

**TESTIMONY OF GREGORY SONNENBERG**

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In the United States Federal District Court for the District of Idaho

*Saint Alphonsus Medical Center-Nampa, Inc., et. al. v. St. Luke's Health System Ltd., et. al.*

Case No. 1:12-cv-00560-BLW

**Page Range: 6:24-6:25**

24 THE WITNESS: Greg Sonnenberg, Director of  
25 Managed Care with Saint Al's.

**Page Range: 10:04-10:12**

02 Q. I know you've had a pretty extensive  
03 experience in the health care industry. Could you  
04 just give me a -- a summary or nutshell of your  
05 experience in the health care industry?  
06 A. Probably a little over 30 years in the  
07 industry I -- I call "managed care." Mostly  
08 working for either insurance companies in an HMO  
09 environment or for health systems in a PHO  
10 environment.

**Page Range: 10:20-11:17**

20 Q. How long have you been working for  
21 Saint Alphonsus?  
22 A. This is my 15th year. About 14 and a  
23 half years.  
24 Q. And you -- in addition -- and Saint  
25 Alphonsus is what you call a "health care  
11:01 provider," correct?  
02 A. Yes. That would include a hospital or  
03 a physician in that -- as a provider.  
04 Q. And you've also worked on the payer  
05 side as well; is that right?  
06 A. I have.  
07 Q. Can you tell me a little bit about your  
08 experience on the payer side?  
09 A. Probably about 15 years. Most --  
10 mostly, as I mentioned earlier, health maintenance  
11 organizations. Mostly small to regional health  
12 maintenance organizations, mostly in the Midwest.  
13 For example, CFO for Health Plan of  
14 Central Illinois and Peoria, Illinois, which was a  
15 probably 125,000 member health maintenance  
16 organization. And I was involved in three of  
17 those in the Midwest.

**Page Range: 13:14-14:07**

14 Q. When you came to Saint Alphonsus, what  
15 was your initial title?  
16 A. Actually, I think it's -- it's  
17 unchanged, Director of Managed Care. I did until  
18 just recently serve in a second capacity, and that  
19 is Executive Director for the PHO.  
20 And that PHO is Advantage Care  
21 Network, which has just had a name change to the  
22 "Alliance." I have been moved out of that  
23 position and doing just the managed care work as  
24 of probably earlier this year.

25 Q. Okay. So you -- you have consistently  
14:01 held the title of Director of Managed Care; is  
02 that correct?  
03 A. Yes.  
04 Q. For what entity?  
05 A. For the various entities of Saint  
06 Alphonsus Regional Medical Center, which has  
07 evolved into the Saint Alphonsus Health System.

**Page Range: 22:08-22:24**

08 Q. What is "ACN"?  
09 A. Advantage Care Network, and that is a  
10 PHO, physician hospital organization, wholly owned  
11 by Saint Al's, Saint Al's Health System.  
12 Q. And what is a "PHO"?  
13 A. A PHO, physician hospital organization,  
14 is a provider entity, provider group with the  
15 purpose of bringing independent physicians under  
16 one signature to contract with payers -- and  
17 "payers" being defined as insurance companies,  
18 major employers -- to provide health care to their  
19 constituents in a health plan design that has  
20 benefit differentials that steer to those  
21 providers.  
22 Q. And ACN included on the hospital side  
23 Saint Alphonsus hospitals?  
24 A. That's correct.

**Page Range: 22:25-23:11**

25 Q. Did it include any non-Saint Alphonsus  
23:01 hospitals?  
02 A. Over the years, yes.  
03 Q. Who did it include in the Idaho  
04 market?  
05 A. It currently includes West Valley  
06 community hospital in Caldwell. It used to  
07 include the Jerome hospital. It currently  
08 includes the Weiser hospital. It had a -- it  
09 includes the Cascade hospital, the hospital in  
10 Mountain Home. Those were all past hospitals that  
11 participated in ACN.

**Page Range: 24:18-24:22**

18 Q. Okay. Do you know whether St. Luke's  
19 has been offered participation of its facilities  
20 in ACN?  
21 A. I don't think we ever have offered them  
22 participation. I hate rejection.

**Page Range: 25:06-25:11**

02 Q. ACN includes in its physician network  
03 physicians employed by Saint Alphonsus, correct?  
04 A. That is correct.  
05 Q. And it also includes physicians who are  
06 not employed by Saint Alphonsus?  
07 A. That's correct.

