UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW Bench Trial **Witnesses:** **Arthur F. Oppenheimer** **Marc Chasin** **Randell L. Page** **Steven D. Brown (Video)** **Rodney D. Reider (Video)** **Blaine Petersen (Video)** **Thomas Reinhardt (Video)** **David Arugue**
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW

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REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on October 16, 2013

Volume 15, Pages 2747 to 2927

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PROCEEDINGS

October 16, 2013

*****COURTROOM OPEN TO THE PUBLIC*****

THE CLERK: The court will now hear Civil Case 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc., versus St. Luke's Health System, for Day 15 of a bench trial.

THE COURT: Good morning, Counsel. It looks like we're ready to go.

Mr. Bierig, are you ready to call your next witness?

MR. BIERIG: I am, Your Honor. Good morning. Defendants call Mr. Skip Oppenheimer.

THE COURT: Mr. Oppenheimer, would you please step before the clerk, be sworn as a witness, and then follow Ms. Gearhart's directions from there.

ARTHUR FALK OPPENHEIMER,

having been first duly sworn to tell the whole truth, testified as follows:

THE CLERK: Please take a seat in the witness stand.

Please state your complete name and spell your name for the record.

THE WITNESS: Sure. My name is Arthur Falk Oppenheimer, and I usually go by Skip. Did you want me to spell the whole name, did you say?

THE CLERK: Please.

THE WITNESS: A-R-T-H-U-R, middle name is F-A-L-K, and last name is O-P-P-E-N-H-E-I-M-E-R.

THE COURT: You may inquire.

MR. BIERIG: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. BIERIG:

Q. Mr. Oppenheimer, good morning.

A. Good morning.

Q. Are you currently a member of the board of directors of St. Luke's Health System?

A. I am.

Q. Could you summarize your education starting with high school?

A. Well, I was -- I graduated from Boise High School in 1964, went to the University of Idaho for two years in Moscow, spent one year in France during that period and got a degree there for -- a one-year degree, and then came back and graduated in 1968 from the University of Idaho.

Was then in the Army; I was drafted in 1968. Took courses in and around Indianapolis during that period at IU and Butler and Purdue in business. I graduated, had a BA in history. Ended up going, then, on to come back here actually and taught at Boise State in the business department. And then went on to graduate school at Harvard

Business School and graduated from there in 1972.

Q. Where do you work?

A. At Oppenheimer Companies, Inc.

Q. What is Oppenheimer Companies?

A. We're in the food business and in the commercial real estate business. The food business is national. The real estate business is pretty much around the Treasure Valley.

Q. What is your position there?

A. I am the chairman and CEO.

Q. How many employees does Oppenheimer Companies have in Idaho?

A. We have approximately 60 in Idaho and about 150 nationally.

Q. Are you involved with obtaining health insurance for those employees?

A. I am.

Q. And what is your role in that process?

A. Well, the way we operate, we have a benefits committee, and that benefits committee puts together recommendations. My role is basically to review and approve or not those recommendations from the benefits committee.

Q. Okay. And you testified that you serve on the board of St. Luke's Health System. How long have you served on that board?

A. I have been on the system board since it began in 2006.

Q. What was your position on the board in 2006?

A. I was the initial chair of the board.

Q. How long did you serve in that capacity?

A. It was a little over two years. Our normal term is two years, but there was an overlap because the formation of the system began midyear. I ended up being the initial chair for about a little over two years, two and a half years, roughly.

Q. Could you describe the role of the board of St. Luke's Health System?

A. Well, the board of the St. Luke's Health System has, in effect, final governance authority over the institution. There are subsidiary boards, but the final authority for all governance matters is the St. Luke's Health System board.

Q. And how many people serve on the board of St. Luke's Health System?

A. The bylaws allow for up to 15. We currently have 13.

Q. Could you generally describe the composition of the system board?

A. Yes. You know, we -- this is not totally objective, but we like to think it's made up of a good

representation of community leadership, largely from the business community. We have an interesting range of people. You know, most of the people on the board have been on the board for -- have been on many boards, as I have. I would say, though, that -- again, not totally objective, but I think this board is one of the finest boards I have served on.

Just some examples of the board members: Bill Whitaker, who is the -- who is the CEO of J. R. Simplot Company, which is a large employer; Bob Lokken, who is an entrepreneur who built ProClarity and ultimately sold it to Microsoft and has started a new venture; Larry Cope, who is the CEO of Clear Springs, which is a large employer -- large for the Magic Valley, about 330 employees -- in the trout business in the Magic Valley; Tom Saladino, who is our current chair, who was a long-time general counsel at Albertsons and also at Idaho Power; Barbara Wilson, who was the head of U.S. West and then Qwest in Idaho. We have an adjudication, water adjudication judge from -- originally Pocatello, now from the Magic Valley. We have the former president of Boise Cascade, who is on the board and been a long-time member.

So there's a, we think, a good mix and a good representation of the community. All of -- all of the board lives in Idaho.

Q. How often does the board meet?

A. The board meets every other month.

Q. About how much time per month do you spend on St. Luke's matters in your capacity as a board member?

A. I would say on the months that we have board meetings, probably 10 to 15. I mean -- I'm sorry -- about 15 to 20. I would say on the months that we are off, the nonboard-meeting months, probably 10 to 15 I would say, on average.

Q. Are you paid for your services to St. Luke's?

A. No.

Q. Are any board members paid for their services?

A. No.

Q. Then why are you willing to spend so much time in service to St. Luke's?

A. Well, you know, first of all, I think -- speaking for myself, but my guess is other board members would concur -- I think there's a feeling that, you know, there's probably nothing much more important than healthcare today, in terms of impact on all of us. As individuals, our families, friends, we're all either have been or will be in hospitals; we'll all be in the healthcare system and are. So I think there's a -- just a strong feeling that this is important, an important endeavor, and a good use of our time.

We also -- or I also feel that, personally, a strong commitment to the direction of St. Luke's and its -- its overall strategic idea of how we can continue to affect, in a positive way, healthcare in this region. And this movement that started some bunch of years ago towards this transformational idea of how -- in this time of major change in healthcare, how can we be a factor that is at the leading, kind of, part of what's going on in healthcare is compelling to me and, I think, probably to other board members.

So we think it's -- or certainly I feel, speaking for myself, it's -- I can't think of a better place to spend my volunteer time than at around -- in and around healthcare and at St. Luke's on that board.

Q. And when you say transforming healthcare, what are you referring to?

A. Well, the institution has begun -- began some years ago to look at how the delivery of healthcare was changing. And we've made a very sort of fundamental decision, strategically, to move towards what we think is a transformational idea, which is to move towards outcomes based -- an outcomes-based system, a value-based system and away from where the world has been in healthcare, which is basically pay-per-procedure, volume-based system.

And so I think, you know, if you're

going to -- the other thing we talk a lot about, if we're going to serve on a board in healthcare, this is probably the time to do it, because there's an opportunity to maybe be part of the significant positive change in healthcare that's happening in many parts of the country and hopefully in this valley, as well.

Q. What role does the St. Luke's Health System board play in St. Luke's acquisitions of physician practices?

A. The St. Luke's Health System board basically approves any acquisitions above a certain dollar amount.

Q. And how does the approval process work?

A. Well, it's an iterative process. The relationship with the -- between the board and management is, in an acquisition, typically -- and the board, when I said above a certain level, for example, any acquisition above a $4 million level would be brought to the St. Luke's Health System board. In the Treasure Valley, for example, 1 to 4 million would be handled by the Treasure Valley board, and below 1 million would be handled by the management. But above a $4 million level, typically there would be discussion that has evolved from the early stages of the idea of moving forward with an acquisition.

We would, at the committee levels, which is where some of these discussions start, have discussions about the advisability, how it might fit or might not fit with the

strategic direction of the institution. There is usually some discussion at the board in the early stages to see if -- and then to get input back from the board as to whether this looks like a fit. And then ultimately as the -- assuming that the process does move forward -- and it doesn't always move forward -- but in the cases where it does move forward, there would ultimately be a formal recommendation to the board and then a formal either vote yes or no on that acquisition at the St. Luke's Health System board.

Am I too close to this mic, or is this working?

Q. I think you're fine.

THE COURT: I think it's fine.

THE WITNESS: Okay. Thanks.

BY MR. BIERIG:

Q. What factors does the board consider when deciding whether or not to approve a transaction?

A. Well, I would sort of categorize it in -- probably in three different strategic categories. One is does the acquisition fit the strategic direction on sort of a broad-brush level. And in particular, as I have mentioned, does it fit the idea of the -- of the integration of healthcare that St. Luke's is trying to move toward and achieve. Does it fit what we call the Triple Aim, which is better health, better care, and lower cost. Does it match

up well with all three of those, what I would call fundamental categories of strategic direction of that institution. So that's kind of the first test under the, I'd say, sort of strategic test.

Also under the more strategic kind of test, I'd say, is it in alignment with the idea of, again, this value-based, risk-based system as opposed to the older school pay-for-performance that the world has experienced and largely continues to. In other words, do the --

Q. You mean pay-for-procedure rather --

A. "Pay-per-procedure" I meant to say. And do the physicians -- are they in alignment with that idea. So those would be a couple of the more strategic kinds of, I think, screens that the board would look at.

Under what I would call the clinical side, the -- the whole idea of culture, I think -- I feel, I think the whole board feels -- is really fundamental. And so under the clinical side, is there a fit with the physicians or physician practice that's being acquired, in terms of are they a fit for the culture? Are they a -- is the quality of care that those physicians represent -- is their reputation one that would also be consistent with the kind of quality that we try to achieve as a standard within St. Luke's.

And then, thirdly, under sort of clinical and then -- and financial, I would say the whole question of

whether it helps us gain certain efficiencies and whether it fills certain geographic voids would be an important consideration that we would make.

And then, lastly, there is just the fundamental financials, is the price of the practice defendable, is it reasonable? We usually get -- of any size we always get third-party reviews, appraisals of real property, tangible, intangible properties, compensation, those kind of things; is that financial construction one that is reasonable and -- from our fiduciary standpoint is it something that we feel comfortable with. So those are the kinds of considerations I think the board would undertake.

Q. So what role, if any, does having increased leverage with payors play in the board's evaluation of an acquisition?

A. You know, honestly, I can't -- I don't think it has any consideration. I don't remember any discussion of that at a board meeting or a committee meeting.

Q. Has the board ever voted to reject an acquisition or an affiliation?

A. Well, as I say, we've -- through that iterative process, we've ended up not going forward with certain kinds of acquisitions. I can't remember it ever coming to a vote because there is too much discussion along the way before it gets there, but -- I mean, I can think of two or three.

One that pops into my mind that -- we signed a confidentiality agreement, so I don't think I should probably say the name of the institution, but it's in another part of the state. They approached us. We considered it. We had a series of meetings with that board, some of the board members, the board chair, the CEO, decided it wasn't a fit for some of the reasons that I explained before. And there have been others.

Q. Okay. In evaluating a transaction, Mr. Oppenheimer, does the board consider potential revenue gains to St. Luke's from the transaction?

A. Well, as part of the consideration certainly revenue and the financial considerations, as I mentioned, is -- would be a consideration. I wouldn't say it's primary, but it's a consideration, yes.

Q. Why is that?

A. Well, when we look at this institution, and you know it's not -- this is different than a for-profit board and a for-profit institution. But when we look at some of our strategic direction, there is a certain scale that the institution needs to get to in order to be able to effectively and, from a financial standpoint, probably from a fiduciary standpoint, appropriately create risk-based and value-based billing and system -- a system that is, in effect, value-based. And so there is a certain scale that

we need to achieve. But we have no desire just to grow to grow. I mean, there is no reason for that. We don't have any incentives.

Even our management, we made a decision -- again this is sort of the culture, I think, but -- many years ago not to have bonuses, for example, of our management based on -- we don't have bonuses, period. And part of the reason and some of the discussion around that was, you know, you sort of -- there are consequences for incentivizing, and we couldn't come up with anything that got to the broader-brush objective of this institution through bonuses. And so things like revenue increases, there is no incentive for anybody just to grow. What we're trying to do is create the highest quality care in this region, but not necessarily grow just to grow.

Q. Turning to the Saltzer transaction, was that affiliation reviewed by the St. Luke's board?

A. It was.

Q. And what considerations did the board take into account in evaluating the transaction?

A. Well, there were really, I'd say, two or three key elements that I think would be a way to capture some of that. One is it gave us a presence in Canyon County. St. Luke's had a relatively modest number of physicians -- I'm trying to remember, I think it was around seven -- in

that market. This gave us an ability to gain a more significant presence in Canyon County, and we had a fair percentage -- I think it's around 20, over 20 percent, I think it's 22 percent -- of the patients of St. Luke's that are traveling outside of Canyon County to get care at St. Luke's. So there was a convenience factor that we thought had some value.

Secondly, in the discussions with Saltzer, there was a strong feeling of alignment with where they wanted to go, where they saw healthcare going, and where the St. Luke's Health System saw healthcare going. So we saw that alignment as a fundamental piece that was of value.

And then I'd say, thirdly, as I mentioned, it created a movement, again, to continue to increase that base of patients and physicians that would allow us to continue to have enough critical mass to move towards the risk-based system, the value-based system that we're embarking on that we think is pretty -- is basic to our strategy. And we think potentially -- trying not to overstate it -- but we do think it's potentially transformational in terms of where healthcare is going in this country and potentially where we can go in this valley.

Q. So what role, if any, did a desire to increase leverage with payors play in the decision to approve the Saltzer transaction?

A. I would say none.

Q. And what discussion, if any, was there of affiliating with Saltzer in order to be able to raise prices?

A. Again, I -- I can't think of one discussion on pricing at the board or any committee level, anything I can remember being involved in that had to do with pricing.

Q. Are you aware that the plaintiffs in this case claim that St. Luke's affiliation with Saltzer will result in prices for the services of Saltzer physicians above competitive levels?

A. I'm sorry. Say that again.

Q. Are you aware that the plaintiffs in this case claim that St. Luke's affiliation with Saltzer will result in prices for the services of the Saltzer physicians that are above competitive levels?

A. Yes. Yes, I do understand that to be the claim.

Q. And how would you respond to that claim?

A. Well, I would -- I would, first of all, respectfully disagree. First of all, the -- as I've said, or tried to say, the mission of this institution is we're a nonprofit, community-based, charitable institution. We have no interest in raising prices in terms of anything above competitive levels. We have no interest in doing that. It's not part of our DNA. There is no incentive for anybody

to do that. That's not our reason to be.

Secondly, you know, there is a lot of competition in this valley, and we have strong competition with Saint Al's, and if you go back many years, that competition wasn't there. And when the antitrust laws changed, it became much more competitive. For good or for bad, there is heavy, serious competition between Saint Al's and St. Luke's, which has an impact on the ability for anybody to raise prices, Saint Al's or St. Luke's, beyond some level.

There is also competition, I think, among insurers, you know, with Blue Cross, with Select that -- and there is a negotiation that we all recognize takes place between St. Luke's and the payors that has an impact on competition -- I mean, on -- that would affect I think any ability to raise pricing.

And then, I guess another point that I would make is that the board, as I described, it's made up of a lot of employers who pay premiums for their employees, and some of them are large-scale employers. So there is sort of a built-in check, in one sense, and that is we would know pretty quickly if there was any kind of pricing above competition because our HR departments and people in this community are not exactly bashful about letting board members, when they know you're on a board, know if there's an issue. So I think if there was anything above

competitive levels, we, as board members, would see it firsthand, and it would affect us directly.

Q. And so what would the board do about it?

A. Well, the board would do what I think any good board does, and that is they would make sure that that became a significant discussion, and there would be a lot of challenge to that at the board level, and I can't imagine the board allowing for anything above competitive pricing levels to happen.

Q. But wouldn't trying to hold down prices be inconsistent with a fiduciary duty of board members to maximize revenue for St. Luke's?

A. Well, first of all, as I said, I don't think the board is trying to maximize revenue. I don't think that's -- that statement is exactly correct.

Secondly, and probably most importantly, you know this board is really serious about what I mentioned as the Triple Aim. I mean, that's become sort of so foundational to what this institution is all about. And the third part of that Triple Aim is lower cost. And we feel that healthcare in this country is moving towards potentially lower reimbursement rates, an absolute requirement that we as an institution and any healthcare institution that's going to be able to deliver good quality and ultimately survive is going to require a whole new way of looking at

how the cost side of this equation, how efficiencies, utilization, all those kinds of things are handled. And this board, I think, feels fundamentally that not only is it not cont -- contradictory to our goals, it's fundamental to our goals to get our costs down.

We, as a country, cannot sustain the kind of increases in cost that we've had in healthcare in this country. And there is a need for transformational change, and I think our board is 100 percent behind the idea that we've got to try some new things to see if we can't make change happen. And our CEO, David Pate, is a great believer in that. He's been a great leader in that.

Frankly, this wasn't just started with David. I was the chair of the St. Luke's Regional Medical Center board before David got here. And Ed Dahlberg who -- and we've only had -- David is our third CEO. We've had two CEOs before that in 40- -- roughly -- -3 years. Gil Gilbertson, who was very well known nationally was chairman of the AHA from Boise, Idaho. And then Ed Dahlberg was the chair for over 20 years. I worked very closely with him, as did all of us on the board.

And I remember 15 years ago, roughly, being in Philadelphia at a panel that talked about health systems and where the world of healthcare might be going in this country. And at that point, even today, nobody really knows

for sure, obviously. But the whole idea that Ed had at that point and the vision he had of -- and the St. Luke's Health System was created under Ed -- was that we've got to create a whole new method of delivery that, in effect, is going to respond to the idea that reimbursement is going to start coming about through quality outcomes, through outcomes and quality measurements; it's not going to be based on volume, and it's not going to be based on pay-per-procedure.

So this idea hasn't just evolved in the last few years. This was something that the institution began embarking on as many as 15 years ago.

Q. Okay. Let me switch gears for a minute. Are you aware of the relationship between St. Luke's and SelectHealth?

A. I am.

Q. What's the nature of that relationship?

A. Well, SelectHealth, St. Luke's feels, has a lot of the same kinds of, sort of, ideas about where healthcare is going and a lot of the same kinds of goals that match with where St. Luke's feels healthcare is going. And so they're an insurance company that's owned by Intermountain Healthcare, which is a hospital system that we find is an interesting model. And because of the alignment of where they see things going and where we see things going, we have formed an alignment -- or an alliance with them to provide a

new healthcare product to this region.

Q. And what is the benefit to St. Luke's from having this alignment with SelectHealth?

A. Well, it's a key part, we think, because if we're going to ultimately move to a risk-based system, then it's, we think, pretty fundamental to have at least as one option a -- an insurance company that has a similar set of strategic goals and because of that allows St. Luke's, as an institution, to pass back or to -- through Select, to gain back some of the savings that might come about through a value-based system. And that would allow St. Luke's to, if we are successful in achieving some of the savings that go back to the lower cost, to get those savings recaptured and to pass those back, either in the form of lower premiums, lower cost of care or, potentially, some rewards for the physicians and people that help make that -- that savings happen.

