

**BEFORE THE PUBLIC SERVICE COMMISSION  
OF THE STATE OF DELAWARE**

IN THE MATTER OF THE APPLICATION OF	)	
DELMARVA POWER & LIGHT COMPANY FOR	)	
AN INCREASE IN ELECTRIC BASE RATES	)	PSC DOCKET NO. 13-115
(FILED MARCH 22, 2013)	)	

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**THE DIVISION OF THE PUBLIC ADVOCATE'S BRIEF ON EXCEPTIONS  
TO THE FINDINGS AND RECOMMENDATIONS OF THE HEARING EXAMINER**

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## PRELIMINARY STATEMENT

Delmarva Power & Light Company (“DP&L”) has received almost \$40 million in rate increases since February 1, 2011. The increase resulting from the Hearing Examiner’s (“HE”) recommended findings and conclusions (the “HER”) is approximately \$23 million. If the HER is approved, DP&L will have received almost \$63 million in rate increases in just three years. And more are coming: DP&L plans to file annual rate increase applications. Tr. at 257; *see also* Ex. 34 at 8 (June 2013 investor meeting presentation references “frequent rate case filings”).<sup>1</sup>

What have DP&L ratepayers received in return for forking over these millions? Pointing to the decrease in its System Average Interruption Duration Index (“SAIDI”) over the last three years, DP&L says that ratepayers have received more reliable service. But have they? Despite the huge amounts spent, DP&L’s customer average interruption duration index has not changed appreciably since 2002. It was 128 minutes in 2002, and it was 120 minutes in 2012. Tr. at 371.

Here *are* things that DP&L ratepayers have gotten for their \$40 million over the past three years: A PHI CEO making over \$11 million in 2012 (when many ratepayers are jobless). Annual 2-3% raises for employees (when many ratepayers have not received raises in years). Ever-increasing operating expenses despite deployment of the \$39 million AMI that was supposed to reduce operating expenses and improve reliability.

The HE mistakenly believed that he was constrained to choose between the two specific recommended return on equity (“ROE”) recommendations, rather than understanding that the witnesses’ testimony presented a range within which he could choose. Consequently, he accepted DP&L’s proposed 10.25% ROE even though capital costs are the lowest they have been in

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<sup>1</sup>References to the exhibits admitted into evidence during the evidentiary hearings will be cited as “Ex. \_\_\_.” Transcripts will be cited as “Tr. at page number.” Briefs will be cited as follows: Delmarva’s Opening Brief - “DOB at \_\_\_;” the DPA’s Answering Brief – “DPA AB at \_\_\_;” Delmarva’s Reply Brief – “DRB at \_\_\_.” The Hearing Examiner’s Findings and Recommendations will be cited as “HER at \_\_, ¶\_\_.”

many, many years. He accepted DP&L's proposal to include 2013 investment in rate base under the mistaken impression that the standard of review for operating expenses set forth in *Delmarva Power & Light Company v. Public Service Commission*, 508 A.2d 849 (Del. 1986) also applies to utility plant. He mechanically cited "precedent" in reaching recommendations on many issues notwithstanding that the Public Service Commission (the "Commission") is not bound by prior decisions, especially *if the facts have changed*. And although he purported to recognize that DP&L always bears the burden of proof, he improperly transferred that burden to Staff and the Division of the Public Advocate ("DPA") on certain issues.

As an investor-owned utility, it is not surprising that DP&L stands firmly on the side of its investors. The Commission, however, must consider the interests of ratepayers as well as shareholders. The DPA trusts the Commission will do so in evaluating the HER.

#### **NATURE AND STAGE OF THE PROCEEDINGS**

On March 22, 2013, DP&L filed an application to increase electric distribution base rates by \$42,044,000 (a 4.97% increase in a customer's total bill but a more than 23% increase in the regulated electric distribution portion of the bill). Ex. 1 at 3, ¶5; Ex. 16 at Ex. NP-5, p. 101.

By Order No. 8337 dated April 9, 2013, the Commission suspended the application pending evidentiary hearings and a final decision; authorized DP&L to implement a statutory \$2.5 million annual increase in intrastate operating revenues effective June 1, 2013, on an interim basis, subject to refund; waived the statutory surety bond requirement in connection with those interim rates in light of DP&L's representation that it would comply with any refund order; waived certain Minimum Filing Requirements ("MFRs"); assigned the docket to HE Lawrence; established an intervention deadline; and established public notice deadlines.

On August 5, 8 and 13, 2013, the HE conducted public comment sessions in Wilmington, Georgetown, and Dover, respectively. A total of 10 people spoke at the comment sessions. Most verbal comments were from customers struggling to make ends meet and who feared the requested increase would have an extremely detrimental impact on their households. In addition, more than 60 written comments were received from the AARP, members of the Delaware House of Representatives, and DP&L customers. AARP and the House members urged careful examination of DP&L's rate increase given that this was its third request for a rate increase in three years and the effect of the increase on residential customers. Others exhorted the Commission to deny any rate increase for the following reasons: (1) the state of the economy; (2) the effect of a rate increase on customers living on fixed incomes; (3) the increased salaries paid to top management while customers' salaries stagnate; (4) DP&L's rates were already some of the highest in the country and significantly higher than the Delaware Electric Cooperative's; and (5) DP&L had received rate increases in each of the past two years.

On August 16, 2013, the DPA and Staff filed their direct testimony.

On September 20, 2013, DP&L filed its rebuttal testimony.

On October 22, 2013, pursuant to 26 *Del. C.* §306(b) and Order No. 8466, DP&L placed \$25,155,265 of additional interim rates into effect under bond and subject to refund.

The HE conducted evidentiary hearings on November 13, 14, and 18, 2013. During the proceedings, DP&L sought to introduce revised schedules into evidence. The DPA and Staff objected. After written submissions, the HE issued a recommendation accepting all of DP&L's arguments, denying Staff and the DPA's objections, and ordering an evidentiary hearing.

Staff and the DPA filed a joint interlocutory appeal of the HE's recommendation. On February 6, 2014, after oral argument and public deliberations, the Commission found that Staff

and the DPA had satisfied the standard for an interlocutory appeal and rejected the HE's recommendation, thus obviating the need for the additional evidentiary hearing. Tr. at 1089-93. A written order reflecting the Commission's decision remains to be entered and the record remains to be closed.

The HE issued his HER on March 4, 2014. This is the DPA's Exceptions to the HER.

### **UNCONTESTED ISSUES**

The DPA did not contest DP&L's test period consisting of the twelve months ending December 31, 2012 and did not contest the following revenue requirement issues in this case:

- Rate Change from Docket No. 11-528 (DP&L Adjustment #1)
- Weather Normalization (DP&L Adjustment #2)
- Bill Frequency (DP&L Adjustment #3)
- Injuries & Damages Expense Normalization (DP&L Adjustment #6)
- Uncollectible Expense Normalization (DP&L Adjustment #7)
- Remove Employee Association Expense (DP&L Adjustment #9)
- Removal of Executive Incentive Compensation (DP&L Adjustment #11)
- Removal of Certain Executive Compensation (DP&L Adjustment #12)
- Storm Restoration Expense Normalization (DP&L Adjustment #13)
- Proform Advanced Metering Infrastructure ("AMI") Operations & Maintenance ("O&M") Expenses (DP&L Adjustment #17)
- Proform AMI O&M Savings (DP&L Adjustment #18)
- Proform AMI Depreciation and Amortization Expense (DP&L Adjustment #19)
- Normalize Other Taxes (DP&L Adjustment #25)
- Amortization of Actual Refinancing Costs (DP&L Adjustment #27)
- Remove Qualified Fuel Cell Provider Project Costs (DP&L Adjustment #28)

- Remove Post-1980 Investment Tax Credit Amortization (DP&L Adjustment #30)
- Remove Renewable Portfolio Standards Labor Charges (DP&L Adjustment #32);
- Interest Synchronization (in concept) (DP&L Adjustment #33);<sup>2</sup>
- Proform Other Post-Employment Employee Benefits (“OPEB”) Expense (DP&L Adjustment #35);
- Income Tax Factor and Revenue Multiplier;<sup>3</sup>
- Cost of long-term debt; and
- Capital structure.<sup>4</sup>

The DPA opposed DP&L’s request that the Commission specifically recognize its ratemaking treatment for the uncontested adjustments (DOB at 50-57), noting that the Commission had expressly declined to do so in Docket No. 09-414:

We approve these uncontested adjustments, but, like the Hearing Examiner, we decline to specifically approve the ratemaking treatment of those uncontested matters. There are many reasons why a party may choose not to challenge a particular adjustment in a particular case. We do not wish to preclude any participant from challenging the proposed ratemaking treatment of any of these uncontested issues in a future case. Therefore, although we approve the amount of the uncontested adjustments for cost of service purposes in this case, we will not tie the participants’ hands in future cases by also approving the ratemaking treatment of those issues.

*In the Matter of the Application of Delmarva Power & Light Company for an Increase in Electric Rates and Miscellaneous Tariff Changes*, PSC Docket No. 09-414, Order No. 8011 (Del. PSC August 9, 2011) at ¶37.<sup>5</sup>

<sup>2</sup>The DPA accepts in this case the conceptual basis of the interest synchronization adjustment, but the amount of it

<sup>3</sup>The DPA accepts in this case the income tax factor and revenue multiplier that DP&L used, but the amount of its adjustment differs from DP&L’s because of their different revenue requirements. (Ex. 13 at 57-58).

<sup>4</sup>The DPA argues later that if the Commission permits DP&L to include the costs associated with its portion of PHI’s credit facility in the revenue requirement, the capital structure should be amended to include short-term debt.

<sup>5</sup><http://depsec.delaware.gov/orders/8011.pdf>.

The HE recommended approval of the uncontested adjustments, finding that they were “well supported by the evidence presented by the parties and ... discussed at length in the Briefs,” but noted that his recommendation of approval was not intended to preclude Staff or the DPA from disputing these adjustments in future cases. HER at 76, ¶189.

The HE’s recommendation is somewhat confusing. On one hand, he agrees that the Commission should not specifically approve DP&L’s ratemaking treatment of these adjustments, but on the other he states that the uncontested adjustments were “well supported.”<sup>6</sup> To avoid confusion, the DPA requests the Commission to include in its final order the same language that appears in Order No. 8011.

The HE omitted DP&L adjustments 11 and 12 (Removal of Executive Incentive Compensation and Removal of Certain Executive Compensation) from his list of uncontested adjustments. Neither Staff nor the DPA contested these adjustments, and they should be included as uncontested adjustments in the final order.

#### **ISSUES ADDRESSED AND NOT ADDRESSED IN THESE EXCEPTIONS**

The DPA does not except to the HE’s findings and recommendations on the following:

- September-December 2013 forecasted reliability plant excluded from rate base;
- Construction Work in Progress (“CWIP”);
- Cash Working Capital (“CWC”) (the Hearing Examiner recommended Staff/DPA positions but did not recommend a specific adjustment; the DPA accepts the amount of Staff’s adjustment);
- Deferred IRP costs (the DPA did challenge these costs before the Hearing Examiner but has elected not to continue to challenge them);

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<sup>6</sup>Neither Staff nor the DPA presented any evidence on the uncontested adjustments, so to say that they were “well supported ... by the parties” (HER at 76, ¶189) is not entirely accurate. Only DP&L briefed the uncontested issues, and did so only in connection with its request for approval of the specific ratemaking treatment it had used for them.

- Deferred RFP costs (the DPA did challenge these costs before the Hearing Examiner but has elected not to continue to challenge them);
- Deferred Dynamic Pricing (“DP”) program costs;
- Deferred Direct Load Control (“DLC”) program costs
- Deferred Medicare tax subsidy costs;
- Non-executive incentive compensation (although we will address that issue in this brief);
- Relocation expense level to be included in revenue requirement;
- IRP operating expense level to be included in revenue requirement;
- Corporate governance expense level to be included in revenue requirement;
- Meals and entertainment expense to be included in revenue requirement;
- Membership fee and dues expense level to be included in revenue requirement; and
- Class cost of service study changes going forward (the DPA did challenge certain aspects of the CCOSS before the Hearing Examiner but has elected not to continue to challenge them).

The DPA does except to, and will address, the following findings and recommendations:

- ROE;
- January-August 2013 reliability plant included in rate base;
- Including the prepaid pension asset and OPEB liability in rate base;
- Credit facility costs;
- Salary and wage adjustments;
- SERP expense;
- Medical benefit expense level to be included in revenue requirement;
- Regulatory expense level to be included in revenue requirement; and
- Rate design.

## ARGUMENT ON EXCEPTIONS

### **I. THE HE ERRED IN NOT ADDRESSING EVERY ARGUMENT THE PARTIES MADE.**

The HE stated that “due to the *overly litigated* nature of this Docket, it was impossible for me to address every argument which was raised which is my practice. If an argument was raised and I did not address it, please assume that I rejected it.” HER at 17, ¶40 (emphasis added).<sup>7</sup>

This is legally insufficient. An agency must explain why it is rejecting a party’s arguments. *Eckhard v. NPC International, Inc.* 2012 WL 5355628 (Del. Super. Oct. 17, 2012) at \*9 (record must clearly show basis on which agency acts; referee’s failure to clearly show the basis for decision warranted remand to Unemployment Insurance Appeals Board); *Delmarva Power & Light Co. v. Tulou*, 729 A.2d 868, 873 (Del. Super. 1998) (no reasonable basis in record for DNREC Secretary’s conclusion where there was no explanation for rejection of arguments). In this brief, the DPA will identify the arguments that the HE did not address.

### **II. RETURN ON EQUITY**

#### **A. THE HE ERRED IN RECOMMENDING A 10.25% ROE FOR DP&L.**

The HE recommended DP&L’s proposed 10.25% ROE, citing several reasons for finding its witness to be “more credible” than DPA/Staff’s witness. But before delving into the HE’s specific analyses, the DPA will address more general aspects of the HER.

#### **1. The HE Erroneously Believed He Was Limited to the Specific ROEs That The Witnesses Recommended.**

It is clear that the HE believed he was limited to choosing between only Staff/DPA’s position or DP&L’s position: “I was presented with only two (2) options: the Company argued

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<sup>7</sup>If this was intended to be a criticism of the parties’ arguments, the DPA does not apologize. The Public Advocate’s job is to advocate for the lowest reasonable rates, especially for residential and small commercial customers, and he was required to marshal every fact and argument that would support his positions. If the HE needed more time to write his recommendations, he should have requested it.

that it was entitled to a 10.25% ROE and the Public Advocate/Staff argued that the Company was entitled to a 9.35% ROE.” HER at 48, ¶122. This Commission, however, has never limited itself to one specific ROE number. DP&L’s last two case decisions are illustrative.

In Docket No. 09-414, DP&L recommended an ROE of 10.75%; Staff recommended 8.5% (with decoupling) or 9.5% (without decoupling); the DPA recommended 7.52% (with decoupling) or 9.58% (without decoupling); and DEUG recommended 9.9%. The Commission authorized a 10% ROE. The Commission selected an ROE within the range of those that the witnesses recommended:

The cost of capital witnesses reached the following conclusions based on their applications of various models:

	DCF	CAPM	ECAPM	RP	FINAL POSITION
<b>DPL</b>	10.7%-11.4%	9.4%	9.8%	10.9%	10.75-11%
<b>STAFF</b>	9.55%-9.93%	9.02%-9.22%	N/A	N/A	9.5%
<b>DPA</b>	9.96%	8.53%	N/A	N/A	9.58%
<b>DEUG</b>	10.10%	9.7%	N/A	9.95%	9.9%

As is apparent, the DCF-derived estimates ranged from a low of 9.55% to a high of 11.4%; the CAPM estimates ranged from a low of 8.53% to a high of 9.7%; the one ECAPM estimate was 9.8%; and the RP-derived estimates ranged from a low of 9.95% to a high of 10.9%. Thus, the record supports a COE anywhere from 8.53% to 11.4%.

*Delmarva Power*, Order No. 8011, at 113, ¶¶284-285 (emphasis added). The Commission noted that it was persuaded by DEUG’s witness, but still *did not* adopt his 9.9% recommendation. *Id.*

In Docket No. 05-304, DP&L recommended an 11% ROE; Staff recommended an ROE between 8.5%-9.5%; DEUG recommended 9.8%; and the DPA recommended 9.2%. The Commission authorized a 10% ROE. The Commission selected an ROE within the range of those that the witnesses recommended. *In the Matter of the Application of Delmarva Power &*

*Light Co. for Approval of a Change in Electric Distribution Base Rates and Miscellaneous Tariff Changes*, Docket No. 05-304, Order No. 6930, at 94-137, ¶¶189-275 (June 6, 2006).<sup>8</sup>

The HE's erroneous belief that he could choose only either 9.35% or 10.25% as the appropriate ROE infected his entire analysis, and should be rejected for that reason alone.

**2. Other Commissions Have Rejected Mr. Hevert's Analyses and Methodologies.**<sup>9</sup>

In both Pepco's and Delmarva's 2009 Maryland cases, the Maryland PSC began its discussion of its decision on the appropriate cost of equity with this statement: "We find, as an initial matter, that Delmarva's recommended 10.75% cost of equity is excessive and unjustified." *In the Matter of the Application of Delmarva Power & Light Company for Authority to Increase Its Rates and Charges for Electric Distribution Service*, Case No. 9285, Order No. 85029 at 77<sup>10</sup> (Md. PSC July 20, 2012); *In the Matter of the Application of Potomac Electric Power Company for Authority to Increase Its Rates and Charges for Electric Distribution Service*, Case No. 9286, Order No. 85028 (Md. PSC July 20, 2012)<sup>11</sup> at 107 (which added the adjective "totally" before "unjustified"). In Pepco's most recent rate case, the Maryland PSC called Mr. Hevert's proposed 10.25% ROE "anomalously high in relation to other recommendations." *In the Matter of the*

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<sup>8</sup>[dep.sc.delaware.gov/orders/6930.pdf](http://dep.sc.delaware.gov/orders/6930.pdf)

<sup>9</sup>DP&L argued that other commissions' discussions of Mr. Hevert's credibility should be disregarded. DPL RB at 25 n.106. The Hearing Examiner apparently agreed, being "unpersuaded" by Staff and the DPA's references to the Maryland PSC's opinions and noting that the Maryland PSC "virtually agreed with Mr. Hevert's proposed ROE in a recent rate case involving Delmarva Power Maryland ..." HER at 32 n.18. The HE cited no opinion so stating; rather, he cited Mr. Hevert's testimony at the hearing in which he appeared to say that the Maryland PSC had authorized an ROE close to his recommendation in a DP&L-Maryland case. Tr. at 462-64. Not so: Case No. 9285 is the only Maryland case decision involving DP&L-Maryland in which Mr. Hevert was the ROE witness, and in that case he recommended a 10.75% ROE, not a 10.25% ROE. See *Delmarva Power* Order No. 85029 at 59, 78.

<sup>10</sup>[http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3\\_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9285\90.pdf](http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9285\90.pdf)

<sup>11</sup>[http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3\\_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9286\117.pdf](http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9286\117.pdf)

*Application of Potomac Electric Power Company for an Increase In Its Retail Rates for the Distribution of Electric Energy*, Case No. 9311, Order No. 85724 at 106 (Md. PSC July 12, 2013).<sup>12</sup> Illinois, Nevada and the District of Columbia have also rejected his analyses, as we will discuss *infra*. And his recommendations have always been higher than the ROEs ultimately approved. Tr. at 457-58.

As Mr. Hevert pointed out, there is probably no cost of capital witness whose recommendations have been adopted wholeheartedly. *Id.* at 455-56. If this Commission adopts the HE's recommendation, it will have the distinction of being the first to do so in Mr. Hevert's career. But the DPA respectfully submits that the discussions of other commissions – especially those that regulate other PHI companies and have considered Mr. Hevert's methodologies – are worthy of consideration in determining the appropriate ROE for DP&L.<sup>13</sup>

**3. The Commission Should Reject the HE's Conclusion That DP&L's Witness' DCF Analyses Were More Persuasive Than the DPA/Staff's Witness' DCF Analysis Because Staff Did Not Present an ROE Witness.**

In concluding that DP&L's DCF analyses were more credible than the DPA's, the *very first* reason the HE stated was: "Staff did not present an ROE witness ... ." HER at 33, ¶78. This is almost unworthy of response. *Never* has this Commission based a conclusion on a contested issue on the fact that a party did not present a witness on that issue. In Docket No. 05-304, Staff did not sponsor an ROE witness. The HE's recommendations and the Commission's decision in that case demonstrate that this had no bearing on their analyses. *Delmarva Power*, Order No. 6930, at 94-137, ¶¶189-275. In this case, the DPA and Staff challenged certain rate

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<sup>12</sup>[http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3\\_VOpenFile.cfm?ServerFilePath=C:\Casenum\9300-9399\9311\164.pdf](http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3_VOpenFile.cfm?ServerFilePath=C:\Casenum\9300-9399\9311\164.pdf)

<sup>13</sup>This Commission has cited to and relied on opinions issued by its sister commissions on other issues involving PHI affiliates. See, e.g., *Delmarva Power*, Order No. 8011 at 57-58, ¶¶152-153.

base and expense items that the other did not; under the HE's logic, DP&L's witnesses' testimony on those issues would be more credible because Staff or the DPA did not challenge it.

Positions on contested issues stand or fall on their merits, regardless of how many parties file testimony on them. The HE's finding that DP&L's witness was more credible because Staff did not sponsor an ROE witness must be rejected.

**4. The HE's Reliance on DP&L's Multi-Stage DCF Analysis Should Be Rejected.**

The HE found it important that DPA/Staff witness Parcell did not offer a multi-stage DCF analysis. HER at 33, ¶78. Mr. Parcell has testified before this Commission in many cases over many years, but this is the first time he has ever been castigated for not offering a multi-stage DCF analysis. And indeed, before DP&L retained Mr. Hevert, none of its ROE witnesses offered a multi-stage DCF analysis. *In the Matter of the Application of Delmarva Power & Light Co. for an Increase in Its Electric Base Rates and for Certain Revisions to Its Electric Service Rules and Regulations*, Docket No. 91-20, Order No. 3389, at 101-02, ¶¶180-182 (DP&L witness offered constant growth DCF analysis); *Delmarva Power*, Order No. 6930, at 95-96, ¶192; *see also* Morin Direct Testimony in Docket No. 05-304 at 38-41 (DP&L witness offered standard DCF analysis and rejected multi-stage model); *Delmarva Power*, Order No. 8011, at 89-90, ¶¶230-232 (DP&L witness offered standard DCF analysis). Under the HE's logic, Mr. Hevert should have been chastised for not offering a CE analysis, as Mr. Parcell did. But he wasn't.

Moreover, Mr. Hevert did not proffer his multi-stage DCF analysis until *rebuttal*, when Mr. Parcell had no opportunity to address it. Were the DPA/Staff supposed to assume that he would perform a multi-stage DCF analysis in his rebuttal testimony so that they could tell Mr.

Parcell to perform one in his direct testimony?<sup>14</sup> The HE's reliance on an analysis that DPA/Staff had no opportunity to rebut is unfair, and should be rejected.

**5. The Number of Models Used Is Irrelevant.**

The HE made a point of stating that DP&L's witness presented four cost of equity models (constant growth and multi-stage DCF, CAPM and bond yield plus risk premium), whereas the DPA/Staff's witness presented only two analyses (constant growth DCF and comparable earnings ("CE")). HER at 48, ¶122. He seemed to be persuaded by the number of models used. Not only is the HE's statement that the DPA/Staff witness only used two models incorrect (because Mr. Parcell also used a CAPM model, *see* Ex. 15 at 25-28), but the number of models a witness uses is irrelevant. Moreover, until Mr. Hevert threw in his multi-stage DCF analysis in *rebuttal* (rebutting *nothing* since Mr. Parcell had not performed such an analysis), both witnesses had proffered analyses using three different models.

Again, the Commission's decision in Docket No. 09-414 is illustrative. The Commission was persuaded by DEUG's witness' testimony and analyses – even though he had performed fewer analyses than DP&L's witness. *Delmarva Power*, Order No. 8011, at 113, ¶284-285. Indeed, this Commission has never found an ROE witness less credible because s/he performed fewer analyses using fewer models than another witness.

**6. It Is Unclear Whether the HE Accepted DP&L's Contentions Regarding Potential Downgrading, But If He Did, DP&L Is Not In Danger of Being Downgraded.**

DP&L argued that it faced a potential downgrade if the Commission rejected its proposed 10.25% ROE. DOB at 35-36. The HE acknowledged DP&L's contention that the terms upon

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<sup>14</sup>Had we known that the HE would rely so much on a model presented for the first time in rebuttal, we would have objected to Mr. Hevert's multi-stage DCF analysis and testimony. In future cases, we will object to any "rebuttal" testimony that does not actually rebut an issue or argument raised or addressed by a DPA/Staff/Intervenor witness in their direct testimony.

which it obtains capital depends on its credit ratings and that more favorable ratings allow it to obtain financing at lower rates and on better terms and conditions, but did not address it. HER at 19, ¶45. In an abundance of caution, the DPA addresses these contentions.

DP&L pointed to Fitch's July 2013 downgrading of Pepco due to the state regulatory environment and the outcome of its rate cases. *Id.* at 35-36. Pepco's situation is different from DP&L's for several reasons: DP&L does not have the history of reliability problems in Delaware that Pepco had, and DP&L has not been downgraded by any rating agency in the last five years. DPA AB at 125, citing Tr. at 169. DP&L has investment-grade bond ratings. Ex. 15 at Sch. DCP-3, p.1. PHI has issued debt since the decision in Docket No. 09-414. Tr. at 169. Moreover, DP&L is one of several utilities that Moody's is considering for upgrades (despite all the doom and gloom of reduced revenues, etc.). Ex. 26. While DP&L may not be upgraded, it is in no danger of being downgraded.