**Page Range: 29:16-29:20**

16 Q. What do you mean by a "direct  
17 contracting strategy"?  
18 A. That would be one where the contract is  
19 with an employer group. For example, a Micron  
20 contract would be considered a direct contract.

**Page Range: 30:20-30:22**

20 Q. And what is Woodgrain?  
21 A. Woodgrain is an employer in the western  
22 end of the valley. Home office is in Fruitland.

**Page Range: 31:12-32:05**

12 Q. And do they have a -- a manufacturing  
13 facility in Nampa?  
14 A. Yes. In Nampa and in Fruitland, yes.  
15 Q. So roughly how many employees does  
16 Woodgrain have total? Do you know?  
17 A. You know, about the last number -- last  
18 count we had, I think it was just over 600  
19 employees.  
20 Q. Do you know what -- what number of  
21 employees it has in the Nampa area?  
22 A. It's slightly larger in Ontario, but  
23 the -- the two are -- the two plants are pretty  
24 similar in size. I think the Ontario -- or the  
25 Fruitland plant is just a little bigger.  
32:01 Q. So somewhere between two or 300?  
02 A. Probably Nampa is probably in the  
03 250 range, and -- and Fruitland is probably in the  
04 350 range. And the major difference there is the  
05 corporate office is in Fruitland.

**Page Range: 32:22-33:12**

22 You described ConnectedCare as a  
23 "narrow network product." What is a "narrow  
24 network"?  
25 A. It is probably one where it is not  
33:01 what would be considered an open access where  
02 every provider is invited to participate in the  
03 network.  
04 So the way the PPO world works is you  
05 try and have enough providers for the clients  
06 and -- and enrollees that you serve. And in doing  
07 so, you are driving business to a smaller group of  
08 providers.  
09 Which, in turn, those providers provide  
10 discounts for those employers that make your  
11 product attractive to bring in more employers. So  
12 that makes the world go round.

**Page Range: 33:24-35:06**

24 Q. And there are narrow network products  
25 in the Idaho market, for example, some of which  
34:01 would exclude either Saint Al's or -- or  
02 St. Luke's; is that correct?  
03 A. That is correct.  
04 Q. So when you came to Idaho and you, you

05 know, began to learn about this market and the  
06 payer side, what was your impression of how the  
07 payer market in Idaho differed from the other  
08 markets that you've worked in?  
09 A. You know, the way we kind of explain  
10 that is managed care did not have the penetration  
11 in this market as it had in other markets. So  
12 fees, on average, were probably higher than other  
13 markets. You know, just the sheer population  
14 here, not a huge population. So you didn't have a  
15 tremendous amount of competition, which also helps  
16 in that regard.  
17 The fact that managed care didn't get  
18 into this market, you didn't have a lot of -- of  
19 aggressive medical management. Those would be the  
20 three things that -- that were apparent. And I'm  
21 from Illinois, so it was a completely different  
22 market in Illinois than it was here.  
23 Q. So when you said "fees were higher,"  
24 what kind of fees were you referring to there?  
25 A. The allowances, the negotiated rates.  
35:01 So when I came here and looked at the contracts  
02 that Saint Al's had negotiated and the contracts  
03 that I started negotiating right off the bat, they  
04 were -- the allowables, again, is what the term we  
05 use for the contractual rate -- the allowables  
06 were higher here than other markets I've been in.

**Page Range: 35:13-35:24**

13 Q. And then you say "there" -- "there was  
14 not a lot of competition." Can you be more  
15 specific what you mean by that?  
16 A. Well, I think there's two major players  
17 here, Blue Cross and Blue Shield. And in other  
18 markets I've been in, you would have anywhere from  
19 three to five major players and probably a -- a  
20 few of up-and-comers.  
21 Q. So when you're saying -- when you say  
22 there was "not a lot of competition," you're  
23 talking about on the payer side?  
24 A. On the payer side.

**Page Range: 38:01-38:05**

02 Q. And what is the market share of Blue  
03 Cross?  
04 A. You know, it -- it probably varies  
05 by -- by geographical area. They are definitely  
06 perceived as the dominant player in our market.

