospital Association Report on the hospital uncompensated care survey referenced in Appendix I to the Final Mercer report.

Response No. 46:

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47. Please provide annual MaineCare enrollment by eligibility group for SFY 2000 through SFY 2005.

Response No. 47: Board does not have enrollment for SFY 2000 throught SFY 2005. The information the Board use is set forth in Attachment D.

Certificate of Need/Capital Investment Fund Initiatives

48. Please describe all projects included in your Certificate of Need analysis and produce all documents related to that analysis, including without limitation, the annual cost table. Include in your response copies of all applications, whether the applications were approved, modified or rejected, whether the projects have been reviewed to determine whether the criteria for CON are being met on an on-going basis, and all documents related to your consideration of each application.

Response No. 48: Objection to request sustained.

49. Please provide a list of all CON projects that were allowed to proceed through review and approval after June 30, 2004 on the basis that a letter of intent had been filed with the Department of Health and Human Services, including the name of the applicant, the nature of the project and the dollar amount in capital investment being requested for each project.

Response No. 49:

The following projects' applications came in after June 30, 2004 and were approved after June 30, 2004.

Facility Name	Key Word	Capital Costs
Eastern Maine Medical Center	Develop a 12 bed CCU	$4,473,926
MaineGeneral Medical Center	Regional Cancer Center	$24,650,455
Maine Medical Center	Ambulatory Surgery Center	$24,205,000
Southern Maine Medical Center	Facility expansion	$22,530,000

The following projects' applications came in before June 30, 2004 and were approved after June 30, 2004.

Facility Name	Key Word	Capital Costs
MaineGeneral	2 Campus ER renovation	$9,934,870
Mercy Hospital	Replacement hospital	$70,728,564

50. Please explain all bases for your conclusion that any reduction in spending on CON projects for operating costs, comparing a three-year historical average for first through third year costs with actual spending from July 1, 2004 through June 30, 2005, is entirely due to the operation of Dirigo Health. Please explain how you determined that a

moratorium on CON projects from July 1, 2004 through June 30, 2005 would reduce total operating expenditures for CON projects for the same period.

Response No. 50: Since there exists large variations from year to year as well as from one project to another, Mercer's approach was to use an averaging technique that combines first, second and third year costs to help smooth wide variations. We consistently applied this technique to both the base period (SFY01-SFY03) as well as the savings measurement period (SFY04-SFY05). We then projected what the costs would have been in the absence of Dirigo and compared that to what actually happened. Projected costs assume that costs will increase in a similar manner as historical costs. Actual costs (taken from approved CON applications) include the impacts of Dirigo initiatives, specifically the moratorium and the CIF. Savings occur when actual costs are less than projected costs.

In calculating savings, the amount used for SFY05 was the third year of projects approved in SFY03, the second year of projects approved in SFY04, and the first year of projects approved in SFY05. Since the moratorium is for the period 5/03–5/04 and the first CIF year covers 1/1/05–12/31/05, much of the three years covered for SFY05 directly overlap with the two Dirigo initiatives.

51. Please explain how you accounted for any possible duplication of any savings from this measure and from the "CMAD" measure, and please provide any work papers, analysis and correspondence you relied on in analyzing this point in developing your report to the Superintendent.

Response No. 51: While the CMAD calculation is meaningful on a hospital-by-hospital basis, the CON/CIF calculation is an overall calculation (based on individual

hospital data) that is meaningful only if all data is included. CON/CIF decisions are made after consideration of all statewide capital and operating expenditures. The only potential overlap would be for the hospital portion in SFY04.

Budget Initiatives

52. Please explain in full how the Board's recommendation to include physician reimbursements in its calculation of aggregate measurable cost savings is accurately and fairly attributable to the operation of Dirigo Health. Please produce all documents related to this recommendation.

Response No. 52: See response to Trusts' Request No. 1 and Attachment 11 to the Board filing.

53. Please produce copies of all correspondence and records related to DHHS's past MaineCare financial obligations to hospitals, including periodic interim payments, from January 1, 2000 through February 1, 2005.

Response No. 53: To the extent the documents responsive to this request are in the possession of the Board or its consultants or were relied upon by the Board, the documents have already been produced in responses to the Trusts and the Superintendent.

54. Please produce copies of all your correspondence and records related to Medicaid physician fees from January 1, 2003 through February 1, 2005.

Response No. 54: See response to Request No. 53.

55. Please provide the calculation of the time value of money, including, without limitation all of the underlying assumptions of your analysis and produce all documents related to this analysis.

Response No. 55: Withdrawn.

56. Please provide the anticipated dates for payments to hospitals related to the hospital fee initiative and physician fee changes.

Response No. 56: See response to Second Information Request of the Superintendent, Request No. 17(f).

57. Please describe all changes to hospital and physician reimbursements from MaineCare, other than Medicaid pay initiatives.

Response No. 57: See response to Request No. 53.

Dated: October 19, 2005

/s/William H. Laubenstein, III__________

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