Regulators should not authorize an above-market ROE based on unsupported conjectures about what rating agencies might or might not do. *In re Permian Basin Area Rate Cases*, 390 U.S. 747, 791 (1968). DP&L's claim that it needs a high ROE to send a positive signal to the rating agencies is exactly that – an unsupported conjecture. It should be rejected.

We now turn to a discussion of the specifics of the HE's analysis.

**7. DP&L's DCF Results Do Not Justify a 10.25% ROE.**

**a. Mr. Hevert's Inconsistency Renders His Testimony Suspect.**

DP&L stated that how the ROE witnesses' analyses correlated with current market conditions and were sensitive to market realities was the "most significant" difference between their positions. DOB at 34. Both ROE witnesses agreed that recent increases in interest rates should be associated with an increase in the ROE, even if not to the same degree. Ex. 3 at 14; Ex.

18 at 3-12; Tr. at 428-29; HER at 34-35, ¶¶81-82. Mr. Parcell also agreed with its corollary: that decreases in interest rates should also be associated with a decrease in the ROE, even if not to the same degree. Mr. Hevert paid lip service to that corollary (Tr. at 429), but he did not apply it in practice. How do we know? In Docket No. 11-528, at a time when interest rates truly were at historic lows (Tr. at 425-26), he recommended an even *higher* ROE (10.75%). Docket No. 11-528, Hevert Direct at 3, 72; Hevert Rebuttal at 5. When questioned about his recommendation, he responded that it was higher because the market was unstable and investors were risk-averse. Tr. at 427.<sup>15</sup>

The HE ignored this inconsistency. The Commission should not. It warrants consideration of all of Mr. Hevert's testimony with a jaundiced eye. Utility cost of capital witnesses are retained to advocate higher ROEs, just as regulatory staff and public advocate cost of capital witnesses are retained to advocate lower ROEs. But a witness should have the courage of his convictions. If ROEs move up with increases in interest rates, they should also move down with decreases in interest rates, and that should be reflected in a witness' ROE recommendation.

**b. The HE Ignored the Fact That the Companies In Both ROE Witnesses' Proxy Groups Are Riskier Than DP&L**

Mr. Hevert agreed that generation companies tend to be riskier than transmission-and-distribution only companies such as DP&L. Tr. at 440. He did not know offhand, but "would not be surprised" if generating plant comprised the majority of his proxy companies' net assets. *Id.* at 445. He agreed that his proxy companies had coal-fired and nuclear generation facilities, and

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<sup>15</sup> The Nevada PUC rejected Mr. Hevert's suggestion that Nevada Power's ROE was rising because of increased capital market volatility. *Application of Nevada Power Company d/b/a NV Energy for Authority to Increase Its Annual Revenue Requirement for General Rates Charged to All Classes of Electric Customers and for Relief Properly Related Thereto*, Docket No. 11-0606 *et al.*, Order Dated Dec. 23, 2011 at 25. It found that the weak economy reduced expected returns and reduced the opportunity cost of investing in utilities. It further found that low bond yields made utility stocks more attractive since they are "significantly less risk than investment within the relatively volatile broad equity market." *Id.*

while he was not ready to concede that these types of generation made them riskier,<sup>16</sup> he agreed that the EPA was considering regulations to require owners of coal-fired generating units to either reduce the amount of coal they burn or to retrofit the units. *Id.* at 442-44. He agreed that as much as 40% of his proxy companies' operating income could come from unregulated operations, which are riskier than utility operations. *Id.* at 446.

The Maryland PSC twice rejected Mr. Hevert's ROE analyses for Pepco and DP&L on the ground that his proxy group included utilities which had greatly disparate growth rates on the high and low ends and had significant generation risk. *Delmarva Power*, Order No. 85029 at 77-78; *Pepco*, Order No. 85028 at 107. The District of Columbia Commission also rejected his high DCF estimates because his proxy group included vertically-integrated companies. *In the Matter of the Application of Potomac Electric Power Company for Authority to Increase Existing Retail Rates for Electric Distribution Service*, Formal Case No. 1087, Order No. 16930 (DC PSC Sept. 27, 2012) at 60.<sup>17</sup> Admittedly, Mr. Parcell's proxy group suffers from the same flaws; there are not enough pure T&D companies to use as proxies for DP&L. But what this means is that DP&L has less risk and therefore does not command as high an ROE as the proxy companies. Mr. Parcell recognized this; Mr. Hevert seemed not to; and the HE completely ignored it.

The HE apparently accepted DP&L's argument that "ROE estimates that are lower than any that have been observed even over the past two years should [not] be considered in determining [DP&L's] ROE." HER at 37, ¶88. The opposite should also apply: ROE estimates higher than those approved over the last two years should not be considered either. The HE

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<sup>16</sup> The HE stated that Southern Company has both nuclear and coal-fired generation but has the lowest beta in his proxy group. Tr. at 444-45. Notably, however, the average beta of Mr. Hevert's proxy companies is 0.73 and for Mr. Parcell's it is 0.72 – essentially identical. And in all other respects their proxy companies are identical. See Ex. 15 at Sch. DCP-12, pp. 1-2.

<sup>17</sup>[http://www.dcpsec.org/pdf\\_files/commorders/orderpdf/orderno\\_16930\\_FC1087.pdf](http://www.dcpsec.org/pdf_files/commorders/orderpdf/orderno_16930_FC1087.pdf)

included charts showing what he called “2012 Approved ROEs” for the witnesses’ proxy companies. Those charts show that only four of the 12 companies in either group have ROEs exceeding 10%.<sup>18</sup> HER at 22, ¶156; 29-30, ¶72. And the data he used for these charts shows that: (1) ROEs *decreased* from 2012 to 2013; (2) only two authorized ROEs exceeded 10.20% in 2012-13; and (3) seven ROEs ranged from 9% to 9.70% in 2012-13. Exs. 51, 52. Since these are the ROEs for the riskier proxy companies, this supports an ROE *under* 10%, not *over* 10%.

**c. Mr. Hevert’s Rebuttal DCF Results Do Not Support a 10.25% ROE.**

The majority of Mr. Hevert’s rebuttal DCF analyses produced ROEs below 10%.

<b>Rebuttal Testimony - Constant Growth DCF</b>	<b>Mean Low</b>	<b>Mean</b>	<b>Mean High</b>
30-Day Average	8.25%	9.18%	10.15%
60-Day Average	8.21%	9.15%	10.11%
90-Day Average	8.37%	9.30%	10.27%
<b>Multi-Stage DCF</b>	<b>Mean Low</b>	<b>Mean</b>	<b>Mean High</b>
30-Day Average	9.49%	10.00%	10.55%
60-Day Average	9.48%	9.97%	10.51%
90-Day Average	9.70%	10.15%	10.66%
	<b>Mean Low</b>	<b>Mean</b>	<b>Mean High</b>
<b>Average DCF Results</b>	8.71%	9.45%	10.32%
<b>Median DCF Results</b>	8.37%	9.19%	10.27%

The HE observed that Mr. Hevert’s projected ROEs for the proxy utilities only exceeded 10.25% in the “mean high” scenario (which used the maximum growth rate reported by any of Mr. Hevert’s various sources (Zacks, First Call or Value Line) for that particular company. Ex. 3 at

<sup>18</sup> To be fair, it appears that the HE may have mistranscribed the data.

130.<sup>19</sup> The average of all his DCF results is 9.49%, and the median of all his DCF results is 9.49% - closer to the DPA’s recommendation than DP&L’s.

Mr. Hevert’s mean and median rebuttal DCF results are 76 basis points lower than 10.25%. So how did the HE get to 10.25% from there? Did he accept the mean high DCF results? He didn’t say that that was what he did. Did he consider the results of the other methodologies (with the exception of the Sharpe-ratio-derived CAPM results, which were too low for Mr. Hevert to give them any weight)? He didn’t say that was what he did. Did he include an allowance for flotation costs or for a small size effect – both of which Mr. Hevert said he considered in concluding that 10.25% was the appropriate ROE? He didn’t discuss either of these. Did he credit the DCF results from Mr. Hevert’s direct testimony, which the HE observed were significantly higher than the rebuttal results? HER at 36, ¶85.

<b>Direct Testimony - Constant Growth DCF</b>	<b>Mean Low</b>	<b>Mean</b>	<b>Mean High</b>
30-Day Average	9.00%	10.21%	11.63%
60-Day Average	9.09%	10.30%	11.71%
90-Day Average	9.08%	10.29%	11.71%

The HE never specifically says, but it appears that he accepted Mr. Hevert’s assertion that his constant growth DCF rebuttal results were “difficult to reconcile with current market conditions, in particular the significant increase in interest rates, and should be viewed with caution.” HER at 36, ¶86, citing Ex. 18 at 9-10. We say this because it appears that the HE accepted everything Mr. Hevert said as gospel and rejected everything that Mr. Parcell said (except for when he agreed with what Mr. Hevert said).

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<sup>19</sup> Likewise, the “mean low” results used the lowest growth rate reported by any of Mr. Hevert’s various sources for the particular company. Ex. 3 at 13.

But even accepting Mr. Hevert's testimony in its entirety, there are only two ways to get to 10.25% on his DCF results: (1) use his "mean high" rebuttal results; or (2) use his "mean" or "mean high" direct testimony DCF results. Neither is appropriate. Using the highest growth rate reported by any of the sources is "cherry picking" to get to the highest possible result. This assumes that investors consider *only* the most optimistic EPS growth rate for each individual company in making investment decisions. Ex. 15 at 37-38. The HE acknowledged that the DPA's witness had criticized using only the highest EPS result, but dismissed it: "Mr. Hevert offered both mean and median results to be analyzed by the Commission." HER at 38, ¶91. That does not address the criticism, especially where – as here – the HE made no recommendation to the Commission as to which one *it* should use.

The DPA respectfully submits that it is equally likely that investors do not focus solely on the highest (or the lowest) projected growth rate. Thus, even accepting an analysis using only forecasted EPS growth as the input for the dividend growth rate (which we will address below), it is more appropriate to use the mean. As shown above, *all* of the means in Mr. Hevert's rebuttal testimony are lower than 10.25%, and most of them are closer to Mr. Parcell's recommendation than they are to Mr. Hevert's.

**d. Mr. Hevert's DCF Results Are Inflated Because He Uses Only EPS Growth Forecasts.**

The DC PSC found that "projected EPS growth rates are overstated and should not be exclusively relied upon." *Pepco*, FC 1087 at 60. It gave greater weight to Mr. Hevert's "low mean" DCF results and to other witnesses' growth rates, including the OPC's witness who calculated his growth rates *the same way as Mr. Parcell did*. *Id.* at 59.

The HE found that analysts' earnings projections are the only relevant growth measure for use in the DCF model. HER at 33, ¶79 and n.19. He rejected Mr. Parcell's growth measures

as “overly conservative” and “excessively” reliant on data from 2008-2012, when the nation was in financial crisis. He agreed with DP&L that there was “no compelling reason” to use historical growth measures. *Id.* at 33, ¶79. And he accepted DP&L’s argument that Mr. Parcell “did not consider the improbability of growth rates that may be too low or unsustainable” because he included growth rates that were zero or negative, and 32 of his growth rate estimates were equal to or less than sustainable growth of 3.10%. HER at 37, ¶89.

To support his conclusion, the HE relied on authorities not cited by any of the witnesses, not presented to any of the witnesses, and not part of the record. HER at 34, n.20. It is improper for an agency to base a decision on information not in the record without notice to the parties.

*Turbitt v. Blue Hen Lines, Inc.*, 711 A.2d 1214, 1216 (Del. 1998). As the *Turbitt* Court noted:

Administrative tribunals exercising quasi-judicial powers that are required to make a determination after a hearing cannot act on their own information. Nothing may be treated as evidence which has not been introduced as such, inasmuch as a hearing requires that the party be apprised of the evidence against him in order that he may refute, test and explain it.

*Turbitt*, 711 A.2d at 1216. *See also Veid v. Bensalem Steel Erectors*, 1999 WL 1240843 (Del. Super. Sept. 29, 1999) (holding that the rationale in *Turbitt* is applicable to a variety of administrative agencies and types of litigation). In *State of Delaware Office of Management and Budget v. Public Employment Relations Board*, 2011 WL 1205248 (Del. Super. March 29, 2011), the Superior Court found that the Board erred *as a matter of law* when it affirmed a decision of the Executive Director that was based on evidence outside the record without giving the parties notice. *Id.* at 8. Thus, it is improper to consider the HE’s reliance on these authorities in determining whether projected EPS growth should be the sole input in the DCF equation.

Second, the facts belie the HE’s conclusion that Mr. Parcell “excessively relie[d]” on historical data. Mr. Parcell’s five indicators of growth were:

- 2008-2012 earnings retention (fundamental growth) from Value Line;
- 5-year average of historic RPS, DPS and BVPS from Value Line;
- 2013, 2014 and 2016-18 *projections* of earnings retention growth per Value Line;
- 2010-2012 to 2016-2018 *projections* of EPS, DPS and BVPS per Value Line; and
- 5-year *projections* of EPS growth per First Call.

Ex. 15 at 23. Three of his five indicators are projections (and two of them are the same sources that Mr. Hevert used).

The HE also seemed to place reliance on Mr. Hevert's statement that Value Line was the sole source for Mr. Parcell's DPS and BVPS growth projections. HER at 38, ¶90. So what? Conspicuously absent is any statement that these data are available from any other sources.

In uncritically accepting DP&L's contention that Mr. Parcell's growth rates were too low, the HE completely ignored Mr. Hevert's admission that a company cannot grow indefinitely at a faster rate than the market in which it sells its product. Tr. at 454. Since 2010, the highest quarterly real GDP growth rate has been 4.1% (4<sup>th</sup> quarter 2011). Real GDP growth for the first two quarters of 2013 was 1.8% and 1.7% respectively. Overall annual real GDP was 2.4% in 2010, 1.8% in 2011, and 2.2% in 2012. Ex. 15 at Sch. DCP-2, pp. 1-2. Only two of the 35 projected growth rates that Mr. Hevert used in his direct and rebuttal DCF studies were less than 3%. Ex. 3 at Sch. (RBH)-1, pp. 1-3; Ex. 18 at Sch. (RBH-R)-1, pp. 1-3. Mr. Parcell's growth rates are more in line with the market in which DP&L's product is sold than are Mr. Hevert's.

Investors come in all shapes and sizes, and they do not all use the same information. If they did not look at past performance, there would be no need to publish such information. But such information is published because they do examine past performance. Ignoring historical data in determining an appropriate growth rate input skews a DCF calculation inappropriately

high. The Commission should reject the HE's recommendation and find that use of only projected EPS growth rates in the DCF equation is inappropriate.

**8. The HE's Erroneous Interpretation of What Mr. Parcell Did With His CAPM Results Warrants Rejecting His Conclusion That Mr. Hevert's CAPM Analyses Were "More Persuasive."**

The HE stated that Mr. Parcell "virtually discounted" his CAPM results, and that since those results "did not form any of the basis of his ROE opinion," Mr. Hevert's CAPM testimony was "more persuasive" than Mr. Parcell's. HER at 39, ¶, 43, ¶107. The HE is wrong. While Mr. Parcell did not include his CAPM results in averaging the results of his three models, here is what he said about them:

Q. YOUR CAPM RESULTS ARE LESS THAN YOUR DCF AND CE RESULTS. DOES THIS IMPLY THAT THE CAPM RESULTS SHOULD NOT BE CONSIDERED IN DETERMINING THE COE FOR DP&L?

A. *No. It is apparent that the CAPM results are less than the DCF and CE results. There are two reasons for the lower CAPM results. First, risk premiums are lower currently than was the case in prior years. This is also reflective of a decline in investor expectations on equity returns and risk premiums. Second, the level of interest rates on U.S. Treasury bonds (i.e., the risk-free rate) has been lower in recent years. This is partially the result of the actions of the Federal Reserve System to stimulate the economy. This also impacts investor expectations of return in a negative fashion. I note that, initially, investors may have believed that the decline in Treasury yields was a temporary factor that would soon be replaced by a rise in interest rates. However, this has not been the case as interest rates have remained low, and even with recent increases, continue to be at historically low levels. As a result, it cannot be maintained that low interest rates (and low CAPM results) are temporary and do not reflect investor expectations. Consequently, the CAPM results should be considered as one factor in determining the cost of equity for DP&L. At the very least, the CAPM results indicate the capital costs continue at historically low levels and that DP&L's COE is less than in prior years.*

Ex. 15 at 34 (emphasis added).

The DPA cannot understand how the HE could interpret this as Mr. Parcell "virtually

discount[ing]" his CAPM results or not forming "any of the basis" for his ROE opinion. He clearly derived his recommended ROE by considering the results of *all* of his analyses.

Moreover, if Mr. Parcell's failure to include his CAPM results in the calculation of the average of his three models was a "virtual discounting" of his results, then Mr. Hevert was guilty of the same thing:

Q42. Do you believe the CAPM results provide a reasonable range of ROE estimates at this time?

A42. *Not entirely.* As a practical matter, the low results are approximately 100 basis points below the lowest ROE ever authorized for an electric utility in at least 30 years. As to the remaining results, the mean low results simply are not reasonable. As to the remaining results, as noted earlier in my Direct Testimony, the intended consequences of continued Federal intervention in the capital markets has been to maintain long-term Treasury yields at historically low levels. Since the CAPM defines the Cost of Equity in terms of Treasury yields, the effect of those actions [is] to decrease, rather substantially, the CAPM estimates. The effect of that policy, however, will not continue indefinitely; consensus forecasts call for the 30-year Treasury yield to increase to 4.70% percent [sic] (from the current level of approximately 3.00%) in the 2014-2018 timeframe. *On balance, then, I do not believe that the results presented in Table 3 fully reflect the appropriate range of ROE results.*

Ex. 3 at 20-21 (emphasis added).

Mr. Hevert took a different approach in his rebuttal testimony, however; there he said that only his Sharpe ratio-derived CAPM results should be disregarded, and that the relevant range of CAPM results was the 9.96%-10.81% (the Bloomberg- and Capital IQ-derived CAPM results from his rebuttal testimony; those results in his direct testimony were lower). Ex. 18 at 41-42.

So: none of the CAPM results in Mr. Hevert's direct testimony should be given much weight, but six months later only his Sharpe ratio-derived CAPM results should be disregarded. His testimony regarding which CAPM results should be used and which should be disregarded apparently changes depending on which approach will produce the highest result for the client.

Not surprising, but not consistent either. And, the DPA respectfully submits, not persuasive.

**9. Mr. Hevert's Bond Yield Plus Risk Premium Analysis Should Be Given No Weight.**

The HE described Mr. Hevert's bond yield plus risk premium analysis and Mr. Parcell's CE analysis (HER at 43-47, ¶¶108-118), but it is unclear whether he gave them any weight. If he gave the bond yield plus risk premium analysis any weight, it was misplaced. The Illinois Commission found that "[a]mong the many problems" with this methodology were its reliance on authorized utility ROEs throughout the United States, its "heavy reliance on historical data and the difficulty in determining an appropriate historical period to rely upon." *Ameren Illinois Company, d/b/a Ameren Illinois Proposed General Increase in Natural Gas Rates*, Docket No. 11-0282, Order (Ill. C.C. Jan. 10, 2012) at 125.<sup>20</sup> Remember that the HE criticized Mr. Parcell's use of historical data in determining the appropriate growth rate to use in the DCF equation; if historical data is inappropriate there, it is inappropriate here too. Moreover, the analysis uses authorized ROEs that have not been seen since 2003. Ex. 15 at 42. The analysis merits no consideration.

**10. If the HE's 10.25% ROE Recommendation Includes Consideration of Flotation Costs or a "Small-Size Effect," It Is Erroneous.**

Mr. Hevert considered flotation costs and DPL's small size compared to the proxy companies in determining that 10.25% was the appropriate ROE for Delmarva. Ex. 3 at 24-27. This Commission has expressly and consistently rejected a flotation cost adjustment. *Delmarva Power*, Order No. 8011, at 115, ¶288; *Delmarva Power*, Order No. 6930, at 136-37, ¶275; *Delmarva Power*, Order No. 3389, at 131-32, ¶231. DP&L proffered no new facts or arguments supporting a change in this policy.

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<sup>20</sup><http://www.icc.illinois.gov/downloads/public/edocket/310038.pdf>

Mr. Hevert admitted that the small size effect is not utility-specific. Ex. 3 at 24. But a utility-specific study found no small size effect for utilities. DPA AB at 136. Moreover, one of the studies Mr. Hevert cited found that any size adjustment was over and above any increase already provided to smaller companies as a result of their high betas. However, utilities are less risky than the market as a whole, and T&D utilities such as DP&L are even less risky than utilities that still own generation, as most of the proxy companies do. Thus, there is no support for considering Delmarva's small size.

\* \* \*

This Commission considers the results of other models, but it primarily relies on the DCF to determine a utility's cost of equity. *Delmarva Power*, Order No. 8011, at 113, ¶284; *Delmarva Power*, Order No. 6930, at 134-35, ¶269; *Delmarva Power*, Order No. 3389, at 130, ¶228. The vast majority of the DCF results obtained from the ROE witnesses' studies are below 10%. The authorized ROEs for the proxy companies that Mr. Hevert used decreased from 2012 to 2013. And in 2012 DP&L agreed to a 9.75% ROE.

The DCF results in this case warrant an authorized return closer to the DPA's recommendation than DP&L's. If this Commission adopts the HE's recommendation, it will be by far the highest ROE of any of PHI's operating utilities. The HE's recommendation, which uncritically accepts DP&L's analysis lock, stock and barrel, should be rejected.

### **III. RATE BASE ISSUES**

#### **A. The Commission Should Reject the HE's Recommendation to Include *Any* Post-Test Period Plant Additions In Rate Base In This Case.**

##### **1. Background**

In its direct testimony, DP&L proposed to include in rate base \$66,794,140 of so-called "reliability" improvements and enhancements that it expected to make during calendar year 2013

– one full year beyond the close of the test period (“Adjustment 26”). Ex. 5 at 27-28 and Schedule (JCZ)-25. DP&L claimed that it was necessary to include Adjustment 26 in rate base to mitigate what it called the negative effects of regulatory lag. Ex. 14 at 5-6, citing PHI Second Quarter 2013 Earnings Call, August 7, 2013 at p. 8; Ex. 17 at 6. In rebuttal, DP&L separated Adjustment 26 into two parts: part (a) sought recovery of the “actual” reliability investment from January-August 2013, and part (b) sought recovery of the estimated reliability investment that it expects to place into service by the end of 2013, which DP&L claims is the rate effective period. Ex. 20 at 52-56 and Schedules (JCZ-R)-6 and (JCZ-R)-7.

The HE split the baby: he included plant added from January-August 2013 in rate base, but disallowed the projected plant from September-December 2013. HER at 71, ¶175. He stated that including the actual post-test period plant through August 2013 was consistent with the Commission’s decisions in Docket Nos. 09-414 and 05-304 because the plant was in service and directly benefitting customers and the additions were known and measurable. *Id.* at 71-72, ¶176. He expressed “concerns” about the cost-effectiveness of Delmarva’s future capital investment, but rejected arguments that DP&L had not established the cost-effectiveness of the Adjustment 26(a) plant because “to date, this Commission has never required a cost-effectiveness study from [DP&L] for its capital investments.” *Id.* at 73-74, ¶181. He acknowledged that DP&L had not had any “major service issues in Delaware” (although he noted that Delaware had largely escaped the effects of the storms that battered New Jersey and Maryland). He observed that DP&L has a statutory obligation to furnish “safe, adequate and proper service” and had to plan future reliability investment to “properly serve its increasingly service restoration and digitally demanding customers in accordance with Delaware law.” *Id.* at 51, 75, ¶¶132, 185.

The HE opined that the proper standard for including Adjustment 26 in rate base was the “waste, bad faith or abuse of discretion” standard for operating expenses set forth in *Delmarva Power & Light Co. v. Public Service Commission*, 508 A.2d 849 (Del. 1986), not the “used and useful” standard set forth in 26 *Del. C.* §102(3) and discussed in *Chesapeake Utilities Corp. v. Delaware Public Service Commission*, 705 A.2d 1059 (Del. Super. 1997). *Id.* at 15-17, 50, ¶¶35-39, 129. He concluded that the “used and useful” standard did not apply to Adjustment 26 because the capital expenditures were not “extraordinary” and because the Commission has included post-test period plant additions in rate base if the plant is in service, directly benefitting customers, and is known and measurable. *Id.* at 15-17, ¶¶35-39.

**2. The HE Applied the Wrong Standard for Determining Whether Plant Is Appropriately Included in Rate Base.**

The HE’s assertion that “used and useful” is not the correct standard for determining whether plant is properly included in rate base is simply wrong. Section 102(3) of the Public Utilities Act defines rate base as “[t]he original cost of all *used and useful* utility plant and intangible assets either to the first person who committed said plant or assets to public use or, at the option of the Commission, the first recorded book cost of said plant or assets; ... .” 26 *Del. C.* §102(3) (emphasis added). It cannot be clearer that for plant to be included in rate base, it must be *used and useful* in providing utility service. The “waste, bad faith or abuse of discretion” standard applies only to a utility’s *normally accepted operating expenses*. *Delmarva*, 508 A.2d at 852, 858-59. Operating expenses are not synonymous with rate base:

Rate determinations involve four basic inquiries, expressed concisely in the formula  $R = E + (V \times r)$ . Defining the four variables,

R equals the utility’s gross revenues under the rate structure examined.

E equals the *operating expenses* including maintenance, depreciation and all taxes incurred to produce R.