**Page Range: 38:08-41:07**

02 In Idaho, what's the market share of  
03 Blue Cross?  
04 A. I don't know the exact number, but they  
05 are -- we consider them the dominant player in our  
06 market. I -- I would say -- say they double their  
07 next competitor in this market.  
08 In northern Idaho, I think it is a  
09 little bit more of a split. I think Blue Shield  
10 is a little bit larger in northern Idaho than it

11 is in our valley.  
12 Q. And when you say "this market," what  
13 market are you referring to?  
14 A. I would call our market the -- the  
15 greater Treasure Valley and probably,  
16 specifically, from Boise to the Oregon border.  
17 So primarily the counties of Ada and Canyon.  
18 Q. And the second -- the second largest  
19 payer you're referring to, is that Regence Blue  
39:01 Shield?  
20 A. Regence Blue Shield.  
21 Q. When you came to this market 15 years  
22 ago or so, were there -- were you aware of the  
23 existence of direct contracts of employers?  
24 A. In this market?  
25 Q. Yes. In Idaho.  
26 A. No.  
27 Q. And has that changed over time?  
28 A. There has been modest growth in that  
29 area.  
30 Q. So you mentioned Micron, Woodgrain.  
31 what other examples are you aware of?  
32 A. Well, each -- each hospital has there  
33 own product. Woodgrain and Micron are the -- the  
34 next largest. I'm trying to think if we've had  
35 any other direct contracts. None comes  
36 immediately to mind.  
37 Q. And do you see the use of direct  
38 contracts increasing, decreasing, staying the same  
39 over time?  
40 A. I -- there's certainly a -- a lot of --  
41 lot of dialogue and requests to investigate direct  
42 contracting. And I think that is driven by just  
43 the sheer escalation of health care costs.  
40:01 Employers are looking at any alternatives they --  
42 they can. They can't afford not to look at other  
43 alternatives.  
44 Q. And how would direct contracting allow  
45 an employer to save money over contracting through  
46 Blue Cross or another established payer?  
47 A. A number of things. One is -- is  
48 without the insurance company in the process,  
49 there's a profit center that is eliminated. That  
50 is one.  
51 If this particular employer has good  
52 utilization, if they are a healthier population,  
53 their costs could very easily be less than if they  
54 are in a pool with an insurance company that has a  
55 higher-risk population.  
56 Three, they can tailor their health  
57 care coverage specifically to their needs and then  
58 manage that accordingly.  
59 And they have -- they have more  
60 flexibility, especially in this market when it is  
61 heavily dominated by Blues, which have pretty  
62 specific requirements as to benefits and networks.  
63 If you go direct, you then have those  
64 opportunities to manage those things and change  
65 those things to your financial benefit, adjust  
41:01 benefits, adjust networks.  
66 Q. So the Blues' plans, they'll have some  
67 set of options, but they just don't have the  
68 flexibility that an employer can get if they go

05 out and negotiate a direct contract with somebody  
06 else?  
07 A. That is correct.

**Page Range: 51:22-52:11**

22 What I would like to know, though, is  
23 are there any employers that -- employers or  
24 payers that you would say have essentially said to  
25 you in one form or another that if Saltzer doesn't  
52:01 stay in ACN, that they are not going to continue  
02 their current relationship with ACN or renew their  
03 relationship with ACN?  
04 A. No. No employer says the contract is  
05 contingent on Saltzer being in.  
06 Q. Has anyone said that -- that any of the  
07 specific terms of their contract may be contingent  
08 on whether Saltzer stays in? For example, rates  
09 or medical management or any of the other things  
10 that you typically negotiate?  
11 A. Not -- not a term of the contract.

**Page Range: 53:02-53:25**

02 Q. Is -- is -- and what is the role of  
03 ACN? I think you described it earlier as somehow  
04 relating to or transitioning to the Alliance?  
05 A. Yes. It -- it really is more of a name  
06 change, the way we define it.  
07 Q. Okay.  
08 A. The organization aesthetically is  
09 unchanged. And by that, for example, all of the  
10 provider contracts, and we have over 1,200  
11 providers, those are unchanged. The same  
12 providers, the 11 contracts, unchanged. So  
13 essentially, from a legal standpoint, ACN's name  
14 has been changed to the "Alliance."  
15 Q. So for the providers that are in the --  
16 in ACN right now, for them to participate in the  
17 Alliance, are they going to have to sign new  
18 contracts?  
19 Or do you mean, literally, that ACN  
20 will be changing its name to the "Alliance" so  
21 that all the existing contracts will be -- be --  
22 essentially, will be Alliance contracts?  
23 A. The latter -- the latter is correct.  
24 It is just a name change. That is correct. All  
25 the contracts roll over.