And SelectHealth was aligned with that idea and were willing to structure products that allowed that to happen, which we think is a piece to the puzzle that's pretty integrated to the idea, as we've looked around the country, of what might be needed in order to have an effective value-based healthcare system in this --

Q. Do you know -- I'm sorry. I didn't mean to interrupt.

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A. -- in this region.
Q. Do you know whether SelectHealth has actually sold any risk-based policies in Idaho?
A. You know, I'm not sure that they -- I don't think there has been a lot sold. I don't have a clear sense for what that number might be. I know that in the strategic plan we have specifically targeted the idea that we would have the systems, the cost controls, some of the evidence-based medicine elements put together for 2015 as a target date for where there would be a very strong marketing effort by Select for that product. And I think you're going to see that happen more in 2015 than you are today.
Q. Mr. Oppenheimer, in your judgment, what, if any, is the relationship between the SelectHealth alliance and St. Luke's affiliation with Saltzer?
A. Well, I've given that, as I would suggest the rest of the board, a lot of thought. And we think -- we think it's very integral. Select, as I suggested, brings a product that allows us to move towards a risk-based delivery system. And that's an important piece to the puzzle.
Select -- I mean Saltzer brings us a group of physicians who are aligned with that idea and willing to participate in that whole idea, and what we think is a big idea. And Saltzer brings us -- as I mentioned, it brings us presence in Canyon County where we had a limited presence;

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it brings us, as I said, an alignment that allows us to put together a risk-based system with Select and ultimately helps us to get to the scale so that, from a financially responsible standpoint, looking at our role as a board fiduciarily, we have enough base to spread that risk out, that that risk-base can go forward in a financially responsible way.
So I would say that those -- they are very connected and very important that they happen because you need both.
Q. Let me turn now to Oppenheimer Companies. I believe that you testified that Oppenheimer Companies provides health insurance for its employees?
A. We do.
Q. What company actually provides the insurance for employees of Oppenheimer Companies?
A. Blue Cross.
Q. When was your most recent contract with Blue Cross signed?
A. Oh, let's see. It was April 1 of 2013.
Q. Did you consider other health plans before selecting Blue Cross?
A. We did.
Q. What other plans did you consider?
A. Well, we looked at SelectHealth. And, as I said,

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we have a benefits committee that's made up of four or five of our associates, including our CFO and our HR director. And they went through a process of evaluation.
Q. Okay. And so why did Oppenheimer Companies choose Blue Cross over SelectHealth?
A. Well, the process -- it was an interesting process. The committee went through a -- we use a third-party broker, Western Benefits, and that broker went out to the marketplace, and basically SelectHealth and Blue Cross were the two that we focused on.
The initial meeting we had -- that I had with the committee when they brought back their original recommendation, SelectHealth care was lower, and Blue Cross --
Q. You said "lower"; you mean lower in price?
A. Lower in price.
But they -- the committee was a little uncomfortable with Select because they felt they were new to the market. They were a little worried about our associates accepting a new entry without a little more seasoning. They had gotten sort of an indication from our broker that Blue Cross had made some noises they might be willing to -- to negotiate further or to bid again. And so their recommendation was to go with Select unless Blue Cross significantly changed their pricing.

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I was a little torn because I -- you know, I have a certain desire for SelectHealth to move forward, and I tried to convince them that we were, you know, this wasn't a -- this was going to be a long-term proposition with Select. But they felt that we ought to go back, and I -- and we've got the committee, and, you know, they felt strongly that they go back, and I didn't veto that. So, anyway, long story short, we went back, Blue Cross came down in pricing to a price very close, and the recommendation of the committee and what we went forward with was Blue Cross.
Q. So based on your experience, what effect has the entry of SelectHealth had on competition in the market for health insurance?
A. Well, I think it's had a very healthy, competitive impact, based on just using that one example and others that I've heard of.
Q. And what effect has entry of SelectHealth had on the price paid by employers for healthcare?
A. Oh, I think it's been very -- I think it's been a very competitive, procompetitive kind of entry that's made a difference.
MR. BIERIG: Thank you, Mr. Oppenheimer. I have no further questions, Your Honor.
THE COURT: Cross. Mr. Wilson.
MR. WILSON: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WILSON:

Q. Good morning, Mr. Oppenheimer.

A. **Good morning.**

Q. That acquisition that you mentioned in the other part of the state that the board considered but did not pursue, that was a hospital, not a physician practice; correct?

A. **Correct.**

Q. And, in fact, you have never personally voted against the acquisition of a physician practice; correct?

A. **No, I have not.**

Q. And during the time that you have been a St. Luke's Health System board member, isn't it true that you cannot think of a time where the board has ever voted against the acquisition of a physician practice that's been recommended by St. Luke's senior management?

A. **Well, as I said, we --**

Q. Yes or no, sir.

A. **Well, I would like to answer yes or no, but I would like to also explain how the process works.**

THE COURT: Mr. Bierig is going to give you a chance to do that on redirect.

THE WITNESS: Okay.

THE COURT: But if you can answer a question

fairly yes or no, then go ahead and do so, and Mr. Bierig will give you that chance. If you think that it's just completely misleading, then I'll give you a limited opportunity to explain.

THE WITNESS: Okay.

THE COURT: Let's rephrase the question, Mr. Wilson.

MR. WILSON: Sure.

BY MR. WILSON:

Q. Isn't it true, sir, that during your entire tenure as a St. Luke's board member, you cannot think of a time where the board has ever voted against the acquisition of a physician practice recommended by St. Luke's senior management?

A. **Correct.**

Q. And, in fact, all of those votes in favor of acquiring physician practices have been unanimous votes by the board; correct?

A. **That's correct.**

Q. I think you've said that you've been a member of the St. Luke's Health System board since there was a St. Luke's Health System board; correct?

A. **Correct.**

Q. And the St. Luke's Health System encompasses all of the St. Luke's facilities, including the facilities in

the Magic Valley; correct?

A. **That's correct.**

Q. Based on your testimony during direct examination that the board has not had discussions regarding pricing, I take it that St. Luke's -- the St. Luke's Health System board hasn't taken any action with regard to pricing in the Magic Valley by St. Luke's; correct?

A. **Correct.**

Q. It sounds, from your testimony, that you believe that the board carefully considered the Saltzer transaction before voting to approve it; correct?

A. **That's correct.**

Q. And are you aware, sir, that Saltzer was a part of the BrightPath network before the acquisition?

A. **Yes, generally.**

Q. And are you also aware that SelectHealth is using the BrightPath network?

A. **Yes. Generally, yes.**

Q. But, nonetheless, the board thought it important to acquire the Saltzer physician practice; correct?

A. **Correct.**

Q. So before voting to approve the Saltzer transaction, the board must have considered whether a looser affiliation with Saltzer was an option; correct?

A. **We -- yes, we discussed different options.**

Q. Mr. Oppenheimer, there are competitors of Saltzer for primary care in Nampa; isn't that right?

A. **Yes.**

Q. For example, Primary Health Medical Group has primary care physicians in Nampa; correct?

A. **Correct.**

Q. And Saint Alphonsus Medical Group has primary care physicians in Nampa; correct?

A. **Correct.**

Q. As a result of the Saltzer acquisition, Mr. Oppenheimer, sitting here today, do you know what market share of the primary care physicians St. Luke's now commands in Nampa?

A. **Again, we -- the board doesn't look at --**

Q. Do you know?

A. **-- Nampa as a discrete market.**

Q. I'll ask the question again. As a result of the Saltzer acquisition, do you know what market share of the primary care physicians St. Luke's now commands in Nampa?

MR. BIERIG: Object to the form of the question. It's implying that Nampa is a market, when this witness has just testified that they don't regard Nampa as a market.

THE COURT: Well, the witness -- all right. I think it's a valid objection, but the witness can simply indicate that he doesn't know because it's not relevant to

their -- Mr. Oppenheimer, am I reading your answer correctly?

THE WITNESS: Yes, that's correct.

THE COURT: Go ahead and proceed.

BY MR. WILSON:

Q. Of the primary care physicians who practice in Nampa, Mr. Oppenheimer, do you know what percentage of those primary care physicians are now employed or have a physicians -- a professional services agreement with St. Luke's?

A. Again, this valley isn't -- Nampa, as I understand it, something like a third of the patients who get treated in Nampa come from outside of Nampa. Two-thirds of the patients in Nampa go elsewhere for treatment. So this valley has grown together -- I've lived here all my life -- it's not like Nampa is a discrete market. And the board didn't look at Nampa as a discrete market. 22 percent of our patients come from Canyon County. And as this valley has grown together, it's hard to imagine Nampa being looked at as a discrete market.

Q. I'm not debating with you what is or is not the market, Mr. Oppenheimer. I have a very simple question, which is: In Nampa -- in Nampa, what percentage of the primary care physicians are St. Luke's physicians? Do you know?

A. And I'm saying that isn't relevant because those physicians don't just treat patients who live in Nampa nor do Nampa patients only get treated in Nampa.

Q. So you don't know; is that right?

A. I don't think it's relevant, and I'm not sure I know. If you define the market as Nampa, I'm not totally clear.

Q. You don't know the answer to my question, do you?

A. Can you rephrase the question?

Q. What percentage of the primary care physicians in Nampa are St. Luke's primary care physicians?

A. Again, I don't see that as a relevant number, so --

Q. Do you know the answer to the question, sir?

THE COURT: Let me just -- again, similar to what we said before, I mean, I think I understand the point you're making, but the question is, that Mr. Wilson is putting to you, is do you know, and yes or no, and then, as I've indicated, Mr. Bierig will give you a chance to explain why you feel like that's not a relevant question.

THE WITNESS: Yeah, I don't know exactly the percentage.

BY MR. WILSON:

Q. Can you hazard a guess?

A. I would -- I mean, I've heard numbers in the range

of 60 percent.

MR. WILSON: Nothing further, Your Honor.

THE COURT: Any redirect?

MR. BIERIG: Very briefly, Your Honor.

THE COURT: Yes.

REDIRECT EXAMINATION

BY MR. BIERIG:

Q. Mr. Oppenheimer, you testified that the board had never voted against an acquisition of a physician practice. Can you explain the process in a way that explains why that is?

A. Well, the process, as I started to mention, it's -- first of all, this is not exactly what I would call a bashful or retiring group of people on this board. It's a group of very strong personalities who -- who I'm sort of gratified when I see, have very strong beliefs in the importance of healthcare, the quality of healthcare, and where healthcare can go in this region. But there is active debate that goes on in every aspect of St. Luke's. There is no higher authority. We don't have a board above our board. We're it. And we're all from Boise and Idaho. We're all from the -- not from Boise. We're all from Idaho. So, we only have one allegiance, and that's: How do we continue to improve the quality of care in this valley and in this region?

When it comes to things like an acquisition of a practice, there is a very strong discussion, starting at the very beginning, of whether we should even look at the practice, between the board committee or the board and senior management. And that's almost -- I can't think of any sizable acquisitions that that hasn't happened. And if there is a fundamental disagreement about whether we should proceed or not, it starts becoming very obvious early.

So there is no point in taking it to the final kind of formal presentation and approval or disapproval at the board. We've had too many discussions along the way to know whether or not the board is going to support it. So it's an iterative process that ultimately makes those kinds of decisions before it gets to a final approval at the board level, and that's just the way this board operates.

But, you know, I want to be sure it's clear, this -- this board is a strong board. They know they've got final authority for making decisions. There is no other authority. People take that responsibility very seriously. And, you know, again, we have no incentive to do anything, as a board member, that doesn't further the interests of healthcare in this region. That's the only reason we're on that board. And when it comes to acquisitions, that discussion takes place, so it never gets to a final vote before -- because we've made those decisions along the way.

And there is no reason to waste the board's time if it's clear that the board feels there is not a fit.

Q. Let me ask you one last question. Mr. Wilson got you to estimate that St. Luke's employs or has a PSA with approximately 60 percent of the primary care physicians in Nampa. Assuming that were the case, would that concern you, from a competitive point of view?

A. Well, as I was trying to say, I -- I feel that the -- first of all, the -- we've got a highly competitive environment here with -- I mean, Saint Al's and St. Luke's do compete vigorously, and so I just don't see, you know, where, first of all, you know, there is any lessened competition. I mean, Saint Al's tried to acquire that same practice and were not successful, so they must have, at that point, thought it was okay to do.

But more importantly, this valley is a pretty grown-together valley, and people in Nampa don't get -- we've got, I think, pretty good facts that show people in Nampa travel to other parts of the valley to get healthcare. They don't just stay in Nampa.

So I wouldn't see that as a relevant percentage because there is too much known travel for patients already clearly established in this valley.

MR. BIERIG: I have no further questions, Your Honor.

THE COURT: Counsel, I did have one question I was going to ask.

And you may have answered this question earlier, and I perhaps just missed it. How is the board selected? I mean, boards have to change over time. Is the -- well, let me just have you describe that.

THE WITNESS: We have a nominating committee that's made up of the board --

THE COURT: Okay.

THE WITNESS: -- of the board members who are selected for the nominating committee.

THE COURT: So the board selects its own --

THE WITNESS: Members.

THE COURT: So it's not the CEO or --

THE WITNESS: No, no. It's the board itself who form a nominating committee, and that's how the board is selected; it's by the board.

THE COURT: All right.

Counsel, any further? Mr. Wilson.

MR. WILSON: Briefly.

RECROSS-EXAMINATION

BY MR. WILSON:

Q. You mentioned, Mr. Oppenheimer, that people like to travel for their care. Is that what you said?

A. Yes.

Q. How far is your primary care physician from your home?

A. My primary care physician today is about, oh, a half a mile from my home, but I live on Warm Springs, and St. Luke's is about a half a mile away.

MR. WILSON: Nothing further, Your Honor.

THE COURT: Anything else?

MR. BIERIG: No, Your Honor.

THE COURT: Mr. Oppenheimer, thank you very much.

THE WITNESS: Thank you.

THE COURT: Counsel, I'm going to take another short break. It's another one of those things I am coping with because of the medicine I'm taking. It's not a huge deal, but my apologies. We'll just take a very short five-minute break and try to start very promptly in about five minutes.

We'll be in recess.

(Recess.)

*****COURTROOM REMAINS OPEN TO THE PUBLIC*****

MR. STEIN: Your Honor, the defendants call Dr. Marc Chasin.

THE COURT: Sir, please step there before the clerk and be sworn.

MARC CHASIN,

having been first duly sworn to tell the whole truth,

testified as follows:

THE CLERK: Please take a seat in the witness stand.

Please state your complete name and spell your name for the record.

THE WITNESS: Sure. My name is Marc Chasin, M-A-R-C, C, as in Charles, H-A, S as in Sam, I-N.

THE COURT: You may inquire of the witness.

DIRECT EXAMINATION

BY MR. STEIN:

Q. Good morning, Dr. Chasin.

A. Good morning.

Q. What is your title at St. Luke's Health System?

A. I currently hold the title of chief medical information officer, as well as the interim chief information officer.

Q. And to whom do you report?

A. I report to Dr. Pate.

Q. What are your responsibilities as chief medical information officer and interim chief information officer?

A. My overall responsibilities are, firstly, to ensure a robust, highly reliable IT infrastructure that is available for our providers, as well as our patients, and as well as my job is to partner with the end users to develop a clinical information technology.

Q. And by "end users," who do you mean in that context?

A. I mean doctors, nurses, billing clerks.

Q. You are also a licensed physician; is that correct?

A. I am.

Q. What's your area of medical specialty?

A. Family medicine.

Q. Could you summarize for the court your educational background, starting with college?

A. Sure. I graduated from the Ohio State University with a bachelor's of science in human nutrition in 1994. I then matriculated to the American University of the Caribbean School of Medicine, and I finished my medical degree in 1997. I subsequently completed a family medicine residency from the University of Medicine and Dentistry of New Jersey in 2001, and then I continued my education at Carnegie Mellon University, where I received a master's of medical management in 2009.

Q. What is a master's of medical management?

A. A master's of medical management is an MBA degree for practicing physicians.

Q. And is it a two-year program like a normal MBA?

A. That is correct. It's two years, full time.

Q. Do you hold any other professional certifications?

A. Yes. I hold a certified healthcare CIO, as well as a certified physician executive.

Q. Do you have any association with the American Institute of Healthcare Quality?

A. Yes. I am a fellow of the American Institute of Healthcare Quality.

Q. And what is -- can you just describe briefly what that organization is?

A. Sure. The American Institute of Healthcare Quality is an organization that develops medical directors on hospital throughput and hospital utilization to improve the overall care of the patient while they are in the hospital.

Q. Dr. Chasin, when did you become employed by St. Luke's?

A. I became employed in fall of 2010.

Q. And can you describe generally your work experience before you came to St. Luke's, focusing on your experience with electronic medical records or electronic health records?

A. Sure. In residency, I was part of a pilot to develop standardized technology for residents to improve patient care. Then as a physician in my own practice, I developed my own electronic medical record. I proceeded to join Bon Secours Health System, based in Marriottsville,

Maryland, and help them deploy and build an enterprisewide electronic health record through 18 hospitals and 6,000 physicians, in both ambulatory and inpatient care.

Q. So when you were hired by St. Luke's in 2010, you were hired from Bon Secours?

A. I was, yes.

Q. And what is it that you were hired to do at St. Luke's?

A. What I was hired to do at St. Luke's in my arrival here as the chief medical information officer was to partner with St. Luke's providers and other end users to engage them in developing a clinical information technology infrastructure to transform the way we deliver care to the patients, our patients and the community that we serve.

Q. The court has heard reference in other testimony to an organization called the "Idaho Health Data Exchange." Are you familiar with that organization?

A. I am.

Q. And do you serve in any capacity in the Idaho Health Data Exchange?

A. Yes. I'm on the board of that organization.

Q. Do you participate in any other professional organizations whose activities focus on health information technology?

A. Yes, I do. I participate in the College of Health

Information Management Executives. I participate in the Association for Medical Directors of Information Science. I also am the chair of the Epic Care Everywhere Network, and I also serve on the governance committee for the National Health Information Exchange.

Q. What is the -- I'm sorry.

A. No.

Q. What is the Epic Care Everywhere Network?

A. The Epic Care Everywhere Network is a network of health systems that have successfully implemented the Epic software, and we develop standards of security and data transmission in order to successfully transmit data throughout the network to improve patient care at the time of service.

Q. And does this organization consist of individuals who are associated with systems that have adopted Epic nationwide?

A. Yes, sir. Worldwide actually.

Q. Worldwide. How widespread generally is the adoption of Epic?

A. In the United States, as of now, 50 percent of the U.S. population have a record in Epic.

Q. How about in Idaho?

A. In Idaho, we have roughly 200,000 Epic records.

Q. And St. Luke's is on the Epic system; is that

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right?
A. Yes.
Q. Are there any other major systems in the Treasure Valley that are on Epic, as far as you know?
A. No.
Q. Now, you also mentioned an organization that you're associated with called the "National Health Information Exchange." Is that a governmental body?
A. It is a governmental body.
Q. And what is that body responsible for doing?
A. So the National Health Information Exchange is a subset of the National eHealth Collaborative. And what that organization does is that their job and their drive is to accelerate the adoption of health information technology to create a more patient- and family-centered health system to drive value and improve outcomes.
Q. And is this an executive agency organization?
A. Yes. It reports right -- directly to Dr. Farzad Mostashari of the office, a national coordinator who reports to Kathleen Sebelius of the Health and Human Services.
Q. And how is it you came to serve on the National Health Information Exchange?
A. By me being the chair member of the Care Everywhere Network positions me well, as the Care Everywhere Network is the largest health information exchange in the

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country. My expertise and the value that I bring to this National Health Information Exchange provides me with that expertise.
Q. So in the course of your work in health information technology, Dr. Chasin, can you just describe some of the electronic medical records systems that you have personally become familiar with?
A. Sure. I am familiar with Epic. I am familiar with eClinicalWorks. I am familiar with Soarian. I am familiar with GE Centricity. I am familiar with Meditech. I am familiar with NextGen. I am familiar with Practice Made Perfect. I am familiar with Allscripts. I'm familiar with HMED. I am familiar with Cerner. And I am familiar with Meditech. I could proceed if you would like.
Q. I don't think we're going to go beyond those. Thank you.
So, Dr. Chasin, what is -- what is "myStLukes"?
A. MyStLukes is the name that we have branded our Epic deployment. We've customized it to fit St. Luke's.
Q. And that's the -- so is myStLukes essentially the St. Luke's electronic health record?
A. That's correct.
Q. And what are your responsibilities with regard to myStLukes?
A. Sure. My responsibilities range from the -- the

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clinical -- the IT infrastructure, in that I have to maintain a highly reliable infrastructure, make sure it's available for our providers, as well as the other end users, as well as the patients to access their data, make sure that it's up 24/7.
Additionally, I have responsibility on engaging the clinicians, as well as the end users, on workflow design, making sure that their work is efficient as possible and they could access the data at the right place at the right time, as well as develop new workflows as they come about to make sure that we are addressing clinical need in the right environment.
Q. Now, Doctor, when you and I have spoken in the past in describing Epic, I have heard you use the phrase "one record, one patient, multiple doctors."
A. Yes.
Q. Can you explain what that means?
A. I sure can. In today's healthcare system, a doctor A sees patient A, and they create a record of their encounter and a relationship is built. When that patient needs care from a specialist, that specialist creates another record and builds a relationship with that patient. And then further, if that patient needs services at a hospital or at a lab, another medical record is created. As you can see, none of these records talk to one another.

