1
UNITED STATES DISTRICT COURT
2
IN THE DISTRICT OF IDAHO
3
- x Case No. 1:12-cv-00560-BLW
4 SAINT ALPHONSUS MEDICAL CENTER - :
NAMPA, INC., TREASURE VALLEY : Bench Trial
5 HOSPITAL LIMITED PARTNERSHIP, SAINT : **Witnesses:**
ALPHONSUS HEALTH SYSTEM, INC., AND : **Deborah Haas-Wilson**
6 SAINT ALPHONSUS REGIONAL MEDICAL :
CENTER, INC., :
7 Plaintiffs, :
vs. :
8 :
ST. LUKE'S HEALTH SYSTEM, LTD., and :
9 ST. LUKE'S REGIONAL MEDICAL CENTER, :
LTD., :
10 Defendants. :
- : Case No. 1:13-cv-00116-BLW
11 FEDERAL TRADE COMMISSION; STATE OF :
IDAHO, :
12 Plaintiffs, :
vs. :
13 :
ST. LUKE'S HEALTH SYSTEM, LTD.; :
14 SALTZER MEDICAL GROUP, P.A., :
:
15 Defendants. :
- x
16

17 *** * * SEALED * * ***

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REPORTER'S TRANSCRIPT OF PROCEEDINGS
19
before B. Lynn Winmill, Chief District Judge
20
Held on October 3, 2013
21
Volume 9, Pages 1467 to 1596
22
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1 **A P P E A R A N C E S**

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1 PROCEEDINGS
2 October 3, 2013
3 ***** COURTROOM OPEN TO THE PUBLIC *****
4 THE CLERK: The court will now hear Civil Case
5 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc.,
6 versus St. Luke's Health System for Day 9 of a bench trial.
7 THE COURT: Good morning, Counsel.
8 I had a gift here on my -- on my bench so I am assuming
9 this was something counsel worked out with Nick Genna,
10 St. Luke's demonstratives?
11 MR. STEIN: Those were the slides that were used
12 with Mr. Genna, and I emailed those to Mr. Powers yesterday.
13 THE COURT: All right. So are we comfortable,
14 then, that the slides have been identified sufficiently for
15 the record? They will be -- Mr. Powers?
16 MR. POWERS: Yes, Your Honor. We have the set
17 that -- five demonstratives we used during Mr. Genna's, as
18 well, marked. Getting it on the record, though, I think is
19 something Mr. Stein and I probably should do at the end of
20 the day today.
21 THE COURT: All right. Very good.
22 MR. POWERS: But if I could approach and give you
23 TVH's set.
24 THE COURT: Yes.
25 MR. POWERS: Mr. Stein has them, as well; I think

1 he was emailed this morning.
2 THE COURT: Perhaps -- well, what I would
3 recommend is that counsel assign them an exhibit number of
4 some type, and then we'll enter those on the record, not as
5 an exhibit, but as a demonstrative that was used with
6 Mr. Genna's testimony.
7 MR. POWERS: We'll do that at the end of the day,
8 Your Honor.
9 THE COURT: All right. Counsel is aware a motion
10 was filed, I think, by the Associated Press -- and I think
11 Mr. Metcalf discussed that with you -- challenging the
12 closing of the courtroom. We scheduled a hearing for, I
13 think, Tuesday afternoon at 3:30, and we'll take that matter
14 up at that time.
15 I think that was all that I had by way of housekeeping.
16 Were there any other items, Counsel?
17 MR. BIERIG: No.
18 THE COURT: The plaintiffs may call their next
19 witness.
20 MR. ETTINGER: Your Honor, we call Professor
21 Deborah Haas-Wilson.
22 THE COURT: Yes.
23 MS. DUKE: And, Your Honor, there is a binder if
24 she wants to reference any of her supporting materials. So
25 may I hand that to Mr. Metcalf?

1 THE COURT: Yes, if you would.
2 Dr. Haas-Wilson, would you please step before
3 Ms. Gearhart, be sworn as a witness and then follow her
4 directions from there.
5 DEBORAH HAAS-WILSON,
6 having been first duly sworn to tell the whole truth,
7 testified as follows:
8 THE CLERK: Please take a seat in the witness
9 stand.
10 Please state your complete name and spell your name for
11 the record.
12 THE WITNESS: My name is Deborah Haas-Wilson,
13 D-E-B-O-R-A-H H-A-A-S, hyphen, W-I-L-S-O-N.
14 THE COURT: Mr. Ettinger, you may inquire of the
15 witness.
16 MR. ETTINGER: Thank you, Your Honor.
17 Your Honor, we're going to be using demonstratives.
18 They're on the screen. And consistent with Your Honor's
19 suggestion, I think we'll call those, collectively, 3000, if
20 you think -- if that works.
21 THE COURT: All right. Dr. Haas-Wilson's
22 demonstratives will be marked as Exhibit 3000, collectively,
23 as a group, and then we'll go back and use that same number
24 designation for the plaintiffs' other demonstratives.
25 Defense I think have already started using the 5000 series.

1 So I think we have that organized.
2 All right. Proceed.
3 DIRECT EXAMINATION
4 BY MR. ETTINGER:
5 **Q.** Professor Haas-Wilson, I think you can see the
6 slides on your screen there. And I've just put up the first
7 slide in the demonstratives, but I'll ask you about some of
8 these things.
9 What's your occupation?
10 **A. I'm a professor of economics at Smith College.**
11 **Q.** And does slide 2, does that describe your
12 background and experience?
13 **A. Yes, it does.**
14 **Q.** How long have you been a professor at Smith
15 College?
16 **A. Since 1984.**
17 **Q.** And in what field are you a professor?
18 **A. In the field of economics.**
19 **Q.** Do you have a particular specialty within
20 economics?
21 **A. Yes, I do. I specialize in the study of**
22 **competition in healthcare markets and the related antitrust**
23 **issues.**
24 **Q.** And has your career focus been on scholarship or
25 on consulting primarily?

1 **A. The focus of my career has been on teaching and**
2 **scholarship.**
3 Q. Okay. And about how many articles and books have
4 you written on healthcare economics?
5 **A. More than 25, and I'd say about half of those are**
6 **specifically on healthcare antitrust issues. And they're**
7 **all published in peer-reviewed journals.**
8 Q. Why don't we go to slide 3. Does this describe
9 briefly some of your consulting experience?
10 **A. Yes, it does.**
11 Q. And I just want to ask about one of the items.
12 The Evanston Northwestern case you testified on behalf of
13 the Federal Trade Commission in that case?
14 **A. That's correct.**
15 Q. What was the general issue in that case? What
16 kind of case was it?
17 **A. It was a challenge to a consummated merger.**
18 Q. Hospital merger?
19 **A. Hospital merger, yes.**
20 Q. What was the relevant product market in that case?
21 **A. The relevant product market in that case was**
22 **general acute care inpatient services sold to commercial**
23 **payors.**
24 Q. And how does that product market relate to the
25 product markets that you're addressing in this case?

1 **A. That is one of the five product markets that I'm**
2 **studying in this case.**
3 Q. Okay. Why don't we go on to slide 4. Does this
4 summarize in general terms your assignment?
5 **A. Yes, it does.**
6 Q. So talk about relevant markets, likelihood of
7 market competition, and evaluating St. Luke's experts.
8 We'll address those in sequence.
9 So let's start with slide 5. What does this slide
10 generally depict?
11 **A. This slide depicts the five relevant markets that**
12 **I studied in this case.**
13 Q. And does the slide describe what you have defined
14 as the relevant markets?
15 **A. That's correct.**
16 Q. Okay. So the first bullet concerns primary care
17 physician services. I think Professor Dranove spoke to that
18 issue yesterday. Do you plan to address that issue in any
19 detail today?
20 **A. No. Professor Dranove covered that yesterday.**
21 Q. So the second bullet talks about pediatric primary
22 care physician services. How would you compare that market
23 generally -- and I'll ask you some more questions about it
24 in a few minutes -- but how would you compare it generally
25 to the general primary care physician services market?

1 **A. Well, it's actually quite similar except on a**
2 **different set of patients. Pediatric primary care physician**
3 **services are the physician services that are provided to**
4 **infants and children.**
5 Q. The three other bullets talk about general acute
6 care inpatient hospital services and certain outpatient
7 surgical facility services. I have a few questions on
8 these. What is inpatient -- what are inpatient hospital
9 services?
10 **A. Inpatient hospital services are those services**
11 **that are provided at a hospital and require an overnight**
12 **stay.**
13 Q. And the last two markets there that talk about
14 outpatient surgical facilities, either general surgery or
15 neuro plus orthopedic, do those markets concern the
16 professional services the physicians provide or the actual
17 facilities and equipment that are provided by hospitals and
18 outpatient facilities?
19 **A. These describe the facility services, not the**
20 **professional services provided by the physicians.**
21 Q. Are your relevant market definitions for the last
22 three bullets, the hospital and surgical facility services
23 markets, are those disputed by St. Luke's experts?
24 **A. St. Luke's experts have not disputed either the**
25 **product or the geographic market for the last three listed**

1 **on this slide.**
2 Q. Nevertheless, let me ask you just a question about
3 the geographic market on these slides. For the physician
4 markets, you talk about Nampa and alternative geographic
5 areas; for these hospital and surgical facility markets you
6 talk about Ada and Canyon Counties. Why is it generally
7 that the geographic market is broader for these hospitals
8 and facility services markets?
9 **A. Patients tend to be willing to travel further**
10 **distances to receive their hospital inpatient and their**
11 **outpatient services than they are for primary care.**
12 MR. ETTINGER: Excuse me, Your Honor. One minute.
13 Trying to resolve an AEO issue quickly, Your Honor.
14 THE COURT: Yes.
15 MR. ETTINGER: Your Honor, we'll try to -- we'll
16 try to blank the screen on the next slide, if we could.
17 THE COURT: All right.
18 BY MR. ETTINGER:
19 Q. So Professor Haas-Wilson, I'm going to ask you
20 about this slide without the entire courtroom seeing it.
21 What does -- how does the statement on the slide relate to
22 the issues that you're addressing today?
23 **A. Well, Dr. Page is saying very succinctly that the**
24 **primary care providers are key to determining where patients**
25 **receive their outpatient services, their ancillaries, and**

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1 how they decide which hospital to use for their inpatient or
2 outpatient services.
3 Q. Why don't we go on to slide 7 -- and we don't need
4 to blank the screen for this, Your Honor.
5 And what does slide 7 depict?
6 A. Slide 7 is showing three different levels of care.
7 The bottom row, that's the primary care physicians. The
8 middle row are physicians who are specialists; that could be
9 cardiologists, orthopedists. The top row, that includes the
10 hospitals in the local market and also the independent
11 ambulatory surgical centers.
12 Q. So when you look at the relevant markets, which
13 are PCP markets and the hospital and facility markets, do
14 you view them in isolation or do you view them in relation
15 to these levels on the chart?
16 A. The three levels are very related. One could not
17 understand what was going on in my top row, the market for
18 hospital services and outpatient services, if you didn't
19 understand the dynamics of what was going down in the bottom
20 row, the market for primary care physician services. They
21 are very highly related.
22 Q. So with that background, let me go on to slide 8.
23 Does slide 8 depict your general conclusions in this case?
24 A. Yes, it does.
25 Q. And I gather, just to quickly go through them, you

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1 conclude that competition is likely to be substantially
2 harmed in the relevant markets; is that right?
3 A. That's correct.
4 Q. And you give two reasons here: network
5 competition and foreclosure of competitors?
6 A. That's correct.
7 Q. And in addition to these conclusions, do you also
8 reach conclusions in the general primary care and pediatric
9 primary care markets?
10 A. I do with respect to the general primary care
11 market.
12 Q. We'll get to that. Did anyone assist you in your
13 work in this case?
14 A. Yes. I was assisted by the Analysis Group.
15 Q. What is the Analysis Group?
16 A. The Analysis Group is a very well-respected
17 consulting firm that often does the backup work for expert
18 witnesses.
19 Q. And what did the Analysis Group do versus what you
20 yourself did in connection with your work in this case?
21 A. Well, first, let me say that all the work that was
22 done at the Analysis Group was done under my direction. And
23 the Analysis Group, they took charge of receiving the data,
24 cleaning the data sets, organizing them for research
25 purposes, and then when I would request a particular type of

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1 analysis, they would actually implement that analysis
2 empirically.
3 They also, under my direction and after much
4 conversation with me, would do first drafts of the exhibits,
5 and then I would have those to review and revise, make
6 comments on, and then they would also revise the exhibits as
7 I requested.
8 Q. Who was the lead person who worked for you at the
9 Analysis Group on this project?
10 A. That's Dr. Tasneem Chipty.
11 Q. And what's her background generally?
12 A. She has a Ph.D. in economics from MIT, and she has
13 done much work in antitrust across multiple markets.
14 Q. Okay. Let me go on to slide 9, "Product Markets
15 for Pediatric Primary Care." My first question is why is
16 pediatric primary care a separate market from general
17 primary care?
18 A. Pediatric primary care physician services are a
19 separate market because general primary care providers, the
20 internists, the GPs, the family practitioners, they are not
21 substitutes for pediatricians. When a health insurer is
22 trying to develop its health plan and provide a viable
23 provider network, that health plan would have to include a
24 provider network that included pediatricians. The health
25 plan could not substitute just general primary care

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1 physicians for pediatricians and not include any
2 pediatricians. That would not be a marketable health plan
3 because many people -- many employees or potential enrollees
4 want access, insured access to pediatricians for their
5 children.
6 Q. Did you examine the composition of the various
7 networks that payors have in the Treasure Valley in
8 connection with your work?
9 A. Yes, I did.
10 Q. Do any of those networks exist without any
11 pediatricians?
12 A. Not a one.
13 Q. You refer to two alternative approaches here.
14 What are those two alternative approaches?
15 A. Those are two different approaches to actually
16 implement the product market. The first one is by physician
17 specialty. So a service that is provided by a pediatrician
18 would be included as pediatric primary care.
19 The second methodology would be to use the age of
20 the patient. So a primary care service provided to anyone
21 who is younger than 18 would be included as a pediatric
22 primary care service.
23 And it didn't matter which methodology I used. My
24 conclusions were robust across those two approaches.
25 Q. Why don't we go on to slide 10, "Geographic

1 Markets for Pediatric Primary Care." Does this slide depict
2 the kinds of evidence you looked at on this issue of what
3 the geographic market should be for pediatric primary care?
4 **A. Yes, it does.**
5 **Q.** I know we'll talk about a couple of these
6 specifically. Let me ask you about one issue, location of
7 physician offices. What did that tell you about the
8 geographic market for pediatric primary care?
9 **A. Well, looking at a map and seeing where physician**
10 **practices located their actual offices, I observed that**
11 **these practices who are providing pediatric care, they**
12 **locate their offices in multiple neighborhoods. They don't**
13 **have just one central large office of pediatric care.**
14 **So, for example, Saltzer, if you look at the map,**
15 **they have a clinic in Meridian that provides pediatric care,**
16 **and then they also have two clinics in Nampa that provide**
17 **pediatric care.**
18 **Q.** And how does that relate to your conclusion on
19 geographic market?
20 **A. Well, that's indicative that the physicians**
21 **recognize that patients are interested in having close,**
22 **convenient access to their pediatrician, that they don't**
23 **want to travel far to get their pediatric primary care**
24 **services.**
25 **Q.** Why don't we go on to slide 11, "Patient Flows for

1 Pediatric Primary Care." And does this reflect what your
2 data indicated in terms of where Nampa residents go and
3 where Nampa providers draw pediatric patients?
4 **A. Yes, it does.**
5 **Q.** A couple questions on this. You talk about, in
6 the bottom of the slide, the majority of Nampa residents
7 stay in Nampa. Why is the majority significant to you?
8 **A. The majority is significant because any health**
9 **insurer or an employer who is trying to develop a marketable**
10 **health plan has to satisfy this 56 percent of the Nampa**
11 **residents who want to receive the pediatric care in Nampa.**
12 **So when they are designing their health plan and determining**
13 **their provider network, they recognize that they need to**
14 **have pediatricians located in Nampa as part of their**
15 **provider network.**
16 **Q.** And why don't we go on to the next slide, slide
17 12. This has "Market Shares and Concentration for Pediatric
18 Primary Care." And what does this slide indicate?
19 **A. This slide is indicating that the levels of**
20 **concentration measured using the HHI are very high. They**
21 **are quite higher than the FTC/DOJ's number of 2500 to**
22 **designate a market as highly concentrated.**
23 **The other thing that's important to notice is that**
24 **it doesn't matter whether I use my geographic market of**
25 **Nampa or I use an alternative, any of these three**