V equals the value of the utility's property which provides the services for which rates are charged, *i.e.*, *the rate base*.

r equals the rate of return, expressed as a percentage, which should be applied to the rate base to establish the return to which the investors in the utility enterprise are reasonably entitled. ... Note that the formula plainly indicates that operating expenses ("E") are not part of the rate base ("V"), but, rather, such expenses are included in the overall calculation of the rate.

*Public Service Commission v. Wilmington Suburban Water Corp.*, 467 A.2d 446, 448 n.2 (Del. 1983) (emphasis added).

The standard for determining whether Adjustment 26 can be included in rate base is "used and useful." Regardless of whether the Commission accepts the HE's recommendation, his incorrect statement of the applicable standard must be corrected.

**3. The Circumstances of This Case Warrant a Different Conclusion from Docket Nos. 05-304 and 09-414.**

As long as an agency provides a rational basis for departing from a prior decision, it "is not forever bound by its prior determinations and may change its mind if such change will aid it in accomplishing an appointed task, since its view of what is in the public interest may change, even if the circumstances do not." *Eastern Shore Natural Gas Co. v. Delaware Public Service Commission*, 635 A.2d 1273, 1283 (Del. Super. 1993), *aff'd*, 637 A.2d 10 (Del. 1994), *overruled on other grounds by Public Service Water Co. v. DiPasquale*, 735 A.2d 378 (Del. 1999); *United Water Delaware, Inc. v. Public Service Commission*, 723 A.2d 1172, 1177 (Del. 1999). Thus, the Commission can change its mind on a particular issue even if the circumstances have not changed; but changed circumstances certainly justify departing from previous decisions.

In Docket No. 09-414, the Commission emphasized that it based its decision on the circumstances of that case. *Delmarva Power*, Order No. 8011 at ¶60; Ex. 13 at 7. The circumstances of this case are different from those in prior dockets.

First, in none of its prior cases had DP&L said that it would file rate cases every nine to twelve months. Compare the timeline below:

- Docket No. 91-20 to next case, Docket No. 05-304: 15 years<sup>21</sup>
- Docket No. 05-304 to next case, Docket No. 09-414: 4 years
- Docket No. 09-414 to next case, Docket No. 11-528: 2 years

But we *have* that guarantee here. PHI's Chief Officer and DP&L's policy witness in this case confirmed that PHI intends to file rate cases every nine to twelve months:

Q: Am I also correct that the company is committed, and by company, I mean PHI, to filing rate cases every nine to twelve months?

A: Yes. The company has been clear that given the level of spend we have, in all of our jurisdictions, and the lack of customer growth, that the combination of those where we're going to have rate base increasing in the eight to ten percent range, with very little, if any, customer or load growth, that the combination of those will drive the need to file rate cases on an annual basis barring some change in the regulatory paradigm.

Tr. at 257; *see also* Ex. 34 at 8.

Here, DP&L selected a test period consisting of the historical twelve months ended December 31, 2012. It also used historical test periods in Docket Nos. 11-528, 09-414, and 05-304. History suggests that DP&L will use calendar year 2013 test period in its next rate case. Or it may use a partially-forecasted test period (as permitted by the Commission's MFRs). In any event, the next test period will include all of the Adjustment 26(a) plant. Under the circumstances of *this* case, there is no need to include Adjustment 26's post-test period plant in rate base in this case because it will be included in DP&L's next base rate case, which Mr. Boyle has stated will be filed in 2014.<sup>22</sup>

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<sup>21</sup>The DPA notes that a rate freeze was in effect from 1999 until May 1, 2006.

<sup>22</sup>The HE noted that the DPA made this argument, but he did not address it. *See* HER at 60, ¶150.

**4. The Commission's Quality Service Regulations Require the Utilities Subject to Those Regulations to Establish That Their Reliability Improvements Are Cost-Effective.**

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The HE found that the Commission's regulation establishing a SAIDI benchmark of 295 minutes is "only one (1) minimum reliability standard which the Company must comply with," and that "under Delaware law, the Company has a broader duty than Docket 50's SAIDI requirement," which is to provide "safe, adequate and proper service." HER at 72-73, ¶¶179). He further found that DP&L "reasonably exercised its professional judgment in providing 'safe, adequate and proper service,' by installing the Adjustment 26(a) plant, "and by addressing service and reliability needs relating to, for example, URD cables, switchgear, substation transformers, equipment assessment, priority feeders, and Distribution Automation." *Id.*

The HE mentioned (and then ignored) another requirement of Regulation Docket 50: "EDCs *are required* to explore the use of proven state of the art technology, to provide *cost effective electric service reliability improvements.*" 26 Del. Admin. Code §3007.1.8 (emphasis added) See HER at 53, ¶135.4; 62, ¶153. Both Staff and the DPA argued that DP&L had not established the cost-effectiveness of any of the post-test period reliability improvements, but the HE gave their arguments the back of his hand: "... as to Adjustment 26(a), I did not find Staff's and the [DPA's] argument that evidence regarding cost-effectiveness was lacking persuasive *because, to date, this Commission has never required a cost-effectiveness study from Delmarva for its capital investments.*" HER at 73-74, ¶181 (emphasis added).

With all due respect to the HE, that is a non sequitur. DP&L may not have to perform studies *per se*, but it *does* have to establish that its reliability improvements were cost-effective. The Regulation Docket 50 standards impose that requirement on DP&L.

The DPA agrees that DP&L is statutorily required to provide “safe, adequate and proper service” (26 *Del. C.* §209(a)(2)), and that the Commission’s regulations provide that compliance with the 295-minute SAIDI metric is a minimum standard. We never suggested otherwise. What we *did* suggest, and established on the record, was that DP&L had performed *no* cost-benefit analyses on *any* of the projects comprising the \$66 million of Adjustment 26 plant that it sought to include in rate base in this case, and proffered *no evidence* that it would result in any appreciable improvement in its reliability in Delaware. It provided no quantification of any benefits of the reliability improvements or enhancements in terms of avoided outages or reduced outage minutes. Ex. 14 at 14-15; Tr. at 399. We asked for such information, and DP&L responded that it did not “engage in traditional economic analysis of work because the costs, measured in dollars, and the benefits accrued, measured in reliability performance, do not lend themselves to those forms of analysis.” *Id.* at 11, citing DP&L’s response to PSC-REL-18. It provided “its budgeting process, ... a Work Request process used to identify the scope of projects, ...its ‘Asset Management/Asset Performance Planning and Equipment Condition Assessment’ procedures, ... a document entitled ‘Description of Delmarva Power’s Planning Process,’ and ... a list of approved expenditures.” Ex. 14 at 14. None of these contained a specific analysis of any of the Adjustment 26 projects, and none include any discussion of how any of the Adjustment 26 projects would contribute to future reliability. *Id.*

DP&L argued that it would not be feasible to perform a cost-benefit analysis on every project (despite the fact that the DPA never suggested that DP&L should perform a cost-benefit analysis for every project). Counsel spent hours examining Mr. Maxwell on “redirect” about how PHI evaluates its projects for necessity and cost-effectiveness and introduced during that redirect numerous documents purporting to show PHI’s policies and how PHI actually does

assess the costs and benefits of projects. Tr. at 700-56, 787-91; Exs. 72-84; DOB at 19-25. DPA witness Dr. Dismukes already knew all of this; he had already reviewed *all* of the documents that DP&L introduced on redirect (he reviewed *all* of the documents DP&L produced during discovery). He testified that DP&L stated that “it employs a variety of other methods to ensure that investments are developed in an ‘economic’ manner, such as: competitive bidding of materials and use of standard engineering design and work practices to ensure that the work is accomplished such that it meets all applicable standards.” But these are not cost-benefit analyses. Ex. 14 at 10-11, 14 citing DP&L response to PSC-REL-18; *id.* at 14. Again: *nothing that DP&L introduced into evidence at the hearing addressed any of the specific Adjustment 26 projects.* If such evidence existed, wouldn’t it be fair to assume that DP&L would have addressed it in its rebuttal, or during its extended redirect examination of Mr. Maxwell?

Cost-benefit analyses *can* be done. Pepco recently filed a cost-effectiveness analysis of its proposed selective underground proposals in Maryland and the District of Columbia using the results of a 2008 Department of Energy meta-study to evaluate the reductions in outage costs for residential customers as a benefit associated with that proposal and then compared that benefit to the undergrounding program cost. Ex. 14 at 12. The Maryland PSC has explicitly directed electric utilities to include a cost-benefit analysis for every reliability improvement proposed in their short-term five-year plans, so DP&L is going to have to perform cost-benefit analyses for the projects in its Maryland REP. *In the Matter of the Electric Service Interruptions in the State of Maryland Due to the June 29, 2012 Derecho Storm*, Case No. 9298, Order No. 85385 (Md. PSC Feb. 27, 2013) at 3-4 (Ex. 44).<sup>23</sup> This belies the contention that cost-benefit analyses cannot

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<sup>23</sup>The HE reprinted this argument from the DPA’s brief (*see* HER at 64-65, ¶159), but his only response, as discussed above, was that the Commission has never required DP&L to file cost-benefit analyses for its capital improvements.

be done because the costs and benefits of its reliability plans do not lend themselves to such analysis.<sup>24</sup>

It seems to the DPA that DP&L repeated the mantra of reliability ... reliability ... reliability ... so often that the HE decided it *must* be true, despite not one shred of proof that they *would* improve reliability. HER at 51-59, ¶¶130-147. In essence, the HE put the burden of proof on Staff and the DPA to disprove DP&L's claim, and then concluded that they had failed to do so. This is improper.

As previously discussed, DP&L *always* bears the burden of proof, and that burden never gets transferred to any other party. The DPA respectfully submits that merely repeating and repeating and repeating that the projects will improve reliability does not satisfy DP&L's burden of proof. There is no evidence in this case that the Adjustment 26(a) projects will make its system performance any better during severe storms or even on blue-sky days. There are no cost-benefit, cost-effectiveness or value of service studies for any of the post-test period projects contained in Adjustment 26. And there is no quantification of the benefits of any of the projects to customers who are being asked to pay for them. Under these circumstances, the DPA

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<sup>24</sup>Mr. Maxwell testified that DP&L does not perform a cost-benefit analysis when a customer requests service because it has an obligation to serve. Tr. at 381. That is not always true, however. DP&L's electric tariff states:

Where the Applicant requests the Company to install facilities which are more costly than those normally furnished, *and the Company agrees, the Applicant will be charged the difference in cost.* Where the Applicant, by virtue of site conditions, causes a more costly than normal installation or maintenance, the Applicant will be charged the difference in cost. The calculation of the difference in cost shall be based on a standardized costing approach that includes all costs, including but not limited to: actual expenses incurred for materials and labor (including both internal and external labor) employed in the design, purchase, construction and/or installation; costs of permits and rights-of-way acquisition; corporate overheads (including engineering, supervision and administrative and general costs) and other loading factors, and any applicable taxes associated with a Contribution in Aid of Construction or otherwise.

Section VII-B; <http://www.delmarva.com/res/documents/DEMasterTariff.pdf> (emphasis added). This suggests that DP&L has done *some* cost-benefit analysis to determine what it normally furnishes.

respectfully submits that the HE erred by dismissing DP&L's failure to justify the cost-effectiveness of the Adjustment 26 projects.

**5. AMI Was Supposed to Improve Reliability.**<sup>25</sup>

In 2007, DP&L filed an application seeking to implement AMI (among other things). One of the AMI selling points was that it would improve reliability and potentially delay or obviate transmission and distribution ("T&D") system investment:

*Delmarva is deploying a number of innovative technologies. Some, such as the automated distribution system, will help to improve reliability...*

\* \* \*

*These savings estimates do not include potential additional customer benefits from reducing transmission losses, improving reliability, reducing rate volatility, enhancing market competitiveness, improving environmental quality, reducing energy prices by lowering the costs of environmental compliance, or potentially obviating or delaying the need for investments in transmission and distribution ...*

*In the Matter of the Filing By Delmarva Power & Light Company for a Blueprint for the Future Plan for Demand-Side Management, Advanced Metering, and Energy Efficiency, Docket 07-28, Business Case at 2, 24 (emphasis added).*

The Commission approved AMI implementation and regulatory asset treatment of the implementation costs. *In the Matter of the Investigation of the Public Service Commission Into Revenue Decoupling Mechanisms for Potential Adoption and Implementation by Electric and Natural Gas Utilities Subject to the Jurisdiction of the Public Service Commission, Regulation Docket No. 59, and In the Matter of the Filing by Delmarva Power & Light Company for a Blueprint for the Future Plan for Demand-Side Management, Advanced Metering, and Energy Efficiency, Docket No. 07-28, Order No. 7420 (Del. PSC Sept. 16, 2008).*<sup>26</sup> DP&L began

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<sup>25</sup>The HE acknowledged the DPA's argument, but did not address it. *See* HER at 67, ¶163.

<sup>26</sup><http://dep.sc.delaware.gov/orders/7420.pdf>

recovering \$39 million of AMI-related costs as a result of the settlement in Docket No. 11-528. Thus, DP&L ratepayers are already paying multi-millions for plant and other AMI costs that were supposed to improve reliability and potentially delay or obviate the need for distribution investments. If millions upon millions of dollars are now required in Delaware to improve distribution reliability, then at least part of the justification for saddling Delaware customers with 100% recovery of the AMI costs was a false promise.

**6. The Real “Reliability” Investment Driver Is What Happened to Pepco In Maryland.<sup>27</sup>**

After receiving what it called “an unusually high number of complaints from customers and elected officials,” the Maryland PSC initiated an investigation in August 2010:

... to investigate, among other things, (i) the number of customers affected by recent power outages in the Pepco service territory, (ii) the root cause for the scope, frequency and duration of storm and non-storm outages, (iii) communication failures between Pepco and its affected customers, and (iv) Pepco’s inability to communicate estimated times of restoration (“ETRs”) to affected customers in a timely and accurate manner. ...

*In the Matter of an Investigation Into the Reliability and Quality of the Electric Distribution Service of Potomac Electric Power Company*, Case No. 9240, Order No. 84564 at 5 (Md. PSC Dec. 21, 2011).<sup>28</sup>

On August 17, 2010, Pepco presented the elements of a Reliability Enhancement Plan (“REP”) that proposed to invest approximately \$250 million over five years to enhance system reliability. *Id.* at 6 and n.6.

After evidentiary hearings and post-hearing briefs, the Maryland PSC issued an opinion which began: “Pepco offers myriad excuses for its performance, but we are not buying.” *Id.* at 1.

<sup>27</sup>The HE acknowledged that the DPA made this argument, but did not specifically address it. See HER at 59-60, ¶149.

<sup>28</sup>[http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3\\_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9240\107.pdf](http://webapp.psc.state.md.us/Intranet/Casenum/NewIndex3_VOpenFile.cfm?ServerFilePath=C:\CaseNum\9200-9299\9240\107.pdf)

Instead, it concluded that the evidence “demonstrates conclusively that Pepco has been operating at an unacceptably low level of reliability *for several years.*” *Id.* at 28 (emphasis added). It rejected contentions that: it should disregard the reliability indices because external conditions like weather can cause normal yearly variations (*id.* at 29); the data should be given little weight because severe weather can have lingering effects on the electric system (*id.* at 29-30); reliability indices were not useful measures of Pepco’s performance because of the “substantial canopy of very mature trees” in its service territory (*id.* at 31); Pepco’s implementation of an outage management system between 2002-03 caused the upward SAIDI and SAIFI trends to be misleading (*id.*); there was no evidence of reliability problems; and customer expectations were “significantly different” than in the past as a result of their growing dependence on electricity at home (*id.* at 32-33). It found that Pepco’s vegetation management had been inadequate and that Pepco had failed to meet its tree trimming goals or to adequately fund vegetation management. *Id.* at 42-43. It also found that Pepco had failed to conduct either periodic inspections of its sub-transmission lines or after-storm inspections or patrols (noting Pepco’s admission that it had no procedure for specific periodic inspections of its overhead sub-transmission lines), and that this failure had resulted in a system highly vulnerable to storm damage. *Id.* at 49-50.

As a result of its findings, the Maryland PSC imposed a \$1 million fine. *Id.* at 57. It observed that a larger fine would have been justified, but it believed the money was better spent to improve reliability than on additional penalties for past behavior, and \$1 million sent “an appropriately serious message.” *Id.* at 57-59. Later, in Pepco’s next base rate case, the Maryland PSC disallowed \$6.4 million of test period O&M costs that it found Pepco had spent to “catch up for its years of system neglect” and disallowed the \$1.5 million of expert witness and outside counsel fees it had incurred in Case No. 9240. *Pepco*, Order No. 85028 at 2, 39, 64.

Mr. Maxwell testified that DP&L learned from the Maryland experience and that its application of that knowledge across its sister companies should be viewed positively. Ex. 19 at 13. He dismissed the concern that DP&L was leveraging its affiliates' reliability problems in other states in Delaware. *Id.* But he then went on to testify that “[t]he REP projects that [DP&L] is pursuing in Delaware are the same type of projects that [DP&L’s] affiliated utilities are conducting in Maryland.” *Id.* at 20. And the projects that DP&L’s affiliates put into their REPs in Maryland and the District of Columbia were a direct response to those affiliates’ reliability problems in those jurisdictions. Ex. 12 at 5.<sup>29</sup>

In Delaware, however, DP&L had no such reliability problems. It was easily meeting the Regulation Docket 50 reliability standards. Ex. 14 at Sch. DED-2. There were no specific (or even general) events *in Delaware* that caused any concern about its reliability *in Delaware*, and there was no evidence that DP&L neglected its maintenance and repair responsibilities in *Delaware*. Given all this, the DPA respectfully submits that the logical answer to the question of why DP&L has put spending on “reliability” projects in Delaware on hyperspeed is that, understandably, it does not want what happened to Pepco in Maryland to happen to it in Delaware. But that concern is not realistic and Delaware ratepayers should not have to pay for it.

**7. DP&L’s Justifications for the Post-Test Period Additions Are Unavailing.**

DP&L proffered several justifications for including the \$66.8 million of Adjustment 26 plant in rate base. First, customers expect and need enhanced reliability because of their growing dependence on electricity in an increasingly digital/electronic society and economy. DOB at 12-13. Second, increased frequency and severity of storms posed new system reliability challenges. *Id.* at 13-14. Third, it must replace aging infrastructure to avoid diminished system performance and

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<sup>29</sup>Staff witness Vavro noted that the District of Columbia’s investigation into Pepco’s reliability had been going on for more than a decade when Pepco filed its REP with that jurisdiction. (Ex. 12 at 5 n.2).

increased customer outages. *Id.* at 14-16. Fourth, its customer surveys have “consistently established” that system reliability and rapid service restoration after outages are the most important issues to them. *Id.* at 16-17. Fifth, its performance compared to its peers is a “useful indicator” of the level of reliability for which it should strive. *Id.* at 17-19. Sixth, it exercised professional judgment in selecting the initiatives it would pursue to maintain and enhance reliability. *Id.* at 19-25. Last, Staff and its consultant had offered no evidence that DP&L failed to exercise professional judgment in determining that reliability should be improved or that the initiatives it selected were inappropriate. *Id.* at 25-31.

The HE noted that DP&L had made these arguments; we assume he found them persuasive but all he said was that DP&L must plan future reliability investment to “properly serve its increasingly service restoration and digitally demanding customers in accordance with Delaware law” and that it “properly reasonably exercised its professional judgment” with respect to the Adjustment 26(a) projects. HER at 73, ¶179; 75, ¶185.

The DPA respectfully submits that the HE erred in failing to address its arguments in opposition to DP&L’s contentions, and that none of DP&L’s justifications is persuasive.

**a. Customers Have Always Expected Reliable Service.**

Customers pay DP&L considerably for reliable service, so it is not unreasonable that that is what they expect to receive. They are not paying for, nor should they expect to pay for, *unreliable* service. Expectations have not changed. And AMI should make service more reliable.

**b. DP&L Adduced No Evidence That Adjustment 26 Plant Will Improve or Enhance Reliability In Delaware.**

DP&L cited the damage that Hurricanes Isabel and Sandy and the 2012 Derecho caused in neighboring jurisdictions and referred to the August 2013 report of the President’s Council of Economic Advisors and the Department of Energy finding that outages from severe weather costs the

U.S. economy billions of dollars annually. DP&L concluded that modernizing the grid will save the economy billions of dollars and reduce hardships. (DOB at 13-14).

The DPA does not dispute that Delaware has been largely spared from severe storms. Nor does it dispute that customers often experience hardships from them and that outages have a significant economic effect. But as we argued previously, DP&L produced no *evidence* that the post-test period Adjustment 26 projects will improve reliability *in Delaware*.

c. **The ASCE Reports Do Not Support Adjustment 26.**

DP&L says that it must replace aging infrastructure to avoid diminished system reliability and increased customer outages. It addressed its policies for replacing aging URD cable, substation transformers and substation switchgear, and referenced two American Society of Civil Engineers' reports from 2011 and 2013 (separately, the "2011 Report" and the "2013 Report;" together, "the Reports") giving the nation's electric grid a D+ and discussing the national economic harm if the grid is not upgraded. DOB at 14-15, 20-21 and Attachments 3 and 4. The HE did not address DP&L's reliance on the Reports.

The DPA agrees as a general matter that reliable electric power, is vital to the nation as a whole and that aging infrastructure that has reached the end of its useful life should be replaced. But that is as far as the agreement goes on the evidence in this case.

First, DP&L witness Maxwell specifically rejected the suggestion that equipment age alone determines whether it should be replaced. Tr. at 316. Second, Delmarva tied none of the policies that it discussed to specific Adjustment 26 projects.

Third, the Reports address the *national* grid, with specific emphasis on *transmission*, and the proposed solutions were national ones. 2013 Report at 60-64; 2011 Report at 3, 4, 14, 48.

The Commission does not have jurisdiction over interstate transmission, so the Reports provide little support for DP&L's arguments regarding reliability in Delaware. The Commission has jurisdiction

over DP&L's distribution system, and there is no indication that *its* grade is a D+. Moreover, the Reports themselves are inconsistent: at the same time the 2013 Report says that national-level distribution investment has decreased since 2006, it also says that the increased adoption of smart grid technologies has led to additional investment in recent years, due in part to infusion of funds from various sources. 2013 Report at 62-63. The 2011 Report observed that investment in electric distribution infrastructure had increased and "now exceeds historical load growth. ... ." 2011 Report at 34. And DP&L has *increased* its investment in its distribution facilities over this time period, not decreased it. Thus, nothing in the Reports supports DP&L's inclusion of post-test period plant additions in this case.

**d. DP&L's Customer Surveys Show That Customers Already Think Service Is Reliable— And Have Thought So For Years.**<sup>30</sup>

DP&L contended that its customers repeatedly tell them that reliable service is important to them. DOB at 16-17; *see also* Ex. 19 at 6; Tr. at 750-51, 754-55; Ex. 83.<sup>31</sup> The DPA does not dispute that; not even one (let alone quarterly) survey is necessary to establish this. But this does not tell the entire story. Customers *already* think DP&L provides reliable service and they have thought so for years. DP&L's score for the question regarding reliable service was 85 in 2000, 86 in 2001, 90 in 2002, 84 in 2003 and 89 in 2004. Tr. at 763. It was 86 in 2008, 84 in 2009, and 85 in 2010. Ex. 83, 8<sup>th</sup> page of document. In 2011, when DP&L apparently went to quarterly surveys, the responses to the reliability question were 86 in Summer 2011, 84 in Fall 2011, 81 in the first quarter of 2012, 86 in the second and third quarters of 2012, and 92 in the fourth quarter

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<sup>30</sup>The HE acknowledged that DP&L had cited its customer surveys in support of its argument, but did not refer to their results any further in reaching his decision.

<sup>31</sup>As Mr. Maxwell admitted, the survey asks customers whether they believe DP&L is providing reliable service – *not* whether reliable service is important to them. Similarly, customers are asked whether they believe DP&L is restoring service in a timely manner - *not* whether restoring service in a timely manner is important to them. Tr. at 785-86. Again, the DPA does not dispute that reliable service and quick restoration is important to customers. But there *is* a difference between the questions being asked and the conclusion that DP&L reaches from the answers.

of 2012. *Id.*, 20<sup>th</sup> page of document. There is nothing in the record for 2013, which of course is the time period for the Adjustment 26 plant. The score has not varied much over the years. At worst, 81% of Delmarva’s customers believe service is reliable.<sup>32</sup>

e. **Comparison to Other Utilities’ Performance Is Not Particularly Useful for Determining Whether the Post-Test Period Plant Should Be Included In Rate Base in *This Case*.**<sup>33</sup>

DP&L determined an “appropriate” reliability level for which to strive by comparing its actual performance to that of other utilities in the Institute of Electrical and Electronics Engineers’ (“IEEE”) annual reliability surveys. DOB at 17-19. It says that a utility with a 295-minute SAIDI would be among the worst-performing in the nation, and only five of the 106 utilities participating in the IEEE survey would not have met that standard. *Id.* at 17-18. It says that its investments have resulted in improved reliability because its SAIDI has decreased from 199 minutes in 2010 to 192 minutes in 2011 to 146 minutes in 2012, and that had it not increased its reliability investments and its SAIDI had remained at 192-199, its performance would be among the worst in the IEEE survey. *Id.* at 18-19.

DP&L’s claim that its investments have resulted in improved reliability (even assuming it is true) does not establish that the projected *post-test period* investments will improve reliability. And in any event, its claim that its investments have resulted in improved reliability is merely an

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<sup>32</sup>The surveys also ask customers their opinion about rates. And there, DP&L didn’t do so well. DP&L witness Maxwell was “pretty sure” that the customers participating in the surveys are not told how much money DP&L plans to spend on reliability improvements and enhancements. Tr. at 786. Customers might respond even less favorably if they were told before answering that enhancing and improving their reliability was going to cost them \$x number of dollars a month every month for the foreseeable future and that DP&L could not tell them how much more (if at all) reliability would improve or how much faster service would be restored in the event of an outage.