**Page Range: 54:01-54:03**

01 Q. Okay. Who do you report to?  
02 A. Right now, it is Blaine Petersen, CFO  
03 of Saint Alphonsus Health System.

**Page Range: 54:14-54:21**

14 Q. And what's the division of  
15 responsibility, if you can summarize it, between  
16 you and Mr. Petersen when it comes to managed care  
17 contracting?  
18 A. I am probably lead on all contracting,

19 but Blaine has -- for system contracts, Blaine has  
20 the signed system contracts, health system  
21 contracts.

**Page Range: 55:03-55:07**

03 Q. So if there are meetings or  
04 negotiations with Blue Cross commercial or other  
05 of the system contract payers, would you  
06 participate in those typically?  
07 A. I would probably lead them.

**Page Range: 55:16-55:22**

16 Q. So on the system level contracts, you  
17 would still be the lead in -- in terms of  
18 negotiating, but ultimately, Blaine Petersen  
19 would be responsible for signing off on those  
20 terms?  
21 A. Yeah. Approving and signing off,  
22 correct.

**Page Range: 55:23-56:02**

23 Q. And so am I right that generally you  
24 would be participating personally in negotiations  
25 with the payers, both at the system level and at  
56:01 the -- the ACN level?  
02 A. That is correct.

**Page Range: 57:11-57:15**

11 Q. BY MR. STEIN: Mr. Sonnenberg, I've  
12 handed you what we marked as Defendants'  
13 Exhibit 90. I'm going to take a guess that this  
14 is a copy of your CV?  
15 A. Good guess.

**Page Range: 57:18-58:06**

18 Q. When did you prepare this version of  
19 your CV?  
20 A. I don't know the exact date, but it  
21 was probably about nine months ago maybe, or a  
22 year.  
23 Q. And does the CV accurately summarize  
24 your -- your work experience and accomplishments?  
25 A. It does.  
58:01 Q. So I just -- there's a few things on  
02 here I just want to ask you about. And first,  
03 under your "Professional Experience," the first  
04 item you've got listed there is "Director of  
05 Managed Care for Saint Alphonsus Regional Medical  
06 Center"?

**Page Range: 58:10-58:23**

10 Q. The first bullet there says,  
11 "Responsible for all payer contracting operations  
12 for a four-hospital system . . ."  
13 You're referring there to Saint

14 Alphonsus?  
15 A. Health system, that's correct.  
16 Q. And you also say you're responsible for  
17 payer contracting for a "wholly owned, 270  
18 physician medical group."  
19 That's SAMG?  
20 A. That's SAMG. That's correct.  
21 Q. You say you're the lead negotiator and  
22 liaison on all payer contracts. That's accurate?  
23 A. That is.

**Page Range: 63:19-64:06**

19 Q. We can skip the next one. Then there's  
20 a bullet that says "developed initial employer  
21 direct contracting strategy." What does that  
22 refer to?  
23 A. That refers to my development of a -- a  
24 strategy to go direct to employers. What is  
25 involved in that strategy, why it would be  
64:01 successful, you know, why that -- that strategy  
02 would be something to consider.  
03 Q. And is that -- is the Micron contract  
04 part of that or a culmination of that strategy?  
05 A. It would be a culmination of that  
06 strategy.

**Page Range: 64:07-64:10**

07 Q. And was the direct contracting strategy  
08 that you developed something that was adopted by  
09 Saint Alphonsus?  
10 A. You know -- I'm sorry.

**Page Range: 64:13-64:18**

13 THE WITNESS: I don't think it was -- I  
14 wouldn't use the term "adopted" by Saint Al's. I  
15 think we -- we have done some dialogue, and I  
16 don't -- don't think we are as aggressive in  
17 direct contracting as -- as I personally would  
18 have -- would have liked to have seen us go.

**Page Range: 64:23-66:10**

23 Q. So your preference would be to -- to be  
24 more aggressive, in terms of seeking out those  
25 direct employer contracts?  
65:01 A. I -- I would.  
02 Q. And why is that?  
03 A. I think that's -- and I think we talked  
04 about this briefly earlier. I think that's where  
05 this market is heading. I think employers are  
06 asking that questions. It is a -- it's a -- it's  
07 kind of a difficult scenario in that there may be  
08 opportunities there. There are certainly  
09 inquiries from employer groups.  
10 But that also is a concern for  
11 leadership in terms of how that is perceived by  
12 the major payers. Payers can perceive direct  
13 contracting as competition, and that may not be  
14 good for your relationship with those payers.  
15 Q. And so you said you've had