1 **alternative geographic areas, the concentration is extremely**
2 **high no matter how one looks at the geographic area.**
3 **Q.** And then what -- in a couple of cases, the change
4 in the HHI is zero on this chart. What's the significance
5 of that?
6 **A. The significance of that or the reason for it is**
7 **that St. Luke's does not employ any pediatricians in**
8 **Canyon County, and Nampa is part of Canyon County.**
9 **Q.** Okay. So if there is no change in concentration
10 in Canyon County, what is the nature of this competitive
11 concern that you see, if any, with regard to this
12 acquisition if the relevant market is either Nampa or Canyon
13 County for pediatric primary care?
14 **A. Sure. This goes back to what I was saying about a**
15 **previous slide, that what is happening in the market for**
16 **primary care physician services affects what is happening in**
17 **the market for inpatient care or outpatient care. So the**
18 **concentration in these markets is going to have an effect,**
19 **competitive effect in the markets that were in the third row**
20 **of that previous slide.**
21 **Q.** Okay. So have we described the bases for your
22 concerns about harm to competition and pediatric primary
23 care?
24 **A. I'm sorry. The question again?**
25 **Q.** Have we covered the bases for your concerns about

1 harm to competition and pediatric primary care?
2 **A. My main concern is the concentration in pediatric**
3 **primary care will affect how competition works in the market**
4 **for outpatient and inpatient services.**
5 **Q.** Okay. So let me ask you about another aspect of
6 these issues. Have you seen any evidence of any health plan
7 in the Treasure Valley offering financial incentives for
8 patients or for enrollees or employees to travel to more
9 distant providers?
10 **A. I have seen no evidence of that.**
11 **Q.** Is that of any significance to your conclusions?
12 **A. Certainly. What that suggests to me is that there**
13 **are no employers or payors who are willing to impose those**
14 **sorts of financial incentives on their employees or**
15 **enrollees. They're not willing to take the risk of angering**
16 **or upsetting or disrupting their employees or enrollees by**
17 **giving financial incentive to travel further to more distant**
18 **providers.**
19 **Q.** Let's go on to another topic, network competition.
20 And I want to go through and show you two slides and ask you
21 about both of them together. So slide 13 says, "Competition
22 Without Provider Networks." And slide 14 says, "Competition
23 With Provider Networks." So what's the difference between
24 what's depicted on these two slides?
25 **A. So as you mentioned, in this first slide, it's how**

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1 the healthcare market would work if there were no provider
2 networks. And in this case, the employer or the payor who
3 was assembling their provider network would have to put the
4 resources, the time and the money, into negotiating with
5 each hospital, each physician group, each outpatient
6 facility and any other type of healthcare provider that it
7 wanted to include in its network. It would have to do
8 one-on-one negotiations, which would be very time-consuming
9 and resource-intensive.
10 In the second slide, you see competition where
11 there are provider networks. And in that case, the employer
12 and the payor need only negotiate a contract with one
13 provider network, where that provider network has already
14 assembled a combination of hospitals and physician
15 organizations to include in its network. So it's much more
16 efficient for employers and payors to use a network. There
17 is huge savings in time and other resources.
18 Q. Are these efficiencies the same for all employers
19 and payors or does it vary depending on who we're talking
20 about?
21 A. Well, there might be a particularly large payor,
22 like in this case Blue Cross, that might prefer to negotiate
23 separately with each hospital and physician group. But for
24 the small employer, the small payor, certainly using a
25 provider network and saving those resources and costs would

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1 certainly be more efficient.
2 Q. How about a national payor like an Aetna that may
3 be large nationally but have a small presence in Idaho?
4 A. Sure. An Aetna, a United, a Cigna, any of those
5 national insurers, it would be much more efficient for them
6 to be able to use an already assembled provider network to
7 provide care for their Idaho enrollees.
8 Q. So what is -- just -- what are these points you
9 just made telling you about the significance of competition
10 by networks to competition in your relevant markets?
11 A. The networks and competition among those networks
12 is of vital importance. Healthcare markets would not work
13 well, would not work efficiently without these provider
14 networks.
15 Q. Did you see a need -- excuse me -- did you see a
16 need to define a separate market for network competition?
17 A. No, I did not.
18 Q. And why not?
19 A. Because what I was studying was how the network
20 competition impacted competition in the five relevant
21 markets that I did define.
22 MR. ETTINGER: Your Honor, the next ten slides
23 include a number of slides that are AEO information, so we
24 may need to close the courtroom briefly, and then we can
25 reopen it again.

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1 THE COURT: I will direct everyone in the
2 courtroom to vacate the courtroom unless they have been
3 identified by counsel as someone who may remain.
4 ****** COURTROOM CLOSED TO THE PUBLIC ******
5 MR. ETTINGER: Your Honor, these are mostly
6 Luke's, but there is one third party, I think, so --
7 THE COURT: All right.
8 You ready to proceed?
9 MR. ETTINGER: Yes, Your Honor.
10 BY MR. ETTINGER:
11 Q. So looking at slide -- I'm going to quickly run
12 through slides 15, 16, 17. They are all entitled, "Networks
13 Without Saltzer Are Not Viable Competitors," and then I will
14 go back to a couple of them.
15 But, collectively, what's the significance of the
16 information on these slides to your opinions,
17 Dr. Haas-Wilson?
18 A. Well, these different individuals, all with a lot
19 of expertise in this area, are reaching the same conclusion,
20 that a provider network that did not include the Saltzer
21 Medical Group would not be a viable competitor.
22 Q. Now, taking the slide 15, Mr. Clement's opinion
23 from Regence, was this -- were you basing your conclusion
24 here just on the opinion he stated, or was there any conduct
25 that was also relevant to your opinion?

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1 A. There was conduct, as well. In his testimony,
2 Mr. Clement of Regence described experience negotiating with
3 Saltzer. And to include Saltzer in the provider network,
4 they had to pay Saltzer -- it was about 5 or 6 percent more
5 than they were paying other providers to get Saltzer to be
6 willing to be part of that provider network. So it was
7 action as well as opinion.
8 Q. Let me skip over slide --
9 THE COURT: Just so we're clear, there was a
10 demand for 5 to 6 percent increase, but actually that was
11 given to all of the competing medical groups. Correct?
12 THE WITNESS: It was initially given to -- to
13 Saltzer.
14 MR. ETTINGER: Your Honor, I'm not testifying, but
15 could I just indicate my recollection of the record on this?
16 THE COURT: Yes.
17 MR. ETTINGER: In the Blue Cross case I think
18 there were increases that were given to all the other
19 providers. I do not believe that was true in the Regence
20 case.
21 THE COURT: Thank you. Perhaps counsel can
22 clarify that as well from St. Luke's if I'm mistaken, but
23 now that I think back on it, I think you're correct. I
24 think -- I don't want to take up counsel's time here.
25 MR. STEIN: The testimony was that there

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1 was -- that Saltzer did not take a 5 or 6 percent decrease.
2 And it's true that that was -- it's not an issue of being
3 extended to everyone else.
4 THE COURT: All right.
5 BY MR. ETTINGER:
6 **Q.** So let's go on slide 17, Mr. Billings' statement.
7 I want to ask you about one particular thing in this.
8 Mr. Billings talks about that if Saltzer were out of the
9 Saint Al's ACN "network, they're going to have a revolt on
10 their hands from employees saying, 'That's our doc. Why
11 can't we see them anymore?'" Does that idea that
12 Mr. Billings expressed, does that have any particular
13 significance to your opinions?
14 **A. It certainly does. I think what he is calling a**
15 **"revolt" on Saint Al's hands is their employees would be so**
16 **upset by the disruption of having to change physicians as a**
17 **result of changes in the provider network, and with respect**
18 **to patients there is tremendous physician loyalty toward**
19 **their physicians, so when you take away that insured access,**
20 **your employees get very upset, and that's often referred to**
21 **as "disruption," and it's something that employers try to**
22 **avoid. They want to keep their employees happy.**
23 **Q.** So let's go on to slide 18. It says, "Micron:
24 Successful Under Unusual Financial Duress." And how is this
25 relevant to your opinions?

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1 **A. Well, Micron is an example of an employer who**
2 **actually had a health plan for a certain period of time that**
3 **did not include Saltzer, and that worked successfully for a**
4 **limited period of time. But it was very unusual. This is**
5 **not representative of what would happen with most employers**
6 **if they were to offer a health plan without Saltzer.**
7 **Micron was under terrible financial duress. They**
8 **were having to -- they were losing money. They were having**
9 **to lay off lots of people. So any employer when they would**
10 **consider -- decreasing their employee's health benefits and**
11 **shrinking the provider network would be considered a**
12 **decrease in the healthcare fringe benefits, similar to a cut**
13 **in pay. Any employer would have to consider the risk of how**
14 **that would anger its employees, and if it could anger its**
15 **employees enough that they might actually leave the firm.**
16 **Most employers don't tend to take that risk. But it made**
17 **economic sense for Micron to take that risk in this case**
18 **because of the terrible financial duress they were under.**
19 **So I would say Micron is kind of a case set up all**
20 **by itself and is not at all representative of other**
21 **employers and their experience with their health plans.**
22 **Q.** So let's go on to slides 19 through 21. I'm going
23 to take these together. This 19 is "St. Luke's Strategy Is
24 to Pull All Its Providers From Competing Networks," and
25 that's the heading in all three of these slides. Without

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1 spending a lot of time on these -- I think the court has
2 seen them before -- what is the significance of these slides
3 to your opinions?
4 **A. Well, these slides show St. Luke's had an actual**
5 **strategy, St. Luke's had an actual plan to pull all its**
6 **providers from competing networks. It's not just**
7 **hypothetical. This plan exists; it's a strategy of**
8 **St. Luke's.**
9 **Q.** In slide 21, Ms. Duer talks about the strategy
10 involving all PPO networks. Is that of any particular
11 significance in terms of your opinions?
12 **A. Most certainly. What that tells me is it's not**
13 **limited to pulling providers from the Saint Alphonsus**
14 **network, but it sounds like it's across all the competing**
15 **networks.**
16 MR. ETTINGER: Your Honor, I think we're past the
17 first slug of AEO materials, so we could open the courtroom.
18 THE COURT: All right.
19 ****** COURTROOM OPEN TO THE PUBLIC ******
20 MR. ETTINGER: I have one other short grouping
21 later. Your Honor, I did try to think about whether we
22 could juggle it and do it once, but it was difficult.
23 THE COURT: No, you know, I think it's one of
24 those challenges, you -- while I appreciate counsel trying
25 to be cooperative with the public and their right to access

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1 the courts, you also have to think about the orderly way to
2 present your case, and I completely understand that.
3 MR. ETTINGER: Thank you, Your Honor.
4 BY MR. ETTINGER:
5 **Q.** So before we get into slide 22, are we now on the
6 subject of foreclosure?
7 **A. Yes.**
8 **Q.** So let me start by asking you, what is foreclosure
9 to an economist?
10 **A. Okay. To an economist, foreclosure is impeding a**
11 **rival or rivals from access to a necessary input. And in**
12 **this case, that necessary input is the patients, and when**
13 **that foreclosure from the necessary input, or the patients,**
14 **impedes rivals' abilities to compete on the merits, to**
15 **compete based on price and quality.**
16 **Q.** So -- and does that -- what does that mean in
17 terms of harm to a competition?
18 **A. That is harm to competition. If you decrease your**
19 **competitor's, your rival's ability to compete with you on**
20 **the basis of price and other competitive variables, then you**
21 **have decreased competition in the market, and consumers will**
22 **be better off. They will be facing higher prices as a**
23 **result.**
24 **Q.** You said "better off"? Is that what you meant to
25 say?

1 **A. No. No. Consumers will be worse off -- I'm**
2 **sorry -- because they will be facing higher prices. Sorry.**
3 **That was a --**
4 Q. Okay. So the quotes on the slide are statements
5 by physicians at St. Luke's. And how do these statements
6 compare to the evidence you've seen in the healthcare
7 literature about how patients make choices of hospitals and
8 facilities?
9 **A. These quotes are very consistent with what I've**
10 **seen published in the healthcare literature.**
11 Q. And what generally is the conclusion you've seen
12 in the healthcare literature?
13 **A. That physicians have a very large influence on**
14 **where their patients go for the next level of care. If they**
15 **need care beyond primary care, they listen to their**
16 **physicians about which specialists to see, which outpatient**
17 **facility to use, and where to get their inpatient hospital**
18 **care. The physician has a huge role in determining where**
19 **patients ultimately get their healthcare services.**
20 Q. So how does the acquisition of physician practices
21 relate to foreclosure?
22 **A. Well, if a hospital system acquires physicians'**
23 **practices, those physicians become part of that health**
24 **system, and at that point the incentives of those physicians**
25 **are aligned with the incentives of the health system that**

1 **has acquired them. So when they have aligned or similar**
2 **incentives, it's likely that those acquired physicians will**
3 **tend to treat their patients at the facilities of the**
4 **hospital system that has just acquired them.**
5 Q. Let me read you a statement from the declaration
6 of John Kee of St. Luke's that was filed in this case in
7 December: Quote, Financial integration ensures the
8 alignment of our partners because they will be mutually
9 invested in the arrangement, close quotes.
10 How does that relate to the opinions you've just been
11 offering, if at all?
12 **A. I think that is summarizing my opinion about what**
13 **happens to the incentives of the physician when they become**
14 **part of a hospital system.**
15 Q. So as a matter of general economic principles, is
16 this idea that there are economic incentives for an acquired
17 business, whether it's a physician practice or some other
18 business, that there are economic incentives for the
19 acquired business to try to benefit the acquiring business?
20 Is that a controversial idea at all in economics?
21 **A. Not one bit.**
22 Q. Do you need to have a requirement in a contract in
23 order for those incentives to be aligned, in your view?
24 **A. Not necessary to have it written in a contract.**
25 Q. Okay. Now, did you base your conclusions in this

1 case just on economic principles or economic theory?
2 **A. Economic theory and principles were just one basis**
3 **for my opinion. I looked at a wide range of evidence,**
4 **including testimony, documents, data from Saint Al's,**
5 **St. Luke's, and Saltzer, data from two of the largest**
6 **payors, Blue Cross and Regence.**
7 Q. Okay. And we'll get to that in a second.
8 Let me jump ahead and just ask you one other question.
9 Are you saying that vertical transactions, hospitals buying
10 physician practices, necessarily harm overall competition in
11 a relevant market or not?
12 **A. No, no, no, that's not what I'm saying. What I'm**
13 **saying is under certain situations when certain factors are**
14 **present, then, yes, vertical integration can hurt**
15 **competition.**
16 Q. Okay. And we'll talk about harm to competition,
17 in particular, later in your examination. But let's go on
18 to slide 23, "Evidence that St. Luke's Acquired Physicians
19 Steer Patients."
20 First of all, that word "steer," is that the most
21 precise word that one could use to describe what goes on
22 with physicians and patients?
23 **A. Well, it's -- it's the word I chose to use, but**
24 **actually it's a bit of an overstatement. When I think of**
25 **steering, I think of someone sitting in their car. They can**

1 **turn the wheel right, and they know their car is going to go**
2 **right, so there is a lot of certainty.**
3 **With respect to patients, while the physicians**
4 **have a very large influence on where the patient goes for**
5 **their hospital care, it's not 100 percent. There may be**
6 **other influences that affect that decision. So steering is**
7 **a stronger word, but, you know, it was the best shorthand**
8 **word that I could come up with to describe the phenomena.**
9 Q. Are there -- based on the evidence you've seen in
10 this case and the healthcare literature, are there any
11 influences on the patient in choosing a hospital or an
12 outpatient facility that are as important as the patient's
13 physician?
14 **A. In the literature, it's clear that it's the**
15 **physician who has the largest influence on where patients go**
16 **for their additional care.**
17 Q. Okay. So to get back to slide 23 or to get to
18 slide 23, there is a variety of different kinds of evidence
19 listed here. Why did you look at so many varieties of
20 evidence?
21 **A. I felt it was necessary because when the data is**
22 **imperfect, there could always be some alternative**
23 **explanations. So by looking at this wide variety of types**
24 **of evidence and finding that it all points in the same**
25 **direction gives me the basis for my conclusions.**

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1 **Q.** So let's go on to some of this evidence.
2 I think, Your Honor, the next couple we may need to
3 blank the big screen on.
4 THE COURT: All right.
5 BY MR. ETTINGER:
6 **Q.** So let me show you slides 24 through 26, and
7 generally can you describe how the evidence in these slides
8 relates to your opinions about foreclosure and steering?
9 **A. Sure. These slides are all about the evidence**
10 **from testimony that -- there is an expectation on the part**
11 **of St. Luke's that its acquired physicians, specifically**
12 **Saltzer, will steer those patients to St. Luke's facilities.**
13 **Q.** And then going on -- and keeping the screen blank,
14 Your Honor -- slide 27, how does that relate to your
15 opinions?
16 **A. Well, here, now, we have a St. Luke's document**
17 **where Mr. Orr, who is the former director of physician**
18 **services at St. Luke's, is stating that St. Luke's has a**
19 **historical willingness to preferentially direct patients to**
20 **St. Luke's affiliated practice rather than equally among all**
21 **medical staff. So he's -- here we have an employee of**
22 **St. Luke's who is stating exactly the point I've been**
23 **making.**
24 MR. ETTINGER: Your Honor, I think we can unblank
25 the screen now.