<sup>33</sup>The HE quoted DP&L’s argument with respect to its comparison to other utilities (HER at 56-57, ¶144), but it does not appear to have influenced his recommendation.

assumption. AMI for electric customers was fully deployed in 2011.<sup>34</sup> Since AMI was supposed to help improve reliability and postpone or obviate the need for reliability spending, it is just as likely that its full deployment had something to do with its SAIDI improvement between 2011 and 2012. And a 50/50 likelihood that DP&L is wrong does not satisfy its burden of proof.

DP&L says that Regulation Docket No. 50's 295-minute SAIDI standard is a minimum standard and it would not be satisfied with only meeting that standard. DOB at 9, citing *26 Del. Admin. Code* §3007.1.3; DOB at 11-12; *see also* Ex. 19 at 4, 8. The HE agreed. HER at 73, ¶179. So does the DPA; only meeting it would be disappointing, particularly given the millions ratepayers are paying for AMI, which was supposed to improve reliability and potentially defer or eliminate the need for distribution improvements.

DP&L's comparison of its current performance to other unidentified utilities<sup>35</sup> provides no evidence that the *post-test period* plant investments will improve its reliability vis-à-vis other utilities. Remember that the issue here is *post-test period* plant: not plant previously placed into service that no one is challenging. There is no evidence that the projected plant additions will have any effect on DP&L's performance compared to its own previous performance, let alone its performance compared to other unidentified utilities.

Finally, that the 295-minute SAIDI minimum represents poor performance at this point probably means that the bar is now too low. That is an issue for another proceeding. But the current Commission standard is 295 minutes, and it is undeniable that DP&L has met that standard for many years running. Ex. 14 at Sch. DED-2.

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<sup>34</sup>Mr. Ziminsky testified that AMI allows DP&L to "ping" a customer's meter to determine actual outages and reduce restoration times. Ex. 5 at 21-22.

<sup>35</sup>The HE seemed to discount Staff testimony discussing DP&L's performance vis-à-vis other unidentified utilities. *See* HER at 65, ¶161.

f. **DP&L's Professional Judgment Is Not At Issue With Respect to Including Adjustment 26 Plant In Rate Base.**

DP&L spent a substantial amount of its briefs explaining how it exercised its professional judgment in determining what to invest in to meet its reliability objectives, and the HE agreed.<sup>36</sup> See HER at 73, ¶179. Again, however, none of this justifies including the Adjustment 26 plant in this case's rate base. Under this logic, plant could never be challenged as long as a utility said it exercised its "professional judgment" in installing it.

Next, DP&L claims that its aging infrastructure makes monitoring and testing its equipment to prevent load-related failures and to increase the system's capacity to handle growing load crucial, and that it practices "reliability centered maintenance" to do so. *Id.* It then proffers a prolonged explanation of how its equipment condition assessment does this. *Id.* at 20-21. Nobody challenged that – but none of this means that the Adjustment 26 plant should be in rate base.

Next, DP&L discussed its URD cable replacement, substation transformers and switchgear policies. *Id.* at 23. But this does not indicate what the problems (if any) with these items in Delaware are, and does not identify which of the projects in its Adjustment 26 will remedy the unidentified problems.

Last, DP&L offered Distribution Automation ("DA") as part of its commitment pursuant to Regulation Docket 50's directive to effect reliability improvements. *Id.* at 24-25. Most of its discussion describes what DA is and what it does. But Delmarva has been required to do this since September 2006, when the Commission adopted the service reliability and quality standards. *Id.* at 8, 23-24. DP&L also identified DA as an important benefit associated with AMI in Docket No. 07-28. See February 6, 2007 *Blueprint for the Future* Application and Plan at 8-9;

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<sup>36</sup>The HE observed that the DPA made these arguments, but did not address all of them.

*Blueprint for the Future* Business Case at 2. These dockets were the genesis for the DA investment – not the REP.

**g. DP&L Ignored Adjustments That Reduce Rate Base and Increase Revenues.**

During the test year, DP&L added \$27.44 million of depreciation to its accumulated depreciation reserve. This reduces rate base and likewise reduces the revenue requirement, but Delmarva did not make an adjustment to reflect this reduced revenue requirement.<sup>37</sup> Ex. 13 at 7. Similarly, the deferred income tax reserve offsets the revenue requirement associated with plant additions because it is also a rate base deduction, but DP&L made no adjustment to reflect the additional deferred income tax. *Id.* at 7-8. The HE did not address this issue, but *these adjustments are required regardless of whether the Commission includes the Adjustment 26 plant in rate base or not, because they are attributable to uncontested 2012 plant additions.*

Additionally, increases in customers and usage would offset the increased revenue requirement associated with the additional plant, but DP&L did not make an adjustment to reflect increased customers or increased usage. *Id.* at 8. This is particularly egregious in light of the “significant load growth” it said it is experiencing in the Middletown-Odessa-Townsend area, the corridor between Dover and Harrington, and the coastal Sussex areas that require action to “avoid a degradation in reliability.” DOB at 20, citing Ex. 19 at 14. If growth in those areas is so significant that it requires reliability investment, then it is significant enough to require DP&L to include that growth in its revenues to determine the revenue requirement. Its failure to do so suggests that it would have reduced its revenue requirement too much to include it.

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<sup>37</sup>DP&L *did* include additions to both the depreciation and deferred income tax reserves associated with the post-test-period plant, but *failed* to include reserve additions associated with the unchallenged plant that was in service at the end of 2012, the test period. Ex. 13 at 7 n.3.

**h. DP&L Could Have - But Did Not - Use a Partially Projected Test Period.**

Commission regulations allow utilities to file rate cases using a partially forecasted test period. DP&L could have used a test period comprised of three months actual data and nine months projected data. *See 26 Del. Admin. Code §§1002.1.2.2.1, 1002.1.2.3.1.* This would have allowed it to project its plant additions nine months out, but would also have required it to project its revenues nine months out, and it would have had to update its projections with actual results. DP&L chose not to use a partially projected test period, but rather relied on an historical test period, which it then adjusted for cherry-picked projected additions. As discussed above, it did not adjust other elements of the regulatory triad that might decrease its revenue requirement.

The HE acknowledged the DPA's argument about this mismatch (HER at 60, ¶151), but concluded that the Commission had authorized post-test period plant additions in prior cases. He did not address the contention that DP&L did not include post-test period adjustments that would have reduced the revenue requirement.

DP&L should not be permitted to sneak in through the back door a fully-forecasted test period that it cannot file directly. Nor should it be permitted to obtain the benefit of a partially-projected test period for one item without including the adjustments to the other portions of the regulatory triad. The Commission should reject DP&L's attempt to use a fully-forecasted test period for plant since this Commission's regulations do not permit them, and it should reject Delmarva's attempt to use a partially-projected test period without adjusting for other elements of the regulatory triad that might reduce the revenue requirement.

i. **No Attrition Analysis Supports DP&L's Claim of Regulatory Lag.**

DP&L claims that it needs Adjustment 26 to combat regulatory lag.<sup>38</sup> Ex. 2 at 5. But it provided no detailed earnings attrition analysis directly linking underearning with its reliability investment requirements. Ex. 14 at 5, citing Delmarva's responses to AG-REL-36 and AG-REL-37. Dr. Dismukes testified that regulators have long recognized that regulatory lag can be key to the overall regulatory process because it imposes discipline on utility operational and investment decisions. *Id.* at 15. Contrary to DP&L's suggestion, regulatory lag is not bad in and of itself: it can lead to both costs and benefits for a utility because it creates opportunities for gains as well as losses. *Id.* at 15-16. DP&L's proposal shifts regulatory, investment and performance risk away from it and onto ratepayers. This is because utilities typically control when they file rate cases, so they not only have the ability to request rate increases but also are protected in time of overearning unless and until their commissions bring them in for a rate decrease. Allowing DP&L to include its projected investments exacerbates these timing risks by allowing it to increase rates for projects that may never be completed and, even if they are, may never be evaluated for reasonableness and appropriateness. *Id.* at 16.

Furthermore, DP&L's underearning is not solely because of regulatory lag. It admitted that its revenues include supply costs, which comprise the majority of sales revenues (Tr. at 637-38), and sales revenues have been decreasing because supply costs have been decreasing.

\* \* \*

DP&L did not establish that it cannot meet its obligation to provide safe, reliable and adequate service without these investments. The only thing it did establish is that ratepayers will pay more if the Commission includes the Adjustment 26 plant in rate base. DP&L has not met its burden of proving that the Commission should include its Adjustment 26 plant in rate base in this

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<sup>38</sup>The HE does not appear to have addressed this argument.

case. For the reasons discussed above, the Commission should reject the HE's recommendation to include Adjustment 26(a) plant in rate base.<sup>39</sup>

**B. The HE Erred in Concluding that DP&L's Prepaid Pension Asset and OPEB Liability Should Remain In Rate Base.**

In its original filing, DP&L included three prepaid items in rate base: a \$61,581,370 pension asset; a (\$8,176,221) accrued OPEB liability; and \$41,431 of insurance. Ex. 13 at 14. It conceded that it double-counted the prepaid insurance asset by including it both in rate base and its CWC requirement, and removed it from rate base in its rebuttal testimony. Ex. 13 at 17-18; Ex. 20 at 65. This leaves the prepaid pension asset and accrued OPEB liability.

Some background may be helpful to frame the issue. Since the adoption of Financial Accounting Standards Board Statement Nos. 87 and 106 ("SFAS 87" and "SFAS 106"), pension and OPEB expense have been determined on an actuarial basis using the accrual method of accounting. The accrual method recovers pension and OPEB benefit costs over the working lives of the employees who receive such benefits based on assumptions regarding salary levels, earnings on fund balances, mortality rates and other factors. A separate calculation determines funding requirements. The actuarial valuation may be positive or negative in any given year. Ex. 13 at 14-15.<sup>40</sup> A prepaid pension/OPEB asset occurs when the accumulated contributions and growth in the plans exceed the accumulated expenses associated with the obligations; a liability

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<sup>39</sup>The DPA made an adjustment to depreciation expense to reflect its exclusion of the entire Adjustment 26 plant from rate base. Ex. 13 at 56. We have not calculated the adjustment to depreciation expense that will be required if the Commission includes some but not all of the Adjustment 26 plant, but that calculation can be easily made once the Commission has rendered a decision.

<sup>40</sup>If the assumptions underlying the actuarial methodology were always accurate, there would be positive pension and OPEB expense each year, and an employee's benefits would be recognized over his/her working life. But assumptions are rarely 100% accurate, so pension and OPEB costs can be negative in some years due to overstated cost assumptions in prior years. As an example, if the methodology assumed a 5% return on investment but the actual return was 7%, a negative expense may be booked in a subsequent year. (Ex. 13 at 15).

occurs when the accumulated costs of the plans are greater than the associated contributions and growth of the plan assets. Ex. 20 at 71.

The DPA recommended removing the prepaid pension asset and OPEB liability from rate base. First, the DPA contended that they were not used and useful in providing utility service. DPA AB at 54. Second, it contended that even if the asset/liability was used and useful, DP&L had not established its burden of proof that investors, rather than ratepayers or market gains, provided the source of the funds in the accounts. *Id.* at 54-56; Ex. 13 at 17; Tr. at 675; DP&L 12/20/13 response to DPA on-the-record data request. The Commission did not consider either of these arguments in its previous dockets, but both support reversing its prior decision. Assuming that the Commission did not accept these arguments, the DPA argued that its decision in Docket No. 05-304 was incorrect.

Although the HE seemed to accept the DPA's argument that only assets funded by investors can be included in rate base, he rejected the contention that the prepaid pension asset should be removed from rate base. First, he noted that DP&L had "directly contradict[ed]" the Texas case upon which the DPA "primarily relied," but had ignored the Hawaii case supporting the DPA. HER at 84, ¶212. Second, he stated that "none of the parties addressed how our neighboring states are currently ruling as to this issue with other utilities, including, but not limited to, [DP&L's] related companies" (*id.*, citing the Commission's order in Docket No. 09-414 at ¶137) and therefore he was "not confident that all relevant nationwide case law" had been provided to him. *Id.* at 84, ¶212. Third, he stated that accepting the DPA's position would require an evidentiary hearing to determine the exact nature of the funds in the pension fund, noting that the Hawaii PSC had concluded that utility investors would have had to contribute the entire amount of the pension fund for it to be included in rate base. *Id.* at 85, ¶213. He found that the

evidence did not establish the source of the funds in the pension and OPEB accounts, dismissing the DPA's contention that mathematics showed that market earnings contributed more than 90% of the prepaid pension account balance. *Id.* at 85-86, ¶¶214-215. He concluded that:

...although the Public Advocate's claim may eventually prove to be valid, I find that the pre-paid pension asset should remain in rate base as the case law and pension plan evidence presented to me do not warrant changing established Commission precedent that this adjustment should be included in rate base.

*Id.* at 86, ¶216. As the DPA will demonstrate, the HE's conclusion is erroneous for several reasons.

### **1. The HE Incorrectly Placed the Burden of Proof on the DPA.**

In concluding that the prepaid pension asset should remain in rate base because "the case law and plan evidence presented to me do not warrant changing" the Commission's prior decisions on the issue, the HE *clearly* placed the burden of proof on the DPA. This is incorrect, and by itself warrants rejecting the HE's recommendation. Under Delaware law, the burden of proof *always* remains with the utility (as the HE correctly noted earlier in the HER, *see id.* at 14-15, ¶¶32-33). 26 *Del. C.* §307(b) provides that the utility bears the burden of proof on "every accounting entry of record questioned by the Commission," and it alone bears the burden of proving that its proposed rates are just and reasonable:

... [U]pon application of a public utility, involving any proposed or existing rate of any public utility or any proposed change in rates, the burden of proof to show that the rate involved is just and reasonable is upon the public utility.

26 *Del. C.* §307(a); *see also Matter of Slaughter Beach Water Co.*, 427 A.2d 893, 895 (Del. 1981). The Commission has recognized that the burden of proof never shifts away from the utility, adopting an HE's explanation of this issue in a case now more than 20 years old:

In the test year/test period process, there is a presumption that for purposes of estimating the future level of a recurring expense item, a prior level of actually incurred expenses associated with that item is reasonable. This presumption

would satisfy the obligation of the utility to come forward with affirmative evidence as to the reasonableness of an actually incurred expense unless that presumption is questioned or challenged, in which event the utility, with the statutory burden of proof, would need to produce evidence that the expense was not the product of abuse of discretion, bad faith or waste. In my view, any other conclusion would result in the Commission Staff or an Intervenor being required to affirmatively establish bad faith, waste, etc., and thereby improperly shift the burden of proof.

*In the Matter of the Application of Artesian Water Co., Inc. for an Increase in Water Rates,*  
Docket No. 90-10, HER, March 8, 1991 at 34-35.<sup>41</sup>

Therefore, once the DPA raised the issue, it was incumbent upon DP&L to come forward with evidence. And while DP&L argued that stockholders funded the prepaid expenses, it presented no such evidence during the hearings. It did not meet its burden of proof.

**2. The Prepaid Pension Asset Is Not Used and Useful.**<sup>42</sup>

Section 102(3) of the Act defines rate base as “[t]he original cost of all used and useful utility plant and intangible assets ...” less related accumulated depreciation and amortization; customer advances and contributions in aid of construction (“CIAC”); and accumulated deferred and unamortized income tax liabilities and investment credits, accumulated depreciation of customer advances and CIAC. Rate base does not include any asset that is not “*used and useful.*”

The prepaid pension asset is not used and useful in providing service. Indeed, DP&L admitted that *it cannot use those funds.* DOB at 91. Under the Employment Retirement and Income Securities Act (“ERISA”), the assets of a qualified retirement plan are required to be maintained in a trust to which DP&L lacks access:

Except as provided in subsection (b) of this section, *all assets of an employee benefit plan shall be held in trust by one or more trustees.* Such trustee or trustees shall be either named in the trust instrument or in the plan instrument described in section 1102(a) of this title or appointed by a person who is a named fiduciary,

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<sup>41</sup>The Commission affirmed the HE’s recommendation in Order No. 3274 (May 28, 1991).

<sup>42</sup>The DPA is not sure that the HE addressed this argument, so the DPA is including it in an abundance of caution.

and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan ...

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Except as provided in paragraph (2), (3), or (4) or subsection (d) of this section, or under sections 1342 and 1344 of this title (relating to termination of insured plans), or under section 420 of Title 26 (as in effect on July 6, 2012), *the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.*

29 U.S.C. §§1103(a), 1103(c)(1). If DP&L cannot use those funds, how then can they be *used and useful*? The DPA respectfully submits that they cannot be included in rate base.

**3. Delmarva Has Not Established That Stockholders, Rather Than Ratepayers or Market Gains, Were the Source of the Funds Creating the Asset.**

As can be seen from the statutory deductions to rate base in Section 102(3), rate base does not include plant and/or intangible assets supplied by any entity other than utility investors. Other courts have so held in interpreting a rate base definition similar to Section 102(3). *Arrowhead Public Service Corp. v. Pennsylvania Public Utility Commission*, 600 A.2d 251, 253 (Pa. Cmwlth. 1991) (utility entitled to earn a return only on property it funded, not on property contributed to it by others); *Consumers Counsel v. Public Utilities Commission of Ohio*, 447 N.E.2d 749 (Ohio 1983) (same); *Northwestern Bell Telephone Co. v. State of Minnesota*, 253 N.W.2d 815, 818 (Minn. 1977) (“since the point of rate regulation is to provide an adequate but not excessive rate of return to investors, property which is acquired in some manner other than the investment of stockholders' equity is generally not includable in the rate base”). As observed previously, it appears from the HE’s discussion of the issue that he accepted the DPA’s contention that rate base items must be funded by investors, but rejected its argument that DP&L had not established this fact. See HER at 84-86, ¶¶212-213. 215.

DP&L argued that its contributions to the pension fund represent a prepayment of pension expense funded by stockholders for which those stockholders are entitled to a return. DOB at 90. But it adduced *no* evidence that shareholders contributed the funds comprising the asset. *Re North Shore Gas Co.*, 2010 WL 537062 (Ill.C.C. Jan. 21, 2010) at 36:<sup>43</sup> “Although the Utilities state that the pension asset was created with shareholder funds, no evidentiary support was provided.” And without such evidence, “there is no reason to believe that the pension asset is funded by any other source than ratepayers.” *Id.* DP&L admitted that it made *no* contributions to the pension fund until 2009, when it contributed \$135 million. Tr. at 675. Over the past ten years, market returns on the fund have totaled almost \$1.245 billion. *Id.*; Ex. 13 at 17; DP&L 12/20/13 response to DPA on-the record data request. Despite the HE’s dismissal of the DPA’s mathematics, it is obvious that the vast majority of the fund assets are due to market earnings, not to capital contributed by DP&L investors.

Based on almost identical facts, the Hawaii PUC rejected a utility proposal to include a prepaid pension asset in rate base. In *Re Hawaii Electric Co.*, 2007 WL 4477336 (Hawaii PUC Oct. 25, 2007),<sup>44</sup> that commission stated:

Upon review of the entire record herein, the Commission finds that the \$78,791,000 of prepaid pension asset should be excluded from rate base. The commission makes this determination based on the specific facts pertaining to the accounting and ratemaking treatment of HECO’s NPPC [net periodic pension costs], consistent with the 2005 test year calculations in this proceeding.

The specific facts in this record do not adequately demonstrate that HECO’s shareholders, in fact, provided the funds represented in the prepaid pension asset, such that HECO’s shareholders should now be entitled to earn a return on the asset. *Rather, it appears that the majority of the funds constituting the prepaid asset resulted from favorable market conditions during 1999 to 2002, and not*

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<sup>43</sup><http://www.icc.illinois.gov/downloads/public/edocket/259769.pdf>

<sup>44</sup>[http://dms.puc.hawaii.gov/dms/OpenDocServlet?RT=&document\\_id=91+3+ICM4+LSDB15+PC\\_DocketReport59+26+A1001001A09G15B80207C3613818+A09G15B80207C361381+14+1960](http://dms.puc.hawaii.gov/dms/OpenDocServlet?RT=&document_id=91+3+ICM4+LSDB15+PC_DocketReport59+26+A1001001A09G15B80207C3613818+A09G15B80207C361381+14+1960)

*from investor contributions.* In particular, from 1999 through 2002, HECO recorded negative pension costs and made no contributions to the pension trust fund. This resulted in the addition of \$56,517,000 to the pension asset, as required by SFAS 87, which represents approximately 74% of the estimated pension balance at the end of the 2005 test year. Thus, the favorable market conditions and the SFAS 87 pension accounting requirements resulted in a reduced NPPC, a growing asset, and presumably less expense and greater investor return for HECO's shareholders. Under these circumstances, the commission will not require HECO's ratepayers to pay for a return on such an asset by placing the asset in rate base.

(*Id.* at 14-15) (emphasis added).<sup>45</sup> See also *Re Central Telephone Company-Nevada*, 1992 WL 402072 at 45 (Nev. PSC Jan. 7, 1992) (“The Commission believes it is illogical to conclude that investors should receive a return on a book entry that reduces expense. Investors are entitled to a return only on funds that are actually provided and not on assets that accrue as a result of accounting procedures”).

**4. The DPA Respectfully Suggests That the Commission's Decision on the Issue In Docket No. 05-304 Was Incorrect.**

DP&L claimed that the prepaid pension asset (and, we assume the OPEB liability) should be included in rate base because ratepayers benefit from their existence. Ex. 20 at 71. This is because, according to DP&L: (1) the existence of a prepaid pension asset means that the cash contributions and return in the pension trust exceed its accumulated benefit obligation; (2) the pension trust's assets are larger than they would otherwise be; (3) which increases the expected return on the asset; (4) which decreases the pension expense; (5) which decreases the cost of service, and thus (6) decreases the amount that ratepayers pay in rates. *Id.* at 72; DOB at 91.<sup>46</sup>

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<sup>45</sup>The Hawaii commission noted that its decision was based on the facts of the case, and different circumstances might warrant a different conclusion. But for purposes of this argument the salient point is that the facts are nearly identical to those presented in this case. *Hawaii Electric, supra* at 15.

<sup>46</sup>As noted above, the Nevada PSC found it “illogical” for shareholders to receive a return on a book entry that reduced expense. *Central Telephone Company, supra* at 45.

The DPA acknowledges that the Commission included the prepaid pension asset in rate base in Docket No. 05-304. It appears, however, that the HE in Docket No. 05-304 and the Commission, which relied on the HE's recommendation, may have misunderstood the issue. (The DPA's current counsel was involved in that docket and accepts blame for not presenting the issue clearly to the HE and the Commission). We have since found a detailed discussion of the issue, which we include here despite its length because of its careful examination of this complex issue.

CENTEL proposes to include in its calculation of invested capital a prepaid pension asset in the amount of \$2,079,022.16. CENTEL witness John P. Meyer testified that CENTEL's pension fund is fully funded and has been since 1985, because of favorable investment experience and reductions in benefit levels. According to Mr. Meyer, ratepayers are receiving a negative pension expense which is used to reduce the cost of service in Texas. The reduction in pension expense and the attendant revenue requirement reduction is supported by investors. Mr. Meyer gave the following example to illustrate his position that a reduced revenue requirement resulted in the need for investor-supplied funds.

First, assume CENTEL incurred and paid allowable operating costs of \$10 million (without considering the negative pension expense). The Commission would presumably set rates to permit recovery of \$10 million from the ratepayers. The ratepayers would be providing revenues sufficient for CENTEL to pay all of the operating costs and no external cash flow would be necessary. Now consider the effects on revenue requirements and outside financing requirements caused by negative pension expense. Note that when the \$1 million negative pension expense is recorded by a non-cash credit to the income statement, the revenue requirement is reduced to \$9 million. This \$9 million of revenue will be used to pay \$9 million of the \$10 million of allowable operating costs (excluding pension), and a \$1 million shortfall results. External financing is needed to pay the shortfall. Thus, Ms. Blumenthal's suggestion that investors are not the source of the prepaid pension asset recorded on CENTEL's books is incorrect because it fails to take into account the resulting cash shortfall caused by the passing on of the over-funded pension trust assets to Texas ratepayers, in the form of negative pension expense.

OPC witness Ellen Blumenthal disagreed with CENTEL's proposal. According to Ms. Blumenthal, CENTEL has made no contributions to its pension fund and the pension asset on which the Company proposes to earn a return was established with ratepayer funds. Pension expense has been historically recovered through rates on a pay-as-you-go basis. Because investors did not supply any funds for

pension costs, and the funds were all provided by ratepayers, Ms Blumenthal recommended that the prepaid pension asset that CENTEL included in rate base be removed.

Further, Ms. Blumenthal recommended that no pension expense be included in rates, because the Company is making no contributions to its pension fund. Ms. Blumenthal testified that by including the prepaid pension asset in rate base, CENTEL, in effect, charges ratepayers again for amounts they have already overpaid.<sup>47</sup>

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The prepaid pension asset proposed by CENTEL to be included in rate base caused the examiner great consternation. CENTEL witness Mr. Meyer provided an eloquent discussion to support his proposal that CENTEL earn a return on the prepaid pension asset. However, the examiner finds that the evidence in the record does not support CENTEL's proposal.

If we revisit Mr. Meyer's example, in which CENTEL would incur and pay operating costs of \$10 million, Mr. Meyer is correct that the Commission would set rates to permit recovery of the \$10 million from ratepayers. The examiner disagrees with Mr. Meyer's next contention, however, that when the \$1 million negative pension expense is recorded by a non-cash credit to the income statement, revenue is reduced to \$9 million, resulting in a \$1 million shortfall. If CENTEL were allowed \$10 million in operating costs, the \$1 million negative pension expense would have already been deleted from the revenue requirement and there would be no shortfall. The \$1 million negative pension expense is simply a non-cash journal entry CENTEL must record on its books.