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There is limited amount of exchange of data. All in all, it's very -- it's not ideal for the patient, as no one clinician has the most up-to-date information on this patient.
By creating a one patient/one record, we remove the disparitiness of the typical way that we practice medicine, move the patient to the center, with one record, one patient, multiple providers participating in the care of that patient. That enables us to have the right care at the right time with the right data, and overall that -- that improves the overall healthcare outcomes of these -- of these patients.
Q. And Dr. Chasin, another phrase I've heard you use when we talked about Epic is "single source of truth." Can you explain what that means?
A. Sure. As I said right before that, when you have multiple instances of a patient record, there is no real -- we don't know who has the most up-to-date information. If we're all collaborating around a single patient with a single record, we have one single source, one source of truth and one central repository where we can get the most up-to-date, most accurate information to make the most and the best medical decision-making at the right time.
Q. And is that just a matter of inconvenience, for example, of having to assemble multiple records, or is this

something that has patient care or quality implications?

A. This has both patient care, patient convenience, and improves the overall quality of the experience that the patient is receiving, as well as the confidence and the medical decision-making rendered by the provider.

Q. Now, does St. Luke's also have a website portal where patients can go to access medical records and other information?

A. Yes. It's called "MyChart."

Q. And what benefits to patients does MyChart provide?

A. MyChart is an application that not only provides lab access, secure email to your doctor, ability to see your past appointments and your upcoming appointments, it allows you to manage your medications, refill those medications. It allows you, really, to treat and delegate access of the elderly patient to improve coordination of care. But what it really does and what is the changing factor of patient engagement of what we're trying to do is that it allows the patient to become engaged in their care by participating in their care.

In the past, patients did not have as much input into their care. Now, by using this patient portal and an integrated electronic health record, patients could add medications that they are on that they forgot to tell the

doctor. They could add problems that they -- that they came to. They can upload photos of dermatological disorders and have a doctor take a look at them, and they have a larger engagement in the care, and having patients engaged in their care turns out to be -- have patients have better outcomes and are more responsible for their care.

Q. Now, is St. Luke's the only provider in the state of Idaho with a patient portal?

A. No.

Q. So what is it that, in your view, makes MyChart unique?

A. What makes MyChart unique is the patient engagement factor, allowing patients to actually engage and participate in how care is rendered and their views and their values and their -- and stuff that they forgot. The doctor becomes more of a partner as opposed to someone that I just go and see.

Q. How much time has St. Luke's spent developing the MyChart patient portal?

A. Over the past three years. It's very difficult to quantify just the specific MyChart portal, but overall we've spent in employee time between 750,000 and a million hours' worth of time developing this application.

Q. Hours?

A. Hours.

Q. And when a patient -- when a St. Luke's patient goes onto the patient portal to review their medical information, a patient in the Treasure Valley, what's the source of that medical information they're looking at?

A. The source of that medical information is the Epic medical record.

Q. And if a St. Luke's patient in the Treasure Valley goes onto the St. Luke's portal, are they able to view data from medical records other than what's contained in Epic?

A. No.

Q. And why not?

A. The other electronic medical records don't integrate with Epic.

Q. So is there just one St. Luke's patient portal, MyChart?

A. No. There are actually three.

Q. And what are the three portals?

A. Well, we have -- as we just spoke about, we have the MyChart medical -- MyChart patient portal, which is attached to Epic. We have the Magic Valley patient portal, which is tied to our Centricity platform. And with Saltzer we have the ECW patient portal, which is attached to Saltzer and ECW.

Q. So there are three different St. Luke's patient portals?

A. Presently, yes.

Q. So if a Saltzer patient wants to look at medical records from Saltzer through the portal, they have to log into the Saltzer portal?

A. That's correct, yes.

Q. And they won't see -- will they see in that portal information that's contained in St. Luke's records on Epic?

A. No. If they saw patients in St. Luke's and in Saltzer, they'd have two patient portals.

Q. And so why doesn't St. Luke's just push all those three portals together so that a patient who goes to Saltzer or St. Luke's in the Treasure Valley or St. Luke's in the Magic Valley can see all of their records from those three systems in one place?

A. Well, presently, the three systems don't integrate, and the amount of technological development as well as resources would be prohibitive to do that.

Q. If Saltzer was on Epic, would a Saltzer patient be able to access his or her Saltzer records and St. Luke's records through the same portal?

A. Yes.

Q. Now, Doctor, in your mind, I think we -- the lawyers have used the terms "electronic medical record" and "electronic health record" interchangeably. In your mind, as somebody who works in this field, is there a difference

between an electronic medical record and an electronic health record?

A. Yes, there is.

Q. Can you explain what the difference is?

A. Sure. An electronic medical record is exactly analogous to what the term implies. So it is typically capturing an electronic or digital representation of a paper chart. It does mainly contain nursing and physician information just based upon that encounter. While an electronic health record is focused on the overall health of the patient, from outpatient to inpatient, to surgery, to home health, to your case management, dieticians, and nutritionists. The scope and the breadth of an electronic health record spans the life of the patient, as well as all of the encounters that they will appear. So an electronic health record, when you see a patient, gives you a better view of the patient's wishes, their desires, their medical status, as well as their path through the health system.

Q. Which do you consider Epic to be?

A. Epic is an electronic health record.

Q. Now, are you familiar with the EMR system that Saltzer is currently using?

A. I am.

Q. What system is that?

A. It's eClinicalWorks.

Q. And how is it that you're familiar with eClinicalWorks?

A. I've had to support eClinicalWorks from both an IT infrastructure perspective, as well as from a partnering with the clinicians on workflow perspective.

Q. Is eClinicalWorks what you would consider an electronic medical record or an electronic health record like Epic?

A. I would consider it an electronic medical record.

Q. Why?

A. eClinicalWorks --

MS. DUKE: Your Honor, at this point, we're going to object to beyond the scope of this witness disclosure.

THE COURT: I don't know -- obviously, I don't have access to the report. I assume we're talking about a Rule 26 expert report?

MR. STEIN: No. It's a fact witness.

MS. DUKE: No. It's a fact witness disclosure.

THE COURT: Okay. I'm sorry.

Mr. Stein.

MR. STEIN: Dr. Chasin is in charge of St. Luke's medical records system. He was disclosed for that purpose. He was deposed about -- he was deposed for a full day by plaintiffs' counsel regarding --

THE COURT: Where are we going? I mean, how far

do you intend to get into the eClinicalWorks?

MR. STEIN: I have just another page of questions about the relationship between the integration of Saltzer system and St. Luke's system.

THE COURT: Ms. Duke, was that not disclosed that he would discuss the --

MS. DUKE: Here is what was disclosed related to medical records: "Dr. Chasin will be called to testify about the benefits and costs of implementing a systemwide common electronic health record," period.

So if it's anything about pros, cons of eClinicalWorks, what it can or can't do, I -- that should have been disclosed.

MR. STEIN: It was disclosed. A systemwide medical record, by definition, means one record for everyone in the system, the system here being Saltzer and St. Luke's. And this is not a surprise. Dr. Chasin was deposed by plaintiffs' counsel. He was asked about Saltzer's record. He was asked about St. Luke's record.

THE COURT: Would you restate what is on that disclosure again?

MS. DUKE: Sure, Your Honor. "Dr. Chasin will be called to testify about the benefits and costs of implementing a systemwide common electronic health record."

THE COURT: Well, I guess my view is that to

discuss the benefits of implementing a systemwide electronic health record would necessarily require at least some comparison of what it is replacing, so I'm going to give counsel some leeway, but -- so I'll overrule the objection -- but we're not going to go any further down that road, except just simply to draw out how moving to the Epic and the MyChart -- I think -- is it MyChart?

THE WITNESS: Correct.

THE COURT: -- MyChart provides benefits to the patients.

MS. DUKE: Great. Thank you, Your Honor.

THE COURT: Mr. Stein.

MR. STEIN: I'm sorry.

BY MR. STEIN:

Q. Dr. Chasin, have you personally been involved in efforts to create some kind of interface between St. Luke's Epic system and Saltzer's ECW system?

A. Over the past couple of months, we have investigated the ability; however, at this time, there is no ability to integrate or interface eClinicalWorks and Epic. The best we are able to do is create a -- what is analogous to a virtual type of handshake that would allow at one specific time a doctor at each site to see minimal data on -- on a specific patient.

Q. So does this handshake allow for an integrated,

you know, fully integrated exchange of medical information between Saltzer and St. Luke's?

A. No.

Q. So what capabilities does this handshake arrangement between Saltzer and St. Luke's provide?

A. What this provides is a basic framework of core data that has basic demographic information, some administrative information, minimal amount of clinical information, such as allergies, some lab work, as well as some patient problems. But it's not of every visit. It is on a specific visit.

Q. So if a -- let's say in the current environment a patient goes to see her Saltzer primary care doctor, and then a few months later that same patient goes to see a St. Luke's doctor. When the St. Luke's doctor pulls up that patient's record in Epic, is there going to be any information in there from the patient's visits to Saltzer?

A. No.

Q. And if the St. Luke's doctor doesn't know that the patient previously saw a Saltzer physician, does this -- what you described as a handshake, is there any way that it will notify the St. Luke's doctor, hey, there is information that you need to go get from Saltzer?

A. No. There is no way of it automatically querying the source record. What would have to happen is an

interaction would have to happen between the doctor and the patient or the nurse of the patient and query them, have they been seen somewhere. And then the patient and that office would have to call over to Saltzer and initiate that handshake from that area. It's not -- they can't query it from the receiving.

Q. So it's still a manual process?

A. It is a manual process, yes.

Q. How would this process that you just described be different if Saltzer were on Epic?

A. If Saltzer were on Epic, the information would be completely integrated. When you see that patient, the entire health history of that patient would be present, all the lab work that they had ever done, all the radiological images they had done, all the contemporaneous notes that the patient has been involved in, as well as all the health maintenance information, as well as all of the pending tests or preventive care measures that haven't been done. You would be able to see referrals that the patient has executed against, as well as care and referrals that have not been completed yet.

Q. So can -- in the current environment can Saltzer and St. Luke's physicians make notes in each other's charts about the same patient?

A. No.

Q. Would they be able to do that if they were on Epic?

A. Yes. It would be one integrated record.

Q. And let's say that in the current environment a St. Luke's physician does find out that a patient previously went to Saltzer, and they are able to call Saltzer, initiate this handshake arrangement, what is it that the St. Luke's physician gets in response?

A. The St. Luke's physician gets, analogous to what I had said before, a minimal amount of core data, and that core data is administrative and demographic data in order to carry out insurance and know where their coverage is. They get patient headers on where they've been -- what their medical record number is and stuff like that, as well as minimal clinical information, problems that they currently have, some lab work on a per-visit basis. It's not all the lab work that they have had. And they get some patient allergies, some core information in order to try to have the most up-to-date information to render care on that patient.

Q. So what -- that sounds like -- you've ticked off a few things. What isn't St. Luke's getting even with this handshake arrangement?

A. Sure. They're not getting the note on the rationale on why the doctor chose the diagnosis, what medications the patient is on, where their most preferred

pharmacy would be, what lab tests they've had a year ago to track and trend. They don't have health maintenance. They don't have the same type of preventive care alerts that an integrated record would provide. And, again, you don't see the full scope of the patient. All you get is the data that happened in the most recent -- the recent visit.

Q. And so, but does not having those things that are missing --I mean, does that have any impact on patient care?

A. In my opinion, it has a tremendous amount of impact on patient care. In order to treat a patient effectively and respectively, you need to have the most up-to-date and most accurate information possible.

Q. And so when St. Luke's calls up and is able to initiate this handshake arrangement, at that point can't St. Luke's just take that information and incorporate it into the Epic record so it's there for future reference?

A. No. There is no way to integrate the two records.

Q. Now, the court has heard or at least there has been cross-examination questions about a recent announcement by eClinicalWorks that they have purportedly developed some kind of interoperability with Epic. Are you familiar with that?

A. I am familiar with that.

Q. And since we're talking here essentially about Epic and eClinicalWorks, should we understand that that

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means that essentially the problems of communication between Epic and ECW that you've described are basically -- have been addressed or are shortly about to be addressed?

A. I can't see that the -- the ubiquitous interoperability of these two records are going to be completed in the foreseeable future.

Q. Well, the capabilities or the limitations that you've described of communication between Epic and eClinicalWorks, do the -- does this recent announcement by eClinicalWorks indicate to you that those problems are likely to be -- are being resolved?

A. No. In looking at that memo, there are two -- and I have -- I have read it -- there are two types of interoperability. And there is syntactic interoperability and semantic interoperability. And what the difference is is syntactic interoperability is just the ability of two separate systems being able to communicate with one another. And that means they have the same communication protocols, a zero in one system will become a zero in another system, an A and an A. And that's the bare bones of interoperability which that memo is referencing, that ECW and Epic have syntactic interoperability.

The next step, which is true interoperability, which I do not see in the foreseeable future, is interoperability that is called semantic interoperability,

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in which both systems can accurately interpret the data that's coming up and act on it appropriately, so much so that the end users of each system agree that the interpretation is appropriate.

Q. And on the subject of creating a systemwide record -- perhaps notwithstanding Epic and eClinicalWorks and other systems -- there were some questions raised yesterday about the government's meaningful use regulations. And are you -- in the course of your work, are you generally familiar with those?

A. Yes, I am.

Q. And you're -- is it your understanding that St. Luke's and Saltzer and other groups have received what are called "meaningful use dollars" in order to facilitate the development of electronic medical records?

A. Yes. Meaningful use is a program that doctors and organizations have gone through to address the adoption of electronic health technology.

Q. And do the meaningful use requirements require that systems that providers adopt meet with certain minimum type of systems?

A. Meaningful use, one of the bullet points or the goals that you have to achieve with meaningful use is the certified electronic health technology that you're using has to be able to communicate with other systems.

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Q. So doesn't that mean that when everyone is compliant with meaningful use, the types of communication and interoperability issues that you've just described are not going to be an issue anymore?

A. No. It's left to the individual vendor or program to determine and define what that communication means. Again, so it suffices -- you -- you hit that meaningful use acceptance or credit for it even if you have this rudimentary interoperability.

Q. So let's switch to another alternative that has been suggested to systemwide integration of St. Luke's and Saltzer's medical records, which is the Idaho Health Data Exchange.

A. Yes.

Q. This is the organization you're still on the board of?

A. Yes, I am.

Q. What is the Idaho Health Data Exchange?

A. The Idaho Health Data Exchange is a repository of health information for the state of Idaho.

Q. Is it an electronic medical record?

A. No.

Q. So what is the relationship between the Idaho Health Data Exchange, this repository that exists, and providers' electronic medical records?

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A. Well, the Idaho Health Data Exchange has bare bones, very much scaled-down information from an -- a completely electronic health record. It essentially will have the same information that we spoke about earlier and with this virtual handshake would be -- it constitutes the same information.

Q. Now, apart from your serving on the board, does St. Luke's support the Idaho Health Data Exchange?

A. Yes.

Q. Financially?

A. Financially, yes.

Q. Why?

A. Having the -- having some data to help with medical decision-making of a patient is better than having none. It's important as a clinician and as a health system supporting our community to provide at least minimal data, where available, to help clinicians render appropriate clinical care.

Q. So is every provider in the state of Idaho a participant in the Idaho Health Data Exchange?

A. No.

Q. And if a provider doesn't participate in the Idaho Health Data Exchange, is there -- is information from their records available to other providers through the exchange?

A. No.

Q. Has Saltzer ever been a member of the Idaho Health Data Exchange?

A. No, they have not.

Q. So even before St. Luke's acquired the Saltzer practice, did St. Luke's have any ability to access any records for services provided by Saltzer doctors at their clinic?

A. No.

Q. And so if Saltzer is not a member of the Idaho Health Data Exchange, does St. Luke's have any ability to get information from Saltzer through the Idaho Health Data Exchange?

A. No.

Q. And what type -- generally, again, what type of information is and is not available to St. Luke's from other providers through the Health Data Exchange?

A. The information that's available is the same as would be in this virtual handshake. It would be some demographic information, some administrative information, limited clinical information, such as allergies, problems, and some medications.

Q. What about things like the doctor's notes and things that they would keep in their chart?

A. That would not be available, nor would any health maintenance or long-term lab work, or radiological studies

are not housed in the Health Data Exchange.

Q. Okay. So if I'm a doctor or a hospital and I participate in the Health Data Exchange and a patient comes to me, how do I know that there are other records for that patient that I might be able to access through the Health Data Exchange?

A. You would have to ask the patient.

Q. And then if the patient tells you, then what do you have to do?

A. Then you would have to query, query the database on a -- through their -- through their portal.

Q. When you say "query the database," you mean you have to go and query the Health Data Exchange?

A. You have to log into their -- their provider portal and search for that patient.

Q. Okay. So let's say the provider does that and then they get some information, they can pull that information off the exchange and then integrate that into their own medical record; right?

A. No.

Q. Why not?

A. Right now, the way that -- the only way -- there is no integration between the Health Data Exchange and Epic.

Q. And so just -- can you explain to the court, just generally, when we talk about querying the Health Data

Exchange, what is it that the provider gets? I mean, are they getting a fax? Is there a paper record? Is it a download? What are they getting?

A. It's a window in their browser that they are able to see what was done by -- what is -- what was done by another provider in care before they've received it.

Q. So it just -- it's something they can view in their Internet browser?

A. Yes.

Q. And can they make notes on the records and things like that?

A. No.

Q. And what happens when they close their web browser?

A. Information goes away, and they are back to their own record.

Q. If Saltzer were to join the Idaho Health Data Exchange, would that provide the same benefits to Saltzer and St. Luke's as if Saltzer were on Epic?

A. No. The current virtual handshake created by the interoperability between Saltzer and Epic is the same type of information that you would get from a connection between St. Luke's and the Idaho Health Data Exchange.

Q. So on this subject of, again, an integrated record, one of the things the court also heard was from

Dr. Peterman of Primary Health about some work that they've done with St. Luke's. And so are we to understand that St. Luke's currently has an electronic health record exchange with Primary Health?

A. No.

Q. So what exactly is the degree of integration, if any, between St. Luke's medical records and Primary Health medical records?

A. The degree of any integration is not between our electronic health record. It is a sending of laboratory data and limited radiological studies to his facility. That's the extent the integration goes.

Q. Lab and imaging?

A. Lab and imaging.

Q. And is that an exchange? In other words, they get St. Luke's lab and imaging data, and St. Luke's gets their lab and imaging data?

A. No, it's just a send.

Q. Who sends who?

A. We send it -- I'm sorry. St. Luke's sends it to Primary Health.

Q. And does St. Luke's get back lab and imaging information from Primary Health?

A. No.

Q. And do you consider the arrangement that St.

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Luke's and Primary Health have with respect to lab and imaging to essentially be equivalent to having a fully integrated medical record?

A. No, it's not a fully integrated medical record.

Q. So if a primary -- even with this interface that Dr. Peterman described, if a Primary Health patient comes in to St. Luke's and the St. Luke's doctor pulls up the patient record in Epic, is there going to be any information in there from any visits that the patient has had at Primary Health?

A. No.

Q. Just before we move off of the issue of the Idaho Health Data Exchange, is the data in there -- when a participant goes to query the Idaho Health Data Exchange, and there is information from another provider, is the one who is doing the query, are they getting real-time data from the other provider's medical record?

A. No, they're not.

Q. So why not? I mean, how -- how old or recent is the data?

A. It's very -- it's very difficult to determine. Each organization has their own way that they've defined how frequently they will set up. Some are weekly. Some are biweekly. That's left up to the individual organization.

Q. And what are the long-term plans for the Idaho

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Health Data Exchange?