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1 THE COURT: I was wondering why we blanked the
2 last one, since she just testified.
3 MR. STEIN: We had the same reaction.
4 MR. ETTINGER: Doing my best, Your Honor.
5 THE COURT: Well, I was looking for Mr. Schafer or
6 Mr. Stein or someone to jump up, and no one did, so I
7 assumed it was acceptable.
8 All right. Proceed.
9 MR. ETTINGER: Thank you, Your Honor.
10 BY MR. ETTINGER:
11 **Q.** So slides 29 and 30 and 31 talk about physician
12 testimony on where patients are admitted and what has
13 happened after practices were acquired. How is that
14 relevant to your opinion?
15 **A. This, again, supports my opinion that**
16 **patients -- sorry -- physicians, after they have been**
17 **acquired by a hospital system, tend to steer their patients**
18 **to the hospital system that has just acquired them and to**
19 **decrease the amount of work that they do at competing**
20 **facilities.**
21 **Q.** So let's go on, then, to slide 31. This is -- is
22 this one of the analyses of data that you performed
23 directing Analysis Group?
24 **A. Yes, it is.**
25 **Q.** And what's the source of the data on this slide?

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1 **A. These data are provided by Blue Cross and Regence,**
2 **the payors.**
3 **Q.** And when you submitted a declaration in this case
4 in December, you presented data on steering. What was the
5 source of your data at that time?
6 **A. At that point in time, I did not have the payor**
7 **data, but I did have data from Saint Alphonsus. So my**
8 **declaration is based on the data from Saint Alphonsus.**
9 **Q.** And when you got the Blue Cross and Regence data,
10 the payor data, and analyzed it, has that data resulted in
11 you changing any of your conclusions or was it consistent
12 with your conclusions?
13 **A. Completely consistent. My opinion didn't change**
14 **one bit.**
15 **Q.** So looking specifically at this slide, slide 31,
16 what does this show?
17 **A. It shows for these five specialty practices, that**
18 **after they were acquired by St. Luke's their business at**
19 **Saint Alphonsus Boise dropped dramatically. It also shows**
20 **that after acquisition by St. Luke's, the amount of business**
21 **that they did at St. Luke's facilities increased**
22 **dramatically.**
23 **Q.** And is this inpatient data?
24 **A. Yes. This is inpatient admissions.**
25 **Q.** And is this specialty practices who were acquired

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1 that are being examined on this chart?
2 **A. Yes. These are five different specialty**
3 **practices.**
4 **Q.** Let me go to slide 32. What does this depict?
5 **A. This is a different way of arranging the data from**
6 **Saint Alphonsus, the data that I used in my declaration.**
7 **And what it does is it aggregates across the five practices**
8 **so that you can see overall across the five practices what**
9 **happened postacquisition. And what you see after the**
10 **quarter of acquisition a dramatic and very rapid decline in**
11 **admissions at Saint Alphonsus by the acquired physicians.**
12 **Q.** Now turn to slide 33, and it looks very much like
13 slide 32. What's the difference between the two slides?
14 **A. So now this one, rather than being based on the**
15 **Saint Al's data, is based on the payor data, the data from**
16 **Blue Cross and Regence.**
17 **Q.** So is slide 32 based on the Saint Al's data?
18 **A. Yes. Similar methodology, aggregating across the**
19 **five practices and looking at what happens to admissions at**
20 **Saint Al's following the quarter of acquisition for each of**
21 **those five practices. So it's just -- it's a methodology**
22 **that aggregates across the practices.**
23 **Q.** And looking at 32 and 33, do you get consistent or
24 inconsistent results with these two different data sources?
25 **A. Very consistent.**

1 **Q.** Let's go on to slide 34. Now, were the prior
2 three slides all inpatient data?
3 **A. That's correct. And now we're looking at**
4 **outpatient encounters in slide 34.**
5 **Q.** What does slide 34 show?
6 **A. It shows that after acquisition by St. Luke's,**
7 **there was a dramatic decline in outpatient encounters**
8 **performed at Saint Al's Boise and Saint Al's Nampa.**
9 **Q.** Why did you look at outpatient as well as
10 inpatient data?
11 **A. I was interested in steering behavior both for**
12 **inpatient and outpatient, and two of my relevant markets are**
13 **outpatient.**
14 **Q.** And does exhibit -- exhibit -- does slide 34
15 simply address Saint Al's or does it show the impact on
16 other providers as well?
17 **A. It shows the impact on other providers. And if**
18 **you look at Treasure Valley Hospital, you can see that after**
19 **the acquisition by St. Luke's, outpatient encounters at**
20 **Treasure Valley Hospital fell by 95 percent -- I'm sorry, 96**
21 **percent.**
22 **Q.** So looking at slide 35, how does slide 35 differ
23 from slide 34?
24 **A. Okay. So now slide 35 is taking a subset of those**
25 **outpatient encounters, so it's looking at outpatient**

1 **encounters that involved neurosurgery and orthopedic surgery**
2 **that was performed on an outpatient basis. And this is one**
3 **of my relevant markets.**
4 **Q.** Now do you recall that an issue was raised by
5 St. Luke's economists concerning whether the before and
6 after St. Luke's results could be distorted on the
7 outpatient side because after an acquisition of a group
8 there might be so-called split billing, separate bill for
9 the ancillary services, and so it might look like there were
10 more procedures being performed when maybe there really
11 weren't?
12 **A. Yes. I do remember them making that argument.**
13 **Q.** And could that -- if true, if you assume that's
14 true, could that explain the results you got in slides 34
15 and 35?
16 **A. No, not at all, because that split billing would**
17 **affect only St. Luke's. It has no effect on Saint Al's or**
18 **Treasure Valley Hospitals -- Treasure Valley Hospital. So**
19 **the issue of split billing has no influence on what we're**
20 **looking at in slide 36.**
21 **Q.** I think we're looking at slides 34 and 35. Does
22 it have any impact on these slides?
23 **A. You're right. That is 34. I'm sorry.**
24 **Q.** So looking at 34 and 35, just so the record is
25 clear, if this split billing phenomenon were present, could

1 that explain any of your results in these slides?
2 **A. It could not.**
3 **Q.** And then going on to slide 36, since you mentioned
4 it, what is slide 36?
5 **A. Slide 36 is showing steering behavior, now, not**
6 **for those five specialty groups that I was looking at in**
7 **Boise, but now looking at the Mercy Group, a group of seven**
8 **primary care physicians who are located in Nampa.**
9 **Q.** And what did you find?
10 **A. So I looked at where they were doing their**
11 **diagnostic imaging services and before -- before, initially**
12 **they were with SAMG, and then they were acquired by St.**
13 **Luke's, and after their acquisition the number of imaging**
14 **services that they performed at Saint Al's Nampa fell from**
15 **81 to 19 where there was a 77 percent drop.**
16 **Q.** So why -- first of all, could the split billing
17 idea explain this data?
18 **A. No. Again, this is -- this is Saint Al's data, so**
19 **that St. Luke's uses split billing will not have an impact**
20 **on what's happening at Saint Al's Nampa.**
21 **Q.** And why did you look at imaging services in
22 particular?
23 **A. Well, initially, I looked at both imaging and lab**
24 **services. St. Luke's expert came up with an alternative**
25 **explanation for the decline in lab services after the**

1 **acquisition. He argued that the reason there was a decline**
2 **is that at Saint -- sorry, at SAMG, these physicians were**
3 **not allowed to have a lab technician right in their office,**
4 **and then when they went to St. Luke's, they were allowed to**
5 **have a lab technician. So that was a possible explanation**
6 **for the decline. But that there is a lab technician in**
7 **their office at St. Luke's and possibly not at SAMG would**
8 **have no influence on imaging services. So here I present**
9 **just the imaging services.**
10 **Q.** So just to be clear, do you know whether this
11 assertion about lab technicians is correct or not?
12 **A. No. That's their assertion. I have not looked**
13 **into whether it was accurate.**
14 **Q.** And assuming it was correct, would that explain
15 the data that you've looked at on slide 36?
16 **A. It could not explain the dramatic drop in imaging**
17 **services that were done after the acquisition at Saint Al's**
18 **Nampa.**
19 **Q.** Okay. So let me show you one more slide, slide
20 37, "Acquired Physicians Steer both SAMG and Non-SAMG
21 Patients." So why did you look at SAMG versus non-SAMG
22 patients?
23 **A. This was in response to, again, an alternative**
24 **explanation that was offered by the St. Luke's expert. The**
25 **St. Luke's expert made the argument that possibly the drop**

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1 at Saint Al's Boise was due to the SAMG physicians no longer
2 referring or decreasing their referrals to the physicians
3 and, therefore, there would be a drop. So what I did is I
4 separated the patients into two groups: those patients who
5 had seen a SAMG primary care doc and those patients who had
6 not seen a SAMG primary care doc. And what I found was very
7 a similar pattern in the decline and, therefore, concluded
8 that the St. Luke's expert alternative explanation cannot be
9 what's driving these results.
10 Q. And by the way, did the issue of admissions
11 through hospitalists come up in connection with some of your
12 data?
13 A. Yes, that issue was raised.
14 Q. And do hospitalists handle outpatient cases?
15 A. No. Hospitalists, their work is based in the
16 hospital for inpatient care.
17 Q. Let's go on to slide 38, "Flaws in the Defendants'
18 Analysis of Referrals and Steering." What does this slide
19 depict?
20 A. This depicts, as you said, a flaw in St. Luke's
21 experts methodology to determine who referred a patient to
22 Saint Alphonsus. And the criticism or the flaw of this
23 analysis is best explained, I think, with this example. So
24 let's say Date 1 is 2010. So in 2010 --
25 Q. Before you jump into that, maybe could you explain

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1 a little bit what is -- what is it that St. Luke's experts
2 did that you think is flawed in this particular case? I
3 think you're jumping ahead just a little bit.
4 A. Okay. Sure. I think they overattributed
5 admissions at Saint Al's to St. Luke's acquired physicians.
6 Q. Okay.
7 A. So I think they overestimated the number of times
8 that that happened.
9 Q. Why don't you explain why.
10 A. Okay. Sure. So going back to my example of one
11 way this might have happened: So 2010 there is an
12 independent primary care physician who refers his or her
13 patient to an independent specialist. Then let's say Date 2
14 is 2011, at which point St. Luke's acquires this particular
15 independent primary care physician. Then Date 3, 2012, the
16 independent specialist refers that patient to Saint
17 Alphonsus.
18 In this case, their methodology would attribute
19 that admission to a St. Luke's acquired PCP. But, in fact,
20 that PCP made the referral to the specialist when he or she
21 was independent. So this would be an example of one way
22 that their methodology overestimates the number of times
23 St. Luke's acquired PCPs refer patients to Saint Al's.
24 Q. Now, did you -- for any of the past acquisitions
25 that you examined, did you look at whether Saint Alphonsus

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1 was able to gain back the lost business?
2 A. No. That wasn't relevant to my analysis on
3 steering.
4 Q. And why not?
5 A. It wasn't necessary to show that the acquired
6 St. Luke's doctors were steering their patients away from
7 Saint Alphonsus and to the hospital system that had acquired
8 them, St. Luke's.
9 Q. Did you consider whether there is a likelihood
10 that Saint Alphonsus Nampa could gain back lost Saltzer
11 referrals if the acquisition went forward?
12 A. Yes. I did try to gather evidence on that.
13 Q. And did you reach any conclusions about whether
14 Saint Alphonsus Nampa could gain back lost Saltzer referrals
15 through recruiting?
16 A. Yes, I did. And given what I learned about how
17 difficult it is to recruit primary care doctors to Nampa, I
18 concluded that there is -- it would be very, very unlikely
19 that SAMG could recruit and ramp up to a productive level of
20 practice enough new physicians to replace the losses from
21 Saltzer.
22 Q. Did you consider whether there are other primary
23 care groups in Nampa that SAMG could buy to replace Saltzer?
24 A. Well, there are other primary care groups in
25 Nampa. There are not close to enough primary care

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1 physicians to replace the business from Saltzer.
2 Q. So do you see any way Saint Alphonsus Nampa could
3 make up for the loss of Saltzer referrals if the acquisition
4 went forward?
5 A. The evidence I studied suggested it would be quite
6 impossible to make that up in a timely fashion.
7 Q. So have we covered your basic opinions on
8 foreclosure and effects on network competition?
9 A. We certainly have covered my opinions on
10 foreclosure.
11 Q. And we talked earlier about network competition.
12 I now want to go on and talk about the effects, if any, of
13 the acquisition on overall competition and take a look at
14 slide 39. What does this describe?
15 A. This slide lists all the likely effects of the
16 acquisition on competition, in my opinion.
17 Q. And why are -- why is this issue of effects on
18 competition relevant?
19 A. It's very relevant under antitrust analysis. In
20 antitrust analysis, it's important to show that the
21 acquisition lessens competition. It's not sufficient to
22 show that -- that the acquisition harms any one particular
23 competitor.
24 Q. And are the specific -- your specific analyses
25 relating to these bullet points shown on subsequent charts?