16 conversations with Mr. Petersen about this.  
17 What -- when you've talked about direct  
18 contracting and your view that Saint Al's should  
19 be more aggressive in pursuing that, what has the  
20 response been?  
21 A. Be cautious, proceed very, very  
22 cautiously. We can't ignore those conversations.  
23 Q. And when you say "proceed cautiously,"  
24 has Mr. Petersen told you why he wants to be more  
25 cautious about pursuing direct contracts?  
66:01 A. I think a lot of it stems from  
02 maintaining our good relationships with Blue Cross  
03 and Blue Shield. The -- in their opinion, maybe  
04 the opportunity of success in -- in direct  
05 contracting, they may not view the opportunity for  
06 success as great. And then view the possible  
07 complications that could arise from the  
08 relationship with Blue Cross and Blue Shield as  
09 outweighing maybe the potential for success in  
10 direct contracting.

**Page Range: 67:22-68:12**

22 Q. The last bullet says "consistently  
23 negotiated the highest commercial reimbursement in  
24 the market." What do you mean by that?  
25 A. As I get information from payers in -  
68:01 in negotiations and from EOBs that we've seen and  
02 other documents that have been observed, there's  
03 the indication that the rates that we have  
04 negotiated have been rates that on paper are  
05 larger or higher than the rates negotiated with  
06 that individual payer and St. Luke's.  
07 Which, in this market, is something  
08 that they kind of brag about with Luke's is  
09 dominance in this market from perception of  
10 quality and scope of network. For the second  
11 largest hospital to be able to negotiate better  
12 rates is a good thing.

**Page Range 68:17-69:03**

17 Q. And how -- so you have determined this  
18 you said, one, by reviewing EOBs?  
19 A. We've seen some EOBs. We've had payers  
20 consistently say that on a very, very consistent  
21 basis.  
22 Q. What -- what payers have --  
23 A. Blue Cross, Blue Shield, and IPN.  
24 Q. And when you say that you've  
25 "negotiated the highest commercial reimbursement,"  
69:01 when you talk about reimbursement in this context,  
02 you're talking about allowed amounts?  
03 A. The allowable. That is correct.

**Page Range: 70:14-71:05**

14 Q. So in what context do these  
15 conversations or these statements from payers come  
16 up in which they'll tell you that you've  
17 negotiated the highest commercial reimbursement

18 rates in the market?  
19 Why is that something that a payer  
20 would be telling you?  
21 A. It probably comes up in -- in  
22 negotiations. It is probably used as leverage, as  
23 you might imagine. Hey, we're paying you higher  
24 than we're paying the competitor. You've got to  
25 come down.  
71:01 I think for obvious reasons, but the  
02 other supporting evidence is enough for me to feel  
03 confident that that is an accurate statement. The  
04 degree of accuracy is probably debatable, degree  
05 of the difference between the two.

**Page Range: 71:17-71:21**

17 Q. So who are the people at Blue Cross  
18 that you deal with primarily in your negotiations?  
19 A. You know, my counterpart is an  
20 individual by the name of Jeff Crouch. I think he  
21 is VP Of Provider Relations.

**Page Range: 73:08-73:14**

08 Q. Do you recall who specifically at  
09 Blue Shield has told you that Saint Al's  
10 commercial rates are the highest in the market?  
11 A. That probably would have been the  
12 predecessor for -- for Melissa, and his name is  
13 Scott Clement. He is no longer with the  
14 organization.

**Page Range: 73:25-74:03**

25 Q. And who do you deal with primarily at  
74:01 IPN?  
02 A. Linda Duer, and she has a support staff  
03 of Nicki Karst.

**Page Range: 74:17-75:06**

17 Q. And has Linda Duer told you that the  
18 rates that Saint Al's gets for IPN -- for the IPN  
19 contract are the highest in the market?  
20 A. I don't think she has.  
21 Q. Do you know, has somebody from IPN told  
22 you that?  
23 A. I -- I -- I think so. We have -- I --  
24 I've seen some RSVPs (sic), request for proposals,  
25 where I've seen some rates, inadvertently, from  
75:01 Luke's to IPN.  
02 Q. And what -- how did you see those  
03 proposals?  
04 A. I think somebody sent me a copy of a  
05 contract to sign, and it inadvertently had Luke's  
06 contract right behind it.