*CENTEL's argument is beguiling at first glance. However, upon further consideration, CENTEL's argument to include a return on the prepaid pension asset is specious.* CENTEL argues that the negative pension expense is deducted from the cost of service for the benefit of the ratepayer, and that if CENTEL does not recover the negative pension expense from the ratepayers, then the Company must obtain the cash from another source and pay a return to investors. However, the characterization of the reduction in cost of service as a negative pension expense is a misnomer. The negative pension expense simply means that CENTEL has no revenue requirement for pension expense in its cost of service. There is no cash credit to ratepayers by CENTEL. There is simply a non-cash journal entry made by CENTEL on its books to reduce the amount of the overfunding, much the same way that a financial obligation is amortized over a period of time.

Mr. Meyer admitted at the hearing that the pension asset was funded by ratepayers and that the credit is a non-cash journal entry. However, he subsequently

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<sup>47</sup>It should be noted that the DPA is *not* challenging the pension expense included in DP&L's O&M expenses.

attempted to characterize this non-cash entry as investor-supplied cash that must be included in rate base. The examiner disagrees that CENTEL must go to investors to make up the amount of the negative pension expense. If CENTEL's pension fund does not require additional funding and CENTEL's revenue requirement is reduced as a result, there is no cash for CENTEL's investors to make up. Section 39 of PURA allows CENTEL to earn a reasonable return on invested capital, over and above reasonable and necessary operating expenses. If CENTEL's pension fund is fully funded, then there should be no pension expense included in rates as a reasonable and necessary expense. *CENTEL should not earn a return on the credit it must make on its books to reduce the overfunding.*

In its brief, CENTEL argues that the excess portion of the pension fund should be treated as an investor-supplied asset because investor monies fund the pension plan in the sense that the funds were earned through authorized rates and are monies that belong to the Company that could either have been used as internal capital or distributed to shareholders. This argument, however, is not credible. CENTEL collected, through its rates, enough money from ratepayers to fund its pension plan. Because CENTEL did not accurately predict that its pension fund would experience favorable investment results and that there would be reductions in benefit levels, the pension fund was subsequently overfunded. If CENTEL had predicted these events in advance, CENTEL's revenue requirement would have been reduced, the ratepayers would not have paid in as much, and CENTEL's pension plan would not be overfunded as it presently is. Therefore, CENTEL's argument that the Company or investors would have had use of the additional money in the pension fund is without merit. The examiner is not convinced, and the credible evidence does not show, that it is reasonable for CENTEL's investors to earn a return on the prepaid pension asset because the pension fund is overfunded. The examiner agrees with OPC that to include the prepaid pension asset in rate base would have the effect of charging ratepayers again for amounts they have already paid. Accordingly, the examiner recommends that CENTEL's proposal to include \$2,079,022 as a prepaid pension cost be rejected.

*Re Central Telephone Company of Texas*, 1993 WL 595464 (Tex. PUC Sept. 8, 1993) at 11-12 (emphasis added). The Texas PUC accepted the Hearing Examiner's findings and recommendations on the issue. *Id.* at 127-28.

Delmarva argued (and the HE apparently found) that the Texas PUC has since reversed its position on this issue. DPL RB at 30-31, citing *Application of Entergy Texas, Inc. for Authority to Change Rates, Reconcile Fuel Costs, and Obtain Deferred Accounting Treatment*, Docket No. 39896, Order at 2 (Sept. 14, 2012) and *Application of AEP Texas Central Co. for*

*Authority to Change Rates*, Docket No. 33309, Final Order ¶¶25-32 (Mar. 4, 2008). Neither of those cases provides much, if any, assistance to DP&L. First, the *Entergy* case specifically notes that “Entergy contributed nearly \$56 million more to its pension fund than the minimum required by SFAS No. 87.” *Entergy, supra* at 2. That is not the case here: DP&L admitted that its sole contribution to the fund was \$135 million in 2009. Second, the only factual finding in *AEP* that corresponds with anything in this case is ¶27, which states that “[i]nvestment income on the pension prepayment reduces pension cost calculated under SFAS 87.” *AEP, supra* at 5, ¶27. The DPA does not dispute that. The *AEP* case contained no discussion about who provided the funds for the asset. There is no discussion in either case about what can be included in rate base in Texas, and as we have contended, these assets are not appropriately included in rate base because Delaware requires rate base items to be used and useful in providing utility service.

The DPA believes that the careful and thorough discussion contained in the *Centel* HE’s recommended decision is persuasive. Ratepayers have already paid for pension expense in rates (remember that DP&L’s operating expenses include an amount for pension and OPEB expense that the DPA is not challenging). They should not be made to pay twice – but that is the result of including the prepaid pension asset/OPEB liability in rate base. Therefore, the DPA respectfully requests the Commission to reconsider its decision on this issue.

**5. Including the Prepaid Pension Asset and OPEB Cost Adjustments In Rate Base Inappropriately Combines the Accrual and Cash Funding Methodologies.**

The DPA further argued that including pension and OPEB cost adjustments in rate base inappropriately combined the accrual methodology used in the actuarial studies with the cash funding approach.<sup>48</sup>

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<sup>48</sup>The HE did not address this argument.

If the Commission has approved using the actuarial valuation (which uses the accrual methodology) to determine the proper level of pension and OPEB expense to be included in the revenue requirement (and the Commission did so in Docket No. 09-414), then it is inappropriate to include any rate base components that reconcile actual versus funded liabilities because the accrual method already takes funding status into account. Over time, the amounts contributed to DPL's pension and OPEB funds will equal its calculated accrual costs. There may be timing differences due to variations in assumptions from year to year and due to actual versus projected results, but these variations will be trued up in subsequent actuarial studies. Ex. 13 at 16. DP&L acknowledged that the DPA proffered this testimony (DOB at 89), but the DPA found no rebuttal of this testimony in DP&L's briefs.

**6. The HE's Statement About Authority Not Presented To Him Is Incorrect.**

Finally, the HE stated that "none of the parties addressed how our neighboring states are currently ruling as to this issue with other utilities, including, but not limited to, Delmarva's related companies" (*id.*, citing the Commission's order in Docket No. 09-414 at ¶137) and therefore he was "not confident that all relevant nationwide case law" had been provided to him. *Id.* at 84, ¶212. The citation to Order No. 8011 in Docket No. 09-414 included in the HE's discussion, however, does *not* support his statement. That portion of the Commission's order addressed DP&L's request to create a regulatory asset in the amount of the loss that its pension plan incurred in 2008 as a result of the global financial crisis and to amortize that regulatory asset. And it was in that context that the DPA cited to the these commissions, which had also denied PHI's utility companies regulatory asset treatment of the 2008 pension plan loss. That portion of the Commission's order did not address the prepaid pension asset. *See* Order No. 8011, ¶¶136-157, and therefore the HE's citation to it for that issue is incorrect.

As for the HE's supposition that the parties had not provided him with "all relevant nationwide case law," had there been other decisions in any jurisdiction that the DPA or DP&L had found to support their positions, they would have cited that authority. The fact that neither party presented the HE with any additional authority simply means that they found no other decisions that supported their positions.

In conclusion, the HE erred in placing on the DPA the burden of establishing that DP&L did not meet its burden of proof. He further erred in not finding that DP&L did not meet its burden of proving that the prepaid pension asset and OPEB liability are used and useful in the provision of utility service and therefore cannot be included in rate base as a matter of law. Assuming the Commission finds otherwise, then the DPA respectfully submits that ratepayers should not be required to pay stockholders a return on money that they have not supplied. Furthermore, if the Commission is not convinced by any of the preceding contentions, the DPA respectfully requests the Commission to reconsider the issue. Last, including the pension and OPEB in rate base inappropriately combines the actuarial and cash funding methods. The DPA respectfully requests the Commission to reject the HE's recommendation.

**C. The HE's Recommendation to Include DP&L's Portion of PHI Credit Facility Costs In Rate Base and Operating Expenses Should Be Rejected Unless Short-Term Debt Is Included In the Capital Structure.**

DP&L increased its rate base by \$520,111 and operating expenses by \$337,108 relating to PHI's short-term credit facility. The rate base adjustment represents amortization of DP&L's portion of the start-up costs associated with the facility (and includes a return on the unamortized balance of the costs), and the operating expense represents its portion of the facility's annual recurring costs. Ex. 13 at 29. The DPA objected to including these costs in rate base and

operating expenses because DP&L does not provide any of the financial benefits associated with the existence of the credit facility to its ratepayers.

The HE rejected the DPA's opposition, observing that the Commission had included the credit facility costs in DP&L's revenue requirement in Docket No. 09-414. He found that the credit facility was "critically important" to DP&L's operations and "very beneficial to ratepayers" because it allows DP&L to fund construction and working capital and represents the first step in "seeking long-term debt issuance which benefits ratepayers." HER at 97, ¶246.

The DPA acknowledges that the Commission has approved including the credit facility costs in DP&L's revenue requirement, but we again respectfully submit that the decision to do so without also giving ratepayers the benefit of that facility was incorrect. We accept for purposes of this argument that the credit facility is important to DP&L and that it benefits ratepayers. But, as things currently are, ratepayers are paying almost \$1 million in rate base and operating expense costs for the credit facility, but getting no benefit from the lower cost debt it represents. DP&L's short-term debt cost as of December 31, 2012 was 0.38%; however, its proposed capital structure contains only equity and long-term debt costing 4.91%. Ex. 13 at 30, citing DP&L's response to PSC-COC-9. Why shouldn't ratepayers get some financial benefit from the credit facility since they are paying a return *on* and *of* the costs associated with it? Neither DP&L nor the HE adequately answered that question, and neither does Order No. 8011.

The HE specifically states that the credit facility allows the Company to fund construction and working capital. *Id.* If so, then why is DP&L getting a separate CWC allowance? DP&L is already getting its day-to-day "working capital" needs in the CWC allowance, materials and supplies, and prepaid insurance, all of which are included in rate base and on which it earns a return. Ex. 13 at 30.

It is unjust to require ratepayers to fund the credit facility costs (in addition to the CWC allowance, materials and supplies allowance and prepaid insurance allowance that they are *also* funding) but deny them the benefit of that much lower cost debt (by some 350 basis points) in the capital structure. The DPA is not suggesting that DP&L cannot recover those costs under any circumstances. All we are saying is that *if* they are included in the revenue requirement, then the capital structure should include short-term debt. Ex. 13 at 30-31. At a time when ratepayers are being asked to pay more and more in rates, they should be given whatever monetary benefit exists.

If the Commission does not want to include short-term debt in the capital structure, another ratemaking treatment would allow DP&L to recover these costs and would match the costs to ratepayers with the benefit of short-term debt. As Staff witness Peterson testified, DP&L first assigns short-term debt to CWIP. This assignment is recognized in the AFUDC rate, which DP&L then capitalizes to its construction accounts. Ex. 11 at 34. Recognizing the credit facility costs as an increase in the effective cost of short-term debt in the AFUDC rate will appropriately compensate DP&L for those costs. *Id.*; Ex. 13 at 31. Delmarva claims that this is inappropriate because the credit facility costs are not associated with the amount of borrowing and are incurred even if it does not borrow on the facility. Ex. 3 at 7; DOB at 73. But DP&L does not like the most appropriate treatment, which is to include short-term debt in the capital structure. The DPA would accept Staff's proposal as an alternative to ratepayers receiving *no* benefit.

The ratemaking treatment that the HE recommends continue is "heads I win, tails you lose" and is unfair to ratepayers. Including short-term debt in the capital structure while allowing DP&L to recover the costs associated with the credit facility in its revenue requirement is a win-win. The DPA respectfully requests the Commission to reconsider its position.

#### IV. OPERATING INCOME ISSUES

##### **A. The Commission Should Reject the HE's Recommended Ratemaking Treatment of DP&L's Salary and Wage Adjustments.**

Although DP&L chose a test period of the 12 calendar months ending December 31, 2012, it based its salary and wage claim on projected payroll costs on the period from January 1, 2012 through November 2014. The \$1,782,036 adjustment included:

- Annualization of the IBEW Local 1238 2% test period increase;
- IBEW Local 1238 estimated 2% increase effective February 2013;
- IBEW Local 1238 estimated 2% increase effective February 2014;
- Annualization of the IBEW Local 1307 2% test period increase;
- IBEW Local 1307 estimated 2% increase effective June 2013;
- IBEW Local 1307 estimated 2% increase effective June 2013;
- Annualization of 3% non-union test period increase;
- Estimated 3 % non-union increase effective March 2013; and
- Estimated 3% non-union increase effective March 2014.

Ex. 5 at 13; Ex. 13 at 32. In rebuttal, DP&L reduced its adjustment to \$1,173,236 to reflect the actual terms of the Local 1238 and 1307 contracts (Ex. 20 at 21-22 and Sch. (JCZ-R)-2), but continued to include projected increases going out almost two years beyond the end of the test period, citing prior Commission permitting it to include salary and wage increases beyond the end of the test period. Ex. 5 at 12; Ex. 20 at 23-24. It also claims that such increases are reasonably known and measurable based on the union contract requirements and its history of granting raises. Ex. 20 at 24-25; DOB at 82.

The HE recommended accepting DP&L's proposed salary and wage adjustments, finding that they were consistent with Commission precedent and Commission regulations allow

modifications to test period data for reasonably known and measurable changes in current or future rate base, expense or revenue items. HER at 106, ¶271.

The DPA acknowledges that the Commission has allowed DP&L to include wage and salary increases far outside the test period in its revenue requirement in previous cases. DOB at 81. The DPA also acknowledges that Commission regulations permit modifications to test period data occasioned by reasonably known and measurable changes in current or future rate base items, expenses or revenues. *26 Del. Admin. Code* §1002.1.3.1. But the circumstances under which that approval was given are much different than the circumstances presented here. As we discussed with respect to post-test period rate base additions, the time between rate cases provided some justification for including post-test-period wage adjustments in the revenue requirement in previous cases because there was no guarantee that DP&L would file another rate case within a short period of time. But in this case, DP&L has been clear about its intent to file annual rate cases, and there is no reason we should not take it at its word. Under these circumstances, the Commission need not include post-test-period adjustments in the revenue requirement in this case because they will be included in the next case.

As discussed previously, DP&L could have used a partially projected test period consisting of as many as nine months of projections, which would have permitted it to include reasonably known and measurable changes, including the 2013 wage increases. *See 26 Del. Admin. Code* §1002.1.2.2. But it didn't. Using a test period consisting of actual results for an historical 12-month period and then including projected increases extending two years past that period renders the Commission's regulation defining permissible test periods a nullity. And, as we also noted previously, DP&L made no adjustment to recognize increased revenues.

The salary and wage adjustment distorts the regulatory triad of synchronizing rate base, expenses and revenues. DP&L alone chose the test period and should be held to that test period. The DPA's recommendation is hardly "arbitrary;" it is based on the fundamental ratemaking principle of matching test period expenses, rate base and revenues. And it is not arbitrary when the circumstances have changed since the Commission's last decision. The DPA respectfully requests that the HE's recommendation regarding DP&L's wage and salary adjustment be denied based on the facts of this case, and that only annualization of the wage and salary increases that occurred during the test period be approved.<sup>49</sup>

**B. The Commission Should Reject the HE's Recommendation to Approve DP&L's Claimed Level of Regulatory Expense.**

DP&L included in its revenue requirement \$53,316 of non-rate case- related regulatory costs (based on a three-year average of actual costs) and \$632,000 of estimated costs for this rate case (including \$92,600 for its cost of capital witness). The DPA objected to DP&L's rate case expense on the grounds that: (1) the Commission had not addressed the issue in prior dockets to which DP&L referred and nothing could be inferred from its silence; and (2) it was excessive based on the costs incurred in its previous three cases (two of which were litigated to a Commission decision). The DPA particularly objected to the cost of DP&L's cost of capital witness. It recommended a normalized level of \$426,432 of rate case expense based on the average of DP&L's costs in its last three cases (\$634,054 in Docket No. 11-528, \$245,241 in Docket No. 09-414, and \$400,000 in Docket No. 05-304). DPA AB at 92-94; Exh. 13 at 48.

The HE accepted DP&L's estimate. First, he observed that it had incurred \$634,054 in rate case expense in Docket No. 11-528, which settled. Second, he noted that the DPA's

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<sup>49</sup>The DPA notes that if its recommendation is adopted, an adjustment to eliminate certain payroll taxes from the revenue requirement is necessary. That adjustment appears at Ex. 13 at 37-38 and Sch. ACC-19.

testimony was filed in August 2013 and there had been “protracted litigation since then,” during which DP&L had incurred additional attorneys and expert witness fees and travel costs for hearings and briefing. HER at 107-08, ¶¶275-276.

The DPA respectfully submits that the HE erred in accepting DP&L’s estimate.

First: DP&L cannot rely on purported ratemaking treatment in prior cases in which the Commission never addressed the issue. No “precedent” can be assumed from silence.

Second, DP&L’s claimed rate case expense is excessive. In its last three rate cases, DP&L incurred rate case expense of \$634,050 (Docket No. 11-528 – settled right before hearings commenced), \$245,241 (Docket No. 09-414 – litigated to Commission decision), and \$400,000 (Docket No. 05-304 – litigated to Commission decision). Ex 13 at 48. Obviously, DP&L will incur expenses in litigating rate cases, whether they settle or not. But that does not mean that its estimate should be taken at face value or that the individual components that comprise the overall claim should be accepted.

It is particularly curious that the cases that Delmarva litigated to a decision before the Commission actually cost *less* than its settled case, despite the existence of contested issues in the litigated cases that were not raised in the settled case (e.g., ring fencing, revenue decoupling and amortization of a past year’s pension loss in Docket No. 09-414; depreciation expense and a late-arising issue in Docket No. 05-304). One might argue that it was DP&L’s rate case costs in Docket No. 11-528 that bore “no relationship to the expected level of costs... .” DOB at 79. Moreover, DP&L’s non-rate case regulatory expenses could involve issues that do not always occur, but it nevertheless included an average of its *actual* expenses for *that* part of its claim. The issues in this case were no more complex than those in prior rate cases.

DP&L contended that the DPA had not offered any “credible” evidence that its expenses for this proceeding were made in bad faith, were wasteful or were inefficient. DOB at 79. First, as discussed previously, it is not the DPA’s burden to prove that the expenses were incurred in bad faith, were wasteful or were inefficient; it is DP&L’s burden to prove that they were *not*. Second, even if it was the DPA’s burden, it offered such evidence. DP&L’s cost of capital witness in Docket No. 09-414 was Dr. Roger Morin, a well-known cost of capital expert who testifies regularly on behalf of public utilities.<sup>50</sup> DP&L paid Dr. Morin \$65,000 for his services. Tr. at 646-47. DP&L paid Mr. Hevert \$92,600 in this case. *Id.* at 643. Is Mr. Hevert \$30,000 better than Dr. Morin? Similarly, the DPA’s cost of capital witness was being paid \$21,600. *Id.* Is Mr. Hevert more than four times as good as Mr. Parcell, who has testified on cost of capital in Delaware in many cases over many years? Additionally, PHI retained Mr. Hevert for all four of its rate cases in its jurisdictions (and paid him \$92,600 for each of those cases). Tr. at 643. He also testified for all the PHI utility companies in their prior rate cases. Ex. 3 at Attachment A. \$92,600 per case is even more striking when his familiarity with PHI and its utility companies is taken into account.

The DPA means no disrespect to Mr. Hevert: he charges what the market will bear. But is it reasonable to saddle ratepayers with the cost of a witness that is four times as high as the cost of the witness retained for the ratepayers – especially where the ROE is an issue of interest only to shareholders? The HE ignored these arguments.

Finally, DP&L proposed to amortize the rate case expenses over three years. DOB at 79. That is, it seeks *dollar for dollar* recovery of its rate case expenses. It proffers no changed circumstances nor any new argument that would support abandoning the Commission’s longstanding practice of normalizing rate case expense. Moreover, DP&L witness Ziminsky

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<sup>50</sup>Indeed, Mr. Hevert cites Dr. Morin in his testimony. *See* Ex. 3 at 31 n.31; Ex.18 at 33 n.58; 38 n.76;

admitted that he did not propose amortization in his testimony. Tr. at 641. The HE did not specifically address this issue; he stated only that DP&L “should be awarded its requested rate making treatment.” HER at 108, ¶276.

The DPA does not dispute that DP&L incurs costs in prosecuting a rate case and is required to support its requested cost of capital in a rate case. That does not mean, however, that its projected expenses must be accepted without inquiry or that ratepayers must pay for the most expensive witness DP&L can get. Respected cost of capital witnesses can be found for a far more reasonable price. And if it does nothing else with respect to these expenses, the Commission should make clear that it is not authorizing amortization of whatever rate case expense it does allow. The DPA respectfully submits that the Commission accept its recommended regulatory expense amount.

**C. The Commission Should Adopt the HE’s Recommendation to Exclude All Non-Executive Incentive Compensation from the Revenue Requirement.**

DP&L included in its revenue requirement \$1,993,802 of non-executive incentive compensation, most of which relates to its Annual Incentive Plan (“AIP”).<sup>51</sup> Under the 2012 AIP, no payments are made unless earnings reach certain targeted levels. Ex. 13 at 33; Ex. 70.<sup>52</sup> If the earnings thresholds are satisfied, then a combination of business unit and individual goals must be met before any awards are made. Award percentages rise as pay scales rise, so higher-paid employees are eligible for proportionately greater awards. Ex. 13 at 34.

The DPA acknowledged that in Docket No. 05-304, the Commission included in rates the amounts associated with the achievement of safety, reliability and customer service goals in

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<sup>51</sup>DP&L removed executive incentive compensation program costs from its revenue requirement in this case. Ex. 5 at 8, 15; Ex. 13 at 34.

<sup>52</sup>The 2013 AIP structure changed slightly to provide that awards are funded from an Enterprise Incentive Pool; however, an earnings trigger must still be satisfied before any incentive payments are made. Ex. 13 at 34.

rates, but excluded the amounts related to the achievement of financial goals.<sup>53</sup> Notwithstanding that, the DPA requested the Commission to reconsider excluding such costs from the revenue requirement altogether. DPA AB at 77-81. DP&L also requested the Commission to reconsider its position and to allow all such expense in the revenue requirement. DOB at 95-96.

The HE removed the entire amount of non-executive incentive compensation from the revenue requirement, stating that doing so was consistent with the Commission's prior decisions in Docket Nos. 05-304 and 09-414 which held that "all costs related to the achievement of financial goals will be excluded." HER at 110, ¶284. He found that the AIP had been structured "such that the achievement of its corporate financial goals overrides its goals of improving safety, reliability and customer satisfaction;" thus, regardless of whether those goals were met, employees would receive no incentive compensation if the financial goals were not met. *Id.* at 110, ¶285. He observed that DP&L could have structured its plan differently to satisfy Commission precedent, but that it presumably selected the structure that it did to satisfy "shareholders, stock analysts and the rating agencies." *Id.* at 110, ¶286.

Generally, parties do not brief issues that they win at the HE level. The DPA is (obviously) satisfied with the HE's recommendation. However, the DPA believes that his recommendation is inconsistent with what this Commission has previously held; thus, the DPA believes that it is necessary to make its argument for approval in these exceptions.

DP&L claims that: the AIP is "critical" for attracting and retaining competent talent; the Company strives to align employee behavior with company business objectives such as customer satisfaction, employee productivity, employee safety and operational efficiency; the Company made a business decision to place a portion of employees' compensation at risk to motivate them

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<sup>53</sup>In Docket No. 09-414, the Commission excluded all non-executive incentive compensation expense from the revenue requirement because DP&L had not quantified the amount of expense related to achieving safety, reliability and/or customer service goals. *Delmarva Power*, Order No. 8011 at ¶¶195-196.

to achieve their “best performance;” such plans are standard in the industry; and the incentive compensation plan benefits customers by (for example) controlling spending and encouraging employees to think of ways to save money. Ex. 2 at 10-11; Ex. 20 at 69; DOB at 95.

These are the same arguments that Delmarva has made in the past and the Commission has not found most of them particularly persuasive. *Delmarva Power*, Order No. 6930, at 46-47, ¶¶96-98. Delmarva proffered no new facts or reasons for the Commission to reconsider its position otherwise (Tr. at 657-59), and the DPA submits that in these difficult economic times, qualified people are unlikely to be quibbling about whether a potential employer has an incentive compensation package.

The HE specifically recognized that employees receive nothing *unless* the earnings thresholds are achieved *even if* they meet all of the safety, customer service, reliability, and “balanced scorecard” goals. *Id.* at 660-61. DP&L witnesses also testified that employees would work safely and would perform their duties in a way that protected customers’ interests without an AIP. *Id.* at 659-60. Indeed, the DPA does not doubt that DP&L’s employees live up to the high standards expected of them regardless of whether there is an incentive plan.

DP&L did not have a non-executive incentive compensation plan until 1999. *Id.* at 1020. It has been providing utility service since before 1999, so employees apparently performed their duties ably and dependably before the incentive plan was implemented. Thus, it cannot be said that these costs are normally incurred in the provision of utility service. And even if incentive plans are standard in the industry, that does not mean that ratepayers should be wholly responsible for paying for them: in other jurisdictions, shareholders are either wholly or partially responsible for the costs of such plans. *See Narragansett Electric Co. v. Rhode Island Public Utilities Commission*, 35 A.3d 925, 937-38 (R.I. Supr. 2012); *Commonwealth Edison Co. v.*

*Illinois Commerce Commission*, 924 N.E.2d 1065, 1077-79 (Ill. App. 2009), *appeal denied*, 938 N.E.2d 519 (Ill. 2010); *Re Public Service Company of Oklahoma*, 2007 WL 6081138 (Okla. C.C. Oct. 7, 2009) at 145;<sup>54</sup> *Pennsylvania Public Utilities Commission v. UGI Utilities, Inc.*, 1994 WL 843040 (Pa. PUC Sept. 23, 1994) at 5-6.