1 **A. Yes.**
2 Q. So why don't we go to them. So starting with
3 slide 40, slide 40 is entitled, "St. Luke's Has a Dominant
4 Share of the Acute Care Hospital Inpatient Market." And
5 what is the significance of that 59.4 percent share that you
6 show?
7 **A. Well, that's showing that St. Luke's is the**
8 **dominant player, the dominant competitor in the market for**
9 **general acute care inpatient services in the geographic**
10 **market of Ada and Canyon Counties.**
11 Q. And so why is that relevant to your conclusion
12 that overall competition is likely to be harmed here?
13 **A. Well, given their current dominance, to the extent**
14 **the acquisition leads to an even greater dominance for**
15 **St. Luke's, that's very important for my overall**
16 **conclusions.**
17 Q. And what's the significance, if any, of the fact
18 that there are in this inpatient market only three other
19 players besides St. Luke's, only one of which has more than
20 a 10 percent or so share?
21 **A. Well, what that suggests is there are very few**
22 **rivals in this market for St. Luke's and only one, Saint**
23 **Alphonsus, that has enough -- a high enough market share**
24 **to really provide some competitive constraints on St. Luke's**
25 **in the inpatient market.**

1 Q. So under these circumstances, with these kinds of
2 shares, what does that say to you about whether harm to
3 Saint Alphonsus specifically relates to harm to overall
4 competition?
5 **A. Well, in this particular case, the number of**
6 **rivals and the market shares of the market participants**
7 **suggests to me that harm to Saint Alphonsus, while just a**
8 **particular competitor, will result in harm to competition**
9 **because of the important role Saint Alphonsus is playing in**
10 **terms of a competitive constraint on St. Luke's, the**
11 **dominant hospital.**
12 Q. So in this inpatient acute care hospital market
13 we're talking about here, would Saint Alphonsus have any
14 market power?
15 **A. It's a duopoly, so only -- it's not quite a**
16 **duopoly, but it's close to a duopoly. And in that situation**
17 **it wouldn't have market power individually, but potentially**
18 **it could have it collectively with St. Luke's.**
19 Q. Let's go on to slide 41, and this has similar
20 share information for your outpatient surgical facility
21 markets. And what general conclusions do you draw from
22 these shares in the outpatient surgical facility markets?
23 **A. Well, again, in the market for neurosurgery and**
24 **orthopedic surgery done on an outpatient basis, St. Luke's**
25 **is the dominant provider with a 54 percent market share.**

1 **And then looking at the second relevant outpatient market,**
2 **the general surgery outpatient surgical facility services,**
3 **again St. Luke's is the dominant player with almost a 56**
4 **percent market share.**
5 **You can also see that, again, St. Luke's has few**
6 **rivals, few competitors in these markets.**
7 Q. And what does that say to you about the
8 significance of harm to these rivals in terms of harm to
9 overall competition?
10 **A. Well, similarly to what I said about inpatient**
11 **care, when there are few rivals -- and so, for example, in**
12 **general surgery, only one rival with any, you know,**
13 **significant market share, that harm to Saint Alphonsus**
14 **in -- will decrease competition in the market for general**
15 **surgery outpatient surgical facilities because, again, Saint**
16 **Al's, if it's harmed, will be less of a competitive**
17 **constraint on St. Luke's.**
18 Q. Why don't we go on to slide 42. With premerger
19 HHIs for these three markets, what does this tell you about
20 the likelihood of harm to overall competition here?
21 **A. This is telling me -- this is reinforcing for me**
22 **what I was seeing on the earlier slides. This -- instead of**
23 **being in terms of market shares of any particular firm**
24 **competing in the market, this is a measure of overall**
25 **concentration in these three markets, and you can see that**

1 **this number is quite high and a lot higher than the 2500**
2 **number in the merger guidelines, where the 2500 number is**
3 **the number above which markets are considered to be highly**
4 **concentrated.**
5 THE COURT: Counsel, just so I'm clear, is this
6 Ada and Canyon County, or just Nampa?
7 THE WITNESS: This now is the relevant market for
8 these three services, which is both counties, Ada and
9 Canyon County.
10 THE COURT: I just wanted to clarify. I thought
11 that was the case, but I wanted to clarify.
12 THE WITNESS: Some of Ada and Canyon.
13 THE COURT: All right.
14 BY MR. ETTINGER:
15 Q. So going on to slide 43, what does this slide
16 depict?
17 **A. This slide is showing how important the patients**
18 **from Saltzer Medical Group are to Saint Al's Nampa. 47**
19 **percent of the inpatient admissions to Saint Al's Nampa were**
20 **patients who had seen a Saltzer physician during the**
21 **previous year. So if Saint Al's were to lose this 47**
22 **percent or even less -- you know, it doesn't have to be all**
23 **of the 47 percent patients -- that would be very damaging,**
24 **very harmful to Saint Al's Nampa's ability to compete.**
25 THE COURT: Counsel, let me just inquire of that.

1 One of the concerns, of course, is that -- I don't believe
2 the antitrust laws are concerned about the impact on a
3 competitor but only about the impact on competition. And I
4 think your last comment suggests that in some instances that
5 can be the same if a competitor is driven out of the market.
6 Is that why this should be of concern?
7 THE WITNESS: Yes. Or not -- it doesn't have to
8 be driven out of the market, but weakened.
9 THE COURT: Weakened. All right.
10 THE WITNESS: If as a result of this loss of
11 patients they had to cut services, that they might have to
12 stop providing pediatric services, you know.
13 THE COURT: That's fine. I just wanted to make
14 sure that that was the point you were making and that you're
15 not concerned necessarily about the impact on a competitor,
16 but how the impact on that competitor may impact competition
17 in the market.
18 THE WITNESS: That's correct.
19 THE COURT: All right.
20 BY MR. ETTINGER:
21 **Q.** So you said this 47 percent is Saint Alphonsus
22 Nampa patients who saw a Saltzer primary care physician; is
23 that correct?
24 **A.** **Yes. So these are the patients who saw a Saltzer**
25 **primary care physician sometime during the year prior to**

1 **their admission at Saint Al's Nampa.**
2 **Q.** So let me go back -- I went back too far. So let
3 me go back to this slide, whose number I'm forgetting. This
4 was a criticism, was it not, of the way that St. Luke's
5 experts used data on which patients had a -- had a St.
6 Luke's primary care physician; is that correct?
7 **A.** **Yes. This is my criticism of their methodology.**
8 **Q.** So my question is: Why does this criticism not
9 apply, if it does not apply, to the 47 percent calculation
10 that you have made?
11 **A.** **Well, the St. Luke's expert was using these data**
12 **for -- trying to use these data for a different purpose. He**
13 **was.**
14 **Actually trying to attribute the visit to the**
15 **physician, the primary care physician, to equate that with a**
16 **referral to Saint Al's hospital. The data just don't allow**
17 **one to do that.**
18 **I was using it for a different purpose, and that's**
19 **just to get a sense of the potential loss of patients were**
20 **the Saint Al's hospitals to lose any patient -- every**
21 **patient or any of the patients from -- that had seen Saltzer**
22 **doctors. So we were using this information in very**
23 **different ways to answer very different questions.**
24 MR. ETTINGER: Your Honor, the next slide I think
25 we can do by blanking the screen.

1 BY MR. ETTINGER:
2 **Q.** Professor Haas-Wilson, let me ask you about the
3 significance of the next slide about Canyon County. And if
4 you can discuss it without saying anything very specific
5 about St. Luke's, that would be helpful.
6 THE COURT: And I'll note that -- obviously, I can
7 read what's on the screen and so -- even though that
8 may -- understandably, that would seem important to explain
9 your testimony. Because this has been designated as
10 attorneys' eyes only, you can -- should comment only
11 generally about it. Go ahead and proceed.
12 THE WITNESS: Thank you for explaining that
13 clearly, and I'm sorry about my previous goof. I was not
14 thinking.
15 THE COURT: No concern.
16 THE WITNESS: So I'm sorry.
17 THE COURT: No concern on my part. All right.
18 THE WITNESS: Okay. So what this slide is showing
19 is the importance of Canyon County to the hospital systems.
20 So Canyon County is a growth area, and both St. Luke's and
21 Saint Al's want to have a presence in Canyon County. It's
22 the growth area, so certainly to have a presence there would
23 be good for both hospital systems.
24 BY MR. ETTINGER:
25 **Q.** So let's go on to slide 45 -- and we don't need to

1 blank the screen for this, Your Honor.
2 And what does -- looking at slide 45 actually, and 46;
3 maybe we can take them together. What do these two slides
4 indicate?
5 **A.** **So here I am looking now at outpatient surgical**
6 **facility fees, facility services, and again I'm looking at**
7 **those patients who received in this -- in the screen I'm**
8 **looking at now, neurosurgery and orthopedic surgery**
9 **outpatient encounters at St. Luke's competitors, and**
10 **particularly Saint Al's Nampa and Treasure Valley, and**
11 **showing that for those outpatient encounters in the case of**
12 **Saint Al's Nampa, 55 percent of those encounters were for**
13 **patients who had seen a Saltzer primary care doctor in the**
14 **previous year.**
15 **Q.** And so what's the significance to your opinion of
16 the information on slides 45 and 46?
17 **A.** **That the Saltzer Medical Group is a very important**
18 **source of patients to both Saint Al's Nampa and Treasure**
19 **Valley Hospital in my relevant markets.**
20 **Q.** Now we go on to slide 47. And what does slide 47
21 depict in terms of network competition?
22 **A.** **It's a way to show how the acquisition of Saltzer**
23 **actually threatens to eliminate network competition,**
24 **eliminate network competition to the point where there might**
25 **be only one network, the St. Luke's network that includes**

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1 **Saltzer, a vital -- vitally important group to have in the**
2 **network. So the first square shows the networks that had**
3 **Saltzer before St. Luke's acquired Saltzer, and you can see**
4 **that includes many, including the Saint Al's network. And**
5 **if St. Luke's follows through with its plan, which --**
6 **Q.** Just -- so I think we understand the implications.
7 Your Honor, I am just trying to avoid some AEOs, so I
8 think I will just move on to the next slide.
9 THE COURT: All right.
10 MR. ETTINGER: Actually, the next slide -- oh, the
11 next slide is AEO, and I think we need to clear the
12 courtroom for this, so maybe it's appropriate -- because
13 it's a St. Luke's slide that's AEO, so maybe we can clear
14 the courtroom and the witness can finish her answer to the
15 last question.
16 THE COURT: Yes. Again, ladies and gentlemen,
17 I'll have to ask those in the audience to leave the
18 courtroom unless you have been advised that you may remain.
19 MR. ETTINGER: Just St. Luke's personnel can stay
20 for this, Your Honor.
21 ****** COURTROOM CLOSED TO THE PUBLIC ******
22 BY MR. ETTINGER:
23 **Q.** You were saying something when I cut you off,
24 Professor, about St. Luke's plan. You can go ahead and say
25 it now.

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1 **A. As was established earlier in my testimony through**
2 **the testimony of different market participants, St. Luke's**
3 **has a plan to pull the Saltzer and other St. Luke's**
4 **physicians from rival networks. And when they follow**
5 **through, that means access to the Saltzer and Luke's**
6 **physicians will be only through the St. Luke's network. And**
7 **this will certainly harm the ability of IPN, the Saint Al's**
8 **Health Alliance network, to compete with the St. Luke's**
9 **network. The other rivals will look a lot less attractive**
10 **to any employer or any payor when they decide which network**
11 **to contract with.**
12 **Q.** And why does the heading on the box on the right
13 say, "Future Networks with Saltzer/St. Luke's"?
14 **A. Because they have talked about not only pulling**
15 **the Saltzer physicians, but also their other physicians.**
16 **Q.** Let's go on to slide 48, testimony from
17 Mr. Billings. And you see these references to not wanting
18 to get into a bidding war. What's the significance to your
19 conclusions about harm to competition of Mr. Billings'
20 testimony?
21 **A. Well, Mr. Billings' testimony, when he states that**
22 **St. Luke's does not want to get into a bidding war with**
23 **Saint Al's, is saying in other words that St. Luke's is not**
24 **willing to compete on the basis of price. They're a**
25 **dominant provider, and they're not going to compete on the**

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1 **basis of price.**
2 **Q.** And from an antitrust economics point of view, are
3 bidding wars a good thing or a bad thing?
4 **A. Bidding wars are a very good thing because they**
5 **benefit consumers.**
6 **Q.** Now, you see in the second comment Mr. Billings
7 says, "I don't want to get into a fee-for-service bidding
8 war." Are incentives to compete or not to compete on price
9 any different as between fee-for-service or risk-based
10 contracting?
11 **A. The incentives would be just the same.**
12 **Q.** In a world of risk-based contracts, if we were to
13 be in such a world in the future, would antitrust economics
14 concerns go away?
15 **A. Not at all. Antitrust concerns about lack of**
16 **price competition cover prices that come in many shapes and**
17 **forms. The antitrust analysis is very broad. It looks at**
18 **prices in commodity markets, in auction markets, in bidding**
19 **markets -- across the board prices, whatever shape or form**
20 **they come in.**
21 **Q.** So do you think that if the prices at issue were
22 prices for risk-based contracts, would that change the
23 antitrust economic analysis in this case in any way?
24 **A. I don't think it would.**
25 **Q.** Would the advent of the Affordable Care Act change

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1 the relevant antitrust economic analysis in any way, in your
2 view?
3 **A. Well, I think the major impact of the Affordable**
4 **Care Act is going to be that many more individuals actually**
5 **have health insurance, and there will have to be new health**
6 **plans that will be bought on these exchanges for all of**
7 **these -- this new influx of individuals getting insurance.**
8 **And certainly those insurers are going to need to contract**
9 **with networks to have a provider network for their health**
10 **plans. So increasing the number of insured individuals in**
11 **no way diminishes the importance of network competition.**
12 **Q.** And would it diminish the importance of the
13 foreclosure analysis?
14 **A. Not one bit.**
15 **Your Honor, we're past the AEO.**
16 THE COURT: All right. Can we -- will this be the
17 end during your direct of AEO, or do you have more?
18 MR. ETTINGER: No, that should be the end of AEO,
19 Your Honor.
20 THE COURT: All right. Let's let the public back
21 in, then.
22 ****** COURTROOM OPEN TO THE PUBLIC ******
23 MR. ETTINGER: Can we just proceed, Your Honor,
24 while they're drifting in?
25 THE COURT: Yes.

1 MR. STEIN: Your Honor, I would just raise one
2 issue before we bring people back in. I would like to have
3 as much of our cross open as possible. I just want to be
4 sensitive to cutting off the witness if she inadvertently
5 starts getting into things that are attorneys' eyes only. I
6 just raise that --
7 THE COURT: In fact, Mr. Stein, yesterday I kind
8 of jumped in to make sure that -- I'll caution witnesses
9 when they are not being responsive and things of that sort.
10 But this is an area where I think I probably need to give
11 counsel some leeway to gently raise the issue that counsel
12 should not get into a particular topic. Obviously,
13 Mr. Ettinger may --
14 MR. ETTINGER: Your Honor, my thought is if the
15 witness feels that to answer the question fully she needs to
16 say something that turns out to be AEO, I don't think the
17 witness should be cut off.
18 THE COURT: Well, I think what we need to do is
19 maybe huddle on the issue, because the concept of AEO is to
20 protect not just the parties, but also third parties and
21 their confidential information. And even -- the balance
22 that we have to draw here is to make sure the witness can
23 testify to what she needs to testify to, but do it at a time
24 and in a place and the court cleared if necessary. And so I
25 think we're just going to have to kind of deal with that as

1 we go along.
2 I'm not going to cut off counsel from raising the issue
3 that this is getting into AEO. We may have to huddle at a
4 sidebar, which is rather unusual in a court trial, but given
5 what we're trying to accomplish here, that may be the only
6 way to do it, and then work out the issue, perhaps clearing
7 the courtroom for a few minutes or else asking counsel to
8 come back and cover that in kind of a wrap-up session at the
9 end, with the courtroom cleared, and allow the witness to
10 fully explain her response.
11 We can't be unfair to Dr. Haas-Wilson or to the third
12 party -- third parties who have economic interest at stake
13 here. So we'll just have to find that balance as we move
14 along.
15 MR. STEIN: Thank you, Your Honor.
16 THE COURT: Proceed, Mr. Ettinger.
17 BY MR. ETTINGER:
18 **Q.** So let me go to slide 49, Professor Haas-Wilson.
19 What does this slide depict?
20 **A. This slide depicts the average insurance payments**
21 **for selected services at two competitors, Treasure Valley**
22 **Hospital and St. Luke's.**
23 **Q.** And what --
24 **A. It's for four different services.**
25 **Q.** What do you take from this information in terms of

1 your opinions?
2 **A. Across the board, for all four services, MRI, CT**
3 **scans, colonoscopies, and hernia repairs, TVH's price is**
4 **significantly lower than St. Luke's average insurance**
5 **payment for these selected services.**
6 **Q.** What's the significance of that in terms of the
7 effect of this transaction on overall competition?
8 **A. Well, harm to the low-price competitor that's**
9 **providing competitive constraint on St. Luke's will harm**
10 **competition.**
11 MR. ETTINGER: Your Honor, could we blank the
12 screen on the next slide?
13 THE COURT: Yes.
14 BY MR. ETTINGER:
15 **Q.** So looking at slide 50, without describing in
16 detail what it shows, what generally does slide 50 show?
17 **A. In general, it shows that in the outpatient**
18 **market, the prices of Treasure Valley Hospital and the**
19 **prices of Saint Alphonsus are lower than the prices at**
20 **St. Luke's in Boise and St. Luke's Magic Valley.**
21 **Q.** Does this analysis control for differences in
22 different kinds of cases, case mixes, between the different
23 facilities?
24 **A. Yes. This analysis takes the bundle of services**
25 **that are provided at TVH hospital and then prices those**