**Page Range: 87:15-87:18**

15 Q. So the loss of the physician groups to  
16 St. Luke's it sounds like forced Saint Al's to

17 accelerate its development of its clinical  
18 integration and value-based contracting strategy?

**Page Range: 87:21-88:06**

21 A. It's expedited that process. It has  
22 required us to focus on -- on other things in  
23 addition to the process of backfilling in those  
24 specialties, and then also the corresponding  
25 communicating to -- to the employers that the  
88:01 providers that we are backfilling, in our opinion,  
02 are just as good as the providers that we've lost.  
03 Which when you move from a named  
04 provider that people are comfortable with to a  
05 provider that they may not know, it is easier said  
06 than done.

**Page Range: 124:22-124:25**

22 Q. And is it your perception, based on  
23 your negotiations with payers in this market, that  
24 they think it is important that Saint Alphonsus  
25 facilities be in network?

**Page Range: 125:01-125:24**

01 A. I -- I think it varies from payer to  
02 payer. This market has historically wanted  
03 access, so I think it is important for -- for most  
04 for most of them.  
05 Q. But a payer like a Blue Cross would be  
06 at a real disadvantage in competing against other  
07 payers in this market if it didn't have, you know,  
08 Saint Al's in its networks?  
09 A. I would agree.  
10 Q. And that's something you would know in  
11 the back of your mind when you're sitting down to  
12 negotiate contracts with them?  
13 A. Yes. Like they would know in the back  
14 of their mind that if we lost them, we would be in  
15 trouble.  
16 Q. Why is that?  
17 A. Because of their volumes. They  
18 represent a pretty -- well, they are our largest  
19 payer, commercial payer.  
20 Q. And for a payer that has insureds and a  
21 significant number of insureds in Nampa, the only  
22 hospital in Nampa is Saint Alphonsus Nampa; is  
23 that right?  
24 A. That's correct.

**Page Range: 148:15-148:18**

15 Q. BY MR. STEIN: Mr. Sonnenberg,  
16 Defendants' Exhibit 95 is an August 24, 2010,  
17 E-mail from you to Janelle Reilly, Ken Fry and  
18 Douglas Hill, marked ALPH00136911 through 23. And

**Page Range: 149:22-150:05**

22 Q. We talked earlier today about direct

23 contracting and the fact that you were an advocate  
24 of direct contracting. And is this a memo that  
25 was prepared to make -- make the case for more  
150:01 involvement in direct contracting?  
02 A. That, and to a little bit broader  
03 extent, a contracting strategy in general. But,  
04 obviously, there was a focus on direct  
05 contracting.

**Page Range: 150:19-152:12**

19 Q. So I just want to ask you about some of  
20 the things that are in this memo. In the first  
21 paragraph, it says, "Well over half of the total  
22 dollars spent by employer-sponsored health plans  
23 in the Boise market are from self-insured plans  
24 and the amount is increasing every year. This  
25 trend should continue through health care reform  
151:01 as employers search for ways to control their  
02 health care costs. Employers, as small as 50  
03 employees, are evaluating self-insuring for health  
04 care benefits."  
05 Was that accurate, as far as you knew  
06 at the time?  
07 A. Yes. At the time, yes.  
08 Q. Do you still think that is accurate?  
09 A. I think the opportunity is still there,  
10 yes.  
11 Q. On the next page, do you see toward the  
12 bottom there's a paragraph that starts, "SLRMC is  
13 the other health system in Boise"?  
14 A. Second paragraph from the bottom?  
15 Q. Yes. And "SLRMC" refers to St. Luke's  
16 Regional Medical Center?  
17 A. Correct.  
18 Q. And in this paragraph, you're talking  
19 about -- I'm paraphrasing here, but you're talking  
20 about St. Luke's is going out and trying to get  
21 direct contracts as well; is that right?  
22 A. Yes. Kind of laying the groundwork of  
23 the market.  
24 Q. And in the last sentence of that  
25 paragraph, you say, "Despite all their advantages,  
152:01 every major payor has confirmed that SARMC has  
02 negotiated more favorable rates with them than  
03 SLRMC."  
04 Do you see that?  
05 A. I do.  
06 Q. And that -- that potentially confirms  
07 some of what you testified to earlier --  
08 A. I seem to be pretty confident about  
09 that point, aren't I?  
10 Q. That's the same point you were making  
11 earlier today though?  
12 A. Yes.