A. Well, right now, the federal grant for HITECH runs out in March. The Idaho Health Data Exchange is working towards a sustainability model, but that's yet -- that's yet to be seen. So that is the fate or the -- what is to be the Idaho Health Data Exchange we'll know after March.

Q. When you say "sustainability" you mean financial sustainability?

A. Financial sustainability, yes.

Q. Just one last thing I would like to touch on that's been broached as, again, another alternative to having St. Luke's and Saltzer affiliated is the affiliate EMR program. And you're familiar with that?

A. I am, yes.

Q. Can you just describe briefly what the affiliate EMR program is?

A. Sure. I spoke earlier about the benefits of being on an integrated electronic health record. And we feel that encouraging other physicians to participate in the care of the patient is not only going to improve their practice as a physician, but it's also going to improve the care of the patient receiving care because that patient and that physician have the most up-to-date, most recent data available.

Q. And so what is the affiliate EMR -- how does the

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affiliate EMR program advance that?

A. By providing services and our myStLukes record, expanding that footprint improves that.

Q. Expanding it to independent providers?

A. Independent providers, yes.

Q. And is it St. Luke's plan as part of the affiliate EMR program to pay all of the costs that are involved for having independent providers in the community adopt Epic?

A. No.

Q. And why not?

A. The Stark and anti-kickback laws prevent -- prohibit us from doing that.

Q. And do they prevent -- is it your understanding they prevent St. Luke's from providing any financial assistance?

A. No. We have agreed to provide assistance for the startup licensure costs.

Q. When you say "startup licensure costs," would that be like the initial cost to purchase the Epic software?

A. Yes.

Q. What is the degree of subsidy that St. Luke's is able to provide for that?

A. We've agreed that 85 percent, the maximum that we are allowed to subsidize, we would.

Q. Now, if an independent provider were to adopt

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Epic, would there just be that one cost associated with using the Epic system, in other words, just buying the software?

A. No.

Q. Are there ongoing maintenance costs?

A. Yes, there are.

Q. And is St. Luke's affiliate EMR program going to cover ongoing maintenance?

A. No.

Q. What about if a provider needs to update their computer hardware in order to be able to run the Epic platform, is St. Luke's going to be able to provide financial assistance for that?

A. No.

Q. What about -- what about the time that providers have to spend on training, you know, their staff and the time they have to spend getting up to speed? Is St. Luke's going to compensate independent providers for any time or income that's lost from that?

A. No.

Q. So what is the status of the affiliate EMR program?

A. The affiliate EMR program has just been approved within the last 60 days.

Q. What does that mean? Does that mean that

St. Luke's is getting ready to roll the Epic system out to everybody?

A. No. It means that we now can start building an infrastructure, developing a plan, getting a team together, as well as a group to pilot this in order to do a proof of concept.

Q. And is there a group that is going to be piloting the Epic platform --

A. Yes.

Q. -- for the affiliate EMR program?

A. Yes.

Q. Who is that group?

A. It is Women's Health Associates.

Q. And how many providers are in that group?

A. There are five physicians.

Q. And have the costs to St. Luke's of subsidizing Epic for that particular group of five providers been estimated?

A. Yes.

Q. And what are the costs to St. Luke's just for that five-provider group?

A. The cost to build out and kick off the pilot program equate to approximately $1.4 million.

Q. And does that $1.4 million include the costs that -- of the subsidy for the software that St. Luke's is

providing?

A. Yes.

Q. So how much is the Women's Health group going to have to pay to access Epic even after the St. Luke's subsidy?

A. Around $20,000 per provider.

Q. So would that be meaning $20,000 times five?

A. Yes.

Q. Okay. So $100,000 for the group just for the software?

A. Yes.

Q. And is that $20,000 cost, is that unique to Women's Health, or is that -- is that a general estimate for what it would cost on a per-provider basis for others who would want to participate in the affiliate EMR program?

A. It is a general estimate of what it would cost to participate in a program like that.

Q. So if a 40-person group like Saltzer wanted to obtain Epic through the affiliate EMR program, they're looking at about $800,000 just in software costs?

A. Yes.

Q. And on top of that, they'd have to pay ongoing maintenance?

A. Yes.

Q. Computer hardware?

A. Yes.

Q. Training and any loss of income or productivity resulting from the switch to a new system?

A. That's correct, yes.

Q. And you mentioned this pilot program. When is it that St. Luke's is currently anticipating, assuming that the pilot were to work, that Epic would be made available to purchase by other independent providers in the community?

A. We anticipate the pilot program going live around the fourth quarter of the calendar year of 2014, and if all goes well and -- we would deploy and open it up for -- in 2015 for other independent providers.

MR. STEIN: No further questions.

THE COURT: Cross.

MR. PERRY: Good morning, Your Honor. Michael Perry for the Federal Trade Commission.

Defendants have designated portions of Dr. Chasin's deposition as AEO, but I think my examination is largely going to cover the same topics, and I think we can keep the courtroom open and address any AEO issues as they arise.

THE COURT: Excellent. Thank you, Mr. Perry.

CROSS-EXAMINATION

BY MR. PERRY:

Q. Dr. Chasin, you recall that you were deposed in this case?

A. Yes.

Q. Are you aware that St. Luke's designated your deposition as testimony on behalf of St. Luke's as an organization for certain topics?

A. No.

MR. PERRY: I'll represent to the court and to Dr. Chasin that St. Luke's designated Dr. Chasin's prior deposition testimony as 30(b)(6) testimony on topics which included -- and I'm paraphrasing -- St. Luke's implementation and use of an electronic medical records system.

BY MR. PERRY:

Q. Dr. Chasin, you mentioned when you were at the Bon Secours system you developed what I believe you called an "enterprisewide EHR system"; is that correct?

A. That's correct.

Q. St. Luke's has not yet fully implemented an enterprisewide EHR system, has it?

A. No.

Q. St. Luke's is in the process of doing so; right?

A. That's correct.

Q. In the Treasure Valley specifically, St. Luke's has implemented this Epic system for ambulatory settings; is that right?

A. No.

Q. St. Luke's has not implemented Epic for the ambulatory settings?
A. They have, but it goes beyond that.
Q. Okay. And the ambulatory setting, that's -- speaking about that specifically, that's primarily physician offices and clinics; is that right?
A. The ambulatory aspect; that's correct.
Q. St. Luke's has not yet implemented Epic even in the Treasure Valley for its inpatient facilities; correct?
A. That's correct.
Q. St. Luke's has not yet implemented Epic for the emergency department?
A. That's correct.
Q. St. Luke's has not yet implemented Epic for nursing documentation; is that correct?
A. Can you -- depending upon which nursing documentation you're referring to. Is it ambulatory nursing documentation or is it inpatient nursing documentation?
Q. Inpatient.
A. Then that is correct.
Q. St. Luke's has not yet implemented the inpatient Epic module for perioperative; is that correct?
A. That's correct.
Q. The obstetrical unit?
A. That's correct.

Q. Anesthesia?
A. Correct.
Q. Home health?
A. Correct.
Q. Interventional cardiology?
A. Correct.
Q. And medical oncology?
A. Correct.
Q. At your deposition, you testified that you don't anticipate these inpatient components of the Epic system will be implemented until September or November of 2015; is that right?
A. That's correct.
Q. And even that September or November of 2015 date won't include some components of the Epic system, such as interventional cardiology?
A. Correct.
Q. In fact, isn't it true that you aren't even sure whether inpatient will be fully implemented by this 2015 target date?
A. That's correct.
Q. Let's talk about the Magic Valley. As of your deposition, there was not even a target date for implementing Epic in the Magic Valley; is that correct?
A. That's correct.

Q. And that is because, at least in part, you first need to see how the Treasure Valley implementation goes; correct?
A. That's correct.
Q. In fact, you explained at your deposition that the Magic Valley implementation hasn't even been budgeted yet; is that correct?
A. That's correct.
Q. And regardless, you are confident that the Magic Valley implementation will be sometime later than 2017; correct?
A. Correct.
Q. St. Luke's Magic Valley is currently on an EMR system called Centricity; is that right?
A. Their ambulatory, yes.
Q. That's a different system than the Epic system that St. Luke's is implementing in the Treasure Valley currently?
A. And that is also different than the system on the inpatient.
THE COURT: Could you get a little closer to the microphone?
THE WITNESS: Yes.
BY MR. PERRY:
Q. At some point in your direct examination you

mentioned the phrase "foreseeable future" on a different topic. Is it fair to say that you don't know whether St. Luke's will be able to implement a systemwide electronic health record for the foreseeable future?
A. No, that's not correct.
Q. You know it won't be until at least 2017 at the earliest; correct?
A. No, that's not correct.
Q. Is it your testimony that St. Luke's will have a systemwide electronic health record before 2017?
A. We will start to build and develop our electronic health system before 2017.
Q. Is it your testimony that St. Luke's will have implemented a systemwide electronic health record before 2017?
A. No.
Q. And when you're describing systems like the Idaho Health Data Exchange and several other alternatives that you were asked about on direct examination, you're describing what's available today, not sometime in the 2017 or beyond time frame; is that correct?
A. That's correct.
Q. You mentioned on direct that Saltzer uses an electronic medical records system known as eClinicalWorks; is that right?

A. **Yes.**
Q. And there are a number of physician groups in the Treasure Valley that use eClinicalWorks; is that correct?
A. **Yes.**
Q. And I believe you mentioned on direct that eClinicalWorks is the system that Primary Health uses?
A. **Yes.**
Q. At your deposition, you testified that no work has been done to get Saltzer -- the Saltzer physicians on Epic; correct?
A. **Correct.**
Q. And you have not even looked at how long that would take?
A. **That's correct.**
MR. PERRY: Mr. Oxford, will you display the demonstrative Exhibit 3005.
MS. DUKE: Your Honor, can we turn the main screen on?
THE COURT: Yes.
MS. DUKE: Thank you.
BY MR. PERRY:
Q. Dr. Chasin, you discussed on direct a recent announcement that eClinicalWorks and Epic have worked collaboratively to make their EHR systems interoperable?
A. **Yes.**

Q. Is this the announcement that you'd mentioned on direct?
A. **Yes.**
Q. And I think you used the term "syntactic interoperability" on your direct?
A. **Yes.**
Q. Nothing in this announcement says anything about "syntactic interoperability," does it?
A. **No.**
Q. That was just your assumption about how the system worked?
A. **Actually, referring to "XDR" and "XDS" is referring to that type of interoperability.**
Q. You are obviously not privy to what strategic plans eClinicalWorks may have; correct?
A. **(No audible answer.)**
Q. Is that a no?
A. **That's a no.**
Q. Thank you.
On direct you discussed St. Luke's affiliate EHR program; is that correct?
A. **Yes.**
Q. And St. Luke's wishes to make the Epic ambulatory EMR available to independent physician practices as quickly as possible; is that right?

A. **Yes.**
Q. And an independent physician participating in the affiliate EMR program would be utilizing the Epic system in exactly the same way as an employed St. Luke's Clinic physician would be; correct?
A. **That's correct.**
Q. You discussed some of the cost estimates regarding the affiliate EMR program on direct. I just want to make sure I have some of the details correct. At your deposition you testified that the estimated cost for a physician in the affiliate EMR program would be 30- to $35,000 for the initial license; is that right?
A. **That's correct, yes.**
Q. And then you estimated an ongoing maintenance of 2500 to 3500 dollars per year; is that right?
A. **That's right, yes.**
Q. And for independent practices that participate in the affiliate EMR program, St. Luke's has decided that it will just defray 85 percent of that 30- to $35,000 upfront cost?
A. **Yes.**
Q. And you mentioned some ongoing costs that an independent group like Saltzer would have if it participated in this program. And you discussed maintenance costs. I think that was the 2500-to-3500-dollar estimate?

A. **Yes.**
Q. If a physician group like Saltzer that currently has an EMR system, if it switched to the affiliate program, it would save whatever they're currently paying to eClinicalWorks, or whoever their vendor is for similar maintenance costs, to the extent that there are any; correct?
A. **That's correct.**
Q. I think you also mentioned the cost of switching computer systems or upgrading hardware. Do you recall that?
A. **I do, yes.**
Q. And, again, if a group like Saltzer that already has an existing EMR system, if it switched to the -- it would incur costs, presumably, upgrading hardware, switching computers, even if it stayed on its existing system; is that correct?
A. **I don't know if I understand your question.**
Q. If an organization like Saltzer that has an existing EMR system, they, presumably, if they needed to update hardware or switch computers, they would incur those costs under their existing system as well; correct?
A. **Yes.**
Q. You mentioned on direct the Idaho Health Data Exchange. Is that often abbreviated as "IHDE"?
A. **Yes, it is.**

Q. The goal of the IHDE is to allow different healthcare providers, including physicians and hospitals, to allow their electronic medical records systems to interact and exchange information; correct?

A. That is their goal, yes.

Q. St. Luke's is building an interface to the IHDE which will facilitate data transfer and better coordination of care as clinicians will have access to critical information from other places care is rendered, such as Saint Al's. Is that accurate?

A. That's accurate.

Q. And, Dr. Chasin, you see the IHDE as an institution that can help allow the facilitation and review of patient care data across different providers; correct?

A. Correct.

Q. And IHDE can help facilitate the coordination of care among providers not on the same EMR; right?

A. Correct.

Q. You mentioned St. Luke's MyChart portal and several other portals that apparently are in place at St. Luke's. Through the IHDE, patients can get access to their electronic health record through a portal even if they receive care from a provider not within the St. Luke's Health System; is that correct?

A. That's incorrect.

Q. Mr. Oxford, can you display cross Exhibit 3016. On the first page.

Dr. Chasin, Exhibit 3016 is an entry from Dr. Pate's Prescription for Change blog, dated July 23rd, 2013. Do you recognize this exhibit?

A. I do.

Q. And other than the introductory paragraph that's currently blown up on the screen, did you write what's written in this exhibit?

A. Yes.

Q. And if you turn to the second page, the last four paragraphs, please, Mr. Oxford.

You can see in the second paragraph that's displayed on the screen that you're discussing in this blog post St. Luke's MyChart tool. Do you see that?

A. Yes, yes.

Q. And then the last two paragraphs on this page, you write -- you ask a rhetorical question and then answer -- I'll read that for you. The question --

MR. STEIN: I'm sorry. It's disappeared from my screen.

THE COURT: There. It should be back up. Is it on your screen now, Mr. Stein?

MR. STEIN: It is, although I can't -- if we could call it up again. I just can't read what's there.

Thank you.

BY MR. PERRY:

Q. "Question: What if you receive care from a provider not within the St. Luke's Health System, can you get access to your record?

"Answer: The answer is yes. St. Luke's has partnered with the Idaho Health Data Exchange to build a connection to our electronic health record for clinicians not practicing on myStLukes to ensure that providers can access the most accurate medical information so the most accurate diagnoses and treatments can be rendered."

Did I read your blog post correctly?

A. No. You -- your question was referring to patients --

Q. My question is: Just now, did I read your blog post correctly?

A. Yes.

Q. Thank you. To the best of your knowledge, Dr. Chasin, the costs for a physician group that -- to join the IHDE for an independent physician is less than $200 a month; correct?

A. I think so, yes.

Q. And the interface through IHDE is easy to use;

right?

A. Relatively, yes.

Q. I believe in your direct, you mentioned that St. Luke's participates in the Idaho Health Data Exchange because you believe -- and I'm paraphrasing your testimony -- that it's important to have some data available. I believe you used -- maybe you used the term "virtual handshake"; is that correct?

A. Yes, that's correct.

Q. But isn't it true, Dr. Chasin, that the same data is available through the IHDE as through Epic?

A. Can you clarify what "same data" means?

Q. I'm asking you. Isn't it true that the same data is available through the IHDE as through Epic?

MR. STEIN: Your Honor, I would just object to the form. I think the issue is -- is the question whether everything in Epic is available on the Idaho Health Data Exchange or whether for those common -- for those things that are available in both it's the same data. I think those are two different questions.

THE COURT: Mr. Perry, if you could clarify.

MR. PERRY: Let me rephrase and ask a slightly different question.

THE COURT: I know we're probably past where we take the break, but I'll let you pick a spot.

MR. PERRY: Okay. I think it will be -- I should be completed relatively shortly.

THE COURT: All right.

BY MR. PERRY:

Q. Dr. Chasin, you remember being deposed in this case?

A. Yes.

Q. And do you recall that you were asked a question, "Is the same data available through the IHDE as through Epic?" Do you recall that?

A. Yes.

Q. And do you recall providing the answer, "Yes"?

A. I don't recall that, no, but --

Q. Is the answer yes?

A. It's -- it's more complicated than that. There is the subset. There is a subset of data available on the Idaho Health Data Exchange that is from the Epic record, yes. Is it as comprehensive? Absolutely not.

MR. PERRY: Mr. Oxford, can you play video clip MC24. For the record, this is Dr. Chasin's deposition, page 35, lines 20 through 22.

(Video clip played as follows:)

Q. "But is the same data available through the IHDE as through Epic?

A. "Yes."

(Video clip concluded.)

MR. PERRY: Nothing further, Your Honor.

THE COURT: Mr. Stein, how much redirect do you have?

MR. STEIN: Maybe five minutes.

THE COURT: Why don't we just take the break, and then we'll come back.

Counsel, just so we're clear, I'm going to take just a moment now since this may affect you in your planning. The issue arose concerning taking the -- or rather using the deposition of Dr. Sonnenberg, who I understand was a former director of Saint Al's at the time his deposition was taken, but it was subsequently learned by Saint Al's that he was at the same time actively negotiating with St. Luke's and potentially moving to St. Luke's, which, ultimately, I guess did not happen, and he is now independent. St. Luke's has indicated they want to take the deposition or to use the deposition of Dr. Sonnenberg.

The rule itself provides, under Rule 32(a)(3), that an adverse party may use for any purpose the deposition of a party or anyone who when deposed was the party's director. Technically, that would seem to be satisfied since at the time of the deposition he was the -- a director of Saint Al's.

The problem is, of course, that the rule I don't think

envisioned a situation where the person, although a director, was actually negotiating with the party opponent in the same litigation; and, therefore, I'm not sure that that really is at least pursuant to the spirit of the rule, particularly given the Ninth Circuit's statement that there is always a preference for live testimony.

I'm mindful of Rule 1, which directs the court to administer and construe the rules in a way which will effectuate the speedy, inexpensive, and just resolution of all matters. I think, to some extent, all three of those are in play here. I think in terms of what is just, I'm not sure that Rule 32(a)(3) should be applied in a way so as to preclude, for example, Saint Al's from being able to cross-examine Dr. Sonnenberg in the same way they would if he were called as a live witness. On the other hand, there is a question of expense. The video deposition is available.

I'm going to resolve the issue by allowing Dr. Sonnenberg's deposition to be played, but on the condition that he can be subpoenaed at any time between now and close of business on Monday and subject to cross-examination on the issues that I think could have been covered if Saint Al's had known of the issue. If he is not available, then his -- I'm not going to allow his deposition to be played. But I am assuming that we can make him

available. Someone will have to subpoena him. I'll allow you all to work that out.

He will be -- if St. Luke's chooses to play the deposition, that, in essence, will be the direct examination, and then Saint Al's will have the opportunity to cross-examine him as a live witness, immediately on the heels of that, if possible, but that's going to require a little, I suppose, juggling of the existing schedule. That's the way I'm going to resolve the matter, which I think tries to be consistent with the spirit of Rule 32(a) and yet accomplish the aforestated goals of Rule 1.

All right, Counsel, I will allow you, then, to effectuate that plan. It will take a little bit of give and take here.

MS. DUKE: Thank you, Your Honor.

THE COURT: We'll be in recess.

(Recess.)

*****COURTROOM REMAINS OPEN TO THE PUBLIC*****

THE COURT: For the record, I'll advise Dr. Chasin that you are still under oath, sir.

Mr. Stein, you may conduct your redirect.

MR. STEIN: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. STEIN:

Q. Dr. Chasin, which is the most current and accurate

per-provider estimate for the affiliate EMR? Is it the 85 percent?

MR. PERRY: Objection, Your Honor. Dr. Chasin provided his testimony -- deposition testimony in March. After that point, plaintiffs served a notice for a Rule 30(b)(6) deposition.