1 **across the different competitors. So we're looking at the**
2 **same market basket, just priced differently at the different**
3 **rivals.**
4 **Q.** Going on to the next slide. Your Honor, this does
5 not need to be masked.
6 This is a statement by Dr. Pate in an article he wrote.
7 How is this relevant to your opinions?
8 **A. This is relevant in the sense that Dr. Pate, who**
9 **is the CEO of St. Luke's, recognizes that when a specialist**
10 **who depends on primary care physicians for referrals, when**
11 **those primary care physicians are hired by a hospital**
12 **system, that independent specialists will feel some pressure**
13 **to consider employment with that hospital in order to**
14 **preserve their referral base to ensure that they have enough**
15 **referrals, enough patients to treat.**
16 **Q.** So if more primary care acquisitions occur, how
17 does that affect the possibility of more specialty
18 acquisitions?
19 **A. Well, the acquisition of additional**
20 **independent -- currently independent primary care physicians**
21 **again shrinks that base of referrals to currently**
22 **independent specialists and will put pressure on the now**
23 **independent specialists to join the hospital system that has**
24 **now acquired those primary care doctors.**
25 **Q.** And how would that affect your markets for

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1 inpatient hospital care and outpatient surgical facilities?
2 **A. Well, since specialists also refer patients to**
3 **outpatient and inpatient facilities, if these specialists**
4 **now become part of a hospital system, they will face the**
5 **incentives to refer their patients to the hospital system**
6 **they are now part of. So that certainly will affect**
7 **competition in the market for outpatient and inpatient**
8 **facility services.**
9 Q. So jumping ahead just to save a little time, let
10 me show you slide 56. What does this depict?
11 **A. This is a timeline that shows St. Luke's prior**
12 **acquisitions of physician groups.**
13 Q. And does this -- do these acquisitions include
14 both primary care groups and specialty groups?
15 **A. Yes, they do. They have been buying up both**
16 **primary care and specialty physician groups.**
17 Q. Now, I think we have covered your opinions. I
18 want to ask you few more questions about your exhibits,
19 Professor Haas-Wilson. In your -- you talked about the role
20 of Analysis Group under your direction. In your experience
21 in economics, is it reasonable for an economist to rely on a
22 firm like Analysis Group to perform number-crunching on your
23 exhibits?
24 **A. It's very common for an economist to work with a**
25 **firm like Analysis Group in cases like this where you are**

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1 **having to juggle and use multiple databases. And these**
2 **databases are not small; they have many, many observations.**
3 **It's -- one person can't do it all in a timely fashion, so**
4 **it's very common for an economist to work with others at**
5 **consulting firms.**
6 Q. In this case, was backup data explaining the
7 calculations for each of your exhibits provided to
8 St. Luke's?
9 **A. It is my understanding that it was.**
10 Q. And given -- in your binder there, I think you
11 have what have been marked as Exhibits 1667 through 1768.
12 Can you take a quick look at those. Are those all your
13 exhibits to your various reports in this case?
14 **A. I'm sorry. Will you repeat the numbers?**
15 Q. 1667 through 1768, your exhibits reflecting the
16 data work attached to your reports in this case.
17 **A. Okay. I found 1768. What was the first number?**
18 **I'm sorry.**
19 Q. 1667.
20 **A. 1667. Mine happens to start, it looks -- oh, here**
21 **it is, 1667.**
22 Q. Without looking at each and every one if you
23 could --
24 **A. I just want to flip through and make sure I**
25 **recognize them.**

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1 Q. Sure.
2 **A. Yes, I recognize these as my exhibits.**
3 Q. That's about a hundred different charts, is
4 that -- just by rough arithmetic?
5 **A. Rough arithmetic, yes.**
6 Q. At any given moment, do you retain in your head
7 all the details of the methodology for all hundred charts?
8 **A. It's -- for me, that would not be possible to do.**
9 Q. Okay.
10 **A. Given how many exhibits and how many data sets we**
11 **used, at any point in time I cannot remember each and every**
12 **detail.**
13 Q. Okay. At your deposition, did you forget a couple
14 of those methodological issues?
15 **A. Yes, I did.**
16 Q. But are you confident that the methodology used in
17 these charts was appropriate?
18 **A. I am very confident. I thought about the**
19 **methodology. I made sure the methodology was being**
20 **implemented correctly.**
21 Q. Okay.
22 MR. ETTINGER: Your Honor, we would move the
23 admission of Exhibits 1667 through 1768.
24 MR. STEIN: Your Honor, we don't agree to the
25 admission of any of those exhibits, and certainly not until

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1 I've had a chance to do cross-examination.
2 I'll point out that Professor Haas-Wilson today has
3 testified about a tiny fraction of the exhibits in her
4 reports. And as to the anticipatory cross-examination
5 questions of Mr. Ettinger regarding Ms. Haas-Wilson's actual
6 knowledge of the work that she claims was done on her
7 behalf, I think we should wait for cross-examination and see
8 if that bears fruit, and then we can determine after that --
9 THE COURT: Well, let me just cut through. I
10 don't think an attachment or matters which the witness
11 relied upon in forming the opinion can be properly admitted
12 on that basis alone. Now, the rule is clear that an expert
13 witness can rely upon evidence not in the record, and not
14 even admissible, in forming an opinion, but that doesn't get
15 the exhibit into evidence. Again, it's a goose-gander
16 situation.
17 My approach generally is that expert reports -- you
18 know, again, I, frankly, would appreciate if counsel would
19 stipulate that all expert reports could come into evidence,
20 but without a stipulation to that effect, I don't think that
21 I can properly admit an expert report into evidence. What I
22 have to depend upon is the examination here in the
23 courtroom.
24 MR. ETTINGER: Your Honor, we have not moved the
25 reports themselves.

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1 THE COURT: I understand. But these are, as I
2 understand it, her responses and other information that she
3 relied upon in forming the opinion? If not, correct me.
4 MR. ETTINGER: It's the data work that was done
5 that reflects and exemplifies her opinions, some of which,
6 of course, we have described in demonstratives today, but
7 not all of them.
8 THE COURT: Well, I have the same problem. I
9 think that we have -- well, you know, if you want, I'm
10 willing to hear you out exhibit by exhibit, but just simply
11 offering them because the witness has relied upon them I
12 don't think is enough of either a foundation, it does not
13 solve the hearsay problem, and whatnot. If you --
14 MR. STEIN: Your Honor, I'm sorry.
15 THE COURT: Go ahead.
16 MR. STEIN: Sorry to interrupt. I was going to
17 say after Dr. Dranove's deposition yesterday, and we saw
18 what actually came into evidence during his testimony, we
19 did go back and review his exhibits, and the vast majority
20 of them we notified Mr. -- we notified plaintiffs' counsel
21 that we would withdraw our objections to.
22 With Professor Haas-Wilson we will undertake a similar
23 endeavor. In other words, after the conclusion of the
24 deposition and testimony, we will go back, and I would
25 anticipate that for the analyses that she has testified

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1 about, subject to the cross-examination, we would probably
2 consent to those. But the issue here concerns a whole slew
3 of exhibits to her reports that relate to analyses that have
4 really not been touched upon at all, they were just simply
5 mentioned as "I did a previous analysis."
6 MR. ETTINGER: Your Honor, with that, I'm not
7 going to go through them one by one now, certainly, and
8 we'll come up with an alternative.
9 THE COURT: All right. Let's -- I expect counsel
10 to be equally cooperative going both ways -- I guess equally
11 noncooperative, but generally --
12 MR. ETTINGER: That was my thought, Your Honor.
13 THE COURT: Well, my point is that neither side
14 should be expected to roll over and play dead or whatever
15 that phrase is. I mean, I expect you to zealously represent
16 the interests of your client, but also hopefully understand
17 that I've got a difficult task to do, and the more -- or
18 the -- the unimpeded access that I can have to the
19 underlying information I think will be most helpful in
20 trying to reach a decision.
21 So it sounds as if St. Luke's has done that with regard
22 to Dr. Dranove's testimony and will do so as to
23 Dr. Haas-Wilson's testimony, and I expect it will go the
24 same when St. Luke's calls its experts.
25 All right. No further questions?

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1 MR. ETTINGER: With that, no further questions,
2 Your Honor.
3 THE COURT: All right. Mr. Stein, we are probably
4 going to take a break in about five minutes or we could take
5 it now. Would you rather take the break now?
6 MR. STEIN: That would be fine, Your Honor.
7 THE COURT: Why don't we just take the break now.
8 We'll take a 15-minute break, reconvene in roughly 15
9 minutes. We'll be in recess.
10 (Recess.)
11 ****** COURTROOM REMAINS OPEN TO THE PUBLIC ******
12 THE COURT: Dr. Haas-Wilson, I'll remind you you
13 are still under oath.
14 Mr. Stein, you may cross-examine the witness.
15 MR. STEIN: Thank you. I just want to let
16 Your Honor know we will, unfortunately, have to provide
17 another copy of the demonstratives used by plaintiffs to the
18 court. The version that we were sent was in a different
19 order and numbered differently than the version that was
20 used by Mr. Ettinger. I don't begrudge them for moving the
21 slides around, but the consequence is that the copy that we
22 have and that we'll be using as an exhibit is numbered
23 differently.
24 I was trying to keep track of the differences in the
25 page numbers, and I will do my very best to try to put on

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1 the record what we understood to be the corresponding slide
2 in Mr. Ettinger's slide deck.
3 THE COURT: Which is only important to keep the
4 record straight.
5 MR. STEIN: Yes. And to the extent Your Honor is
6 looking --
7 THE COURT: Can we have you just file your own --
8 MR. STEIN: I will do that, as well. But for the
9 court's convenience, I will try, where I was able to
10 identify it, what the slide number was in Mr. Ettinger's
11 deck.
12 THE COURT: I don't know, frankly, it matters to
13 me a whole lot as long as the record is clear, which would
14 be -- a clear record would be created by your marking your
15 own set of slides as a 5000 series demonstrative, and then
16 we won't need to worry about it, which might make your job a
17 little easier on cross.
18 MR. STEIN: That's what we'll do. Thank you,
19 Your Honor.
20 CROSS-EXAMINATION
21 BY MR. STEIN:
22 **Q.** Good morning, Professor Haas-Wilson.
23 **A.** **Good morning.**
24 **Q.** You originally filed a declaration in this case in
25 connection with Saint Al's and Treasure Valley Hospital's

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1 motion for preliminary injunction; is that right?
2 **A. That's correct.**
3 **Q.** I would like to call that up on the screen. It's
4 Trial Exhibit 1852. And this is the cover page of your
5 declaration dated November 16, 2012. And I would like to
6 turn to paragraph 43 of that declaration.
7 THE COURT: Counsel, obviously this is being used
8 for impeachment or other purposes. You're not offering or
9 intend to offer this exhibit?
10 MR. STEIN: That's true. I do not intend to offer
11 her declaration.
12 BY MR. STEIN:
13 **Q.** We'll enlarge that for you, Professor Haas-Wilson.
14 **A. Thank you.**
15 **Q.** You stated in November, quote, "Antitrust analysis
16 balances any competitive harm that may arise as a result of
17 a particular transaction with transaction-specific
18 efficiency gains that may arise as well."
19 And that's still a true statement; correct?
20 **A. That's a true statement.**
21 **Q.** You also stated in your affidavit that "In this
22 context, vertical integration between hospitals and
23 physicians may be efficiency-enhancing. Vertical
24 integration may result in higher quality care as a result of
25 better alignment of the incentives of hospitals and

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1 physicians and lower costs as a result of economies of scope
2 (lower costs due to more efficient joint production of two
3 or more services). When the treatment of patients includes
4 care provided at both the hospital and physicians' offices,
5 vertical integration may facilitate coordination of care
6 across sites and thus, facilitate the realization of
7 economies of scope."
8 And those statements are also still true today;
9 correct?
10 **A. Yes.**
11 **Q.** And as an economist, in order to assess the net
12 competitive impact of a transaction, you have to weigh
13 essentially on a scale the anticompetitive effects on one
14 side against the procompetitive benefits on the other;
15 right?
16 **A. Correct.**
17 **Q.** But you didn't look at any procompetitive benefits
18 in connection with the Saltzer transaction; right?
19 **A. That was not part of my assignment.**
20 **Q.** And you didn't think it was an important thing for
21 you to do even though you weren't asked to do it; correct?
22 **A. I -- I was asked to do a certain assignment, and**
23 **that's what the client was willing to pay me for. So, of**
24 **course, that is what I did on behalf of the client.**
25 **Q.** So when you say that you've reached a conclusion

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1 that the Saltzer transaction will have -- will be
2 anticompetitive, that's a conclusion you reached only
3 considering one side of that scale; correct?
4 **A. One side of the scale; correct.**
5 **Q.** Now, am I correct that it is your opinion that the
6 city of Nampa is the correct geographic market in which to
7 assess the competitive effects of the Saltzer transaction in
8 the pediatrics market?
9 **A. In the market for primary care pediatric physician**
10 **services, yes, Nampa is the geographic market definition.**
11 **Q.** And in the city of Nampa, if that is, indeed, the
12 market for pediatric services, then the transaction does not
13 present any concerns from a horizontal perspective because
14 St. Luke's had no pediatricians in Nampa prior to the
15 transaction; correct?
16 **A. In Nampa, St. Luke's had no pediatricians prior to**
17 **acquiring Saltzer.**
18 **Q.** And that means there would be no horizontal
19 competitive effects, meaning a merger of competing pediatric
20 groups, in the city of Nampa; right?
21 **A. That's correct.**
22 **Q.** I would like to pull up your demonstratives. This
23 is, for the record, our Cross Exhibit 5090. And go back to
24 what will be our slide 10, what I believe was Plaintiffs'
25 Exhibit 3000, slide 11.

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1 This was your calculation of where -- this was patient
2 flows for pediatric care; right?
3 **A. That's correct.**
4 **Q.** And the right-hand column is titled "Where Nampa
5 Providers' Patients Come From." Is that also referred to
6 sometimes as "inflows"?
7 **A. Yes.**
8 **Q.** And there you're looking at the universe of
9 pediatricians in Nampa and what communities their patients
10 come from; is that right?
11 **A. That's correct.**
12 **Q.** And why is it relevant to look at inflows in
13 determining what the relevant geographic market is?
14 **A. It's relevant to determine the geographic market.**
15 **Q.** Why is that?
16 **A. Because, by looking at the inflows, one gets a**
17 **sense of which providers outside of Nampa potentially**
18 **compete with those pediatricians inside of Nampa.**
19 **Q.** And why is it -- why is it important to understand
20 which pediatricians outside -- or whether pediatricians
21 outside of Nampa compete with pediatricians in Nampa in
22 defining the geographic market?
23 **A. To the extent there are competing pediatricians**
24 **outside of Nampa, then it's -- it's relevant to -- it's a**
25 **relevant market. To the extent you do find that there are**

1 **physicians outside, it would be one indication that you**
2 **should expand the geographic boundaries.**
3 Q. And is that because those pediatricians outside of
4 Nampa might serve as a competitive constraint on the
5 pediatricians in Nampa?
6 **A. That's potentially true.**
7 Q. Now, you testified that you have written a number
8 of books and articles, and one of those books that you wrote
9 was titled "Managed Care and Monopoly Power"; is that right?
10 **A. That's correct.**
11 MR. STEIN: Your Honor, we have a binder. I
12 should have had this provided before.
13 THE COURT: Mr. Metcalf.
14 BY MR. STEIN:
15 Q. Professor Haas-Wilson, I would like to ask you
16 some questions about some statements in your book. So if
17 you'd turn to what in the binder is tab 5096. Let me know
18 when you're there.
19 **A. I'm there.**
20 Q. And this is the title page for your book; is that
21 correct?
22 **A. That's correct.**
23 Q. And one of the chapters that you wrote was titled
24 "The Effects of Vertical Consolidation in Healthcare
25 Markets"; is that right?