**Page Range 153:17-154:08**

17 Q. And what do you think is needed to  
18 control costs in order to help employers move to  
19 more -- more directed health plans?  
20 A. Controlling utilization. The

21 utilization of services versus the price of  
22 services I think is probably paramount.  
23 Q. And by "the price of services," you  
24 mean the unit cost?  
25 A. Yes, the unit cost.  
154:01 Q. So when you think about the expense of  
02 health care services, you've got at least a couple  
03 of factors, right?  
04 You've got the unit -- you've got the  
05 unit price for the services, but you also have to  
06 consider the level of utilization of those  
07 services, right?  
08 A. That's correct.

**Page Range 154:13-155:15**

13 Q. Of the page that ends "916," there's a  
14 section titled "What is the Goal?"  
15 A. Okay. I've got it.  
16 Q. It says, "The goal is to be Idaho's  
17 highest quality, lowest cost provider network. A  
18 'one-stop shop' for all of self-insured employers'  
19 needs. Offering a comprehensive integrated  
20 provider network, a number of patient care  
21 management options, a proven third-party  
22 administrator and a trusted broker. Cost is  
23 defined as a PMPM overall health care cost versus  
24 the current thinking of just unit price."  
25 What does that mean, a "PMPM overall  
155:01 health care cost"?  
02 A. "PMPM" stands for per member per month.  
03 It is kind of the widget of the health care  
04 industry. How we communicate cost is on a PMPM  
05 basis, and this would be in the context of the  
06 overall cost for that defined population. And --  
07 Q. I'm sorry.  
08 A. -- and reducing that cost.  
09 Q. So is what -- is part of what's being  
10 conveyed there that Saint Al's should be thinking  
11 about the cost of services to employers and  
12 payers, not just in terms of unit price or  
13 discounts from charges, but really the overall  
14 cost of providing care to the population?  
15 A. That is correct.

**Page Range 156:07-156:22**

07 Q. Now, traditionally, most of Saint Al's  
08 contracts have been on -- reimbursed on some sort  
09 of fee-for-service basis; is that right?  
10 A. Just like -- yeah, just like every  
11 other contract in this market. Correct.  
12 Q. Do you see the market moving away from  
13 that form of reimbursement?  
14 A. You know, I see us moving away from it  
15 more than anyone else, including Luke's, because  
16 of our need to -- to look for ways to -- to combat  
17 the -- the issues we talked about, the perception  
18 of quality, the loss of key physicians in our  
19 network.  
20 I -- I think that's one of the tools we  
21 have left, and I see us moving that direction. I

22 don't know about the rest of the market.

**Page Range: 170:10-170:13**

10 Q. BY MR. STEIN: Plaintiff's Exhibit 96  
11 is a PowerPoint stamped ALPH00369291, titled "The  
12 Saint Alphonsus Health Alliance Payor Strategy -  
13 Idaho." My first question, once you've had a

**Page Range: 176:21-176:23**

21 Q. Could you turn to Slide 10. Take a  
22 look at these bullets, and then just let me know  
23 when you've had a chance to read them.

**Page Range: 176:24-177:08**

24 A. Okay.  
25 Q. So the first bullet under this slide  
177:01 says, "SAHS payor strategy is to work with the  
02 three major payors, BCI, Regence and PacificSource  
03 to create new narrow network products that include  
04 only SAHS and affiliated providers."  
05 Do you see that?  
06 A. I do.  
07 Q. And is that an accurate statement?  
08 A. That is an accurate statement.

**Page Range: 179:01-180:03**

01 Q. The next bullet says, "SAHS's goal is  
02 to tie up as many lives as possible before the  
03 competition can sign similar contracts."  
04 Is that accurate?  
05 A. It is.  
06 Q. And the competition there is  
07 St. Luke's?  
08 A. Yes.  
09 Q. And what does that mean, "to tie up  
10 lives"?  
11 A. Well, it's -- again, this is a -- this  
12 is one of those things I mentioned earlier, our  
13 efforts to try and find ways to compete with the  
14 issue of the market advantage of Luke's in this  
15 market.  
16 And one of it is get in early, get in  
17 quick and try and do some exclusive arrangements  
18 early. Get an advantage in the marketplace.  
19 Q. And "lives" there refers to individuals  
20 who are -- who have -- individuals covered by  
21 payer contracts?  
22 A. Correct. Enrollees.  
23 Q. And at the risk of asking a question  
24 that may sound too obvious, when you talk about an  
25 "exclusive contract," you mean a contract in which  
180:01 Saint Al's is an in network provider and  
02 St. Luke's is not?  
03 A. Correct.