DP&L claimed that the arguments that the AIP's financial goals only benefit shareholders were "unsupported." DOB at 96. In reality, however, it is DP&L's claim of ratepayer benefits that is unsupported. The benefit to stockholders is easily identified: reduced costs equal greater profits and potentially higher dividends. What are the benefits to ratepayers of employees meeting the safety, customer service, reliability and other non-financial goals, and how does meeting them benefit ratepayers? The AIP basically requires ratepayers to pay higher compensation costs as a consequence of high corporate earnings. Ex. 13 at 35. The Commission suggested that "fewer accidents means less time missed by employees and hopefully fewer outages." *Delmarva Power*, Order No. 6930, at 47 ¶97. There is no evidence that the AIP does result in fewer accidents or outages, and savings that accrue between rate cases benefit shareholders, because rates are not adjusted in between cases to reflect such savings.

True, DP&L could pay higher salaries in lieu of an incentive plan. But that does not mean that higher salaries would be deemed reasonable. Furthermore, there is no evidence that its employees are *underpaid*; Delmarva has given employees raises every year save one in the last ten years. Ex. 20 at 24-25. It also gears its compensation packages to be at the midpoint of peer group comparisons (which includes non-regulated companies). Tr. at 203. By definition, the midpoint means that at least 49% of the peer group companies' employees earn less than their DP&L equivalents. Nor has DP&L provided any evidence that it would have difficulty attracting

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<sup>54</sup><http://imaging.occeweb.com/AP/Orders/0035DC7E.pdf>

qualified employees in the AIP's absence: Mr. Boyle was unable to identify any employee who had selected a position with DP&L *because of* the incentive plan. Tr. at 203.

In Docket No. 05-304, the Commission acknowledged that this is a difficult issue. It expressed a belief that such plans benefit ratepayers by extending the time between rate cases. *Delmarva Power*, Order No. 6930 at ¶96. That rationale no longer holds in light of DP&L's recent record of rate case filings and its stated intent to file annual rate cases. The Commission also observed that it could not examine the issue in a vacuum, but had to consider the effect of such plans on ratepayers in the context of the then-existing economic circumstances which it recognized would change. *Id.* The economic circumstances have changed: Delaware is slowly recovering from the worst financial crisis since the Great Depression. If anything, the circumstances are more dire now than in 2006, when deregulation was going to result in a nearly 60% increase in electric supply rates but the economy was better than it is today.

Stockholders clearly benefit financially from the existence of incentive programs triggered by financial goals. Ratepayer benefits are ephemeral at best. The DPA respectfully requests the Commission to affirm the HE's recommendation and find that the costs of the AIP should be borne by the primary (if not the sole) beneficiaries: the stockholders.

**D. The Commission Should Reject the HE's Recommendation to Include SERP Expenses In DP&L's Revenue Requirement.**

DP&L included \$1,101,782 of Supplemental Executive Retirement Plan ("SERP") benefits expense in its revenue requirement. SERP benefits are known as "top hat" or "excess benefit" plans; generally, the difference is that a top hat plan can have multiple broad purposes, but the sole purpose of an excess benefit plan is to avoid the limitations imposed by Internal Revenue Code §415. *Garratt v. Knowles*, 245 F.3d 941, 946 n.4 (7<sup>th</sup> Cir. 2001). PHI's SERP provides benefits to key executives *in addition to* its normal retirement programs:

The PHI 2011 Supplemental Executive Retirement Plan, or the 2011 SERP, provides retirement benefits to participating executives in addition to the benefits a participant is entitled to receive under the Pepco Holdings Retirement Plan to supplement benefits which participants forego due to certain limitations on benefit calculations imposed by the [Internal Revenue] Code. If the benefit payment that otherwise would have been available under the applicable benefit formula of the Pepco Holdings Retirement Plan is reduced due to a contribution or benefit limit imposed by law, the participant in the Pepco Holdings Retirement Plan is entitled to a compensating payment. In addition, a participant in the Pepco Holdings Retirement Plan is entitled to either or both of the following enhancements to the calculation of the participant's retirement benefit:

- the inclusion of compensation deferred under the Company's executive deferred compensation plans; and
- to the extent not permitted by the Pepco Holdings Retirement Plan, the inclusion of annual cash incentive compensation received by the participant.

Ex. 13 at 39-40, quoting PHI 2012 Proxy Statement at 44; *see* Ex. 67.

DP&L argued that including SERP benefits in its revenue requirement was consistent with Commission precedent and Delaware law. DOB at 91. The HE recommended including the SERP expense in the revenue requirement since the Commission had "relatively recent[ly]" addressed this issue in Docket No. 09-414, DP&L's arguments, and his belief that the DPA had not raised any "new compelling arguments." HER at 117, ¶301.

The DPA acknowledges that the Commission rejected its argument to exclude these expenses from the revenue requirement in Docket No. 09-414. But this Commission may change its mind on an issue "if such change will aid it in accomplishing an appointed task, since its view of what is in the public interest may change, *even if the circumstances do not.*" *Eastern Shore*, 635 A.2d at 1283. Times have changed, and the DPA respectfully submits that allowing Delmarva to include over \$1 million of expense incurred to supplement already extremely-well remunerated executives is not in the public interest.

We do not have to remind the Commission that the economy is sluggish; the customer comments in this case indicate that many of them are struggling to pay their energy bills. Contrast this to the lavish compensation that PHI's senior executives get *even before* the SERP benefits are considered:

- In 2012, Joseph Rigby, Chief Executive Officer, received more than \$11 million of total compensation: \$985,000 in base salary, \$4.7 million in stock options, \$1.19 million in non-equity incentive compensation, and more than \$200,000 of "other" compensation. (Ex. 67 at 50; Tr. at 662-63).
- In 2012, Anthony Kamerick, former Chief Financial Officer, received more than \$2.6 million of total compensation: \$513,000 in base salary, over \$650,000 in stock awards, and over \$370,000 of non-equity incentive compensation. (Ex. 67 at 50; Tr. at 664).
- In 2012, Kirk Emge, former General Counsel, received more than \$1.9 million in total compensation: \$400,000 in base salary, almost \$300,000 in non-equity incentive compensation, more than \$400,000 in stock awards, and more than \$70,000 of "other" compensation. (Ex. 67 at 50; Tr. at 665-66).
- In 2012, Frederick Boyle, current Chief Financial Officer, received almost \$1.3 million in total compensation: consisting of almost \$321,000 of base salary, more than \$233,000 of non-equity incentive compensation, over \$500,000 in stock options, and \$144,402 of "other" compensation. (Ex. 67 at 50; Tr. at 663-64).
- In 2012, David Velasquez, received total compensation of more than \$2.9 million: \$503,000 base salary, almost \$316,000 of non-equity incentive compensation, over \$640,000 of stock awards, and a \$100,000 bonus. (Ex. 67 at 50; Tr. at 664-65).
- In 2012, Kevin Fitzgerald, the new General Counsel, received over \$1.5 million of total compensation: \$159,000 of base salary, more than \$115,000 of non-equity incentive compensation, and over \$1.27 million of stock awards. (Ex. 67 at 50; Tr. at 665).

These executives also receive one or more additional "perquisites and personal benefits" that DP&L did not include in its revenue requirement, such as: a car allowance; company-paid parking; tax preparation; financial planning services; an annual executive physical; payment of certain club dues; personal use of company-leased entertainment venues and company-purchased

tickets to sporting and cultural events not otherwise used for business purposes; and reimbursement for spousal travel. Ex. 67 at 45. And remember that they also receive all of the *normal* retirement benefits that other DP&L employees receive, for which ratepayers are already paying, and which the DPA did not challenge in this case.

Other commissions have rejected arguments that SERPs help to attract and retain qualified employees, that they are common, that they are within the utility's business judgment, or that they benefit ratepayers. *See Re Yankee Gas Services Company*, 2011 WL 2816882 (Conn. DPUC June 29, 2011)<sup>55</sup> at 71-73; *Re UNS Gas, Inc.*, 2010 WL 1634233 (Ariz. C.C. Apr. 4, 2010)<sup>56</sup> at 32-34; *Public Service Company of Oklahoma, supra* at 114-15; *Re Consumers Energy Company*, 2005 WL 3617546 (Mich. PSC Dec. 22, 2005)<sup>57</sup> at 34. The Connecticut DPUC stressed that ratepayers should not be funding benefits over and above those deductible under the Internal Revenue Code, especially during difficult economic times. *Yankee Gas, supra* at 72.

These executives are already well paid. Moreover, if the Commission does accept the HE's recommendation to exclude all non-executive incentive compensation from the revenue requirement, it would seem very difficult to justify over-and-above benefits for already highly-paid executives.<sup>58</sup> The DPA respectfully suggests that this is not the signal this Commission wants to send to ratepayers in these difficult economic times. If DP&L wants to provide additional retirement benefits to these executives, shareholders should fund them. The DPA respectfully requests the Commission to reconsider its position.

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<sup>55</sup>[http://www.dpuc.state.ct.us/FINALDEC.NSF/2b40c6ef76b67c438525644800692943/e90fe40d54d3f7cf852578bf00627433/\\$FILE/101202-062911.doc](http://www.dpuc.state.ct.us/FINALDEC.NSF/2b40c6ef76b67c438525644800692943/e90fe40d54d3f7cf852578bf00627433/$FILE/101202-062911.doc)

<sup>56</sup><http://images.edocket.azcc.gov/docketpdf/0000111281.pdf>

<sup>57</sup>[http://www.dleg.state.mi.us/mpsc/orders/electric/2005/u-14347\\_12-22-2005.pdf](http://www.dleg.state.mi.us/mpsc/orders/electric/2005/u-14347_12-22-2005.pdf)

<sup>58</sup>The SERP expenses are only approximately \$800,000 less than the amount of non-executive compensation expense despite the fact that there are many more non-executive employees.

**E. The Commission Should Reject the HE's Recommendation to Accept DP&L's Claimed Medical Benefit Expense Amounts.**

DP&L is self-insured for its medical benefits costs, so its actual medical costs vary based on the amount of services required each year. Ex. 13 at 41. As it did in Docket No. 09-414, it based its proposed medical expense level on forecasts by Lake Consulting, Inc., its benefit plans consultant, for the first quarter of 2013. Ex. 5 at 14 and Sch. (JCZ)-9.1. It proposes an 8% increase for medical expense and 5% increases for both dental and vision expense. *Id.* at 14-15.

The DPA opposed this adjustment. On brief, we argued that the Lake report was hearsay and since the DP&L witness sponsoring it was not an expert in the health benefits field he could not rely on it. The HE dismissed these arguments, opining that the DPA should have made them at the hearing and had waived them by not doing so. HER at 120, n.33. He further found that 26 *Del. Admin. C.* §1001.2.13.1 permitted him to rely upon hearsay testimony “when supported by other evidence,” which he found to be the case since no one had objected to the admission of DP&L’s testimony on this issue. *Id.*

The DPA respectfully submits that the HE erred in rejecting the DPA’s legal contentions. It is true that administrative proceedings are less formal than court proceedings, and hearsay is frequently admitted (indeed, 26 *Del. Admin. C.* §1001.2.13.1, on which the HE relied, expressly provides that the Commission is not bound by the technical rules of evidence). Nevertheless, there are limits. Our courts have long held that administrative rulings cannot rest *solely* upon hearsay evidence. *See Crooks v. Draper Canning Co.*, Del. Supr., 633 A.2d 369 (table), 1993 WL 370851 (Sept. 7, 1993); *Morris v. Gillis Gilkerson, Inc.*, Del. Super., 1997 WL 819110 (Nov. 25, 1997) at \*3; *Lavelle v. Kent County Personnel Administration Board*, Del. Super., 1997 WL 719134, (Sept. 12, 1997) at \*8. The Lake report is an out of court statement offered to establish the truth of Delmarva’s claim for an increase in medical benefits cost. *Del. R. Evid.*

801(c), 803. No one from Lake testified at the evidentiary hearing. Therefore, it is hearsay. And the *only* “evidence” DP&L adduced in support of its claim was this hearsay evidence report. As a matter of law, then, the Commission may not rely on it to approve the adjustment.

Nor can the Lake report come in as hearsay on which an expert relies in forming an opinion. *Del. R. Evid.* 703. DP&L’s witness on this issue, Mr. Ziminsky, is an accountant. Based on his curriculum vitae, he has always been employed in finance and accounting. Ex. 5 at 1-2. There is nothing to suggest that he has any experience or expertise in the area of medical benefits. He cannot be considered to be an expert in the area of medical benefits, and his reliance on the Lake study is entitled to no more weight than if anyone off the street were sponsoring it. The HE’s suggestion that he could rely on this hearsay because it was supported by Mr. Ziminsky’s testimony is bootstrapping: essentially, he is saying that he can rely on Lake’s hearsay report because a witness with no experience in the medical benefits field attached it to his testimony and no one objected.

The HE rejected the DPA’s factual arguments, finding only that the Commission had “relatively recent[ly]” considered this same adjustment in Docket No. 09-414 and “no new compelling arguments” had been raised. HER at 120, ¶308.

The DPA respectfully submits that (assuming that the Commission rejects our preceding legal arguments) the Commission should reconsider its position. The DPA did raise new arguments, and they compel a different conclusion.

New argument #1: unlike the last case, the record in this case contained evidence of Delmarva’s actual experience from 2008 through 2012. That evidence showed that the four-year average increases for medical, dental and vision benefits were 4.58%, 2.33% and 9.72% respectively, and the five-year average increases were 6.61%, 1.95% and 13.17% respectively.

Ex. 20 at 31. As can be seen, its actual averages increases for medical and dental (but not vision) benefits are below the average percentage increases proposed in this case. A utility's adjustments are supposed to have some basis in its experience: that is why a test year is used. *See Artesian Water, supra*. One wonders why DP&L did not base its adjustment on its own experience.

New argument #2: this is essentially an inflation adjustment, and the Commission has rejected inflation adjustments in the past. *See Delmarva Power*, Docket No. 91-20, Order No. 3369 at ¶¶139, 142.

The DPA also argued that this study provides *no* data specific to Delmarva (or even to PHI). Rather, it is based on "trends" in medical premiums by several major insurance companies. Ex. 13 at 41; Ex. 5 at Sch. (JCZ)-9.1. The use of "trends" does not rise to the level of a reasonably known and measurable change. Ex. 13 at 41. The attached PricewaterhouseCoopers ("PwC") report on 2013 medical cost "trends"<sup>59</sup> shows different medical costs trends. We are not suggesting that PwC is correct and Lake is incorrect; all we *are* suggesting is that there are different opinions on "trends" in medical costs.

Furthermore, the Lake study is based on a crabbed definition of the "mid-Atlantic" region: it only looked at Virginia, Maryland and the District of Columbia. There is no information in the study about the trends in medical costs in *Delaware*, where DP&L is located and which is a mid-Atlantic state. Nor is there any information about Pennsylvania or New Jersey, which are also "mid-Atlantic" states.

The Lake study is hearsay and cannot form the sole basis of the Commission's decision, and there is no other evidence to support DP&L's adjustment. The witness sponsoring the adjustment is not an expert in the medical benefits field. Even if the Lake study could serve as

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<sup>59</sup>The DPA attached this report to its brief to the HE. We did not submit it for its truth, but merely to show that there are different opinions on "trends" in medical insurance costs.

the basis for a Commission decision, it is no more worthy of reliance than any other study documenting purported medical cost trends: it is not specific to DP&L or even to Delaware. DP&L has not established that its proffered cost increases are reasonably known and measurable. The DPA respectfully asks the Commission to reconsider its position and reject this adjustment.

## V. REVENUE DISTRIBUTION

### A. The HE's Recommendation Not to Apply Gradualism Is Unsupported By Any Analysis and Should Be Rejected.

The DPA argued that DP&L's proposed rate design was unjust and unreasonable for residential customers and that gradualism should be applied in light of the recent rate increases that they have experienced. DPA AB at 153-56. The HE disagreed: "Unlike past situations involving Delmarva and other Delaware utilities, based on the rate increases described above which, including the interim rates in this case, total \$13.48 per month for the average residential user since January 2011 (including charges for legislative enactments), I recommend that the Commission not employ gradualism in this case." HER at 133, ¶348. He also characterizes the DPA's argument in favor of gradualism as "warrant[ing] that residential ratepayers pay less than 100% of the rates approved in this case." *Id.* at 133, ¶346.

The DPA respectfully submits that the HE misunderstood the DPA's argument and provided no basis for his recommendation to reject applying the principle of gradualism. The DPA never suggested that residential ratepayers should pay less than 100% of any rate increase approved, and indeed the HE cites nothing in support of that assertion. Residential ratepayers will pay whatever portion of the revenue requirement they are assigned.

Designing rates and distributing revenue requirement requires a balance between just, fair and reasonable rates (codified at 26 *Del. C.* §311) and policy goals, such as: (1) protection from rate shock; (2) rate continuity; (3) rates informed by, but not based solely on, cost allocation; and

(4) customer understanding. Ex. 14 at 37-38. The weight assigned to any of these can change depending on the circumstances and the importance of the policy. In Docket No. 05-304 the Commission emphasized gradualism because it believed customers would experience substantial rate shock as a result of expiring price caps on supply rates becoming effective at the same time as the distribution rates. *Delmarva Power*, Order No. 6930 at ¶¶289, 298. The Commission approved a two-step revenue distribution that: (1) determined specific class revenue goals for the classes targeted to receive rate increases to move them closer to their required class returns; and (2) decreased rates based on scaling back DP&L's claimed cost-based class revenue requirements for those classes proportionately. *Id.* at ¶¶277-278, 289, 298. The Commission set customer charges halfway between the current customer charge and DP&L's proposed customer charge to move those charges toward cost of service while limiting the rate impacts that would have resulted from DP&L's proposed rate design. The residual revenue requirement for classes with demand charges was assigned to the demand charges so that no class' demand charge would increase, and any remaining revenue requirement was assigned to the energy charge. *Id.*<sup>60</sup>

Here, DP&L proposed to distribute the revenue increase across the classes by: (1) moving each class rate of return toward or within a "reasonable band" (0.90-1.10) of the overall system rate of return; and (2) allocating the remaining revenue increase to all classes equally based on their current distribution revenue as a percentage of total distribution revenue. Ex. 6 at 4; Ex. 14 at 41, citing DP&L's response to AG-RD-25. Under its proposal, the largest rate increase any service classification would receive was 1.5 times the overall percentage increase. Ex. 6 at 4. Any remaining portion of the class' revenue requirement would be recovered through the energy

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<sup>60</sup>The Commission did not specifically address rate design in DP&L's two prior rate cases, Docket Nos. 11-528 and 09-414; it approved stipulations in both in which the settling parties agreed to a distribution of the approved revenue increase across all customer classes except GS-T on an equal percentage basis. *Delmarva Power*, Order No. 8265 at 30; *Delmarva Power*, Order No. 7897 at Ex. A, pp. 4-5.

charge; however, for classes that also have a demand charge, DP&L would recover the entire remaining revenue requirement through the demand charge. Ex. 6 at Sch. (MCS)-1.

DP&L's proposal disproportionately affects residential customers. Currently, the typical residential bill for delivery service only is \$39.01; under Delmarva's proposal it will increase to \$46.64 – a \$7.63 (almost 20%) increase. Tr. at 864-65. That increase is driven by an even larger residential customer charge increase: the current charge is \$9.35/ month, but DP&L's proposal will increase it to \$13.98 – a \$4.63 (almost 50%) increase. *Id.* at 865. DP&L's proposed monthly residential customer charge is higher than those of 16 other utilities in this general geographic area of the Atlantic region,<sup>61</sup> and higher than those utilities' average residential customer charge.<sup>62</sup> Ex. 14 at Sch. DED-16. And although its proposed \$12.54 small commercial customer charge is lower than the average small commercial monthly customer charge for those regional utilities, 55% of them have lower actual customer charges than Delmarva proposes. *Id.* at 45 and Sch. DED-16. The HE addressed none of these undisputed facts.

DPA witness Dismukes recommended a revenue distribution similar to the two-step methodology approved in Docket No. 11-528. Step 1 limited the increase to any underearning class to 1.15 times the system average increase; step 2 distributed any remaining revenue deficiency across all other classes in proportion to their test year revenues. Ex. 14 at 43 and Sch. DED-13. He testified that this approach was consistent with the overall allocation of the rate increase to underearning classes, but was tempered by allocating a share of the proposed increase to the overearning classes. *Id.* at 43. Costs not recovered through the customer charge are

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<sup>61</sup>The U.S. Census Bureau defines the Atlantic region as New York, Pennsylvania, New Jersey, Maryland, Delaware, the District of Columbia, West Virginia, North Carolina, South Carolina, Virginia, Georgia and Florida. (Ex. 14 at Sch. DED-16).

<sup>62</sup>The average includes high monthly customer charges for six New York utilities (over \$15/month) and very low customer charges for four New Jersey utilities (less than \$4/month). Ex. 14 at Sch. DED-16.

recovered through the energy charge. The increase is allocated equally between the demand charge and the delivery service rate for classes having both. *Id.* at 47-48 and Sch. DED-15.

The Public Utilities Act specifically provides that “[n]o public utility shall make, impose or exact any unjust or unreasonable ... individual or joint rate for any product of service supplied or rendered by it within the State ... .” 26 *Del. C.* §303(a). The DPA submits that DP&L’s proposed rate design is unjust and unreasonable to residential ratepayers, and that the HE erred in rejecting the DPA’s proposed rate design, which incorporates the principle of gradualism to ease the effect of this rate increase on residential and small commercial ratepayers.

The DPA agrees with DP&L that on a strict cost basis, neither the current nor the proposed residential or small commercial customer charges recover all the costs assigned to those classes. Ex. 14 at 46 and Sch. DED-17. But that is not the be-all and end-all; costs can be instructive for rate setting, but they need not (and perhaps should not) be the sole basis for setting optimal rates. Fixed charges need not strictly equal fixed costs, and variable rates need not strictly equal variable costs). Ex. 14 at 45. Unfortunately, “the ‘fixed charge-equals-fixed-cost’ dogma gets repeated so often that it can often drown out meaningful discussions about other equally important considerations in setting rates in imperfect markets.” *Id.* at 45-46.

DP&L’s rate design seeks to eliminate subsidization. In a vacuum, the DPA would agree - but we are *not* in a vacuum. The real world effect of DP&L’s proposed revenue distribution is that the average residential customer will experience a 21% rate increase and the average residential space heating customer will experience a 35% increase, thus making residential customers responsible for *almost 65%* of DP&L’s revenue requirement. Ex. 14 at 43, citing Ex. 6 at Sch. (MCS)-1. DP&L did not dispute this; it merely responded that its proposal “better serves

the ultimate goal of designing a rate that appropriately reflects customer costs,” is consistent with its submissions in prior dockets, and is “reasonable and practical.” Ex. 21 at 4; DOB at 110.

If there was ever a time to apply the principle of gradualism, it is now. The economy is sluggish at best. Delaware ratepayers are struggling to make ends meet. DP&L ratepayers have seen their rates increase by 38% in just three years. Tr. at 256. In Docket No. 09-414, the Commission granted DP&L a \$16.7 million revenue increase that raised the average residential customer’s bill by \$3.69 per month (Order No. 7897 dated Jan. 18, 2011); in Docket No. 11-528 it granted a \$22 million revenue increase that raised the average residential customer’s bill by \$4.49 per month (Order No. 8267); and the \$27.7 million interim rate increase raised the average residential customer’s bill by \$5.36 per month. (Order No. 8566). In addition, approximately 120,000 of DP&L’s electric customers are also DP&L natural gas customers, and in Docket No. 12-546 DP&L received a \$6.8 million revenue increase that raised the average residential customer’s bill by \$5.34 per month. (Order No. 8465). Thus, DP&L’s electric ratepayers have experienced an almost \$14 per month increase in three years; if they are also Delmarva natural gas customers, they have experienced an almost \$20 per month increase in that same time.

The Commission has recognized that it cannot consider the effect of certain operating expense adjustments in a vacuum but must consider their effect in light of current economic circumstances, which change from time to time. *Delmarva Power*, Order No. 6930 at ¶96. This observation holds true for revenue distribution as well. The DPA submits that trying to move all classes to cost in one fell swoop in this case is unjust and unreasonable because so doing requires residential ratepayers to shoulder 65% of the requested revenue requirement. DP&L’s proposed revenue distribution should be rejected in favor of the DPA’s, which also moves the classes

closer to their actual cost of service but does so more gradually in light of current economic circumstances.

### CONCLUSION

Based on the foregoing arguments and authorities, the DPA respectfully requests the Commission to reject the HE's findings and recommendations as discussed herein, and to approve the findings and recommendations that the DPA has not addressed herein.