At that point, defendants took the opportunity to review Dr. Chasin's testimony, and rather than make a representative available on behalf of St. Luke's to provide updated testimony, they elected to designate his prior deposition testimony that had been -- you know, that was earlier in this case. So I think plaintiffs really haven't had an opportunity to take any sort of new, updated information since the time of his deposition.

THE COURT: Mr. Stein.

MR. STEIN: Well, Your Honor, Dr. Chasin has already testified that the -- that the amount for the affiliate program after subsidy is $20,000, and then they played a clip from his deposition however long ago. I'm simply trying to clarify which of those is the accurate figure. One was an estimate a while ago, and one is the current figure. And that was -- that was from his direct.

THE COURT: But if I understand Mr. Perry's objections that he was -- well, not he -- that Saint Al's or the FTC or the State of Idaho was not provided the

opportunity to redepose or to depose Dr. Chasin.

MR. PERRY: Let me clarify there. We served a Rule 30(b)(6) notice. There were a number of topics. Defendants designated three representatives to provide live 30(b)(6), testimony and those witnesses' depositions were taken for the topic that relates to EMR systems that I alluded to in my examination. They first took the opportunity to review the deposition testimony that Dr. Chasin had already provided and then decided to designate that retroactively as 30(b)(6) testimony on behalf of the -- St. Luke's as an organization.

THE COURT: But why does that exclude or limit Dr. Chasin in responding to counsel's question?

MR. PERRY: My understanding of the question was that he is asking for updated information, you know, that's happened since the time of his deposition. His deposition took place in March. It was one of the earlier depositions in this case, and to the extent it calls for information that we could have had an opportunity to ask Dr. Chasin about or another representative of St. Luke's, I think it's improper in light of the decision-making with regard to the 30(b)(6) notice.

MR. STEIN: Your Honor, the 30(b)(6) notice was issued, I think, within a couple of weeks of Dr. Chasin's deposition. And, really, what we're talking about here is

clarifying the record so we don't have a misleading inference. He was asked at his deposition: What is the estimated cost for X? He testified today, based on his knowledge, what the actual cost is to a provider. And I'm simply trying to avoid a situation where --

THE COURT: Well, I'm going to allow it. I'll overrule the objection. I understand the concern, but the problem is there is a dynamic here. If there is some specific prejudice, then perhaps I'll give counsel some leeway to explore the issue further. But I think at this point, I think it's -- particularly, where the witness is simply clarifying his prior testimony, I'll allow it.

Go ahead and proceed, Mr. Stein.

BY MR. STEIN:

Q. So, Dr. Chasin, can you clarify the relationship between the estimate of -- that St. Luke's would be able to subsidize 80 to 85 percent of a total 30- to $35,000 cost and your testimony that the per-provider cost currently after the subsidy is estimated to be $20,000?

A. That's correct.

Q. Which is the current estimate?

A. It's $20,000.

Q. And Mr. Perry asked you whether Saltzer has been integrated on Epic yet, and I think you said the answer is no; right?

A. That's correct, they haven't.

Q. Does that have anything to do with the court's order on the preliminary injunction that St. Luke's limit the integration of Saltzer pending this trial?

A. That's -- yes, sir. That's correct.

MR. STEIN: No further questions.

THE COURT: Any recross?

MR. PERRY: Nothing further, Your Honor. Thank you.

THE COURT: All right. Dr. Chasin, you may step down.

Call your next witness.

MR. STEIN: Your Honor, our next witness will be Dr. Randell Page.

THE COURT: All right.

Dr. Page, would you please step before the clerk, be sworn as a witness, and then follow Ms. Gearhart's directions from there.

RANDELL PAGE,

having been first duly sworn to tell the whole truth, testified as follows:

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: Randell L. Page, P-A-G-E.

THE COURT: You may inquire, Mr. Schafer.

MR. SCHAFER: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. SCHAFER:

Q. Good morning, Dr. Page.

A. Good morning.

Q. What is your current profession?

A. I'm a physician at Saltzer Medical Group.

Q. And how long have you worked with the Saltzer Medical Group?

A. 24 years.

Q. Do you serve on the executive committee at Saltzer?

A. Yes, I do.

Q. And how long have you served on the executive committee?

A. Close to 20 years.

Q. Have you held any other administrative positions at Saltzer?

A. Yes, I have. I was president of the group for about four years, and I have been on the exec -- and I'm also chairman of the contracts committee.

Q. What is your educational background?

A. I graduated from Princeton University, undergraduate; medical school at Philadelphia College of Osteopathic Medicine; internship and residency at Emanuel

Hospital, now Legacy Health Systems in Portland, Oregon.

Q. Can you describe the nature of your practice today?

A. I'm an internist, but my practice for the last ten years or so has been limited to gastrointestinal problems.

Q. And at what locations do you see patients?

A. Primarily at Saltzer Medical Group clinic in Nampa, and also at Saint Al's hospital in Nampa.

Q. And that is still true today after Saltzer's affiliation with St. Luke's?

A. That's correct.

Q. And how long has that been the case?

A. I'm sorry?

Q. How long has it been the case that those are the two locations where you see patients?

A. Oh, I'm sorry. The whole time that I've been here.

Q. Now, Dr. Page, I just have a very few number of questions to ask you today, given the fact that plaintiffs have already introduced a large portion of your deposition testimony. But the first thing I wanted to cover was some statements made by Linda Duer of IPN.

And, Dr. Page, are you aware that during her testimony in this case, Linda Duer testified that she had a conversation with you roughly two years ago and that you

discussed the potential St. Luke's transaction with her?

A. Yes.

Q. And are you aware that Ms. Duer testified that you told her with respect to affiliating with St. Luke's that you were damned if you did and damned if you didn't and that you told her that if you didn't join St. Luke's, St. Luke's would just build a clinic wherever you went because they had more money and more resources than Saltzer?

A. Yes, I'm aware that that's what she said.

Q. Are you also aware that she testified that you told her there was no way that you could compete against St. Luke's?

A. Yes.

Q. How did you become aware that Ms. Duer had made those statements?

A. I read it in the newspaper.

Q. What was your reaction to reading about that in the newspaper?

A. Well, my first reaction was that I was very angry that I had been misrepresented in that fashion by someone that I had known for a long time and felt I had a good relationship with.

Q. Do you recall having any conversations with Ms. Duer regarding the potential St. Luke's deal roughly two years ago?

A. We actually had a number of conversations, casual, candid, brief conversations at IPN board meetings.

Q. And, Dr. Page, did you ever make the statements to Ms. Duer that she attributed to you in her testimony?

A. Absolutely not.

Q. And, you know, it was two -- two years ago, maybe longer. How can you be so sure that you didn't make those statements?

A. Well, because those statements represented thoughts that were not mine. I never thought any of those things, and, therefore, I wouldn't have said them.

Q. So, specifically, did you at any point believe that, you know, if Saltzer didn't affiliate with St. Luke's, St. Luke's would just put a clinic wherever you went?

A. I did not.

Q. And I assume because you didn't believe that, that wasn't part of your consideration as far as supporting the Saltzer affiliation with St. Luke's; is that right?

A. That's correct.

Q. And you were an advocate of the Saltzer affiliation with St. Luke's. True?

A. Yes.

Q. Was any part of your reason for advocating for that affiliation with St. Luke's because you were afraid of competing against St. Luke's?

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A. Absolutely not.
Q. Did you and others at Saltzer have some concerns regarding Saltzer's competitiveness more generally going forward?
A. I think we did. We had had a consultant who had advised us that with changes in the healthcare marketplace, that as an independent group, there would be pressures on us, and if we found the right partner, we'd probably be better off going forward.
Q. And when you say pressures on you and you reference sort of the changes in healthcare market, can you be a little more specific about what it was in that respect?
A. Well, everybody recognizes that there are dramatic changes occurring in the healthcare marketplace. And in order to be successful going forward; to be able to provide the kind of care that we want to, that we have been accustomed to; to be able to make changes that we might need to make going forward in terms of recruiting new physicians, developing new services, and, in particular, changes related to the delivery of healthcare, healthcare reform with respect to providing quality and being reimbursed on that basis; we felt it was very necessary to be part of a larger system than being independent.
Q. Thank you, Dr. Page.
I want to talk to you about an exhibit right now.

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MR. SCHAFER: Your Honor, this has been marked AEO, so if we could leave the screen off, I think there is basically just one number in it that I'll avoid talking about, so I think we don't need to clear the courtroom.
If you could put up 1361. It's Trial Exhibit 361.
BY MR. SCHAFER:
Q. And, Dr. Page, this is a -- Trial Exhibit 1361 is a document that plaintiffs have referenced repeatedly during this trial. Do you recognize this document?
A. Yes.
Q. Can you tell the court, generally, what the issue was that was being discussed in this email chain?
A. The issue was that Blue Cross had changed policy and was no longer going to reimburse for consultation codes.
Q. And do you see in the last sentence of your email at the top of the page, you state that: Perhaps if the Saltzer/St. Luke's affiliation came to fruition, this will be something we could try to get back, i.e., consult codes, as there would be the clout of the entire network. Do you see that?
A. Yes.
Q. What was the basis for your statement or belief that that might happen?
A. I think it was primarily hope and speculation.
Q. Did anyone from St. Luke's ever tell you that they

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believed that Saltzer would be able to bill for those consult codes again if Saltzer affiliated with St. Luke's?
A. No.
Q. And since Saltzer has joined with St. Luke's, has Saltzer been able to start billing Blue Cross again for those consult codes?
A. No.
Q. In fact, do you have an understanding as to whether that change affected all providers in the area?
A. That was my understanding.
Q. And if you look at the second email on the page, I want to avoid saying the specific number here, but you see that Nancy Powell assigns a specific dollar amount to, you know, what she attributed to that change. Do you see that?
A. Yes.
Q. And is the number listed there consistent with your understanding of sort of how big or small an issue it was?
A. Yes.
Q. How much did your desire or hope to get -- to be able to bill Blue Cross for consult codes again, how much did that influence your advocating for the Saltzer affiliation with St. Luke's?
A. Oh, it was tiny. It was sort of a tip of the iceberg, a burr under the saddle kind of a thing. It was

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just another example of insurance companies making random changes in reimbursement and then you just have to deal with it.
Q. More generally speaking, did you ever hear anyone from St. Luke's discuss that Saltzer would be gaining the clout of St. Luke's network in payor negotiations if the parties affiliated?
A. No.
Q. Did anyone from St. Luke's ever discuss Saltzer being able to increase its reimbursement rates from commercial payors as a result of the transaction?
A. No.
Q. When Saltzer was an independent group, did you and others at Saltzer ever attempt to get commercial payors to agree to quality incentives and shared savings plans?
A. We did. We had been trying to get them to do that for years and with -- never with any success.
Q. Did you have any expectation as to whether Saltzer might have more success in getting those sorts of incentives or shared savings plans in contracts with commercial payors if Saltzer were part of St. Luke's?
A. That was the hope that by being part of a larger system with a compelling strategy, a compelling capability, a compelling commitment to dealing with healthcare reform and being able to deliver the quality-not-quantity issue

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that we'd be much more successful.

Q. And was that important to you personally as you considered the potential affiliation with St. Luke's?

A. It was very important to me. It was one of the major reasons for being involved.

Q. Thank you, Dr. Page.

MR. SCHAFER: No further questions.

THE COURT: Cross.

MR. WILSON: Thank you, Your Honor.

THE COURT: Mr. Wilson.

CROSS-EXAMINATION

BY MR. WILSON:

Q. Dr. Page, Linda Duer is the executive director of IPN, is she not?

A. Yes, she is.

Q. And you are still a board member of IPN; correct?

A. That's correct.

Q. It's fair to say that the board of IPN has quite a bit of input as to whether Ms. Duer keeps her job; correct?

A. I actually don't know how that would work.

Q. Well, let's be clear, Dr. Page, about what you're testifying here today. Is it your testimony that Ms. Duer came into this courtroom and when she testified about that conversation she had with you, she lied under oath? Is that your testimony?

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A. I would prefer not to accuse her of lying. I don't know if that's what she was doing or if she was misrepresenting or misunderstanding or if she was -- I have wondered if, as I have thought about why in the world would she say those things, I didn't think it was just a misrecollection because she was so precise in the wording. But I wondered if she was perhaps projecting her own concerns about what was happening onto that discussion and it came out that way in the testimony.

Q. She was precise with her wording, wasn't she?

A. It appeared as though she was recalling word for word a conversation that we had.

Q. And you've testified here today that, in fact, you had several casual and brief conversations with Ms. Duer about the deal between Saltzer and St. Luke's; correct?

A. That's correct.

Q. So you admit that conversations occurred. You're just testifying today that you dispute that this particular conversation occurred the way Ms. Duer characterized it; correct?

A. That's correct.

Q. And you don't have any alternative version of that conversation; correct?

A. Again, there were --

Q. Is that correct, sir?

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MR. SCHAFER: I'll object to form. The basis being if he didn't have that conversation, I don't know how he could have an alternative conversation of that conversation as opposed to generally the conversations he had.

THE COURT: I'll sustain the objection. I think we need to establish that --

BY MR. WILSON:

Q. Are you dispute --

MR. WILSON: I'm sorry, Your Honor.

THE COURT: Just a moment.

MR. WILSON: I apologize.

THE COURT: Just so it's clear, the problem is that the doctor has testified that there were some general conversations but not one on this specific topic. So I think the question assumes a fact that, in fact, such a conversation took place, and I'm not sure the witness is -- in fact, has agreed with that starting proposition.

So Mr. Wilson.

BY MR. WILSON:

Q. Sitting here today, Dr. Page, do you recall the conversation Ms. Duer testified about that occurred following an IPN board meeting out in the hallway?

A. Again, we had a number of conversations, and so I don't recall that -- any specific conversation or this one

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in particular.

Q. You said during your direct examination that when you read about Ms. Duer's testimony in the newspaper, it made you angry, is that right?

A. Yes, I did.

Q. And you were angry when you heard about her testimony because it made you look bad, isn't that right?

A. It was actually a concern of mine that it would make me look as though I was saying things in that setting that I didn't believe or that I wouldn't have said to my friends and colleagues.

Q. You thought it would hurt Saltzer's position in this lawsuit, didn't you?

A. I don't think I considered that. I was more concerned about how it reflected on me and on my relationship with my peers.

Q. Well, you would agree, wouldn't you, that Ms. Duer's testimony about what you said wasn't exactly consistent with what Saltzer is telling this court about the reasons it did its deal with St. Luke's?

A. It's entirely inconsistent.

Q. And, in fact, when you saw that story in the newspaper, you sent a statement to the "Idaho Statesman" to complain about Ms. Duer's testimony, didn't you?

A. Yes, I did.

Q. And I'm reading here from a article that appeared the next day titled "Saltzer Doctor: Deal With St. Luke's Not About Control." And it says here, reading from your statement: "At no time did we feel threatened by St. Luke's."

Was that in your statement?

A. Yes.

Q. Is that the truth, Dr. Page?

A. That's absolutely the truth.

Q. How long have you been practicing in the Treasure Valley?

A. 24 years.

Q. You mentioned you've been on the executive committee at Saltzer for almost 20 years?

A. Correct.

Q. Been chair of the contracting committee at Saltzer for 18 years or so; is that fair?

A. Correct.

Q. And you've been a board member of the Idaho Physicians Network for a number of years; correct?

A. That's correct.

Q. So you've been watching what St. Luke's has been doing in the Treasure Valley over the last several years, haven't you?

A. Yes, I have.

Q. They've been acquiring practice after practice; correct?

MR. SCHAFER: Object to form.

BY MR. WILSON:

Q. Isn't that right?

THE COURT: Well, I'll overrule the objection.

THE WITNESS: I'm aware that they've been acquiring practices.

BY MR. WILSON:

Q. And they've been acquiring clinic after clinic; correct?

A. I am aware that they've been acquiring clinics.

Q. Well, they've been acquiring clinics right in your backyard in Nampa, haven't they?

A. I don't know that acquiring a clinic in Nampa is the right -- I don't think that's what happened.

Q. Well, you mentioned Ms. Duer says that you complained to her about the specialty clinic out near Costco; correct?

A. She was mistaken. There isn't a specialty clinic out near Costco except in the building where Saltzer has a number of physicians.

Q. And despite the acquisition activity that St. Luke's has been pursuing in the last several years, it's your testimony that you did not feel threatened by

St. Luke's.

A. That's correct.

Q. You read that newspaper article the following day that quoted you; correct?

A. Yes, I did.

MR. WILSON: Mr. Beilein, if you could please put up on the screen Exhibit 3033.

And, Your Honor, this is not AEO if you --

THE COURT: Well, I need to know what it is because I'm not sure that's in our exhibit list.

MR. WILSON: It is not. It's an exhibit we prepared for purposes of cross-examination.

THE COURT: All right. Well, until it's admitted, let's see where we are.

MR. WILSON: Okay.

BY MR. WILSON:

Q. This is the statement you sent to the newspaper; correct?

A. It looks like it.

Q. I notice here, though, that you didn't personally send this statement; correct?

A. That's correct.

Q. A St. Luke's spokesperson sent this statement to the newspaper on your behalf; isn't that right?

A. That's correct.

Q. Who wrote this statement, Dr. Page?

A. I did.

Q. You didn't get any help?

A. That's correct.

Q. You wrote every single word?

A. I wrote every single word.

Q. So you agree with everything in the statement; correct?

A. Yes.

Q. And in this statement, in the second paragraph, you wrote, "In fact, it was made clear" --

THE COURT: Let me inquire. Is there going to be any objection to the exhibit, Mr. Schafer?

MR. SCHAFER: Just on AEO grounds or --

THE COURT: No.

MR. SCHAFER: No, there's no objection, Judge.

THE COURT: All right. Exhibit 3003 [sic] will be admitted and now published -- well, put on the public screen. I want to publish it to the jury, but we have no jury.

Counsel, what is the exhibit number?

MR. WILSON: 3033, Your Honor.

THE COURT: 3033 will be admitted.

MR. WILSON: Thank you.

(Plaintiffs' Exhibit No. 3033 admitted.)

BY MR. WILSON:

Q. In the second paragraph of the statement that was sent to the "Statesman" on your behalf, you write: "In fact, it was made clear to us on many occasions that if no merger occurred, they would still want to work with us in whatever ways could be beneficial."

You mean that St. Luke's indicated to Saltzer that even if the transaction didn't work out, St. Luke's was still committed to working with Saltzer in whatever ways could be beneficial; correct?

A. Yes.

Q. And you still believe that to be the case; correct?

A. Yes.

Q. This conversation that Ms. Duer alleges to have occurred, that occurred, according to her, prior to the filing of this lawsuit; correct?

A. I don't recall the exact date the lawsuit was filed, but if it was 2011, I suppose it would have been.

Q. That's right. And similarly, it would have occurred prior to your knowledge of any government investigation; correct?

A. I -- I don't know.

Q. Well, if it occurred in 2011, Dr. Page, you didn't know about the government investigation then, did you?

A. I'm saying I don't recall when I first became aware of the government investigation.

Q. This statement you sent to the newspaper, though, that was wrote -- written not only after the litigation commenced, but during this trial; correct?

A. Correct.

Q. And it's your testimony, as you wrote in this statement that you sent to the newspaper during the trial, that Saltzer joined St. Luke's because Saltzer and St. Luke's shared the same goals and values; is that right?

A. Yes.

Q. That's your testimony today?

A. Yes.

MR. WILSON: I have nothing further, Your Honor. My colleague, Mr. Ettinger, has some questions.

THE COURT: Mr. Ettinger.

MR. ETTINGER: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. ETTINGER:

Q. Dr. Page, I think I heard you say that Ms. Duer's comments expressed thoughts that were not yours. Did I get that correctly?

A. Yes.

Q. In fact, your position in your deposition on numerous occasions was that your own documents written by

you expressed thoughts that were not yours; correct?

A. I don't recall ever saying that.

Q. Well, not in those words, but for example, why don't we look at Exhibit 1366.

MR. ETTINGER: Your Honor, I think this is AEO. I think Mr. Schafer knows the words I'm going to refer to. I assume that those can be used in open court.