1 **A. That's correct.**
2 Q. And the Saltzer transaction at issue here would be
3 an example of vertical consolidation?
4 **A. That's correct.**
5 Q. Okay. So if you turn to page 161, which is the
6 eighth page of this exhibit, this is the first page of that
7 chapter on vertical consolidation; is that right?
8 **A. That's correct.**
9 Q. Okay. So starting at the bottom of that page and
10 going on to the next page, you wrote, "Analyses of the
11 welfare effects of vertical consolidation are further
12 complicated by three factors. First, there is considerable
13 theoretical debate concerning whether and when vertical
14 consolidation in healthcare markets facilitates the exercise
15 of market power."
16 Is that still true?
17 **A. No, it is not. There is much less debate.**
18 **Basically, there is a small group referred to as the**
19 **"Chicago School" that present an opposing position, but the**
20 **vast majority of economists are in agreement about whether**
21 **and when vertical consolidation facilitates market power.**
22 Q. And then you say, "Second, there is virtually no
23 empirical research providing evidence of the impacts of
24 vertical consolidation in healthcare markets. The major
25 exception is an unpublished study of physician-hospital

1 integration in three states between 1994 and 1998." Do you
2 see that?
3 **A. Yes.**
4 MR. ETTINGER: Your Honor, just a question. I
5 just want to make sure I understand how you think we should
6 handle this. I think this is part of a chapter in the
7 binder. She has been given certain quotes. There is other
8 relevant information in that chapter. Is it appropriate for
9 me to object now or simply to show her the other material on
10 redirect?
11 THE COURT: Well, there is two answers to that.
12 One is, under the doctrine of completeness, if it is simply
13 misleading if something is so out of context that the
14 balance needs to be shown to prevent it from being
15 misleading, that's one. But, in the alternative, on
16 redirect, you're certainly entitled to show other matters
17 which will clarify and explain that information. I'll give
18 you that leeway.
19 MR. ETTINGER: Your Honor, my view is that it's
20 misleading that the --
21 THE COURT: Well, it has to be obviously
22 misleading. So I think the better course is just to go
23 ahead and allow you to cover that on redirect.
24 MR. ETTINGER: Thank you, Your Honor.
25 THE COURT: Mr. Stein.

1 BY MR. STEIN:
2 Q. I'm going to withdraw my last question and move to
3 the third item. You see the sentence starting "Third"?
4 It's in the middle.
5 **A. Yes.**
6 Q. You say, "Third, when healthcare firms consolidate
7 vertically, individual competitors, physician organizations,
8 hospitals, or insurers are often hurt. For example,
9 individual competitors may lose customers or even be driven
10 out of business. Complications arise because individual
11 competitors can be hurt both in cases where vertical
12 consolidation decreases competition and in cases where it
13 enhances or at least does not lessen competition. Harmed
14 competitors are likely to raise antitrust challenges to the
15 vertical consolidation in either case; however, the
16 antitrust laws were designed to protect competition, not
17 individual competitors."
18 Now, I know you wrote this ten years ago, but those
19 statements are equally true today, are they not?
20 **A. Earlier this morning, I testified that in this**
21 **case, harm to a competitor translates into harm to**
22 **competition and, thus, is an antitrust concern.**
23 Q. Are the statements that I just read from your book
24 equally applicable today as they were ten years ago?
25 **A. In general, the antitrust laws, it's my**

1 **understanding, are meant to protect competition. And in**
2 **this case -- and that is still true. In this case, harm to**
3 **a competitor and harm to competition are one and the same.**
4 Q. And it's also true today that harm to competitors
5 are likely to raise antitrust challenges whether or not the
6 transaction harms competition; right?
7 A. **There are times when individual competitors will**
8 **challenge that consolidation. And often in those cases**
9 **where there is no evidence that it has harmed competition,**
10 **those cases will be decided against the individual**
11 **competitor.**
12 Q. And, in fact, you mentioned that one way the court
13 could determine whether competition has been harmed is if
14 the Saltzer transaction raises Treasure Valley Hospital's
15 costs or makes it more difficult for it to compete; is that
16 right?
17 A. **I testified that to the extent the acquisition**
18 **weakens Treasure Valley, decreases its base of referrals,**
19 **that will harm Treasure Valley Hospital.**
20 Q. Right. And, of course, any acquisition of a
21 group, no matter how small, by definition, would reduce the
22 base of referrals to Treasure Valley Hospital or Saint Al's
23 for that matter; right?
24 A. **In this case, the acquisition greatly reduces the**
25 **referral base or the potential patients to Treasure Valley**

1 **in at least one of my relevant markets.**
2 Q. Professor Haas-Wilson, maybe my question wasn't
3 clear.
4 Any transaction, any acquisition of a physician
5 practice, no matter how small, will deprive a rival of a
6 source of patients; correct?
7 A. **Yes, but under the circumstance where --**
8 Q. So what is the threshold for determining when
9 the -- when the foreclosure of a certain group of patients
10 rises to the level of a violation of the antitrust laws?
11 A. **While I have not tried to establish a bright line,**
12 **in my opinion, significant loss of patients would certainly**
13 **be 30 percent, 40 percent and higher.**
14 Q. So would that be 30 percent of the practices of
15 the competitor's existing base of patients, or would you be
16 looking at 30 to 40 percent of the patients available -- for
17 which the competitor could compete in the overall market?
18 A. **That would -- would you ask your question again,**
19 **please?**
20 Q. Sure. When you say 30 to 40 percent, do you mean
21 the transaction would be anticompetitive if it forecloses 30
22 to 40 percent of the existing patients of Treasure Valley
23 Hospital and Saint Al's or 30 to 40 percent of all the
24 available patients in the market that you've defined?
25 A. **What I have looked at is 30 to 40 percent of the**

1 **patients that would be denied from the acquired physicians.**
2 Q. Not the available patients in the market as a
3 whole; is that right?
4 A. **That's correct. I looked at the percent of the**
5 **patients of the particular practice.**
6 Q. Now, you talked before -- you talked before about
7 Micron. And you said that they are, in essence, a
8 snowflake; that they're unique. Nobody else is like them;
9 right? That the court shouldn't draw too much from the
10 Micron example; is that right?
11 A. **That's correct.**
12 Q. But, in fact, there has been a greater interest in
13 narrow-network health plans in response to the enactment of
14 healthcare reform; right?
15 A. **Nationally, I would say that is correct.**
16 Q. In fact, you wrote about this in your report in
17 this case; right -- narrow networks?
18 A. **I wrote about narrow networks in my report, yes.**
19 Q. Let's pull up Trial Exhibit 1854. And I believe
20 if you've got the binder Mr. Ettinger gave you, I think your
21 report is in there to the extent you want to look at it.
22 But this is the cover page from the report that you
23 submitted on June 5th of 2013. And I would like to take a
24 look at paragraph 60.
25 A. **Sorry about that.**

1 Q. And starting in the second -- let me know when
2 you're ready.
3 Starting in the second sentence there, you wrote,
4 "Until the last couple of years, as a result of strong
5 consumer preference for broad networks" --
6 A. **Excuse me. I'm not quite there, if you don't mind**
7 **waiting another minute.**
8 Q. Sure. It's on the screen, as well, if that makes
9 it easier.
10 MR. ETTINGER: Your Honor, the screen cuts off the
11 quote in a very interesting place. I'm sure not
12 intentionally, but maybe she could look at the hard copy.
13 THE WITNESS: I am now at paragraph 60 of my
14 report.
15 BY MR. STEIN:
16 Q. So starting at the second sentence, you said,
17 "Until the last couple of years, as a result of strong
18 consumer preference for broad networks (insured access to
19 all healthcare providers), health plans have tended to offer
20 inclusive networks including most area providers. More
21 recently, however, there has been greater interest in
22 narrow-network plans in response to the enactment of the
23 Patient Protection and Affordable Care Act. Increasingly,
24 employers are offering plans with narrow or tiered provider
25 networks. Among those employers providing health benefits,

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1 the percent offering a health plan that includes a narrow or
2 tiered provider network increased from 15 to 20 percent
3 between 2007 and 2011."
4 Are those statements still true as far as you know?
5 **A. As far as I know, yes.**
6 Q. And then in the next sentence, you say that "In
7 Idaho, narrow-network products have not been successful."
8 Can you tell me which narrow-network products you're
9 referring to?
10 **A. Sure. I'm referring to, for example, the**
11 **Blue Cross narrow-network product called ConnectedCare. I**
12 **think at this point, it's got just about a little over 220**
13 **enrollees. So it has not caught on.**
14 Q. Any other -- are there any other narrow-network
15 plans in the market that you're aware of?
16 **A. The -- Saint Al's has a narrow-network product for**
17 **its own employees.**
18 Q. Has that been successful?
19 **A. Well, the Saint Al's employees actually insisted**
20 **that that network include Saltzer. So Saint Al's was not**
21 **able to make it quite as narrow as it wanted, but Saint Al's**
22 **is still using that narrow-network product for its**
23 **employees.**
24 Q. When you say "not as narrow as it wanted," is it
25 your understanding Saint Alphonsus did not want to have

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1 Saltzer in network for its employees?
2 **A. Oh, no. My understanding is that Saltzer may not**
3 **have been willing to be part of that network. I think it**
4 **had been part, and the employees were very clear that they**
5 **wanted Saltzer to remain part of that network. There was a**
6 **transition when Saint Al's bought the hospital facility in**
7 **Nampa.**
8 Q. Any other narrow-network plans that you're aware
9 of?
10 **A. Sitting here, I can think of employers who tried**
11 **to use tiered network plans. Boise Schools. Let's see,**
12 **there was another one. I think it might have been Idaho**
13 **Power. And those did not last long; they were not**
14 **successful.**
15 Q. Now, when you say those were not successful, you
16 didn't actually do any analysis to see whether those -- the
17 incentives in those plans, in fact, succeeded in moving
18 patients from Saint Al's to St. Luke's; correct?
19 **A. I read documents and testimony concerning the**
20 **experience of these health plans.**
21 Q. Sure. But you didn't do an analysis?
22 **A. I did not use data -- my own data to analyze the**
23 **impact of these tiered or narrow-network products.**
24 Q. Now, St. Luke's has a network called the "Select
25 Network"; is that right?

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1 **A. My understanding it's called the "Select Medical**
2 **Network."**
3 Q. And Saint Al's has a competing network called the
4 "Alliance"?
5 **A. My understanding it's called the "Health**
6 **Alliance."**
7 Q. IPN is another competing network?
8 **A. That's correct.**
9 Q. First Choice is another network?
10 **A. Another network.**
11 Q. And all these networks, they're out there in the
12 market competing against each other for business; right?
13 **A. That's correct.**
14 Q. Does St. Luke's have an obligation to make its
15 providers available to competitors' networks so that those
16 competing networks look as attractive to purchasers of
17 St. Luke's network?
18 **A. Not to my knowledge. There is no obligation.**
19 Q. Okay. So then why should the court be concerned
20 if St. Luke's were to withdraw its providers from competing
21 networks?
22 **A. Because the impact of their withdrawal of their**
23 **physicians from competing networks would cripple network**
24 **competition -- in fact, eliminate network competition**
25 **because having those Saltzer and St. Luke's physicians as**

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1 **part of the provider network is vital.**
2 Q. Because nobody wants a network without St. Luke's
3 doctors?
4 **A. Individuals would prefer a network that included**
5 **the St. Luke's doctors.**
6 Q. Right. I have no doubt of that. But why does
7 that mean rival networks would be destroyed if St. Luke's
8 providers didn't participate in rivals' networks?
9 **A. As I testified to earlier, Saltzer, in particular,**
10 **is essential to having a vital, marketable health plan. And**
11 **there was all sorts of evidence from testimony and documents**
12 **to support that.**
13 Q. And so I just want to be clear. You're telling
14 the court that if the Saltzer transaction goes forward and
15 if St. Luke's were to withdraw Saltzer from competing
16 networks -- IPN, the Saint Alphonsus Health Alliance -- they
17 would all go out of business?
18 **A. It's my opinion if St. Luke's actually initiates**
19 **its plan to pull all of its physicians, including the**
20 **Saltzer physicians, from competing networks, that those**
21 **networks would be unable to compete against Select Medical**
22 **and potentially be driven out of business.**
23 Q. Let's say hypothetically St. Luke's pulled all of
24 its providers except the Saltzer doctors from competing
25 networks. Would network competition be destroyed then, too?

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1 **A. So you're asking if they let -- left in the**
2 **Saltzer but pulled out their other doctors?**
3 Q. Yes.
4 **A. That's not something I have given much thought to**
5 **as that is not the St. Luke's plan. So I have given thought**
6 **to what would happen if St. Luke's actually implemented the**
7 **plan that they --**
8 Q. I understand --
9 **A. -- have written about.**
10 Q. I understand your testimony. You don't have an
11 opinion on that, correct, on the hypothetical I gave you?
12 **A. I would like to have more time to think about**
13 **that. I am not of the school of thought that one should**
14 **come to a split-second opinion. You should base your**
15 **opinion on all sorts of evidence, and I haven't had the**
16 **opportunity to do that.**
17 Q. And if the court concludes that the transaction
18 would not give St. Luke's and Saltzer market power in the
19 market for adult primary care services or pediatric
20 services, would it still be your opinion that the
21 transaction should be stopped because it will harm network
22 competition?
23 **A. That is correct.**
24 Q. So the network competition really is a separate
25 market?

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1 **A. Well, no. It's network competition in addition to**
2 **the foreclosure that would result in the markets for**
3 **inpatient and outpatient services.**
4 Q. I see. So your conclusion that network
5 competition would be harmed turns on both your conclusion
6 that the Saltzer transaction would give St. Luke's market
7 power in the physician services markets and your conclusion
8 that there would be substantial foreclosure in the hospital
9 services markets?
10 **A. No. You're misstating my conclusions.**
11 **My conclusions are based on the harm to network**
12 **competition in addition to the harm that comes from**
13 **foreclosure in the market for outpatient and inpatient**
14 **services and in addition, on top of that, the horizontal**
15 **harm that would result in the market for general primary**
16 **care physicians.**
17 **My opinion is based on all of those factors.**
18 Q. Well, let's try getting at it this way so that we
19 and the court can be clear on the role of this network
20 competition theory of yours.
21 You've identified five markets: primary care services,
22 pediatric services, inpatient services, and two outpatient
23 services markets; right?
24 **A. That's correct.**
25 Q. Assume for the moment that the court at the

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1 conclusion of this trial determines that St. Luke's does not
2 have -- that the transaction will not create or enhance
3 market power in any of those markets. Okay?
4 **A. In any of the five?**
5 Q. Yes. Are you with me?
6 **A. I'm with you.**
7 Q. Okay. Would you still contend that the Saltzer
8 transaction should be unwound because it harms network
9 competition?
10 **A. If the court finds that there is no**
11 **anticompetitive effect in all five of my relevant markets,**
12 **then what the court would be concluding is that network**
13 **competition has not had an anticompetitive effect in those**
14 **five markets.**
15 Q. I want to move on to the subject of --
16 **A. Let me just -- I misstated it. That network**
17 **competition -- harm to network competition in combination**
18 **with the harm due to foreclosure, the court would have**
19 **concluded that there was no anticompetitive effect.**
20 Q. You defined "foreclosure" as impeding a rival's
21 access to a necessary input; is that right?
22 **A. That was part of my definition.**
23 Q. Can you explain the rest of it?
24 **A. Sure. In addition to that, the lack of access to**
25 **that necessary input -- in this case, patients -- prevents**

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1 **rivals from competing on the basis of the merits. And by**
2 **that, I mean price, quality, any other competitive**
3 **variables.**
4 Q. And is the necessary input in this case patients
5 of Saltzer primary care physicians?
6 **A. Yes, the necessary input is -- is Saltzer**
7 **patients.**
8 Q. Why -- why are patients of Saltzer doctors
9 necessary to compete? In other words, why can't Saint Al's
10 and Treasure Valley Hospital go out and compete for the
11 patients of other doctors if they don't have the Saltzer
12 patients?
13 **A. Well, the Saltzer doctors represent a very high**
14 **percentage of the independent doctors or at least who was**
15 **independent prior -- Saltzer represented eight out of nine**
16 **of the pediatricians that were practicing in Nampa.**
17 Q. Let's get at it this way, Professor Haas-Wilson:
18 If we're going to consider foreclosure from the market for
19 inpatient hospital services in Ada and Canyon County, the
20 first thing we have to do is figure out what's the available
21 base of patients for inpatient hospital services in Ada and
22 Canyon County; right?
23 **A. Yes. You would want to look at the base of**
24 **patients.**
25 Q. And of all the patients, inpatients, in Ada and

1 Canyon County, what portion of those are referred by Saltzer
2 physicians?
3 **A. That's not something that I have calculated. What**
4 **I'm talking about is how foreclosure from the Saltzer**
5 **patients would specifically hurt two of the rivals: the**
6 **Treasure Valley Hospital and the Saint Al's Nampa hospital.**
7 **Q.** But it would only hurt them if they couldn't go
8 out and compete for replacement admissions from other
9 doctors in the market; right?
10 **A. Again, there are very few remaining independent**
11 **doctors out in the Nampa/Canyon County area.**
12 **Q.** Okay. Let's get it this way, then, Professor
13 Haas-Wilson: What percentage of all the inpatient
14 admissions in Ada and Canyon County come from independent
15 doctors? Is it 10 percent? 30 percent? 50 percent? Some
16 other number?
17 **A. That's not a number that I calculated.**
18 **Q.** So you don't know?
19 **A. As a percent of all Canyon County, that is not a**
20 **percent I calculated.**
21 **Q.** And, likewise, you haven't -- you don't know what
22 percentage of admissions -- strike that.
23 You don't know what percent of outpatient procedures in
24 Ada and Canyon County in your two outpatient markets are
25 accounted for by the Saltzer doctors; right?