**Page Range: 230:01-230:17**

01 Q. And from your perspective, has the  
02 St. Luke's acquisition of Saltzer had any effect  
03 on your -- on your negotiations with payers or  
04 your perception of their willingness to, you know,  
05 continue those efforts with you?  
06 A. All the payers have asked about the  
07 status of Saltzer, yes.  
08 Q. Meaning what?  
09 A. Meaning they have a concern as to  
10 whether or not Saltzer is in our network.  
11 Q. Okay. So who from -- who from Blue  
12 Cross has talked to you about Saltzer?  
13 A. I don't recall any specific  
14 conversations. I know it has come up in -- in our  
15 conversations. So it could be any one of the four  
16 that I mentioned earlier. So Jeff Crouch, Dani  
17 Jones, Stina Proctor or Todd York.

**Page Range: 230:19-231:04**

19 Has anyone from Blue Cross said that  
20 whether or not Saltzer remains in the ACN or  
21 Alliance network is going to impact their  
22 willingness to contract with you for their PPO  
23 product, for example?  
24 A. Not specifically, no.  
25 Q. Okay. Has anyone from Blue Cross  
231:01 indicated that Saltzer's participation in the  
02 Alliance or ACN is going to affect the rates that  
03 Saint Alphonsus will get under the --  
04 A. No conversations of that nature.

**Page Range: 236:14-237:10**

14 Q. Mr. Sonnenberg, Mr. Stein asked you  
15 some questions about your references to Saint Al's  
16 reimbursement in your resume. Do you remember  
17 that topic?  
18 A. Um-hum.  
19 Q. That's a yes?  
20 A. Yes. Yeah. I'm sorry.  
21 Q. Let me just ask you a couple of  
22 questions about that. You mentioned EOBs. What  
23 is an "EOB"?  
24 A. Explanation of payment -- explanation  
25 of benefits, actually. There's such a thing  
237:01 called "EOPs" too. They're -- they're one and the  
02 same. But explanation of benefits is EOB.  
03 Q. So is -- does an individual EOB cover a  
04 whole lot of patients or just one patient?  
05 A. Just one patient.  
06 Q. And how many individual EOBs have you  
07 seen that shed light on someone's reimbursement  
08 other than Saint Al's reimbursement in the last  
09 five years?  
10 A. Probably no more than five.

**Page Range: 237:11-237:24**

11 Q. You mentioned -- on the same topic, a  
12 couple other questions. You mentioned, I believe  
13 you said payers have used as leverage their  
14 statement that they are paying you more than  
15 others; you've got to come down. Something to  
16 that effect. Do I have that right?  
17 A. Um-hum. Yes.  
18 Q. If a payer in negotiations tries to get  
19 you to come down by saying we're paying you more  
20 than others, does that -- would the payer have  
21 the -- have the incentive to make that statement  
22 only if it were true or might the payer have the  
23 incentive to make that statement if it were  
24 exaggerated or false?

**Page Range: 238:03-238:04**

03 A. So a payer would, I guess, have an  
04 incentive to -- to say it both ways.

**Page Range: 238:11-238:17**

11 Q. You mentioned that someone at Blue  
12 Shield made a comment about this reimbursement  
13 subject. Do you remember when that statement was  
14 last made by somebody at Blue Shield?  
15 A. I don't know the exact date.  
16 Q. Do you know the approximate date?  
17 A. I don't.

**Page Range: 238:18-238:22**

18 Q. You talked about being a little bit  
19 creative in contracts to offset some of St. Luke's  
20 acquisitions. Are -- looking at the future, are  
21 you confident that that creativity is going to --  
22 going to do the job or not?

**Page Range: 238:24-239:01**

24 THE WITNESS: No. No, I'm not confident. I  
25 think that is an ever-ending battle, and it  
239:01 gets -- appears to be getting worse with time.

**Page Range: 239:02-239:15**

02 Q. BY MR. ETTINGER: Mr. Stein asked you  
03 some questions about whether payers were  
04 disadvantaged if they didn't have Saint Alphonsus  
05 in the network.  
06 And I just want to ask you, have you  
07 ever threatened a payer that you would pull Saint  
08 Alphonsus out of their network?  
09 A. I have not.  
10 Q. Why not?  
11 A. For the assumption that they would  
12 accept it, and, actually, our perception that  
13 they could consider a network -- they would  
14 consider a network being sufficient without  
15 Saint Al's in it.