BY MR. ETTINGER:

Q. Okay. So you recall Exhibit 1366, an email you wrote, Dr. Page? Actually, a letter you wrote to your colleagues.

A. Yes.

Q. And you remember this is a letter that got signed by the majority of the Saltzer physicians?

A. Yes.

Q. And you showed it to Mr. Savage and Dr. Kaiser before you sent it around?

A. Yes.

Q. And in the last bullet on the first page, you called St. Luke's the "dominant provider," didn't you?

A. Yes, I did.

Q. And in your deposition, you said, well, by "dominant," I didn't mean they dominate the market; correct?

A. I don't know if those were my exact words. I said that there were probably other words that served the purpose

besides "dominant."

Q. Well, let's look at what you said.

MR. ETTINGER: Your Honor, if we could go --

THE WITNESS: I think I chose "preeminent" --

BY MR. ETTINGER:

Q. All right. Well, you said that --

A. -- or "preferred."

Q. You said the word "dominant" did not -- was not really your thought even though it was your word in your document; correct?

A. I didn't say it wasn't my thought. I said that if I had known I was going to be testifying in court years later, I might have chosen a different word.

Q. And you said that you were not trying to imply that St. Luke's dominates the market by your use of the word "dominant"; correct?

A. Yes.

Q. Okay. And in the same document, you talked on a later page, the second page, about how this provided a wonderful opportunity to control services in Canyon County; correct?

A. Yes.

Q. And your testimony in your deposition was, well, when you used the word "control," that didn't really reflect your thoughts. You didn't mean control in the ordinary

English sense; correct?

A. I didn't mean "control" in the sense that you might have been trying to put on it. "Control" in my mind, when I made that statement, was that Saltzer would be in a position to have input into our own future in the decision-making process. I never thought for a second we could actually control anything because in the insurance marketplace, physicians don't control anything.

Q. Oh, but your word in your letter signed by the majority of the Saltzer physicians, reviewed by the CEO and president of Saltzer was, quote, control, close quote, right?

A. That was the word.

Q. Yeah. But that was not your thought; correct?

A. I didn't say it wasn't my thought. I said that in retrospect, I could have used a different word.

Q. Okay. And -- okay. And then Mr. Schafer showed you the document where you used the word "clout" referring to St. Luke's; correct?

A. Yes.

Q. And was that another poor choice of words?

A. I don't think it's necessarily a poor choice of words. I think clout, if you want to put a negative connotation on it, you can. Clout, if it's used for the right things, is a good thing. You know, the United States

of America has lots of clout; it uses it to accomplish good things all around the world. So that doesn't make clout a bad thing or a bad word.

Q. Well, you said in multiple documents that St. Luke's [sic] would have clout with payors if you did a transaction with St. Luke's; isn't that right?

A. In multiple documents?

Q. Right. You said it in Exhibit 1361, and you said it in a piece you wrote called "FTC Filing: A Saltzer Physician's Perspective," didn't you?

A. I don't know if I used that word in that -- in that document or not.

Q. Okay. Well, let's refresh your recollection.

MR. ETTINGER: Can we -- I think this is also AEO. It's not an exhibit. Your Honor, it's for impeachment.

THE COURT: What's the exhibit number?

MR. JULIAN: It's been claimed as privileged.

MR. ETTINGER: This document has been claimed as privileged?

MR. JULIAN: Yes.

MR. ETTINGER: Your Honor, I don't have a recollection one way or the other, so I guess I can't dispute that. I don't believe it's privileged.

THE COURT: Well, what's the exhibit, 1368?

MR. ETTINGER: Your Honor, this is a deposition

exhibit; it is not a trial exhibit. We're going to use it for impeachment.

MR. JULIAN: It was stated in the deposition that it was privileged and was intended to be clawed back. There was an inadvertent disclosure and was prepared at my insistence.

MR. ETTINGER: Your Honor, I don't believe it's privileged, but I don't want to take up the court's time now to argue about it. We'll move on.

THE COURT: Thank you, Mr. Ettinger. If there is a need to resolve it, we'll do it. But it would take, you know, a in-camera review of the statement. But, Mr. Ettinger, it's your -- your choice.

MR. ETTINGER: Yeah, I'll just proceed for now, Your Honor.

THE COURT: Thank you.

BY MR. ETTINGER:

Q. Dr. Page, you do believe that St. Luke's has the clout, combined with Saltzer, to get better reimbursement from payors, don't you?

A. This is -- no, I don't. This has never been about better reimbursement.

Q. Well, in Exhibit 1361 when you were talking about the clout of the entire network, you were talking about the clout to get more money, weren't you?

A. No, I wasn't.

Q. If you got the consult codes, as Mr. Schafer showed you, there'd be more money involved; isn't that right?

A. No.

Q. No?

A. The change in the consult codes was taking away money. It was --

Q. They changed the codes and took away the money; you wanted it back; correct?

A. Yeah. What's wrong with that?

Q. The issue is not at the moment what's wrong, but the issue is did you believe that St. Luke's and Saltzer together would have the clout to do so? And when you wrote that email, the answer to that question was yes; correct?

A. I said earlier that I think it was hope and speculation.

Q. Well, in your deposition, you had a different explanation, didn't you? You said that you were naive when you wrote it; correct?

A. Yes.

Q. And at the time you wrote it, you had been chair of the contracting committee at Saltzer for 18 years; isn't that right?

A. That's right.

Q. And you were not naive about managed care contracting after 18 years, were you, Doctor?

A. I wasn't naive about contracting, but I think the statement I made was naive.

Q. The statement you made was about contracting, wasn't it, Doctor?

A. Yes.

Q. And, finally, Mr. Schafer asked you about shared savings and the hope that with St. Luke's you could engage in shared savings programs, that you had tried and the payors were not interested. Was that your testimony?

A. Yes. We tried for years to institute some programs of shared savings. We finally did get one, what I considered to be a minor program with Blue Cross regarding generic prescribing. But considering the number of years that we had been requesting it, the number of suggestions that we had made for ways to try to do that, that was very, very minor.

Q. Doctor, isn't it true that Saltzer never made a specific proposal to any health plan or payor relating to risk sharing, a specific proposal where you used specific numbers? Isn't that true?

A. That's true. Saltzer was never in a position to make a proposal of that nature.

MR. ETTINGER: Nothing further. Thank you.

THE COURT: Redirect, Mr. Schafer.

MR. SCHAFER: Just briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. SCHAFER:

Q. Dr. Page, plaintiffs' counsel just asked you questions about whether or not when you made the statement about potentially getting back those consult codes, whether that was a naive statement. You remember those questions?

A. Yes.

Q. And did it turn out that, in fact, that that was a naive hope?

A. Well, we didn't get them back; that's for sure.

MR. SCHAFER: No further questions.

THE COURT: Any further cross?

MR. WILSON: No, Your Honor.

MR. ETTINGER: No, Your Honor.

THE COURT: All right. You may step down. Thank you, Dr. Page.

THE WITNESS: Thank you.

THE COURT: Call your next witness.

MR. SCHAFER: Your Honor, we are going to be showing the video deposition of Dr. Steven Brown of Saint Al's. Roughly 75 percent of it has been marked AEO by plaintiffs' counsel, so, I mean, we could do the -- switch things on and off and mute or not, but I don't think it's

going to be very efficient, given the amount of AEO in the testimony. It's roughly -- I think it's roughly a 40-minute clip, but the vast majority of it is -- has been marked AEO.

THE COURT: Well, the way that we had approached this is for me to turn off the monitor and the sound, and I could just watch the scrolling transcript for the AEO. But given the -- counsel, you will, however, make available to the public as part of the redacted transcript those portions which are not AEO?

MR. SCHAFER: Yes. And, obviously, I understand that plaintiffs' counsel will have to file an affidavit and actually figure out which parts of that it's going to stand on.

THE COURT: All right.

MR. SCHAFER: So some more will be released, but yes, we will make public what has not been marked AEO.

THE COURT: All right. Ms. Duke, are you agreeable to that?

MS. DUKE: That's my understanding of the process, Your Honor.

THE COURT: All right. Very good. All right. Then we will -- we'll have to clear the courtroom. Who has designated it?

MR. SCHAFER: Saint Al's employees can stay, Your Honor.

THE COURT: So Saint Al's employees may remain in the courtroom, but everyone else will have to leave, except for counsel for -- who have been -- who have signed the protective order in this matter.

******COURTROOM CLOSED TO THE PUBLIC******

THE COURT: All right. Let's go ahead and proceed. Let's -- we do need to catch up on publishing some depositions. Ms. Gearhart, if you want to make a list, perhaps we can do that after the next break. All right.

(Testimony of Steven Dunning Brown via video deposition.)

MR. SCHAFER: That concludes Dr. Brown, Your Honor. I don't know how -- we're at 12:16. We have two shorter clips that could get us to 12:30.

THE COURT: Yeah, let's definitely go until at least 12:30 since we're running a little bit late today.

MR. SCHAFER: This will be the deposition of Rodney Reider.

THE COURT: AEO?

MR. SCHAFER: Like five of the eight minutes are AEO, so it probably makes sense to be --

THE COURT: Follow the same process, then.

MR. SCHAFER: Yes.

THE COURT: Play the video, but you'll ensure that --

MR. SCHAFER: Yes, Your Honor.
THE COURT: -- the non-AEO is made available to the public.
MR. SCHAFER: We will.
(Testimony of Rodney Reider via video deposition.)
MS. DUKE: Your Honor, could we pause real quick? In all fairness, a lot of this is not AEO, so I mean, there's a few designations, but they can certainly -- we can do the same thing that we did with our case and --
MR. SCHAFER: It's five of the eight minutes, and I don't it --
MS. DUKE: Is it really five minutes?
MR. SCHAFER: -- makes sense. Yeah.
MS. DUKE: I mean, it's only a couple of pages, but okay. That's fine. I'm just trying to balance it, so --
THE COURT: No. I understand, and I appreciate that. But I think we will go ahead and follow the same format.
(Continued testimony of Rodney Reider via video deposition.)
MR. SCHAFER: That was the end of the Reider deposition.
Your Honor, we have a -- we've got either a 5-minute clip or a -- or a 5-minute deposition or a 27-minute

deposition. We can play whichever one you --
THE COURT: Ms. Duke.
MS. DUKE: And before we go there, page 77, line 3, it says, "take their supplies; other than ones take deficiencies." It should have been "efficiencies."
THE COURT: Okay. Is there any disagreement with that?
MR. SCHAFER: I didn't see it, but if counsel is representing it, I'm sure she's --
THE COURT: All right. Why don't we do the 5-minute clip. Or was it 5 or 7?
MR. SCHAFER: Yeah. There was a 5-minute and a 27. Do you want to take the 5?
THE COURT: Let's take 5-minute clip. And then when we return, we'll also publish a bunch of depositions.
MR. SCHAFER: And this is the deposition of Blaine Petersen.
THE COURT: Also AEO?
MS. DUKE: Yes.
MR. SCHAFER: Yes.
THE COURT: All right.
(Testimony of Blaine Petersen via video deposition.)
MR. SCHAFER: That's the end of Blaine Petersen, Your Honor.
THE COURT: All right. Ms. Gearhart.

THE CLERK: Your Honor, there were some exhibits that were referenced that weren't admitted during the deposition of Blaine Petersen and Steve -- Steven Brown.
THE COURT: Did you say there were some?
THE CLERK: Yes.
THE COURT: Counsel, let me review very briefly the exhibit numbers, and we'll...
There was an objection to Exhibits 2135 -- excuse me, 2131, 2135, 2141, and 2142. Those were all referenced in -- I think it was Dr. -- was it Brown? I think Dr. Brown's deposition. Is there any objection to those exhibits?
MS. DUKE: Yes, Your Honor. I mean, the 402 and 403 you have already ruled on with respect to the motion in limine; yet we still continue to have the --
THE COURT: I'm sorry. I couldn't hear that.
MS. DUKE: 402 and 403 are noted on the 2131 and 2135 exhibits. That, again, is the motion in limine that you've previously ruled upon with respect to Saint Alphonsus and whether there were any offers related to some type of different relationship between Saltzer and Saint Alphonsus.
THE COURT: Right.
MS. DUKE: So, yes, we would maintain those same objections.
THE COURT: I'll overrule the objections given my prior ruling. The understanding, or at least the court's

prior ruling was that those offers could have independent relevance. And rather than sit down and, I think, try to flyspeck that distinction, I'm going to overrule the objection. I'll admit Exhibits 2131, 2135, 2141, and 2142. Now, those were hearsay objections, 2141 and 42.
MS. DUKE: Those are -- the hearsay objection we'll withdraw.
THE COURT: All right.
(Defendants' Exhibit Nos. 2131, 2135, 2141, and 2142 admitted.)
THE COURT: Now, with regard to the depositions during Mr. -- was it Reider --
MR. SCHAFER: Yes, Your Honor.
THE COURT: Wasn't it a hearsay objection to and a relevance objection to Exhibit 2170.
MS. DUKE: We'd maintain the relevance objection, Your Honor.
THE COURT: All right. The objection will be overruled. Those two exhibits will be admitted.
(Defendants' Exhibit Nos. 2164 and 2170 admitted.)
MR. SCHAFER: And, Your Honor, just for the record, I think those documents may have been used with Petersen and not Reider, just so the record is clear.
THE COURT: Oh, I think that's correct. I'm sorry. That is correct.

All right. Anything else at this time?
MR. SCHAFER: No, Your Honor.
MS. DUKE: No, Your Honor.
MR. STEIN: Just as a heads-up as far as the rest of the afternoon, we'll be beginning the direct examination of our economic expert Dr. Argue. We'll probably have a little more video before we start, and then Dr. Argue will be back tomorrow morning.
THE COURT: All right. Very good. All right. We'll be in recess for 15 minutes.
(Recess.)
******COURTROOM OPEN TO THE PUBLIC******
THE COURT: We're going to call the next witness again by video?
MR. SCHAFER: Yes, Your Honor, Thomas Reinhardt. And we have discussed with Ms. Duke the first 11 minutes of this are nonAEO, so we can keep the courtroom open. And then most of -- it's 27 minutes total. Most of the 16 after that will be closed. We'll take a break, maybe clear the courtroom, and mostly just St. Luke's people here that would need to leave.
THE COURT: All right. Very good.
(Testimony of Thomas Allan Reinhardt via video deposition.)
(Video deposition paused.)

MR. SCHAFER: Your Honor, this is where the AEO portion starts. I think we need to clear the courtroom.
THE COURT: I'll have to ask anyone in the courtroom to leave unless they're affiliated with Saint Al's.
******COURTROOM CLOSED TO THE PUBLIC******
(Video deposition of Thomas Allan Reinhardt resumed.)
(Video deposition of Thomas Allan Reinhardt concluded.)
MR. SCHAFER: That's the end.
******COURTROOM OPEN TO THE PUBLIC******
THE COURT: Counsel, I believe there was reference to Exhibits 2188, 2189 in that -- in Mr. Reinhardt's deposition. There was a relevance objection to 2188, but it had to do with referrals, I think, not necessarily the acquisition.
MS. DUKE: Correct, Your Honor.
THE COURT: Do you intend to stand on that objection or do you withdraw it?
MS. DUKE: We'll stand on it, Your Honor.
THE COURT: I'll overrule the objection. Exhibit 2188 will be admitted.
(Defendants' Exhibit No. 2188 admitted.)
THE COURT: Hearsay was the grounds for objection to 2189.
MS. DUKE: That's withdrawn, Your Honor.

THE COURT: The exhibit will be admitted.
(Defendants' Exhibit No. 2189 admitted.)
THE COURT: Mr. Schafer.
MR. SCHAFER: Defendants call Dr. David Argue.
MR. STEIN: We can begin the examination with the courtroom open, but we'll have to close it.
THE COURT: That's fine.
MS. DUKE: Your Honor, while they are bringing Dr. Argue up, may I just take a few moments to read in a couple of exhibits -- a handful of exhibits that were agreed to by Mr. Stein related to Deborah Haas-Wilson's testimony?
THE COURT: Yes.
MS. DUKE: So it's been agreed that Exhibits 1668, 1669, 1673, 1674, 1675, 1682, 1683, 1686, 1693 --
THE COURT: 1693?
MS. DUKE: Yes -- 1694, 1695, 1696, 1697, 1702, 1703, 1704, 1705, 1706, and 1741 are admitted.
THE COURT: Mr. Stein, is that correct?
MR. STEIN: I don't have my list with me, but I trust Ms. Duke's representation.
THE COURT: All right. Exhibits 1668, 1669, 1673 through -- -74 and -75, 1682 and -83, 1686, 1693 through -97, 1702 through 1706, and I believe it was 1741 are admitted.
(Plaintiffs' Exhibit Nos. 1668, 1669, 1673, 1674,

1675, 1682, 1683, 1686, 1693, 1694, 1695, 1696, 1697, 1702, 1703, 1704, 1705, 1706, and 1741 admitted.)
MS. DUKE: Thank you, Your Honor. And one last exhibit --
THE COURT: Yes.
MS. DUKE: -- was Joint Exhibit 54 had been agreed to, as well. So that will be admitted, and I'll provide a copy to counsel.
Thank you, Your Honor.
THE COURT: Thank you. Exhibit 54 also will be admitted.
(Joint Exhibit No. 54 admitted.)
THE COURT: Dr. Argue, please step before the clerk and be sworn.

DAVID ARGUE,

having been first duly sworn to tell the whole truth, testified as follows:
THE CLERK: Please state your complete name and spell your name for the record.
THE WITNESS: My name is David Argue. First name is David, D-A-V-I-D. Last name is Argue, A-R-G-U-E.
THE COURT: Mr. Stein, you may inquire.

DIRECT EXAMINATION

BY MR. STEIN:
Q. Good afternoon, Dr. Argue.

A. Good afternoon.
Q. Did you prepare a demonstrative exhibit in order to aid the court in understanding your testimony this afternoon and tomorrow morning?
A. Yes, I did.
Q. And it's the exhibit that we have marked for the record as 5119 and the demonstrative exhibit that you prepared in front of you?
A. Yes, it is.
Q. Dr. Argue, I would like to begin this afternoon and have you describe for the court, if you could, your background and qualifications.
A. Certainly, I received my Ph.D. in economics at the University of Virginia in 1990. Prior to that, I had received an MA in economics also with the University of Virginia and a BA in economics at American University.
Subsequent to receiving my Ph.D., I joined Economists Incorporated, a consulting firm in Washington, D.C., and I have been a principal at Economists Incorporated for the past 11 years.
Over the past 20 years or so, I have analyzed markets and competitive effects analysis in over a hundred hospital or government investigations or mergers and litigation in healthcare matters, including 40 mergers of hospitals or physicians or health insurers.

For a three-year period, I was an adjunct professor in healthcare economics at Johns Hopkins University, Washington, D.C., campus in their school -- in their business school in their MBA program.
Q. And have you also written and spoken on healthcare antitrust-related matters?
A. I have. I have spoken a number of times and written several articles.
Q. And so this is obviously -- what we're showing here on slide 5, it's not a complete list of your publications and speeches; correct?
A. That's correct.
Q. Can you talk briefly about the ones that you have identified on this slide.
A. Certainly. I'll go through the ones that I think are probably most pertinent for the case at hand.
At the top of the list is a study that I did in the state of Utah on behalf of the Utah state legislature examining competition in healthcare markets in that state. It involved insurance markets, health insurance markets, hospital providers, physician providers, ancillary service and ambulatory providers.
I testified before the state legislature on my findings, and the task force continued with its recommendations.