1 **A. I -- I have calculated the percent -- the number**
2 **of Saltzer patients, those who have seen a Saltzer**
3 **physician, those -- a Saltzer primary care physician for the**
4 **Treasure Valley Hospital and the Saint Alphonsus Nampa**
5 **hospital.**
6 **Q.** Yes, I understand that. You have not -- but what
7 you have not done is determine, if those patients were
8 foreclosed, what the volume is of other patients,
9 outpatients, in the market that the plaintiffs could go
10 compete for?
11 **A. Hmm. But what I'm saying is --**
12 **Q.** Am I right about that?
13 **A. Well, let me clarify what it is I'm saying. I'm**
14 **looking at the base of independent physicians and,**
15 **therefore, the base of patients associated with those**
16 **independent physicians.**
17 **So the patients that are going to Saint Alphonsus,**
18 **that you can compete for those. But to the extent that the**
19 **Saint Al's doctors are directing their patients to**
20 **Saint Al's, those are Saint Al's patients that -- so you're**
21 **really looking at competition for the patients of the**
22 **independent physicians.**
23 **Q.** Okay. So what percentage of the outpatient
24 procedures in the general surgery market and the ortho-neuro
25 markets that you've defined are accounted for by independent

1 physicians?
2 **A. That's not a number I calculated.**
3 **Q.** Now, in a number of your slides, you talked
4 about -- your slides have the title of "steering" on them,
5 but then I understood from your testimony from Mr. Ettinger,
6 that you said that's not quite an accurate term or something
7 to that effect. Is that right?
8 **A. What I was saying is it overstates a little bit**
9 **because it's not complete control that the physician has,**
10 **but the physician has a very large influence and -- on where**
11 **their patients receive their inpatient and outpatient care.**
12 **Q.** But when you use the term "steering," should the
13 court infer from that that what you're saying is that
14 physicians who affiliate with St. Luke's take patients that
15 previously would have been admitted to Saint Al's and,
16 instead, move those inpatient or outpatient procedures to
17 St. Luke's?
18 **A. I did all sorts of data analyses to test that**
19 **hypothesis that acquired physicians change where they admit**
20 **their patients or change where they have their patients**
21 **receive outpatient services. So I used the data analysis to**
22 **look at this steering, and I also read the deposition**
23 **testimony and looked at documents and --**
24 **Q.** Dr. Haas-Wilson, I had a very specific question
25 about what steering means, not what you looked at.

1 MR. ETTINGER: Your Honor, she is in the middle of
2 her answer.
3 THE COURT: Counsel, I think it required a
4 narrative response. Finish your response, and then let's
5 put another question before the witness.
6 Go ahead.
7 THE WITNESS: Okay. So basically what I'm saying
8 is I didn't just assume that. I used the data, the
9 documents, and the testimony to -- to test that hypothesis.
10 And all the evidence pointed in the same direction: That
11 after acquisition, these physicians who used to admit at
12 Saint Al's changed their behavior and now admit more at
13 St. Luke's.
14 BY MR. STEIN:
15 **Q.** They changed their behavior. Let's explore that.
16 Let's say that prior to affiliating with St. Luke's, an
17 independent practice admits a hundred patients a year to
18 Saint Al's because they're getting a hundred referrals a
19 year from Saint Al's. Are you with me so far?
20 **A. Yes.**
21 **Q.** Okay. Now, let's say that after that practice
22 affiliates with St. Luke's, SAMG doctors completely stop
23 referring patients to the now-St. Luke's provider. The
24 percentage of the acquired practice's admissions at Saint
25 Alphonsus is going to go to zero in that hypothetical;

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1 right?
2 A. Will you say that one more time?
3 Q. Yes. I'll make this -- I'll try to make this
4 simple. Let me know if I can --
5 THE COURT: You threw in the words "SAMG doctors."
6 Is that the doctors that, in your hypothetical, have now
7 transferred to work for St. Luke's?
8 MR. STEIN: Thank you. Let me try to make it
9 clearer.
10 THE COURT: Thank you.
11 BY MR. STEIN:
12 Q. SAMG are the physicians who are employed by Saint
13 Alphonsus; correct?
14 A. Correct.
15 Q. Okay. So now let's -- in this hypothetical, let's
16 take an independent surgical practice. Okay? And let's say
17 that as an independent practice, they get a hundred
18 referrals in a year from SAMG, Saint Alphonsus doctors, and
19 they do those procedures at Saint Alphonsus because that's
20 where the SAMG doctors would prefer that they be done.
21 Okay?
22 A. Okay.
23 Q. And now let's say that independent practice, they
24 affiliate with St. Luke's; because of that affiliation, the
25 SAMG doctors stop sending them patients; and as a result,

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1 they're not doing procedures at Saint Al's anymore. Are you
2 with me?
3 A. I'm with you with your hypothetical.
4 Q. Okay. Would you call that "steering"?
5 A. I -- I know this was a hypothesis put forward by
6 the expert, the hospital's expert, and that's why I did that
7 test.
8 Q. Would you call that "steering"?
9 A. Well, I don't think I need to put a label on it
10 because I tested that hypothesis, and that cannot be what --
11 what happened. I looked at SAMG --
12 Q. Can you please answer my question?
13 A. -- versus --
14 THE COURT: Just a moment. I know in your
15 original testimony, you were a little concerned about using
16 the word "steering." So that may explain your reticence to
17 describe this as steering or not. But I think it is a
18 fairly straightforward question as to whether or not you
19 would regard what occurred in the hypothetical as
20 constituting steering. You can answer it any way you want,
21 but I will ask you to answer that specific question.
22 THE WITNESS: Sure. So my answer is: I would not
23 consider that steering, but also that that is not a
24 phenomena that happened in the market. My -- my test --
25 THE COURT: Mr. Ettinger will give you a chance to

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1 explain that with great detail if you wish.
2 So I think we have the answer. Let's go ahead and
3 proceed, Mr. Stein.
4 BY MR. STEIN:
5 Q. I would like to go to -- back to your
6 demonstratives. This is our Exhibit 5090 and put up
7 slide 31.
8 And, Professor Haas-Wilson, this was your analysis of,
9 again, what you call steering inpatient admissions by
10 certain specialty groups that affiliated with St. Luke's.
11 A. I'm sorry. Which -- which tab am I on?
12 Q. It's slide 31 of the slides that you were going
13 through with Mr. Ettinger. It's on the screen in front of
14 you.
15 A. I see.
16 Q. This was your analysis of what you called
17 "steering" of inpatient admissions by five surgical
18 practices who affiliated with St. Luke's?
19 A. That's correct.
20 Q. So let's focus for a minute on one of those
21 groups. The second one is Idaho Cardiothoracic and
22 Vascular. And that's a group that's known as CVA; is that
23 right?
24 A. That's right.
25 Q. And your analysis shows that when they were

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1 independent -- in the far right there, that red number --
2 34 percent of their 888 total inpatient admissions were to
3 Saint Al's; is that right?
4 A. That's correct.
5 Q. So in the pre-period when they were independent,
6 CVA surgeons did roughly 300 inpatient procedures at
7 Saint Al's?
8 A. I don't have a calculator up here with me, but
9 what is 34 percent of 888?
10 Q. Well, if we increase it just by 12, to 900, a
11 third of 900 would be 300?
12 A. Fair enough.
13 Q. And after CVA was acquired by St. Luke's, none of
14 CVA's admissions were to Saint Alphonsus; correct?
15 A. That is correct.
16 Q. And so should the court infer from this that
17 Saint Al's experienced a decrease of roughly 300
18 cardiovascular and thoracic surgeries in the postacquisition
19 period?
20 A. That's -- that's correct.
21 Q. But you didn't actually look at what happened to
22 the overall levels of cardiothoracic and vascular surgeries
23 at Saint Al's before and after the acquisition, did you?
24 A. That is not relevant to my steering analysis.
25 Q. So you didn't undertake any analysis to determine

1 whether the decrease in admissions by this particular group,
2 CVA, was offset by an increase in cardiovascular --
3 cardiothoracic and vascular surgeries by other surgeons;
4 right?
5 **A. I was doing this analysis to test for steering.**
6 **And the calculation that you're suggesting is irrelevant to**
7 **my test for steering, so I did not do it.**
8 **Q.** But the reason you're doing the steering analysis
9 is to determine ultimately whether there is going to be
10 foreclosure; right?
11 **A. That's correct.**
12 **Q.** So your own analysis also shows that when the CVA
13 surgeons affiliated with St. Luke's, Saint Al's primary care
14 doctors dramatically decreased their referrals to CVA;
15 right?
16 **A. I'm sorry. Would you say that again?**
17 **Q.** Sure. Your own analysis shows that after CVA
18 affiliated with St. Luke's, Saint Al's primary care doctors
19 dramatically decreased their referrals to CVA?
20 **A. No, that's not what I'm saying.**
21 **Q.** Let's put up Trial Exhibit 1673. That's in the
22 binder we gave you, Professor Haas-Wilson.
23 **A. The numbers are pretty small. Would you mind**
24 **telling me in what tab?**
25 **Q.** 1673. We'll put it up on the screen, too.

1 Professor Haas-Wilson, this was your analysis of what
2 happened to referrals of patients who visited Saint
3 Alphonsus doctors to these specialty groups; is that right?
4 **A. That's correct. This is a sensitivity analysis**
5 **that I ran using only patients who had an office visit to a**
6 **SAMG primary care doctor up to 12 months prior to the actual**
7 **admission.**
8 **Q.** Right. And your analysis shows that when the
9 Cardiothoracic and Vascular Associates surgeons went from
10 being independent to affiliated with St. Luke's, their
11 referrals from SAMG doctors dropped from 113 to 37; right?
12 **A. That was the decrease in total inpatient**
13 **admissions for SAMG patients. This doesn't tell me how many**
14 **referrals SAMG doctors were making to Idaho Cardiothoracic**
15 **and Vascular Associates.**
16 **Q.** Well, then why did you put those numbers under the
17 heading "Cardiothoracic and Vascular Associates"?
18 **A. Because I was counting the number of admissions**
19 **made by the physicians who were part of that particular**
20 **specialty practice.**
21 **Q.** Right. And for the -- if we can, George, get rid
22 of that call-out.
23 Your analysis also shows a similar decrease for Boise
24 Orthopedic Clinic from 36 to 14; right?
25 **A. Right, in total admissions at Saint Al's.**

1 **Q.** And a decrease for Idaho Pulmonary Associates from
2 70 to 22; right?
3 **A. That's correct.**
4 **Q.** And it's possible that while there was a decrease
5 in admissions to Saint Alphonsus by the specific group
6 Cardiothoracic and Vascular Associates, there was actually
7 no decrease in the total number of cardiothoracic and
8 vascular surgeries done at Saint Al's as a result of the CVA
9 acquisition; right?
10 **A. As I said earlier, that question is irrelevant to**
11 **my analysis of steering behavior.**
12 **Q.** And so for -- I'm sorry. Were you finished?
13 **A. I was.**
14 **Q.** Okay. And so we could go through each of these
15 five surgery groups, but am I correct the answer would be
16 the same, that you are not showing on slide 31 of your
17 demonstrative here that the decrease in admissions by these
18 groups to Saint Alphonsus actually resulted in any net
19 decrease in the amount of surgeries being done at Saint
20 Alphonsus; correct?
21 **A. I did not test for that because it was not**
22 **relevant to answer my questions about steering.**
23 **Q.** Now, you also talked about you did an HHI
24 calculation, is that right, for the surgery markets?
25 George, if we can go back to 5090, slide 42.

1 These are your pre -- again, this is on the screen in
2 front of you, Professor Haas-Wilson.
3 **A. That's a nice, big one.**
4 **Q.** These are your premerger HHI calculations; is that
5 right?
6 **A. That is correct. These are premerger.**
7 **Q.** These are for the inpatient and outpatient surgery
8 markets?
9 **A. That is correct.**
10 **Q.** I noticed that you have not put a postmerger HHI.
11 Is there a reason for that?
12 **A. I calculated all the postmerger HHIs and the**
13 **deltas.**
14 **The point I was making in this slide was that**
15 **the -- these markets were already highly concentrated; and**
16 **to make that point, I need to look at the premerger HHIs.**
17 **So to address the question of the title, I put in the**
18 **necessary information, which is the premerger HHIs.**
19 **Q.** But consistent with the merger guidelines, you
20 agree that if the Saltzer transaction were to result in a
21 concentration change of less than 100 points, your
22 conclusion that the transaction would be anticompetitive, at
23 least in these markets, would be different?
24 **A. Not necessarily, no. Because these markets are**
25 **already so highly concentrated, even small changes in**

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1 **concentration could harm competition.**
2 **Q.** So does that mean any change in referral patterns
3 by the Saltzer doctors, no matter how small, would render
4 the transaction anticompetitive?
5 **A.** **The foreclosure analysis that I did, which is**
6 **based on changes in referral analysis, is but one part of**
7 **the harm to competition. I also looked at harm to network**
8 **competition.**
9 **So even if there were less foreclosure, to the**
10 **extent there is harm to network competition, the acquisition**
11 **of Saltzer could, in fact, be anticompetitive.**
12 **Q.** What change in HHI would be required for you to
13 determine that the Saltzer transaction will have
14 anticompetitive effects in your hospital services markets?
15 **A.** **I would have to look at, again, this foreclosure**
16 **analysis, which leads to, you know, the change in the HHI in**
17 **combination with the change in network competition, which,**
18 **again, could lead to changes in the HHI. I would want to**
19 **consider all those simultaneously.**
20 **Q.** Can you -- for the court's sake and our sake, can
21 you identify any objective threshold, any number change in
22 the HHI at which you would be -- you would say the
23 transaction goes from being anti- -- competitive -- or not
24 anticompetitive to competitive?
25 **A.** **Again, I didn't try to come up with a bright line**

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1 **that anything greater than this will be anticompetitive,**
2 **anything less than this will be not -- not anticompetitive.**
3 **Certainly, from the merger guidelines, there is the**
4 **suggestion that greater than 100 is likely and greater than**
5 **200 it's presumed to be anticompetitive.**
6 **Q.** And less than 100, it's presumed not to present a
7 competitive problem; right?
8 **A.** **Less than 200.**
9 **Q.** Okay.
10 **A.** **It's not presumed.**
11 **Q.** So let's go back to your demonstratives. I want
12 to move through some of these other analyses, back to slide
13 32 of 5090, which I believe corresponds with slide 34 of
14 Plaintiff's Exhibit 3000.
15 So on this slide titled "Evidence of Steering
16 Outpatient Encounters" and the next slide for
17 "Neuro+Orthopedic," as with the inpatient slides we just
18 looked at, you're purporting to show a decrease in
19 outpatient procedures by five specific surgical practices
20 acquired by St. Luke's; right?
21 **A.** **That's correct -- no, no, no. I'm sorry. In this**
22 **second one, the neurosurgery and orthopedic surgery, there**
23 **are actually only two of the five acquired practices that**
24 **perform this type of surgery.**
25 **Q.** Thank you for clarifying that.