Respectfully submitted,

/s/ Regina A. Iorii

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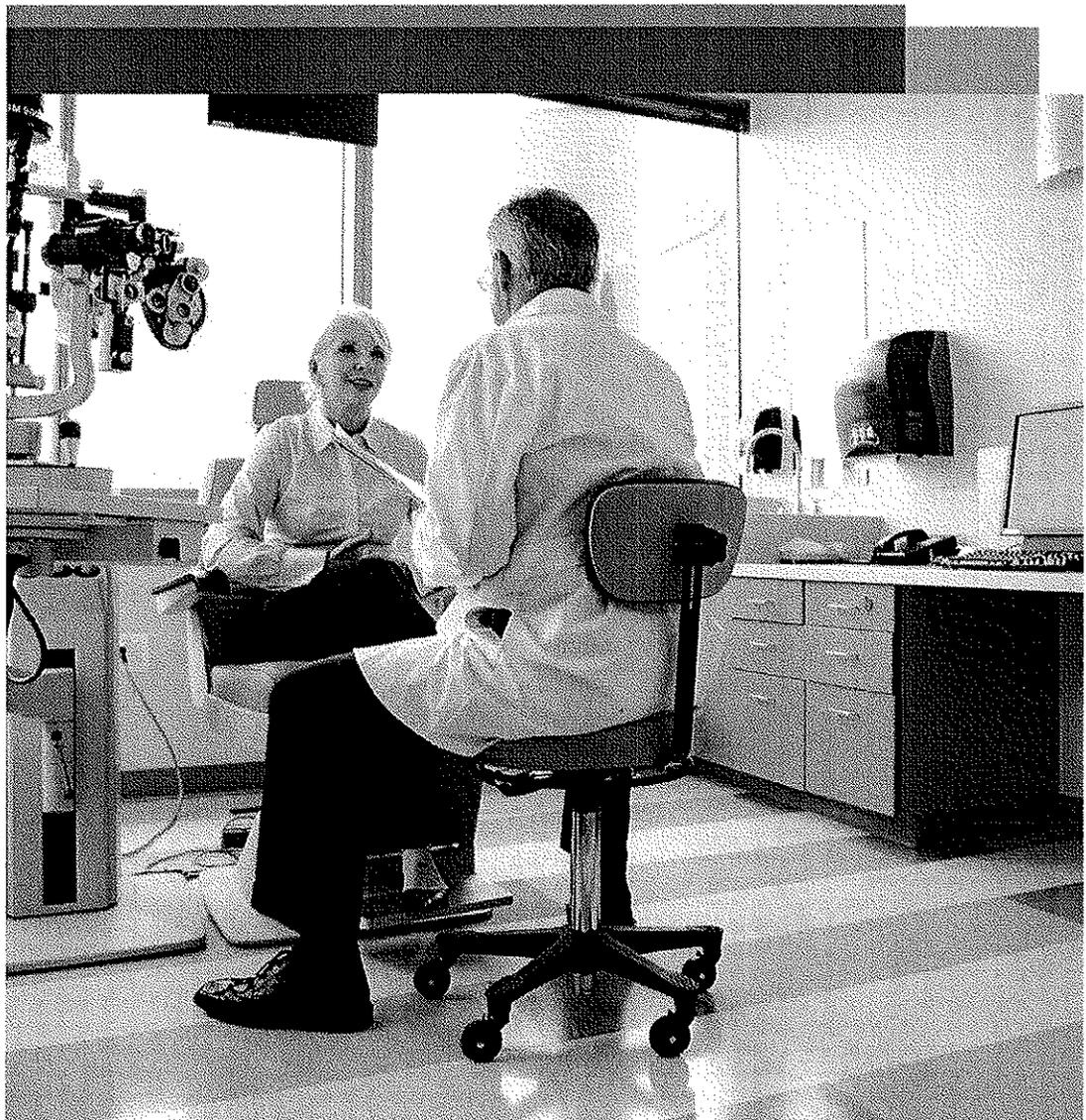
Dated: March 17, 2014

# **ATTACHMENT 1**

# ***Medical Cost Trend:*** Behind the Numbers 2014

*June 2013*

Health Research Institute



**pwc**

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### ***The heart of the matter***

Defying historical patterns—and placing added tension on the health industry—medical cost trend in 2014 will dip even lower than in 2013. Aggressive and creative steps by employers, new venues and models for delivering care, and elements of the Affordable Care Act (ACA) are expected to exert continued downward pressure on the health sector.

Medical cost trend measures spending growth in healthcare services and products—a key ingredient in setting the coming year’s insurance premiums. For 2014, PwC’s Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

For an industry that until recently had consistently seen double-digit growth, the ongoing slowdown poses immediate financial challenges. At the same time, the imperative to do more with less has paved the way for a true transformation of the health ecosystem, from fee-for-service medicine to consumer-centered care that rewards quality outcomes.

Great uncertainty hangs over 2014, the watershed year for ACA implementation. Millions more Americans are expected to gain coverage through Medicaid or new online marketplaces. No one knows exactly who will enroll, what their medical needs will be, or how the industry will manage them. But none of these changes will likely directly affect the medical cost trend. Total spending will rise with the cost of caring for the newly insured, but the rate of growth, which is based on unit cost, should remain at some of the lowest levels since the government began measuring national health expenditures in 1960.

Even so, the headlines will be dominated by news of insurance premium increases, primarily in the individual market. The seeming contradiction between rising premium rates and slow spending growth can be explained by how the health system manages risk and uncertainty. When faced with covering a newly insured, largely unknown population, health plans sometimes increase premiums to guard against financial risks.

Industry executives, policymakers, and academics continue to debate whether the nation is finally reining in healthcare costs or just experiencing a temporary respite from skyrocketing growth rates. Historically, medical inflation jumps after the nation recovers from a recession. But changes in how the industry operates and how average consumers choose healthcare appear to be having a more sustained effect.

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### ***An in-depth discussion***

For 2014, PwC's Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI projects a net growth rate of 4.5%.

## ***Executive summary***

Healthcare organizations, hurt by a squeeze on reimbursements and what might best be described as a recession “hangover,” have spent the past few years adapting to more modest growth rates. The industry will continue those efforts in 2014, including pushing care to locations and personnel that cost less.

The tepid economic recovery continues to impact the health sector. The slowdown—and even decline—in personal wealth has tamped down demand for healthcare. As we reported a year ago, the sluggish recovery has created a “new normal” in healthcare spending patterns.

Individual consumers, bearing more financial responsibility for their medical bills, are questioning and sometimes delaying procedures, imaging, and elective services. New delivery models, such as accountable care organizations (ACOs) are promising, but their prospects for significant savings remain largely unproven.

The ACA will also play a role in the slowdown in 2014, with hospitals working to hold down expensive readmissions (or face the law’s penalties) and employers being given greater power to influence employee behavior through increased or discounted premiums—up to 50% in some cases.

Each year, HRI issues its projection for the following year’s medical cost trend based on activity in the market that

serves employer-based insurance. For its 2014 projection, HRI interviewed industry executives, health policy experts and health plan actuaries, whose companies cover a combined 95 million members. In this year’s report, we identified:

### ***Four factors deflate medical cost trend in 2014***

- Care continues to move outside costly settings such as hospitals to more affordable retail clinics and mobile health. Consumers value the convenience, and costs can be as little as one-third of the bill in a traditional healthcare site.
- Major employers such as Walmart, Boeing, and Lowe’s now contract directly with big-name health systems for costly, complicated procedures such as heart surgery and spinal fusion. The employers are making the move to “high-performance networks” far away from the home office in the belief that even with travel costs, these networks still deliver overall savings.
- The federal government’s new readmission penalties take direct aim at waste in the health system, estimated to be as high as 30%. According to government data, hospital readmissions dropped by nearly 70,000 in 2012, and this trend is expected to accelerate through 2014 as hospitals focus on discharge planning, compliance and the continuum of care.<sup>1</sup>

- Seventeen percent of employers in PwC’s 2013 Touchstone Survey today offer a high deductible health plan as the only option for employees. And more than 44% are considering offering it as the only option. When consumers pay more for their healthcare, they often make more cost-conscious choices.

### ***Two factors inflate medical cost trend in 2014***

- Until recently, widespread adoption of generic medicines helped dampen overall medical inflation, but the rise of expensive complex biologics will nudge spending trends upward. Approvals of new biologics now outpace traditional therapies, and that pattern will continue in 2014 as research efforts target complex cases such as cancer.
- Health industry consolidation has increased more than 50% since 2009—activity that is expected to continue through 2014.<sup>2</sup> Higher prices are sure to follow in some markets. According to a recent report, hospital mergers can lead to price increases of up to 20%.<sup>3</sup> These price increases are especially acute in markets with one dominant system.

### ***What this means for your business***

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

## Medical cost trend in 2014

PwC's Health Research Institute (HRI) projects that 2014 medical cost trend will be 6.5%—a full percentage point lower than our estimate of 7.5% for 2013.<sup>4</sup> This projection is based on data analysis of medical costs in the large employer market, which covers about 150 million Americans.

The net growth rate, after accounting for benefit design changes such as higher deductibles, will be about 4.5%. In recent years, adjustments to employer benefit plans have helped to reduce benefit cost increases by 1.5 to 2 percentage points by shifting some expenses onto workers and implementing incentives for employees to be more cost-conscious consumers.

The historically low medical cost trend for 2014 did not occur overnight. Utilization of many medical services

slowed over the past decade, as consumers made fewer visits to the doctor's office, postponed procedures, cut back on medications, and reconsidered imaging and elective surgeries. First quarter results for publicly-traded hospitals in 2013 reported a decline in demand for services.<sup>5</sup>

PwC's 2013 Touchstone Survey of large US employers confirms that businesses are increasing cost sharing and plan to continue using that strategy to moderate spending growth. Between 2009 and 2013, emergency room copayments were up 50%, while prescription drug copayments for specialty drugs increased 94%. The average deductible for in-network services is now more than \$1,000, and out-of-network services is more than \$2,000 (see Figure 1).

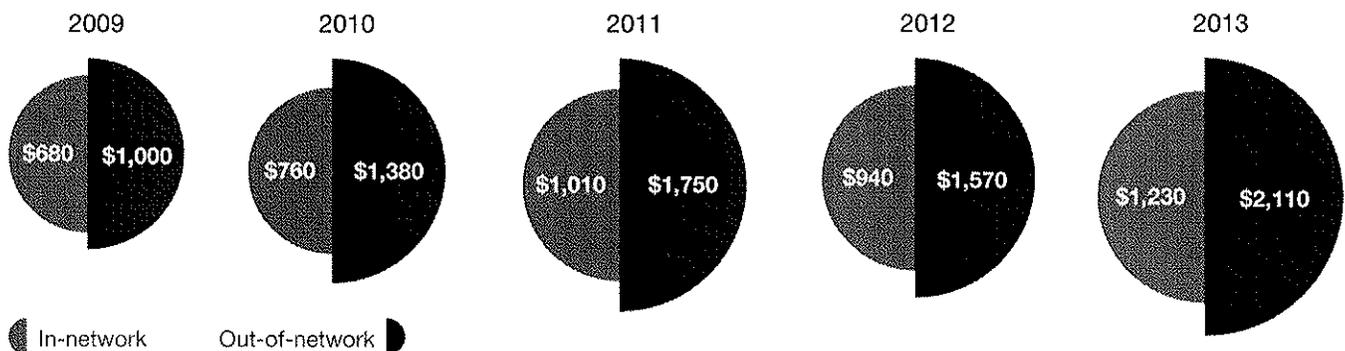
### What is medical cost trend?

Medical cost trend could be defined in several ways; for this report, medical cost trend is the projected increase in costs of medical services assumed in setting health insurance premiums for commercial insurers and large, self-insured businesses. Medical cost trend is the projected percentage increase in the cost to treat patients, or the healthcare spending growth rate. The projection is used by insurance companies to calculate health plan premiums for the coming year. For example, a 10% trend means that a plan that costs \$10,000 per employee this year would cost \$11,000 the following year. The cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services, known as unit cost inflation
- Changes in the number of services used, or per capita utilization increases

Figure 1. Average deductibles for in and out-of-network visits are increasing\*

### In-network and out-of-network deductibles



Source: PwC 2013 Health and Well-Being Touchstone Survey

\* Calculations are based on employee health plans with a deductible

## Factors affecting 2014 trend

New care venues, high-performance networks, lower hospital readmissions, and high deductible plans deflate cost trends

### Convenient care is cost-efficient care

Healthcare will continue to move out of hospital and physician offices in 2014. More care will be delivered via the Internet and in locations such as retail centers, a trend fuelled by the rise of cost sharing, the arrival of millions of newly insured patients, and a growing demand for convenience. The new care venues are not only consumer-friendly, but also less expensive. Gaining in popularity, these will slow the rise in medical costs next year.

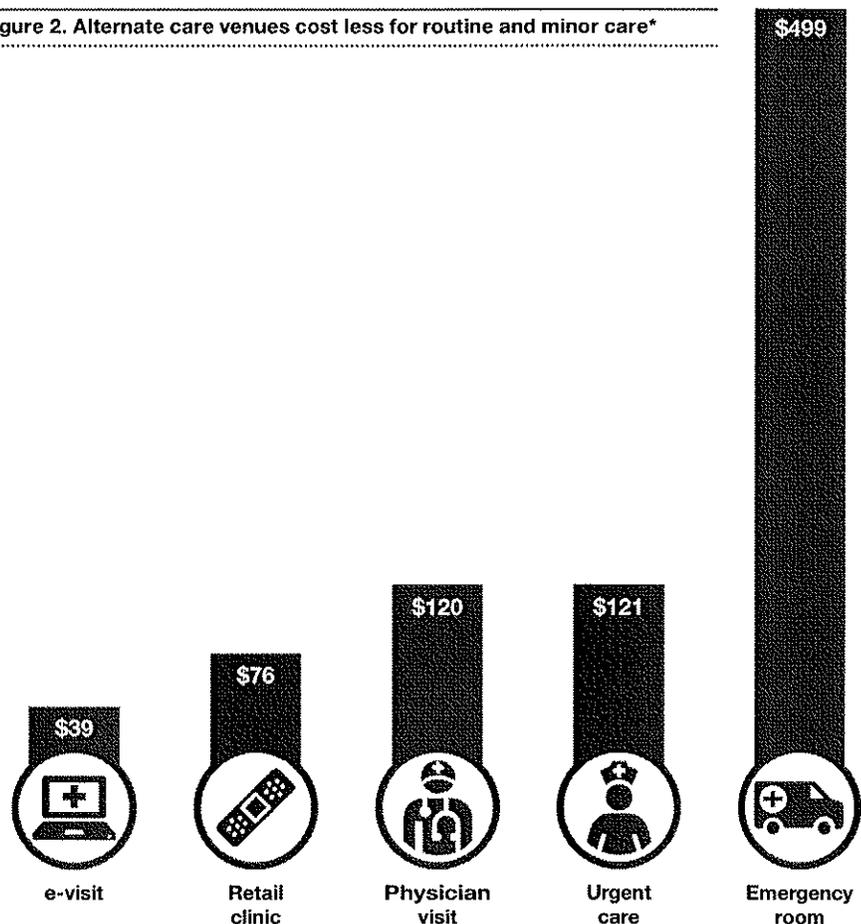
Consumer use of retail clinics nearly tripled over the last five years, according to an HRI survey of more than 1,000 consumers conducted in late 2012. In 2007, 9.7% of consumers had visited a clinic; in 2012, 24% had. Virtual visits also can be consumer-friendly and lower-priced. One industry analysis projects telemedicine visits will grow 55% in 2013.<sup>6</sup>

HRI's analysis of cost of care for simple conditions such as sinusitis or colds shows that these visits in emergency rooms cost almost seven times more than retail clinics and 13 times more than e-visits (see Figure 2).<sup>8</sup> In one calculation of potential savings, HealthPartners, a non-profit insurer based in Minnesota, reported an average savings of \$88 per episode in online clinics versus traditional clinics. Customer satisfaction was also high.<sup>7</sup>

As consumers seek more convenient care, businesses such as Walgreens are responding by offering more sophisticated services, such as chronic health management, in their retail clinics. The clinics will assess a person's chronic condition and guide treatment and management of the illness. With more than half of the nation's population expected to have at least one chronic condition by 2020, the market potential is phenomenal.<sup>9</sup> Chronic illnesses represent 75% of healthcare spending today.<sup>10</sup>

Mary Grealy, president of the Healthcare Leadership Council, a Washington, DC-based membership organization for health executives, is "seeing more members pushing full speed ahead to offer more healthcare services in retail clinics and on-site employer clinics to keep employees out of the emergency room and lower costs."

Figure 2. Alternate care venues cost less for routine and minor care\*



Source: PwC Health Research Institute

\* Minor illnesses include sinusitis, urinary tract infections, common cold, or flu.

## ***High performance- networks deliver more***

Faced with high medical bills, employers are combing the country for doctors and hospitals that can provide high-quality care at a lower price. These newly-formed groups of providers, known as high-performance networks, often specialize in high-cost or high-risk procedures such as heart surgery or transplants. The use of high-performance networks is still in its infancy, but early data suggest the savings range from 10–25% off the total cost.<sup>11</sup>

With money and employee productivity at stake, employers have started to contract directly with providers. This is especially true of large employers that are self-insured and bear the financial risk for their workers' health costs (see Figure 3). For example, Lowe's has chosen Cleveland Clinic for heart surgery. The care is provided for a flat fee, and Lowe's covers all travel expenses.

"We have had good success with the program. The outcomes are good, service is world class, and 98% of those who have used the program are very satisfied," said Randy Moon, vice president of international human resources and benefits at Lowe's. "Costs per episode have been cheaper because of the bundled payment model and Cleveland Clinic's coverage of any follow up treatment. We are now considering offering similar programs for other health situations at Cleveland, as well as utilizing centers of excellence that are more regionally-based."

These "centers of excellence" have such strong quality scores and competitive pricing that the cost of travel is easily recouped, proponents say. Expect to see more large employers embark on this path, helping slow medical inflation.

"Large employers are the vanguard, and they see the value in high quality at a lower cost. That's why a few of the larger companies are pursuing these

## ***Adding confusion to a complicated year, premiums may rise in the individual market***

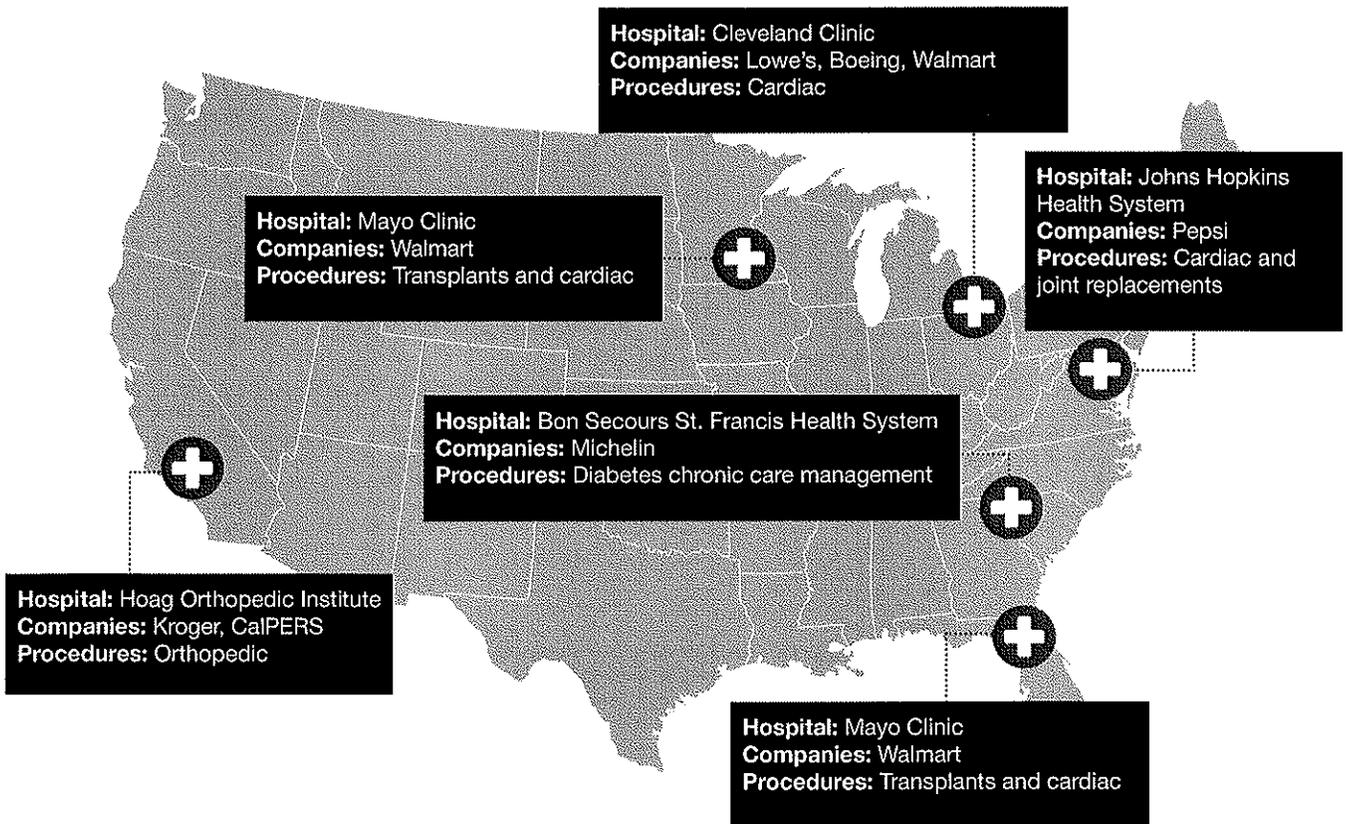
The scope of this research is limited to trends in the large employer market. However, premium costs will generate headlines and likely confuse the public with seemingly contrary signals. A decrease in the overall growth rate does not mean automatic decreases in premiums, particularly those in the individual market. Premium increases tend to be highly variable and depend on many factors such as region, age, and types of plans. When setting premiums, insurers must try to forecast the risk profile of the members—and their medical needs.

In 2014, there will be a new force pushing apart premiums and medical cost trend—the ACA. The law requires virtually every American to have health insurance coverage. Many of the newly insured will participate in new online marketplaces known as exchanges. Insurers face the uncertainty of who will enroll—the sick, the healthy or a combination of the two. A plan dominated by severely ill patients could wipe out reserves; healthier members would help spread the financial risk.

"When there is uncertainty, along comes conservatism," Mark D. Birdwhistell, vice president, administration and external affairs for the UK HealthCare in Lexington, Kentucky, said in an interview. "Health plans will have to accommodate for that uncertainty through increases in premiums to ensure they have all bases covered."

**Figure 3. Large employers partner with providers for specialized services**

*Large employers such as Lowe's and Walmart are partnering directly with hospitals to provide services. Many of these are bundled payments for procedures such as heart surgeries or knee replacements. Some employers pay all related travel costs as well as waive deductibles.*



Source: PwC Health Research Institute<sup>12,13,14,15,16,17,18</sup>

specialized networks directly with health systems,” said Helen Darling, president and CEO of the National Business Group on Health.

In 2012, grocery chain Kroger, signed an agreement with Hoag Orthopedic Institute in Irvine, California and several other hospitals for hip, knee, and spinal fusion surgeries. Employees pay 10 % out of pocket if they choose one of the 19 selected hospitals, compared to 25 % to 50 % for centers not on the list.<sup>19</sup> In 2012, 8% of Kroger employees chose the high-performing

hospitals for surgery, exceeding its goal of 6% utilization. Total costs were 25.5% less for surgeries, and patients using the facilities had no reported readmissions.<sup>20</sup>

The UK HealthCare has built a “virtual high-performance network” in which specialists travel to rural clinics to deliver care for complex cases such as cancer and transplants. “The approach reduces duplication of tests and standardizes treatment, two major cost savers,” said Birdwhistell.

## Readmissions ratchet down

According to the Centers for Medicare and Medicaid Services (CMS), 30-day hospital readmissions for Medicare beneficiaries had been stuck at about 19% for years when the ACA imposed penalties for high readmissions in late 2012. Almost immediately, the rate fell to an average of 18.4%. Even so, more than 2,200 hospitals (two-thirds of US facilities) will face penalties for unacceptably high rates in 2013.<sup>22</sup>

With the penalties set to increase and the public focusing on patient safety, hospitals will act aggressively in 2014 to ensure patients don't require a return trip (see Figure 4). As this activity spreads, it will push down medical cost trend.

Reducing hospital readmissions not only improves care, but it also significantly reduces the cost of

treating hospital-related problems such as infections, falls, and poorly managed follow-up. The cost of readmissions for Medicare patients alone is \$26 billion annually.<sup>23</sup>

The ACA encourages hospitals to get treatment right the first time. The estimated savings from better care is \$630 million in 2014, increasing to more than \$1 billion in 2015.<sup>24</sup>

Some analysts caution that hospitals can record a decline in readmissions if more care is billed as "observational," but many healthcare executives say they are focused on true improvements to care. According to a recent survey, 69% of hospitals had a readmissions reduction program in place. Eighty percent of the hospitals without a program reported that they plan to launch one this year.<sup>25</sup>

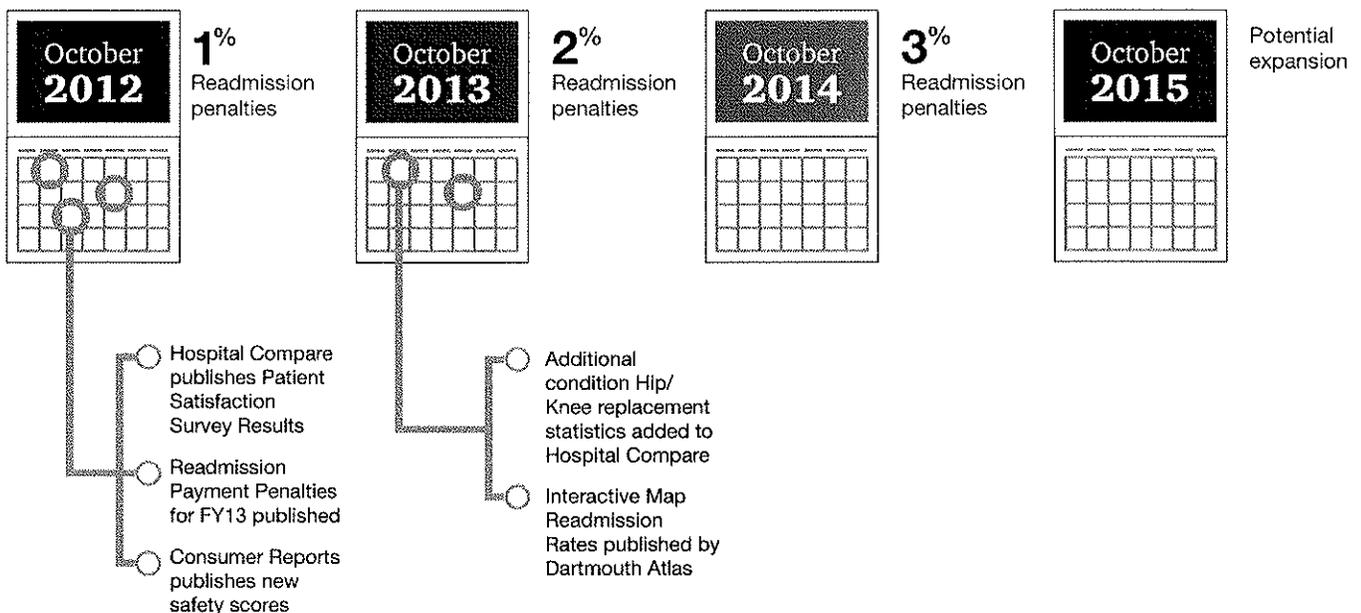
This response is not just about avoiding penalties. An increase in media coverage of readmissions shows the topic is capturing the public's attention and may amplify financial penalties through reputational risk.