The second matter down is particularly pertinent. It's a transaction that occurred in North Carolina in the Greensboro area. In many ways, it's similar to this one. Cone Health was a multi-hospital system that employed a significant number of physicians. Alamance Regional Medical Center was located not far. It was a standalone hospital. It had a moderate-sized employed physician staff that I was the economist who analyzed that on behalf of the parties. We presented our findings or our opinions before the Federal Trade Commission. That transaction was ultimately allowed to go through.
The third item, HealthPartners, Park Nicollet Affiliation, involved two integrated systems in the Minneapolis-St. Paul area. Both had at least one or multiple hospitals, but the key feature there was they both had large physician practices. Again, that was a merger review. I was the economist for the parties. We presented before the FTC. And that transaction also was allowed to go through.
Q. Dr. Argue, if I could interrupt you for just one second. The slide here refers to a Hart-Scott-Rodino review, and you have referred to merger review. What is the context in which you have been doing these types of reviews?
A. I'm sorry. The Hart-Scott-Rodino review is a requirement for transactions of a specific size. They need

to be presented and reviewed by the Federal Trade Commission or the U.S. Department of Justice. There are rules about the process that goes through that. And typically the parties hire -- obviously, they hire attorneys, but they may hire economists to help them in that process.
Q. Thank you. I'm sorry. Can you continue.
A. Certainly. The fourth item down and -- let's see -- the last item are some presentations that I made. These both happened to have been at the FTC. The fourth one I was invited last fall to speak at an FTC conference on hospital competition. The one at the bottom was from several years ago when the FTC was holding hearings on competition in healthcare, and I gave a talk there or participated in a panel on physician service competition.
Come up a little bit, back maybe five or six down, there is a chapter called market -- a book called *Market Definition in Antitrust*, and I wrote a chapter on market definition for healthcare providers -- hospitals, physicians in particular.
Q. Dr. Argue, you talked a little bit about work that you have done in presenting on behalf of private parties to the Federal Trade Commission. Have you in the past ever been hired by the Federal Trade Commission?
A. Yes, I have.
Q. In connection with your work in this case, how are

you being compensated?
A. I'm being paid on an hourly basis for my time.
Q. Is your compensation dependent in any way on the outcome of this case?
A. No, it is not.
Q. Dr. Argue, have you conducted an analysis of the likely competitive effects of the Saltzer transaction?
A. Yes, I have.
Q. Can you describe generally the sources of information that you have considered in that analysis.
A. I took into account as many relevant sources of information as I could get my hands on. That included some data provided through Regence and Blue Cross of Idaho; certainly, the deposition transcripts; the documents that were produced. I had talked to numerous people and interviewed them and have attended some of the trial hearings, as well.
Q. Now, we're obviously going to be spending a fair amount of time getting into the specifics, but can you summarize for the court what conclusion you have reached about what the likely competitive impact of the Saltzer transaction is.
A. Certainly. My conclusion is that I think there is very little likelihood that this transaction would result in harm to competition in the provision of primary care or

pediatric physician services. In fact, I think the transaction will also result in significant procompetitive benefits.
Q. And have you also analyzed the competitive impacts in the vertical markets that the plaintiffs have identified, the hospital services markets?
A. Yes. I have examined that, as well.
Q. And is your conclusion any different?
A. No. It's the same, no harm to competition.
Q. So, Dr. Argue, let's start -- let me ask you to explain to the court generally the approach that you've taken in analyzing the competitive impact of the Saltzer transaction.
A. I think the easiest way to look at this at a very high level is to separate into these three components that I have got here.
The first is identifying the market. And the purpose of identifying the market is to determine who the likely competitors are, who the alternatives are for customers and for patients in this case and for health plans and employers.
The second component there is assessing the competitive effects, and that actually is very closely tied with the identifying the market. Many of the same tools are used; much of the same data is analyzed. And the -- the

assessing the competitive effects really is just talking about: How does this market work? What makes it tick? How do the interactions come together?
And then the third point is assessing the procompetitive benefits.
Q. Now, Dr. Argue, we have heard a lot in the trial about harm to competition and harm to competitors. Can you define what harm to competition means to an economist and how that's different from harm to competitors?
A. Certainly. Harm to competition occurs when an action results in prices that are higher than competitive levels or quality being provided that's lower than competitive levels. And market power -- which is another concept we have heard and I'm sure I'll talk about more today -- is closely related to the question of harm to competition.
And market power exists when a supplier has the ability to harm competition, to raise prices above competitive levels or reduce quality below, and not lose so many customers as to make that change unprofitable.
Now, that's distinctly different from harm to a competitor. Competitors get harmed all the time in the competitive process. Every time a seller loses out in a transaction, they are harmed for not having made that sale. That's what the competitive process is all about. It's a

rough-and-tumble world to see who is going to prevail, but that doesn't necessarily mean it's harm to competition.
Q. So does that mean harm to competition -- or harm to competitors can never amount to harm to competition?
A. No. It certainly could amount to harm to competition. If you harm your competitors enough or enough of them, it could enable the supplier to gain market power.
Q. And what does that mean more specifically to say "harm them enough"? What is the standard that has to be met?
A. It's -- to put it in words -- there is no magic number on this, but to put it in words, it's so that they are no longer an effective competitive constraint.
Q. Dr. Argue, again, just by way of background, we have talked about market definition a little bit. Can you explain the role of market definition in the antitrust analysis and how that relates to understanding the competitive effects of the transaction.
A. Market definition is a little bit of an abstract concept. It's certainly not the final point. It's a step in the way to trying to figure out what the competitive consequences may be of a particular transaction. It's not an end. The agencies in the merger guidelines specifically talk about the need not to start with market definition. They might start with a competitive effects analysis first.

The outgrowth or the follow-on concept from market definition is market shares and market concentration. And those aren't an end, either. There again, they may be informative; they may be not so informative. But they are not intended to be a rigid guideline. They are nothing more than another piece of information to consider whether additional analysis is necessary.

As I mentioned before, market definition and competitive effects are greatly intertwined, and it's -- the -- there may be difficulties, so it would seem, as you do a market definition analysis and a concentration analysis. But if it turns out from the competitive effects analysis that this market is functioning well anyway, that's ultimately what's going to be most important in a competitive analysis.

Q. Now, Dr. Argue, in order to reach opinions in this case, did you undertake to understand how competition for the healthcare services in the Treasure Valley works?

A. Yes, I did.

Q. Why did you do that?

A. I think that it's important in considering any competitive -- in doing any analysis of competition to get a clear understanding of the foundational interaction between the buyers and the sellers in the market. It's not just background. This is really important to being able to

understand how the -- the transaction might possibly harm competition. We can't get to that point unless we understand the nature of the markets themselves.

Q. And, Doctor, does your slide 12 identify features or key features of healthcare competition in the Treasure Valley --

A. Yes.

Q. -- that you've identified?

A. Yes, it does.

Q. And are the features of healthcare competition that are identified here in slide 12, are these important to -- just to understanding how the market should be defined or the competitive effects analysis or both?

A. I think it's for both, certainly.

Q. So let's start with the first feature of healthcare competition that you've identified here, system-to-system competition.

First, can you explain what you mean by a system?

A. A healthcare system is -- comprises a collection of entities. It's often named around a hospital, although that's not always the case. In the case of the Treasure Valley, the St. Luke's Health System is focused around St. Luke's hospitals; same on the Saint Al's side.

But it's more than just a hospital, of course. It includes the physicians; it includes the ambulatory surgery

centers, the ancillary service providers. And some of these systems have close relationships with particular insurers, as well. In the Treasure Valley, we have got two substantial healthcare systems.

MR. STEIN: Your Honor, at this point we are going to be moving into some slides that have been designated attorneys' eyes only by Saint Alphonsus. So I think we'll need to ask others to leave.

THE COURT: All right. Anyone in the courtroom other than an employee of Saint Al's or an attorney who has subjected himself or herself to the protective order issued by the court will have to vacate the courtroom.

******COURTROOM CLOSED TO THE PUBLIC******

THE COURT: While that's happening, I was trying to go back over something you just testified to, Dr. Argue. By the way, that's a great name for --

THE WITNESS: Thank you. Everyone tells me I should have been a lawyer.

THE COURT: I was going to say that, but I'm sure you have heard that so many times that you're probably bored with it.

But you indicated the market definition and competitive effects are greatly intertwined. So it would seem as you do a market definition analysis and a concentration analysis, that it turns out -- in essence, my sense was that you might

do a competitive effects analysis first, and that's kind of what -- my understanding, that's the approach you took and decided that you could define the market later?

THE WITNESS: It's not strictly the approach I took. And as I mentioned, the merger guidelines suggest you can put it in the opposite order. But it's imprecise or it's incomplete to do them totally separately from each other. There is enough back-and-forth that one informs you as to the other.

THE COURT: Okay. The problem is, I guess I have a hard time seeing how you could assess the competitive effects analysis without knowing what the market is.

THE WITNESS: I think -- if I could respond to that, I think the way that I would articulate a response is it may not matter much what the market definition is to what the competitive effects outcome is. You could have a narrow market and, with the same dynamics, have highly competitive outcomes as if the market were broader.

Now, as we'll get into this, in my analysis of market definition, I didn't put an outside bound on what I thought that market should be. And that was largely because of what I was learning from the competitive effects analysis and because it wouldn't have added any more players to the story; it wouldn't have changed the way that the competition was working in the Treasure Valley.

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THE COURT: Doesn't that kind of assume that we're going to talk about the Treasure Valley as the relevant market?

THE WITNESS: I used that term too loosely. Adding additional -- expanding the market into other parts of Boise.

THE COURT: Okay. Go ahead.

MR. STEIN: Thank you, Your Honor.

BY MR. STEIN:

Q. So turning to this issue of system-to-system competition, Dr. Argue, there have been a number of St. Luke's witnesses who have talked about this concept of building an integrated delivery system.

In your review of the evidence, did you see any evidence that others in this market are also viewing competition as developing on this system-to-systemwide basis?

A. There is certainly evidence in Saint Al's documents as to their perspective on this market also being a Saint Al's to St. Luke's system-to-system competition.

Q. And so what are we looking at on slide 13?

A. Slide 13 is a page from a Saint Al's strategic planning document. You can see right there in the title, it says, "Two integrated health systems in the region." Now, this map shows more than just the Treasure Valley, more than

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Nampa.

But it's clear that the Saint Al's system views itself as a system in competition with St. Luke's. You can see at the bottom in that shaded box, it says the "Saint Al's has a broad reach as a regional referral network and competes with the St. Luke's Health System."

Q. And what about on slide 14? What are we looking at here?

A. Again, this is -- it's a Trinity Health document. It appears to be a planning document. It refers again just to Saint Al's key competitor being St. Luke's Health System. And it talks also about changing the rules of engagement to take initiative to compete on its strengths -- this is Saint Al's talking -- and considers a proposed strategy statement which talks about engagement in aggressively developing its clinically integrated network.

It goes on and talks a little bit about gain-sharing contracts and some of these concepts that will come up in a few minutes.

Q. On slide 15.

A. Again -- again, a Saint Al's strategic plan of some sort. And the first highlighted line here from inside that text was -- it says "Intense competition from the major competitor, St. Luke's Health System."

If you come down one, two, three -- four lines,

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there is a reference to the payor market desiring a shift to more risk in quality and cost to providers. Again, that's in the system-to-system context, but it's talking about some of the value-based contracting.

Coming back up to the second point, it makes a reference to "physicians having uncertainty about their future and seeking security through employment, particularly as it relates to capital investments." And I expect that most of that was referring to investments in information technology.

Q. And what are we looking at on slide 16?

A. This slide also is a page from the Saint Al's strategic plan. Its title talks about physician delivery networks, but the second bullet point down is particularly interesting in the context of what I'm talking about here in the system-to-system competition.

It says, "The region will have two fully aligned systems with few crossover physicians." I interpret that "few crossover physicians" to mean that there are some that are going to be loyal to Saint Al's, some that are going to be loyal to St. Luke's -- whether that's employed or not employed -- but there are going to be few that are admitting patients at both institutions.

This slide also talks a little further down about more physicians will be highly aligned. But it's

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interesting; there is a point at the very last bullet that says "strength and alignment with independent physicians." It's clear and there is other documents and testimony that alignment with independent physicians is an important part of Saint Al's strategy, but it's part of St. Luke's strategy as well. And neither system plans to employ every physician in the Treasure Valley.

Q. So the second major feature of healthcare competition in this market you identified is increasing physician employment. And so, Dr. Argue, what are we looking at on slide 17?

A. Again, it's a Saint Al's strategic planning document. And the title says what the slide is all about, "Physician employment is increasing."

The red bars on this chart are for Saint Al's employed physicians. You can see that's rising over time. The last bar, of course, compares that with St. Luke's. And it's clear that both of them have a significant employed physician base.

The shaded box at the bottom, the implication says "Rapid alignment of physicians is accelerating the development of Saint Al's and St. Luke's into two integrated health systems."

MR. STEIN: Your Honor, at this point, we'll be able to open the courtroom back up for a while until we have

to close it again.
THE COURT: All right. Thank you.
******COURTROOM OPEN TO THE PUBLIC******
BY MR. STEIN:
Q. Dr. Argue, the third feature of healthcare competition that you identified is the movement from volume to value. Can you explain what you're referring to here and the significance of that.
A. Certainly. I probably ought to start with defining what I mean by "volume" in this context. And volume care -- volume-oriented care derives from the fee-for-service system where the more you provide, the more you get paid. So there is an incentive for providers to enhance, to expand the amount of volume that they're going to provide.
Value contracting or value-based care is just the opposite where the incentive is on providing an equal or higher quality of care at a lower cost to payors. And there are different mechanisms that can be used for this. I have got gain sharing on there, and that's kind of the baby steps of value-based care, followed by bundling, and then ultimately out to full risk.
The next-to-last bullet here talks about information technology. And that's clearly a key point. We have heard an awful lot about that in the trial so far. And

the systems, to the extent they want to compete or are compelled to compete on value-based care, need to understand what is the value, what is the quality, and what is the cost of the care that they're providing.
And these sophisticated information systems collect the data and aggregate it and report it and feed it back to the providers and to the system managers so they know what's going on.
The -- let me just go back, if you could for a second, Scott, to the last slide.
One of the important implications of this move from volume to value is the transition that's going to be required for providers, both for the health systems and certainly for the physicians as well, as they adapt to the new system.
Q. Dr. Argue, the fourth key feature of healthcare competition you identified is how provider and health plan contracts are actually negotiated. Can you explain the significance of this to your opinions.
A. This slide gets us out of kind of the basic profile of who the major players are or the types of major players and begins to think about the dynamics of the network process or the contracting process.
And the general understanding that I have got here is that the contracts are negotiated on a -- over the

percentage change in the total payments that the provider is going to receive from the health plan. This is the lower-right-hand corner that Professor Dranove talked about last week or two.
And that total payment is then often allocated among the services. Maybe it's split between inpatient and outpatient. You could have a high increase in inpatient and a lower increase in an outpatient; looking for an average that's going to be X percent, whatever that is.
The way they get to this point -- the way the health plans get to this point, the plans and the providers, is with this bargaining process with the health plan on the one side of the table and the providers, the health system, on the other side.
Now, the health plan is there representing its enrollees. It's trying to put together a product that's going to be attractive to its enrollees and include the providers that the enrollees think are going to be valuable.
But as they're sitting there at this conference table trying to figure out what this contract is going to be, they both have to think about: What happens if I don't get an agreement? What happens if I can't come to terms with the plan or -- if you're on the provider side, or with the provider if you're on the plan side.
And -- now, Professor Dranove didn't think that

second part, the provider's outside option or best alternative to a negotiated agreement -- didn't think that was as important, but I'll talk about that more later.
An important feature of this -- this dynamic as they're sitting at this conference table is: What is their relative bargaining strength? There is more to it than that, and I'll talk about it a little bit more later on. But it's important to understand that the bargaining strength of a plan or provider is determined by a lot more than just its size.
Yes, a plan's enrollment affects its bargaining strength, or a hospital or health system's physicians or the number of surgery centers it's got affects the bargaining power, but so do other things. So does their reputation or the quality of the doctors that they have or the -- how they fit into a network or their location. There are any number of factors that affects that relative bargaining position.
Q. Dr. Argue, the fifth feature of healthcare competition you identified is how health plan products are marketed. Can you explain what you mean by this and why it's important?
A. Having just gone through the last slide, where the health plans and the providers sat down and negotiated their contract, now the health plans have a network in place, and now they have to go and market this to their -- their

customers.

And from my research, all of the major health plans market all of their products throughout the Treasure Valley. Now, when I say "all of their products," there could be some narrow network products that don't include as many providers. There could be some broad products that have very comprehensive set of providers located in there.

But the significant part about this is that none of the plans markets their products in a narrow geographic area. There is no plan that sells a product just in Nampa. They sell a product that includes Nampa but includes the rest of the area as well. And it doesn't matter whether that's a narrow product or a broad product.

And I have just got some examples down at the bottom with BCI and Micron that show their broad network and their narrow network products.

Q. And the last key feature of healthcare competition that you identified is the movement from broad network to narrow network products. Can you explain what you mean by that.

A. This is a change that's been happening certainly in the Treasure Valley; that is, the growth of more narrow network products. And it's happening elsewhere around the country for sure.

The principle behind the narrow network, how they

work and how they are made attractive in the first place is that the health plan offers to set up a product that does not include every provider. It includes some subset of providers, and that's going to concentrate and channel that patient volume to that smaller group of providers.

And this is attractive to the provider because it gives them greater volume, greater chance of getting a higher volume of patients. And they're willing to give up something for it, so they will offer to reduce -- or they will be compelled to reduce their rates if they want to be the primary provider in that narrow-network product.

That reduction in cost -- in rates by the providers leads to a reduction in costs by the health plans. So that allows the health plan then to turn around and sell this product at a lower premium and a lower out-of-pocket cost.

Different consumers have different preferences. Some like broad networks. Some are happy with the narrow network at a lower price. So you can have a market like the Treasure Valley where both products coexist.

There also are variations on this kind of a mixed blend, the tiered network product -- we have heard about that before, and I'll talk about it again in a little bit -- where there are both narrow network and broad networks offered to a set of enrollees at the same time, and

sometimes they can just choose. At the point they need a physician, they can go to the broad network, and they can go to the narrow network, and their costs would reflect that.

A term that's -- that's used periodically -- and I'll probably use it myself -- is this "directed benefits" designs. And it's not -- it's kind of a close cousin to a tiered network. And the more important point is that it is another means by which health plans can try to influence the choices of providers that their patients choose.

MR. STEIN: Your Honor, just for the next slide, if we could turn the public screen off.

THE COURT: Yes.

BY MR. STEIN:

Q. Dr. Argue, you just referenced a couple of minutes ago this tradeoff between cost and volumes and a narrow network.

Can you -- first of all, can you identify the document or where this document comes from, the page that's reflected in slide 23.

A. It looks to me to be a Micron document.

Q. Can you describe for the court generally how this -- what's shown in this document relates to the testimony you just provided?

A. Okay. I was just talking about the tradeoff in the narrow networks and how the increase in volume can

offset the reduction in costs, and that's what makes it attractive to the -- to the health plan.

And this on the left-hand side, that box shows what Micron anticipated their increase in volume had to be to break even, to get enough extra volume to account for that reduction in their prices or their rates.

The box on the right-hand side shows what they actually achieved in the first -- it looks like the first six months of the -- of their arrangement. And you can see that was substantially larger than what they needed to achieve to make that a profitable change for them.

Q. Profitable change for the providers who took the discounts?

A. That's correct.

Q. We can turn the monitor back on now, Your Honor.

THE COURT: We can turn it back on?

MR. STEIN: Yes.

THE COURT: I'm sorry.

BY MR. STEIN:

Q. So on the subject of Micron, Dr. Argue, obviously the court has heard a fair bit about Micron over the last few weeks. What is described on this slide, slide 24?

A. This is just a -- a somewhat souped-up graphic version of a brochure that was handed out to the Micron employees.

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I don't need to go over in great detail what's here. The two parts of it that are most interesting to me and to my analysis are the -- you have got those bullets, target rings there for the Micron networks. Not the center one but the next one out, the Micron Health Partners Network, that's their limited, their narrow network product. And you can see from the box on the bottom, that the MHPN only accounts for about 25 percent of area physicians. Micron and their consultants were very selective in who they included in that network.

And the next ring out, the Wise PPO, was much broader, with 1600 Treasure Valley providers.

Q. What's reflected on slide 25?

A. This is just showing us again, for Micron, the view that the patient has or the enrollee has as they're thinking about or in need of care. What do they do?