Hospitals are not alone in the push to reduce costly readmissions. Insurance giant Cigna, for example, provides hospitals with data to identify patients at risk for readmission. Early identification means doctors and nurses can pay special attention to the risk factors most likely to trigger a return to the hospital.

Many healthcare systems are also creating plans for better follow-up after discharge. Some are even partnering with skilled nursing facilities and home health services.

Figure 4. Hospital readmission penalties increase along with publicly reported results

## Hospital readmissions timeline and highlights of consumer ratings



Source: PwC Health Research Institute<sup>26,27,28,29,30</sup>

## High-deductible going mainstream

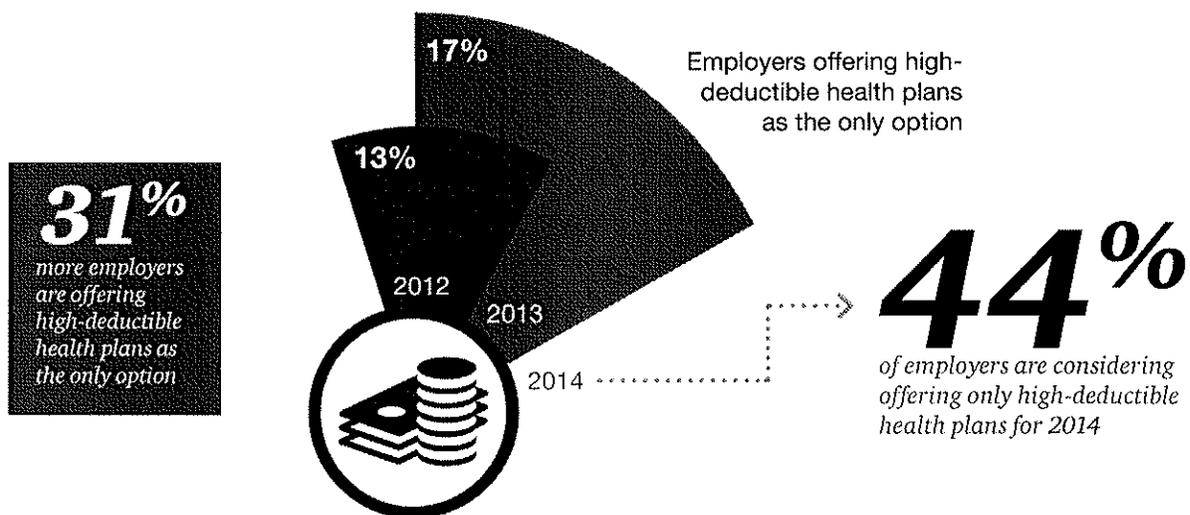
Consumer-driven health plans—insurance coverage with a high-deductible—are set to go mainstream in 2014. According to the 2013 PwC Touchstone Survey of major US companies, 44% of employers are considering offering high-deductible health plans as the only benefit option to their employees in 2014. Already, 17% of employers offer high-deductible plans as their only option in 2013, a 31% increase over 2012 (see Figure 5).

While medical cost trend does not take into account specific changes in benefit structure, shifts in design ultimately influence consumer behavior, which in turn impacts medical spending and cost patterns. High-deductible health plans, which place greater responsibility on consumers, are designed to promote cost-conscious decisions. A recent study reported families that switched

from a traditional health plan to a high-deductible plan spent an average of 21% less on healthcare in the first year.<sup>31</sup> If 50% of workers with employer-sponsored programs chose high-deductible plans, healthcare spending could be reduced by about \$57 billion, or a 4% decline in total healthcare costs, according to a study in the journal *Health Affairs*.<sup>32</sup>

The ACA, with its new insurance marketplaces, accelerates the move to consumer-driven plans. In 2014, an estimated 12 million consumers will choose a health plan in the new insurance exchanges.<sup>33</sup> HRI demographic analysis and consumer interviews indicate this will be a price-sensitive customer group. Many of the newly insured say they are willing to accept plan features such as higher deductibles in return for lower monthly premiums—as found in the new bronze and silver plans.

Figure 5. High-deductible health plans are becoming more prevalent for employers



Source: PwC 2013 Health and Well-Being Touchstone Survey

**Specialty drug costs cancel out generic drug savings**

The growth rate in drug spending has been declining for years due to the widespread adoption of generic medications. But that is about to change. First-time generic approvals peaked in 2012 with generic versions of medications such as Plavix, Singulair, and Lexapro.<sup>34</sup>

Although generic drug use will remain high, there will be fewer new ones entering the market. And there will be a major counterweight to the spending trajectory—an increase in the use of complex, expensive specialty drugs.<sup>35</sup>

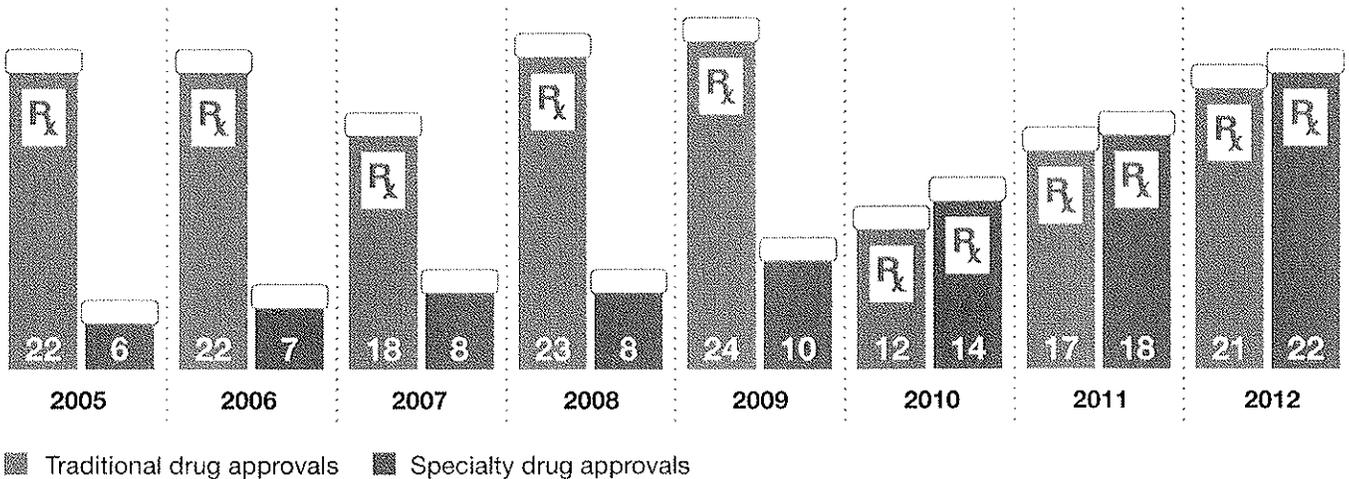
Greater understanding of the molecular and genetic basis of disease has promoted development of sophisticated new medications for chronic illnesses such as multiple sclerosis, rheumatoid arthritis, and cancer. In 2005, 21% of new drug approvals by the U.S. Food and Drug Administration (FDA) were for specialty medications. By 2012, these therapies accounted for over half of approvals (see Figure 6). The pace is expected to quicken in 2014, with specialty drugs poised to account for up to 60% of new approvals and seven of the top 10 best-selling therapies.<sup>36</sup>

The numbers illustrate why prescription spending is poised to nudge medical cost trend up. Specialty drugs—biologics made from living organisms—are more complex than many traditional therapies and have a much higher average cost. Spending on specialty drugs increased 18% in 2012 and is expected to rise by 22% in 2014.<sup>37</sup> The drugs are projected to hit 45% of US prescription sales volume by 2017.<sup>38</sup>

Figure 6. FDA approvals of specialty drugs rising rapidly

**Specialty drug costs cancel out generic drug savings**

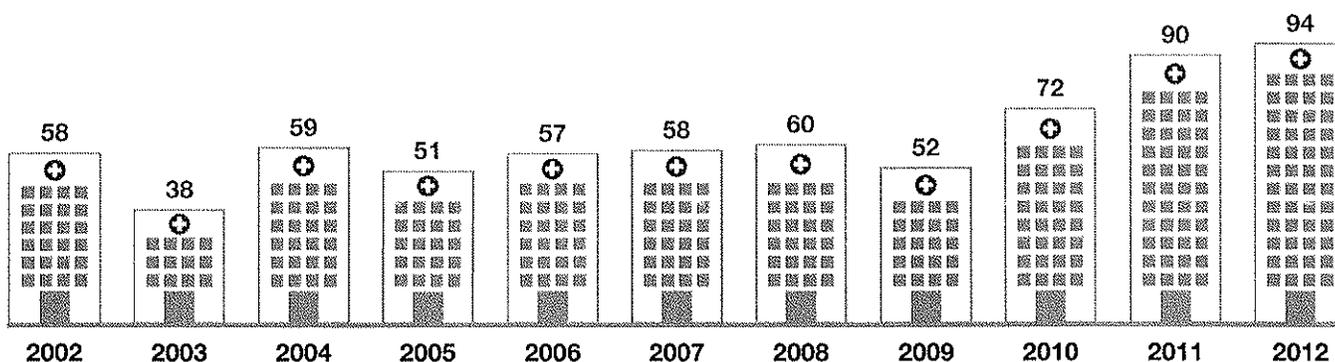
2010 was the first year specialty drug FDA approvals were higher than traditional drug approvals. This trend is expected to continue into 2014, with specialty drugs poised to account for up to 60% of new approvals.



Source: FDA, PwC Health Research Institute

Figure 7. Hospital deals on the rise

### Industry consolidation can lead to higher prices



Source: Irving Levin Associates

#### Industry consolidation can lead to higher prices

Hospital merger and acquisition activity has increased nearly 50 % since 2009, reaching its highest point in the last 10 years—even surpassing the number of deals seen at the height of the 1990’s merger craze (see Figure 7). The activity shows no sign of abating in 2014. Over half of hospitals plan to acquire physician practices in 2014, compared to 44% in 2012, according to one industry survey.<sup>39</sup> And the data understate the volume of activity happening through affiliations and joint ventures.

With consolidation, higher prices often follow. Studies have shown that hospital mergers in concentrated markets can increase prices by more than 20%.<sup>40</sup> Insurance companies contract with hospitals for services, and they are often the first to experience price changes.

Despite the economies of scale that consolidation offers, many insurance companies report an immediate increase in hospital rates. Often the new entity adopts the higher payment rates of the two. Some smaller, independent hospitals have used the mere specter of consolidation with a larger hospital to negotiate better payment.

Physician employment can also increase prices. When physician groups join a hospital system, a “facility fee” is typically added for procedures performed in a hospital or surgery center. The result—overall costs are greater than if the same procedure were conducted in the physician’s office.

Higher prices associated with hospital consolidation can trigger increased government action. In Massachusetts, one-third of hospitals have merged, acquired, or partnered with another

system in the past three years, and prices have remained among the highest in the nation.<sup>41</sup> In response, the legislature has enacted laws that peg health spending to economic growth and increased price transparency.

The promise of provider consolidation is that it can improve efficiency by both eliminating duplication and by delivering integrated care supported by a larger organization with more resources. But it also can lead to increased market power and higher prices. “They aren’t taking the waste out of these systems fast enough,” Darling, of the National Business Group on Health, told HRI.

## ***Early hints of promise from accountable care organizations***

Some ideas need time to mature. Accountable care organizations (ACOs) have big ambitions—to lift quality, hold down costs, and create happy customers. Hopes are high that these new groups can curb healthcare spending too, though it may be years until the evidence is in. Although some say they resemble HMOs from the 1980's, they are different because they are physician- and hospital-led.

Hundreds of hospitals, physician groups, and insurers are assembling into ACOs, trying to capture savings generated by better—and better-coordinated—care. Providers such as Baylor Health Care System and Advocate Health Care are developing their own ACOs, as are insurers such as Highmark and Aetna. Cigna has committed to forming 100 ACOs by the end of 2014.

The Centers for Medicare and Medicaid Services (CMS) has approved more than 250 Medicare ACOs, serving more than 4 million beneficiaries. During a U.S. Senate Finance Committee hearing this spring, CMS chief Marilyn Tavenner called the programs “one of the Affordable Care Act’s key reforms to improve delivery of care.”

Early data from a federal pilot program of Medicare patients point to modest savings. The pilot, formally known as the Physician Group Practice Demonstration, saved \$137 million over five years across 10 participating physician groups, an average of \$114 per year per beneficiary.<sup>12</sup> Similarly, in 2009 spending grew about 2% less per quarter for enrollees in Blue Cross Blue Shield of Massachusetts’ ACO-like program compared to its traditional programs.<sup>13</sup> Blue Cross Blue Shield reported that 2010 savings were even higher.

Cigna believes its ACOs can bring costs down and is aiming for 1 million members in its ACOs by the end of 2014. “Our per patient annual cost growth is 50% lower for members in our ACO than members covered by traditional fee-for-service,” said Cigna Healthcare national medical officer Dr. Ozzie Khan.

Emergency room visits fell 7% across the system, while quality indicators for procedures such as mammograms and cervical cancer screenings are up about 5%, Khan said. To achieve these results Cigna encourages primary care physicians to refer patients to specialists with proven quality. Khan adds that, “we share specialist quality data with our ACO physicians so they can make an informed decision about who they send their patients to.”

Yet some healthcare executives interviewed by HRI remain skeptical and stressed that savings from ACOs will likely take a few years before influencing overall U.S. health spending. Some said that ACOs may even push costs higher in the beginning as systems invest in infrastructure and technology such as electronic medical records. “There are promising signs of cost savings, but it’s still a little too early to tell how extensive and sustainable they are,” said Mary Grealy, president of the Healthcare Leadership Council.

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## **Conclusion**

In short, 2014 will be one of the most complex years the health sector has faced as it takes on major uncertainty in an environment of constrained resources.

The numbers are encouraging. Medical inflation has slowed—from an unsustainable 11% in 1990 to 3.9% in 2011, according to the most recent government data available.<sup>44</sup> Annual Medicare spending rose just 1.7% per beneficiary from 2010 to 2012, compared to 6% per year in the previous two decades. The slower trend has been welcome news for healthcare purchasers and federal budget writers, but poses difficulties for healthcare organizations.

Initially, the slowdown was attributed primarily to cuts in payments to doctors, hospitals, and drug makers. Over time, however, the industry has begun to refashion itself, and for the second year in a row, HRI's annual report on medical cost trend identifies structural changes that are altering how and where care is provided. In the case of some changes, such as accountable care organizations,

it is still too early to know whether the savings will be significant and long term.

Employers and consumers are also impacting medical cost trend as they comparison shop for healthcare—whether it is a business sending complex cases to a “center of excellence” hundreds of miles away or a family enrolling in a wellness program to reduce its insurance premiums.

Millions of new customers are on the way because of coverage expansions in the ACA. Much will depend on the health risk profile of the newly insured and how the industry manages them. HRI demographic analysis projects the group as a whole is relatively young (median age 33).<sup>45</sup> On average, these potential new customers also consider themselves to be in good health, are less educated, poorer, and may not speak English as its first language. Few have navigated the formal health system, presenting challenges around education, outreach, and enrollment.

It appears the cost curve is starting to bend—now the question is whether the health industry can continue on the path to full transformation.

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### ***What this means for your business***

Employer engagement and individual consumers are powerful and growing forces in the health ecosystem. To succeed, healthcare organizations should fashion strategies around new demands for value.

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## Employers

### **What are they doing now?**

Employers remain concerned about their long-term ability to provide comprehensive health benefits. Despite a slowdown in medical inflation, costs continue to rise faster than GDP. In answer to the rising costs, businesses continue to shift more of the financial burden onto workers, are reducing retiree benefits and pursuing more aggressive strategies to promote measurable health outcomes.

Employers still describe health insurance as a valuable tool for recruitment and retention, and tax advantages are expected to keep employer coverage at high levels in 2014. In Massachusetts, employer-sponsored coverage has risen since the state enacted its healthcare overhaul seven years ago, even as employer coverage declined nationally.<sup>46</sup>

Employers are self-insuring more than ever before. Over 80% of large employers and a third of small employers are providing their own coverage. The ACA exempts self-insured employers from a new industry tax on commercial insurance plans.<sup>47</sup> Some employers are evaluating a move to private insurance exchanges, in which employees choose from a range of benefits packages. Other employers are considering paying a penalty in lieu of providing coverage.

### Things to consider

- *Explore high-performance networks even if they are not local.* Employee travel expenses may be well worth the cost if employees have better outcomes at lower prices. Employers should find health plans that offer a high-performance network for medical care or contract directly with these health systems.
- *Encourage use of new care venues.* Onsite work clinics, retail clinics, and mobile health options are convenient and typically less expensive than traditionally delivered care. Round-the-clock care centers reduce time spent away from work.
- *Educate employees and families about their options and responsibilities.* As high-deductible plans become more of the norm, employers should ensure that employees understand their benefits and responsibilities. Studies have shown that some people in high-deductible plans forgo preventive care that is fully covered by the plan.<sup>48</sup> “Health navigator” programs that guide employee decision-making can be a worthwhile investment for businesses.
- *Embrace the data.* Employers need to evaluate program results to determine what works and then continuously modify strategies to improve the value of the programs they offer and the care that their employees receive.

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## Providers

### ***What are they doing now?***

Reducing costs has been the focus for hospitals for the past few years. Many have addressed simple reductions in labor force and supply chain management. Now other factors are coming into play. As the federal government continues to shrink reimbursement, hospitals and doctors are focused on full-scale transformation that shifts incentives away from fee-for-service medicine toward outcomes-based payment. Additionally, hospitals have been forming partnerships with urgent care centers and retail clinics that offer less expensive and more convenient options and that also expand their referral network for complex cases.

### **Things to consider**

- *Apply predictive analytics to target high-cost patients.* After years of preparing to meet the government's "meaningful use" requirements, hospitals can now use EHR data to target high-risk/high-cost patients. Health information technology will be critical to achieve care integration and to reduce costs associated with redundant testing and delays in follow-up care.
- *Forge new alliances.* As accountable care and readmission penalties become the norm, hospitals should partner with long-term and home care to ensure sustainable results. Hospitals may also need to build on their current information technology capabilities by partnering with insurers to access data beyond their systems.
- *Invest in the human side of HIT.* Hospitals should not only continue to focus on building their technology infrastructure, they should also develop the resources necessary to implement and run these systems. Two-thirds of healthcare providers are experiencing IT staff shortages, according to HRI research.<sup>49</sup>
- *Align individual incentives with organizational incentives.* As organizations switch to different payment models, clinicians and staff need incentives such as performance metrics that link compensation to quality.

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## Health insurers

### **What are they doing now?**

Preparing for the uncertainty of 2014 has been a major challenge for insurers. The health insurance business model is fundamentally shifting from a wholesale approach primarily focused on group insurance to a retail approach focused on serving the growing individual market. New rules related to the ACA have prompted insurers to develop plans to meet the requirements for operating in health insurance exchanges, which will serve the 27 million individuals expected to gain coverage over the next decade.

Health insurers face intense scrutiny regarding premiums. The ACA requires a review of rate hikes of 10% or more by state insurance commissioners or the U.S. Department of Health and Human Services. Insurers are struggling with how to price new products when the risk profile of the newly insured is largely unknown. Early premium pricing in state exchanges has already prompted some payers to lower their prices under the spotlight of transparency.

### **Things to consider**

- *Form strong partnerships with providers.* As health insurers shift to payment models rewarding quality and efficiency, they should work closely with providers to hit ambitious new targets. Insurers should share data that helps hospitals and physicians manage the highest cost population segment with multiple chronic conditions.
- *Empower consumers to make cost-efficient choices.* Team up with employers to give employees information on lower-cost options. Encourage the transparency of quality measures, and provide information comparing different treatment options.
- *Focus on high-cost specialty drugs.* A top concern of government and private purchasers is the growing use of expensive specialty drugs. Insurers can help push for data to manage this growing cost.
- *Provide access to high-performance networks.* Offer companies new solutions to bend the cost curve. Identify and promote high-performing hospitals for complicated and costly procedures. Help companies understand that poor quality compounds the total cost of treatment.

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## ***Pharmaceutical and life sciences***

### ***What are they doing now?***

Pharmaceutical and life sciences companies have been realigning business strategies to address the new environment of constrained growth. One recent HRI survey found that 35% of life sciences companies have revamped their R&D models in the past three years. Those models are now focused more on partnerships, alliances, and even outsourcing.<sup>50</sup> The need to demonstrate cost-effectiveness has prompted companies to invest in clinical informatics and health economics analytics teams.

Biologics have become an increasing focus for many drug makers. They offer long term market protection from generic competition as high start-up costs are a barrier to market entry for biosimilar manufacturers. However, pressure to address the rising costs of specialty drugs is a top priority for employers and insurers, and may create challenges to the growth and profitability of these drugs. Pharmaceutical companies are addressing cost pressures by investing in companion diagnostics that use evaluation tools to ensure these expensive drugs are targeted at the right patients.

### **Things to consider**

- *Get closer to insurers and providers.* Collaborative relationships that demonstrate effective outcomes enable drug makers to address challenges early in the development process and adapt drug design and payment methods to make them attractive to purchasers.
- *Follow pharmacy benefit decisions.* Which drugs are covered will vary significantly from state to state and plan to plan. Drug makers will need to assess how the pharmacy benefit differs in each exchange and develop an appropriate strategy to get their products covered.
- *Evaluate data and apply to R&D processes.* The push for cost-effective medications continues. Drug makers must continually demonstrate the value of their products with compelling cost and quality studies.
- *Understand how companion diagnostics affect drug treatment decisions.* Companion diagnostics offer the promise of targeted therapies and reduced spending on treatments that may not be effective for certain individuals. Insurance companies hope to use companion diagnostics to shrink total costs through more effective treatment.

## Notes

- 1 Good news on innovation and healthcare, White House Blog, Secretary Kathleen Sebelius, May 28, 2013, <http://www.whitehouse.gov/blog/2013/05/28/good-news-innovation-and-health-care>.
- 2 Irving Levin Associates.
- 3 Robert Wood Johnson Foundation, "The impact of hospital consolidation—Update", June 2012.
- 4 All numbers are national estimates. Cost trends may vary from market to market depending on the level of provider and health plan competition as well as the regional economy. In addition these numbers will vary by employer based on the benefit plan design and impact of their specific health and productivity efforts.
- 5 Kutscher B. "Feeling the outpatient pinch." *Modern Healthcare*. 27 April 2013.
- 6 IMS InMedica study: Telehealth—An Analysis of Demand Dynamics—2012 Edition.
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## **About this research**

Each year, PwC's Health Research Institute provides estimates on the growth of private medical costs over the next year and what the leading drivers of the trend are expected to be. Insurance companies use medical cost trend to help set premiums by estimating what the same health plan this year would cost the following year. In turn, employers use the information to make adjustments in benefit plan design to help offset cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how medical cost trend is impacted.

This forward-looking report is based on the best available information through May 2013. HRI conducted interviews in March and April 2013 with 10 health plan officials (whose companies cover a combined 95 million people) about their estimates for 2014 and the factors driving those trends. Findings from PwC's Health and Well-Being Touchstone Survey of 1,047 employers from over 35 industries are also included. HRI also examined government data sources, journal articles, and conference proceedings in determining medical cost trend.

*Behind the Numbers 2014* is our eighth report in this series.

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**BEFORE THE PUBLIC SERVICE COMMISSION  
OF THE STATE OF DELAWARE**

IN THE MATTER OF THE APPLICATION OF )  
DELMARVA POWER & LIGHT COMPANY ) PSC DOCKET NO. 13-115  
FOR AN INCREASE IN ELECTRIC BASE )  
RATES (Filed March 22, 2013) )

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**CERTIFICATE OF SERVICE**

I hereby certify that on March 17, 2014 I caused the attached **THE DIVISION OF THE PUBLIC ADVOCATE'S BRIEF ON EXCEPTIONS TO THE HEARING EXAMINER'S FINDINGS AND RECOMMENDATIONS** to be served upon all parties on the attached service list in the manner indicated thereon.

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