This says copays for primary care office visits. And it shows -- again, skip the health center, but go to the MHPN. The MHPN, the coinsurance amount, is 10 percent. And for PPO, the coinsurance is 20 percent.

And I -- this coinsurance is really just a part of a -- it's just a percentage that's multiplied by the allowed amount to get what their out-of-pocket copay is.

Q. And, Dr. Argue, based on the evidence that you have examined, did the implementation of the Micron Health

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Partners Network succeed in causing patients to switch providers?

A. There are several sources of information that confirm that.

Q. Okay. So let's talk about one of the main responses that the plaintiffs have to that argument, which is this argument that Micron is just different, that -- that there is really nothing to take away from what's happened with Micron as far as what might happen in response to a -- an above competitive price increase in this case. Do you agree with that argument?

A. No, I don't.

Q. And why not?

A. You know, I looked at this. I heard that argument, and I -- I tried to collect what information I could about Micron and the others.

And it doesn't strike me that Micron is substantially different in the context of what we're talking about here. Micron faces intense competition; there is no doubt about that. But they're not the only employer in the Treasure Valley that faces intense competition.

Part of competing in a difficult market is controlling your costs. And it's hard to think of a competitor who is more adept at controlling their costs than Walmart, also in a very intensely competitive retail

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industry. They're here in the Treasure Valley.

Paul's Market is a series of grocery stores or a chain of grocery stores. They typically have very narrow margins, and they surely are facing intense competition with any other grocer in the area.

Now, there is also the argument and the testimony by Mr. Otte that Micron was losing money, losing buckets of money, in 2008, at one point, $6 billion. And 2009 was the start of the recession that undoubtedly affected Micron as well as other firms.

But by 2010, Mr. Otte testified that Micron was making $1.8 billion, and the following year it acquired a large competitor. This is not the profile of a company that is continuously wallowing in financial stress. They didn't end up changing their health plan after 2009, when things turned around.

Q. And is Micron the only company that -- in this market that you've seen that's implemented one of these narrow or directed type products?

A. No, it's not. I mentioned Walmart in the last slide as a competitor. And Walmart is one that has signed onto a network that's very similar to Micron's. It's not identical, but it's similar.

Paul's Market, I mentioned, has a directed benefit type program, as does Thomas Cuisine and Woodgrain. The

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other two, Boise Schools and Idaho Power, had those similar types of agreements until just recently.

Q. And this -- this move toward more -- toward the growth of narrow networks from broader networks, are narrow networks right now -- do they have a large share of the -- of the covered lives in Idaho or in the Treasure Valley?

A. I think -- I haven't measured that exactly, but I think generally not. I think more people are currently in the broader network products.

Q. Does that mean that that is, in fact, likely the way things are going to stay in the future?

A. There are a lot of indications that that's not the way. I don't know what's ultimately in the future in terms of the split between the two, but it's clear that the narrow network products are growing.

Q. And have you seen any evidence from the -- from the plaintiffs that, in fact, they likewise think that the narrow networks will be increasing in the future?

A. Yes. There are a number of sources of evidence.

Q. And what are we looking at here, for example, on slide 29?

A. This slide is a document from Saint Al's production from the hospital plaintiffs' counsel to the FTC that makes reference to clinical advancement being

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inextricably linked to narrow networks. That's in the first sentence.

A couple of sentences down it says, "This requires that those patients' lives be exclusive or virtually exclusive to the particular network."

That reference to "particular network" is the narrow network that we're talking about.

And going on to the next sentence, you can see references to managing care of patients. This -- when Ms. Jeffcoat was asked about this in her deposition, she confirmed that she agreed to it -- agreed with that paragraph largely, and Mr. Peterson agreed with it as well in his deposition transcript.

Q. So, Dr. Argue, I would like to move on now to one of the other major components of your analysis, which is a critical loss analysis. And I would like to start and see if you could explain to the court in as layman's terms as possible what a critical loss analysis is.

A. The antitrust question before us, the antitrust question in this type of hearing, is: Does this transaction give St. Luke's-Saltzer the ability to raise prices above competitive levels by some what we call small but significant amount, usually thought of as 5 to 10 percent? Does it enable the parties to raise prices above competitive levels without losing so many patients that that price

2911

increase is unprofitable?

And the last part of that is really important, "without losing so many patients." What the critical loss does is it gives us a measure of what is enough lost patients to make that price increase unprofitable.

Q. And in the slide here, you refer to -- there is a bullet about halfway down. It says, "Are there enough 'marginal' customers who would react in response to a supracompetitive price increase?"

Can you explain what you mean by that?

A. "Marginal" is one of those terms that economists throw around a lot, and it's not a terribly complicated one, but it's probably worth, as you point out, defining it a little bit.

We're talking here about a change from one state of the world to another, before there is a price increase or supposed price increase to after. And what we're looking -- what we want to see is what's going to happen to customers, to patients and health plans and employers in those two states of the world.

Some people are not going to change their behavior. They are going to be just like they were before. Some people might change their behavior, and those are the marginal customers. It's not everybody. It may not even be very many patients or purchasers.

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But that's the response that's going to be most important for determining the profitability of that price increase and ultimately whether the transaction is creating market power.

Now, I mentioned here that this is used in market definition in competitive effects, and we'll use it in market definition with this hypothetical monopolist. We will use it in competitive effects when we're talking specifically about St. Luke's and Saltzer.

What's really most important about this critical loss is it's an objective yardstick. It gives us something to shoot at. We don't have to guess how many patients would have to be lost. This number comes out of the revenues and costs -- directly out of the revenues and costs, in this case of St. Luke's Family Medicine Centers.

Q. So if I -- if we understand correctly, the first thing you do as part of this analysis is you calculate this critical loss figure?

A. That's right.

Q. And what type of information do you use to identify for, let's say, the combined St. Luke's and Saltzer, what that critical loss would be?

A. I collect information -- excuse me -- I collect information on revenues for the St. Luke's primary care practices and on their costs, both their fixed costs and

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their variable costs.

Q. And is the relevant question once you have identified that critical loss, is it whether if a combined St. Luke's and Saltzer raised price by a certain amount, like 5 percent, would they lose enough patients that the price -- that the loss of patients would exceed that critical loss amount?

A. That's -- that's the question that's ultimately where we want to get.

Q. Now, you talked about critical loss being kind of an objective benchmark. You know, you can look at the data and just calculate this number.

Is this critical loss test, is this something that David Argue just came up with himself, or is it something propriety that Economists Incorporated came up with?

A. No. The critical loss has been around for close to 30 years. It's been used -- it was first published in articles. It's been discussed in articles over the years. It's been used in many, many transactions, analyses, antitrust analyses, healthcare and nonhealthcare.

It's even incorporated or it's discussed in the merger guidelines as a tool that can be used for analyzing transactions of this type.

Q. Now, you submitted several reports in this case; is that right, Dr. Argue?

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A. Yes.
Q. And Professor Dranove in his reports criticizes the use of critical loss analysis; is that right?
A. That's right, he does.
Q. I anticipate we will probably be hearing about that some on Monday. But since you won't be here then, could you summarize for the court your understanding of what the basic critiques that Dr. Dranove has of critical loss are and what your response to those is.
A. The way I understand it, he has got, let's call it, two basic critiques. The first one maybe encapsulates more than one, but the fundamental issue that -- let me back up a little bit.

As I mentioned, we have this price-cost margin. I guess I didn't mention it, but a key part of the critical loss analysis is determining the price-cost margin. Professor Dranove has -- he and I disagree on the implications of that price-cost margin as it relates to the elasticity of demand. I promise I won't use that term again.

But what we're talking about is the price sensitivity of patients to changes in price. And I'm not the only one who disagrees with Professor Dranove on that concept. There are published articles that have critiques that supports my view. So that I think is the first one.

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Well, there are -- well, yeah, I'll just leave it at that. It's all about how you use this margin and whether you can use it to test sensitivity of patients.

The second one is that he articulated a position that he thought the critical loss analysis was not relevant for assessing hospital transactions that were where the bargaining process was used to reach an agreement and determine what the terms of the contract would be.

And that critique was based on his examination of six or seven articles. I have read those articles. I read them before he issued his critique. And I thought each one of them to be, independently of the issue of critical loss, just to be not -- not very well established for assessing antitrust issues and competitive effects in the hospital transactions that he was looking at there.

I thought that some of them had measures of price that were not accurate or the market definition was largely arbitrary. There were other theoretical components of those that were not appropriate. And they may be fine for an academic article; it may be completely benign to make an assumption about what the price is. But when we're talking about applying the lessons -- or if there are lessons from those articles -- to a real-world situation like we have got here, I think that's inappropriate basis for a critique of the critical loss.

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Q. And I take it that this discussion of competing positions between you and Professor Dranove on critical loss is something that's discussed more fully in your reports?
A. Yes, it is.

MR. STEIN: Your Honor, at this point we are going to be moving into a few slides that are -- contain St. Luke's attorneys' eyes only information. My thought is maybe we would just ask anyone not affiliated with St. Luke's to leave the courtroom, and that would probably take us through the end of today.

THE COURT: All right. Again, anyone who is not affiliated with St. Luke's or is otherwise not been designated as someone who can stay because they have signed the protective order will be instructed to leave the courtroom.

******COURTROOM CLOSED TO THE PUBLIC******

BY MR. STEIN:

Q. So, Dr. Argue, you mentioned that you did a critical loss analysis. And is the summary of your analysis of critical loss reflected on slide 32?
A. Yes, it is. It shows a critical loss of 8.8 percent for a 5 percent price increase.
Q. Okay. So this is, I think for a lot of people, a difficult but I think important concept to understand. So can you explain what it means when you say that the critical

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loss for St. Luke's for primary care physicians services is 8.8 percent for a 5 percent price increase.
A. What it means is that if, as a result of this transaction, St. Luke's-Saltzer tried to raise the prices of their primary care physicians services by just 5 percent and they lost as little as 8.8 percent of their patient volume and the associated patient revenue, that price increase would be unprofitable. They would have lost too much in revenue from these lost patients that's not made up by the increase in the price for the patients who stay.

If that is unprofitable, it means that St. Luke's-Saltzer is not able to impose that price increase on payors, and the price would then revert to the competitive levels.

The conclusion would be that St. Luke's-Saltzer does not have market power.
Q. And the analysis that you did calculate that figure, is that reflected in Exhibit 2570, the exhibit to your report?
A. Yes. Yes. The fuzzy numbers behind are all there.

THE COURT: Let me make sure I understand what you're saying. If I understand you correctly, what you're -- that if -- if the -- if St. Luke's and the Saltzer Medical Group were to increase prices by 5 percent, a loss

of 8.8 percent in their volume would make that a losing proposition for them?

THE WITNESS: That's essentially right.

THE COURT: You're not saying that that, in fact, would result -- that a 5 percent increase would result in an 8.8 percent loss in volume, but that's kind of the -- I'll call it a break-even point or a point at which they would have to make that kind of an assessment?

THE WITNESS: That's actually a critical point, and we'll get into this in a little bit more. But calling it a break-even point is spot on. That's exactly what it is.

THE COURT: All right. Go ahead.

BY MR. STEIN:

Q. And, Dr. Argue, the 8.8 percent figure, did you -- had you previously in the course of your work in this case calculated a different critical loss?

A. Yes. When I first calculated it, I had a number of 6.8 percent for a 5 percent price increase.

Q. So that would have been a -- obviously a lower break-even point for the price increase; right?

A. That's right. It would have been exceeded with even fewer patients leaving.

Q. So what is it that caused you ultimately to calculate a different critical loss of 8.8 percent?

A. Well, Professor Dranove in his reply report reviewed the critical loss calculation I had done and critiqued it. I think his conclusions in his critique were very excessive, but it gave me reason to go back and check the sources I had used to confirm that I had done things -- I had interpreted the information correctly, that I had gathered all the information that I needed to do it.

And in the process of collecting that data and laying it all out, I realized that I had needed to make some adjustments to that. So I ended up recalculating the critical loss. It made it worse as far as St. Luke's-Saltzer go, but the 8.8 percent I believe is the correct figure.

Q. Now, the way you described the critical loss figure is if St. Luke's lost 8.8 percent of primary care physician service revenue, that would make a 5 percent increase unprofitable. Does that mean the only thing that we -- one would focus on in considering the effect of a hypothetical price increase is just lost revenues from the professional services of primary care physicians?

A. No. You know, this is a health system. So as the -- the tape that was played here a little while before talked about PCP services can result in additional services provided to those same patients, whether it's ambulatory care or ancillary services, or some of them get admitted

into the hospital.

So it's fair enough in this context to say: If they raise the price of their physician services and that causes some patients to leave, what are the follow-on lost revenues that may occur?

The only price increase is in the PCP services. There is only that little sliver, that 5 percent at the top of the PCP services, and there is some lost volume, but that lost value ripples through the health system in the form of a lost inpatient and outpatient and so forth. And there is no price increase there. There is nothing there to offset it, so that's just a pure loss to the extent that that carries through.

And I did some calculations on that. I tried to figure out, you know, on average what was the kind of follow-on revenue that might come from certain number of PCP visits. And I did these calculations, and it turns out that it's about fivefold. The one dollar lost in PCP -- or for every dollar in PCP revenue, the system can trace another five dollars in additional revenue elsewhere. That really magnifies the impact of the critical loss.

So now, instead of losing 8.8 percent, you lose a much smaller number of patients and their revenue because there is the additional revenue that's lost going -- carrying out throughout the rest of the system. That's

all -- all that lost revenue is offsetting that little sliver of increased price or increased revenue that's coming on just those PCP services.

So my calculation is that, instead of an 8.8 percent, it could be as little as one-and-a-half percent. And that's unusual, but it's because of that, the breadth of the system and the follow-on care that might be -- might be lost as well.

Q. So is the idea that if a -- for example, if -- if because the price of certain services goes up and a patient decides to go to a different provider, then St. Luke's is losing not only the primary care professional revenue, but to the extent that patient needed other services -- lab services or they had an outpatient surgery -- those revenues go to another system or provider as well?

A. That -- that's exactly right. And I hope I explained it clearly that there is this multiplier effect. And it's not literally a multiplier effect, but there is some natural follow-on care that's provided in the health system that would be lost along with the PCP revenue.

Q. And so when you consider those other revenues that might be associated with a primary care visit, how does that affect the loss of patients or the extent to which there would need to be loss of patients for the critical loss threshold to be exceeded?

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A. Well, it would greatly reduce it.

Q. So let's turn to the question that the court asked a couple of minutes ago, which is -- so you've identified this critical loss. Now, obviously, the key question is: If Saltzer and St. Luke's were to try to raise prices by a small but significant amount, say 5 percent, are they going to lose enough revenue that it would be unprofitable? Did you calculate what the specific losses would be?

A. There is no specific single number that you can put your finger on. It's nice enough to have the 8.8 percent to put your finger on, but it's not practical. There is no -- insufficient information to say I know exactly what's going to happen.

A lot of my analysis throughout the rest of this testimony is going to be about trying to get my hands around would that actual loss exceed the critical loss, the 8.8 percent. And I have to evaluate a lot of different sources of information and give my opinion and my value judgment or my judgments as part of this analysis as to whether that would actually occur.

Q. And what type of information do you consider in trying to determine whether the actual loss that would be -- would be experienced in this hypothetical price-increase world would exceed that critical loss?

A. If you don't mind, Scott, if you could go back one

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slide. There is a point on this that I think is important not to lose.

THE COURT: Could I just ask -- just so I'm absolutely clear on this, when we use the word "critical loss," we're talking about a loss of volume, a loss of patients; correct?

THE WITNESS: That's right. It's the loss of patients that really ought to be thought of as the revenue associated with those patients. Now, there is some cost loss as well, but it's really this balancing that we're talking about.

THE COURT: The problem is when I think of losses, it's -- I immediately start thinking with a dollar sign associated. And I guess at the end of the day, there is a dollar sign. But what you're referring to by "critical loss" is a loss of volume --

THE WITNESS: That's right. That's right.

THE COURT: -- reflected in patients and ancillary services and whatnot.

THE WITNESS: Yeah.

THE COURT: Go ahead, Mr. Stein.

BY MR. STEIN:

Q. Dr. Argue, with respect to the loss of patients -- and maybe this is what you were about to discuss -- but one way that's been discussed is: Well, if the price of primary

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care services goes up, is that going to cause patients to choose a different primary care provider? And is that one of the ways that you're talking about how patient volume can be affected by a price increase?

A. Yes. A price of -- the price that's felt by the patient, the out-of-pocket costs, could cause the patient, him or herself individually, to make a decision not to use that provider. And that would contribute to the critical loss.

Q. But are there other ways that -- that a combined St. Luke's-Saltzer could be affected by an attempted increase in price apart from just the immediate effect on the patient?

A. Absolutely. One of the other ways is the possibility that a health plan will decide they don't want that provider in their network. They don't want St. Luke's and Saltzer in their network anymore -- maybe an employer, maybe a health plan -- because of that increase in price. That could also contribute to the critical loss. Maybe it would exceed it, maybe it wouldn't, but it would add into the critical loss.

And there is a third part which we often don't think about. But as the price of the provider goes up, it's adding to the cost of the health plan, and the health plan is going to add that on in premiums. It's going to go up,

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and it's going to cause premiums to increase.

To some extent, patients are going to just be unable to afford the healthcare anymore, the health insurance anymore, and will drop off the commercial insurance rolls. They may become uninsured. They may become Medicaid insured. But, in any event, all three of those parts -- the patient moving, the change in the network, and the premium -- can cause losses to the provider that's raising prices.

THE COURT: With regard to that third component, how does the Affordable Care Act play into that, or does it?

THE WITNESS: It ultimately may play into that. I think it's going to depend a lot on the dynamics or the specific terms of how these contracts are set up in Idaho and the level of payment that gets -- now, if a commercial product has a higher payment rate for a regular product than it would for one that's in one of these networks, then even if somebody drops out of a commercial product and joins one of the exchanges -- that's what I meant to say -- one of the exchange products, if it's being reimbursed at a lower rate, that's a loss relative to what St. Luke's and Saltzer would have had had they not had that price increase and not had that loss of patient because of the increased premium.

BY MR. STEIN:

Q. So, Dr. Argue, what kind of information have you

considered in trying to determine whether the actual loss would exceed this critical loss threshold?

A. There are a number of them listed on this slide. Certainly the patient origin data that I mentioned early on is an important source. I looked at the proximity of PCPs to folks' homes and their work. I examined the experience of employers with tiered networks.

I looked a lot at the price sensitivity of enrollees and patients. And there was some information on the willingness of patients to change physicians. All of those were part of determining what the actual loss would be.

MR. STEIN: Your Honor, this is actually a natural breaking point.

THE COURT: All right. Why don't we -- we'll reconvene at 8:30 tomorrow morning. I'm trying to think -- oh, we need -- let's go ahead and publish depositions very quickly, just put it on the record.

Ms. Gearhart, if you'll announce the depositions that I have directed to be published.

THE CLERK: The depositions of Steven Brown taken May 2nd, 2013; Alain Enthoven taken August 9th, 2013; Marc Chasin taken March 21st, 2013; William Deal taken July 2nd, 2013; Patricia Richards taken June 13, 2013; Roberto Barresi taken June 3, 2013; Kurt Seppi taken

May 14th, 2013; Rodney Reider taken April 10th, 2013; Blaine Petersen taken May 17, 2013; and Thomas Reinhardt taken May 22, 2013, are published.

THE COURT: All right. Thank you.

All right. Counsel, we'll reconvene tomorrow morning at 8:30. I have another hearing at 3:30 in here. But it's I think just an audio status conference in an MDL case. So I guess you clear out every night pretty much anyway, but I thought I would just let you know you probably don't need to clear out as much as you might otherwise.

We'll be in recess until 8:30 tomorrow morning.

(Court recessed at 2:32 p.m.)

REPORTER'S CERTIFICATE

I, Tamara I. Hohenleitner, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 17, 2013.

-s-

Tamara I. Hohenleitner
Official Court Reporter
CSR No. 619