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1 Now, on the inpatient slides, you had information about
2 procedures at St. Luke's before and after the acquisition.
3 Why is there no information on these slides about what
4 happened to the volume of these procedures at St. Luke's on
5 these slides?
6 **A.** **The expert attorney -- sorry -- expert economist**
7 **for St. Luke's offered an alternative explanation for what**
8 **is going on at St. Luke's. So I wanted to focus my analysis**
9 **on those facilities where that -- that alternative**
10 **explanation could not possibly be driving the results.**
11 **Q.** But as with the inpatient analysis you did, it's
12 quite possible that what's reflected here is that, while
13 there is a decrease in outpatient encounters associated with
14 the acquired practices, there is a corresponding increase in
15 outpatient encounters by other physicians at these
16 hospitals; correct?
17 **A.** **That is a possibility, yes.**
18 **Q.** Now, let's go to slide 34 of Exhibit 5090. This
19 was the slide you titled "Evidence of Steering Diagnostic
20 Imaging Services." Do you see that?
21 **A.** **Yes, I do.**
22 **Q.** And what's your understanding of how many primary
23 care practices St. Luke's has acquired over the last three
24 or four years?
25 **A.** **Well, if you go back to that time line that I put**

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1 **up previously, we could actually count. I don't know if you**
2 **want to put that up so I can count for the last three or**
3 **four years.**
4 **Q.** How did you pick Mercy Group as the one group for
5 whom you would do this analysis?
6 **A.** **I selected Mercy Group because they're a group of**
7 **primary care physicians and also they are located in Nampa.**
8 **Q.** And you said that you did diagnostic imaging and
9 laboratory services. How did you select those two services
10 to do your analysis on?
11 **A.** **I -- I chose services that were typical ambulatory**
12 **services.**
13 **Q.** Did you do a broader analysis that included other
14 services besides diagnostic imaging and laboratory that
15 wasn't included in the report?
16 **A.** **I did not.**
17 **Q.** And are the diagnostic imaging services reflected
18 here, are these inpatient procedures? Outpatient
19 procedures?
20 **A.** **These are outpatient procedures.**
21 **Q.** Now, you testified that you -- you did look at
22 laboratory services, and then St. Luke's expert provided an
23 alternative explanation, and so that's why you focused here
24 on diagnostic imaging.
25 Did you consider any alternative explanations for a

1 decrease in diagnostic imaging services other than just the
2 fact of affiliation with St. Luke's?
3 **A. I didn't consider it because I can't think of**
4 **other alternative explanations other than steering.**
5 **Q.** Well, were there any new freestanding diagnostic
6 imaging facilities that opened in the after-acquisition
7 period that were not available in the pre- period?
8 **A. I don't have the answer to that question.**
9 **Q.** Okay. And the Mercy Group physicians, do they
10 have an office in North Nampa?
11 **A. Their office is in Nampa.**
12 **Q.** Do you know where in Nampa?
13 **A. I don't know exactly where in Nampa.**
14 **Q.** Okay. Can we put up Cross Exhibit 5097.
15 So, Professor Haas-Wilson, this is a --
16 MR. ETTINGER: Your Honor, I don't think this is
17 in evidence. It's --
18 THE COURT: It's some kind of demonstrative
19 counsel is using. It appears to be a map.
20 MR. STEIN: Yes.
21 THE COURT: Is there any objection?
22 MR. ETTINGER: Well, it's a representation of
23 where there are imaging centers. I have never seen it
24 before. I have no idea if it's accurate. It's not
25 something the witness has authored.

1 THE COURT: Mr. Stein.
2 MR. STEIN: I just want to ask the witness -- I am
3 not seeking to introduce the map. I just want to ask the
4 witness some questions.
5 THE COURT: Well, let's see where it goes. You
6 can object, and I'll strike the testimony if it's in any way
7 misleading. But it appears to be just a map with some
8 imaging centers identified.
9 Now -- well, part of the problem may be, of course,
10 that Dr. Haas-Wilson may not be familiar with the specific
11 imaging centers. But, Mr. Stein, I will give you some
12 leeway but subject to a possible objection from
13 Mr. Ettinger.
14 BY MR. STEIN:
15 **Q.** Professor Haas-Wilson, in the middle of the page
16 there, do you see there is a blue dot for St. Luke's Nampa
17 Medical Plaza?
18 **A. I see the blue dot.**
19 **Q.** Were you aware that the St. Luke's Nampa Medical
20 Plaza has freestanding imaging facilities?
21 **A. I knew St. Luke's had imaging facilities. That it**
22 **was located right at that blue dot, no, I didn't.**
23 **Q.** Okay. So you didn't know that there was a new,
24 freestanding imaging facility --
25 MR. ETTINGER: Your Honor, I guess I'm going to

1 object. If the question were "Do you know whether or not
2 there is a facility at a location?" I suppose that's a fair
3 question. Mr. Stein is asking it as if these are facts that
4 are in evidence. And his basis is apparently this map which
5 is not in evidence which we have never seen.
6 MR. STEIN: Your Honor, if Mr. Ettinger is
7 challenging that there is a St. Luke's Nampa Medical Plaza,
8 I will represent -- that opened in July of last year, I will
9 represent to the court we will close the loop on that in our
10 case-in-chief. And I think it's fair for me to inquire not
11 just to facts the witness knows but the facts this witness
12 doesn't know.
13 THE COURT: Well, all right. Let's -- I think the
14 objection is the way the question was phrased. We're
15 wasting a lot of time on something that really doesn't
16 matter a whole lot. I think the question could just be:
17 Are you aware of that? And then tie it in later. But, of
18 course, you will need to tie it in since Mr. Ettinger is
19 correct. It is not a fact in evidence at this point.
20 Proceed.
21 BY MR. STEIN:
22 **Q.** Could the opening of a new imaging facility in
23 Nampa that would be a more convenient location for some
24 number of patients -- more convenient than Saint Alphonsus
25 Nampa -- explain a decrease in diagnostic imaging procedures

1 sent to Saint Alphonsus?
2 **A. That could be an alternative explanation.**
3 MR. STEIN: Okay. So the next slide, I think we
4 need to turn the screen off, Your Honor, but I don't think
5 we need to clear the courtroom.
6 And if we can go to slide 52 of 5092.
7 BY MR. STEIN:
8 **Q.** This was an analysis you said you did of certain
9 prices at certain facilities. And I think you said you were
10 holding volumes constant; is that right?
11 **A. I was holding the market basket, the combination**
12 **of services that were performed at each hospital. I chose**
13 **the basket of services that were performed at Treasure**
14 **Valley Hospital and then looked to see the prices at**
15 **Treasure Valley, Saint Al's Nampa, Saint Al's Regional**
16 **Medical Center, St. Luke's Regional Medical Center, and**
17 **St. Luke's Magic Valley combined.**
18 **Q.** Right. Now, when you say you chose the basket of
19 services, I see in the bottom of the slide there, it says,
20 "Distribution of visits for 2012 across a common set of 21
21 CPT codes."
22 A CPT code, that's the five-digit code that would be
23 used to describe a particular medical procedure or service;
24 is that right?
25 **A. That's correct.**

1 **Q.** Roughly, how many CPT codes are there? Do you
2 know?
3 **A. I don't know.**
4 **Q.** Do you know how many CPT codes Treasure Valley
5 Hospital bills or billed in 2012, even generally?
6 **A. No, I don't know exactly. But it's my**
7 **understanding that these are the 21 CPT codes that represent**
8 **the services that are provided at Treasure Valley.**
9 **Q.** Your understanding from whom?
10 **A. The people I work with at Analysis Group. We**
11 **decided that we wanted to look at the market basket at**
12 **Treasure Valley to compare to -- so we could -- Treasure**
13 **Valley offers the fewest number of services of these five**
14 **different facilities. So we started with Treasure Valley**
15 **because we knew these CPT codes were offered at all five of**
16 **these facilities.**
17 **Q.** Okay. So, just to be clear, is it your
18 understanding that the 21 CPT codes you selected, that's the
19 universe of all the CPT codes that Treasure Valley Hospital
20 billed in 2012?
21 **A. No, that's not my understanding. These are a**
22 **common set of CPT codes across all the five facilities.**
23 **Q.** Right.
24 **A. But not necessarily every single CPT code.**
25 **Q.** Right. So we understand where this is being

1 cherry-picked, how representative are these 21 CPT codes of
2 all the procedures that are done at Treasure Valley
3 Hospital?
4 **A. Each one of these CPT codes represents one of the**
5 **services. Now, these CPT codes for any particular service**
6 **can vary based on, you know, minor differences between the**
7 **way, say, the surgery is performed or the kind of resources**
8 **that might be required in addition.**
9 **Q.** Isn't it a fact, Professor Haas-Wilson, that the
10 21 CPT codes that you or Analysis Group selected represent 6
11 percent of the allowed amounts for Treasure Valley Hospital?
12 **A. What do you mean "of the allowed amounts"?**
13 **Q.** I mean if you looked --
14 **A. The CPT codes of a percent of an allowed amount?**
15 **Q.** You don't understand what I'm referring to?
16 **A. Yeah. I don't understand your denominator.**
17 **Q.** Okay. Well, you understand that when Treasure
18 Valley Hospital submits a claim to an insurer like Blue
19 Cross or Regence, that Blue Cross will pay them a certain
20 negotiated amount; right?
21 **A. That is correct.**
22 **Q.** And that they may also have to collect a copayment
23 or a deductible from a patient; right?
24 **A. That's correct.**
25 **Q.** And do you understand the total amount paid by the

1 insurer plus the copayment or deductible to be known in the
2 health insurance industry as "the allowed amount"?
3 **A. That's correct.**
4 **Q.** So if you add up all of the allowed amounts and
5 you try to -- and you calculate what percent of those are
6 represented by these 21 CPT codes, it's only 6 percent,
7 isn't it?
8 **A. I did not calculate that number.**
9 **Q.** Likewise, you don't have any idea how
10 representative these 21 CPT codes are for either Saint
11 Alphonsus or St. Luke's; right?
12 **A. I know that these CPT codes are performed at**
13 **Saint Al's and St. Luke's.**
14 **Q.** I understand that. But you don't know how
15 representative they are of the -- of the total services
16 provided at either Saint Al's or St. Luke's; correct?
17 **A. I'm pretty sure that the CPT codes provided at**
18 **St. Luke's and Saint Al's, those range of CPT codes would be**
19 **quite similar. So you can look at the comparison between**
20 **St. Luke's and Saint Al's and be pretty sure you're looking**
21 **at a similar range of services.**
22 **Q.** Have you done that analysis, or is that an
23 assumption?
24 **A. That is an assumption.**
25 **Q.** Okay. Now, Professor Haas-Wilson, would you agree

1 that the antitrust laws are not concerned with higher prices
2 unless those prices are above competitive levels or
3 supercompetitive?
4 **A. Market power is the ability to charge prices above**
5 **competitive levels. And that is what the antitrust laws and**
6 **analysis is concerned with, yes.**
7 **Q.** And you haven't done any analysis to demonstrate
8 that any price increase that St. Luke's has implemented was
9 for a supercompetitive or above market level; right?
10 **A. That's correct.**
11 **Q.** And medical services like the ones in slide 52, am
12 I correct that those are what an economist would call
13 "heterogeneous products"?
14 **A. Yes, potentially.**
15 **Q.** And can you explain --
16 **A. By looking -- let me just say, by looking at a**
17 **single CPT code, you're controlling for complexity of the**
18 **service because it's the same CPT code which has a**
19 **particular level of complexity across each of the five**
20 **facilities.**
21 THE COURT: Counsel, just so I'm clear, when you
22 refer to these as being heterogeneous products, you're
23 referring to the 21 CPT codes?
24 MR. STEIN: I'm referring to medical services
25 generally, but I was going to ask the witness to explain

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1 next what heterogeneous means.
2 THE COURT: Bring the dictionary out. I think
3 most of us -- well, go ahead. Maybe it means something
4 different in economic terms, but we will find out. Go
5 ahead, Mr. Stein.
6 BY MR. STEIN:
7 **Q.** What does that mean when you say medical services
8 are heterogeneous products?
9 **A. It means they are differentiated products.**
10 **Q.** Okay. And just to get back to the 21 CPT codes
11 for a second, is it your understanding that when health
12 insurers and payors sit down, that they will sit down, for
13 example, with this list of 21 CPT codes and just go down the
14 list and negotiate each one separately?
15 **A. That's not my understanding of how negotiations**
16 **work.**
17 **Q.** Right. They will sit down and they will
18 negotiate, according to some of the testimony we heard, an
19 overall level of payment or payment increase; right?
20 **A. That's correct.**
21 **Q.** And then that payment increase will be allocated
22 among, in the case of a Saint Al's or a St. Luke's, hundreds
23 or thousands of CPT codes; right?
24 **A. That's correct. They -- they could allocate it**
25 **toward inpatient. They could allocate it toward outpatient.**

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1 **Q.** Right. So if you -- if you cherry-pick a few CPT
2 codes from one provider or another, you're certainly not
3 getting an accurate picture of the overall price levels for
4 that particular provider; right?
5 **A. You're getting an estimate of those price levels.**
6 **Q.** Only if you assume that those 21 CPT codes are
7 representative of all the rest of the CPT codes prices at
8 that hospital, right?
9 **A. Well, again, my thinking is that when you compare**
10 **Luke's to Al's, these 21 CPT codes would be representative**
11 **of the range of services. I mean, not that they cover all**
12 **the services, but they would be, you know -- they would be**
13 **representative to the same extent at either St. Luke's or**
14 **Saint Al's is what I'm trying to say.**
15 **Q.** That's your assumption; correct?
16 **A. That would be my assumption based on what services**
17 **are provided at St. Luke's and what services are provided at**
18 **Saint Al's.**
19 **Q.** With regard to Micron, did you analyze any data to
20 see whether, in fact, the financial incentives in that plan
21 resulted in patients traveling for healthcare services?
22 **A. I relied on the evidence and the testimony and the**
23 **documents.**
24 **Q.** So the answer to my question is: You did not
25 analyze the data yourself; is that correct?

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1 **A. That's correct.**
2 **Q.** And you didn't do any analysis of the data to
3 determine whether implementation of the financial incentives
4 succeeded in moving patients from one tier to another tier;
5 is that right?
6 **A. I -- I relied on the deposition testimony and the**
7 **documents.**
8 **Q.** So just a few more questions on this issue of
9 foreclosure. I want to make sure that I understand your
10 view?
11 MR. STEIN: And we should take this off the
12 screen, Your Honor.
13 THE COURT: Yes.
14 MR. STEIN: Oh, it is off the screen.
15 THE COURT: It is.
16 BY MR. STEIN:
17 **Q.** Professor Haas-Wilson, have you been reading any
18 of the trial testimony as it's been coming in over the last
19 two weeks?
20 **A. I have been reading summaries put together of that**
21 **trial testimony.**
22 **Q.** And is it -- do I understand your testimony to be
23 that Treasure Valley Hospital is at risk as a result of this
24 transaction of being harmed as an effective competitor?
25 **A. The shrinking referral base is likely to harm**

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1 **Treasure Valley Hospital.**
2 **Q.** Let me ask, George, if you could please put up
3 5088-25.
4 Professor Haas-Wilson, this was a demonstrative that
5 was used during the testimony of Mr. Genna of Treasure
6 Valley Hospital that looks at the total cases being done at
7 the Treasure Valley Hospital combined with the Treasure
8 Valley Surgery Center between 2008 and 2012. And there were
9 some annualized numbers for 2013.
10 Let me ask you first: Would you -- would you conclude
11 from the information that's reflected here that these two
12 entities, the Treasure Valley Hospital and the Treasure
13 Valley Surgery Center, are experiencing a decreasing
14 referral base?
15 **A. What I observe in this demonstrative is that the**
16 **total surgical cases are going up. What I can't observe in**
17 **this demonstrative is by how much more they would be going**
18 **up but for -- if the acquisition hadn't occurred.**
19 **Q.** Would it be fair to conclude from the information
20 that's reflected here that, notwithstanding the decrease in
21 procedures by the Saltzer surgeons, these entities were able
22 to go out and compete and obtain additional referrals from
23 alternative sources?
24 **A. The total does suggest that they were able to**
25 **increase the number of surgical cases.**

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1 **Q.** And then if we go to slide 27 from Exhibit 5088,
2 would you characterize these as the financials of a flailing
3 competitor?
4 **A. Again, what I can see from this demonstrative --**
5 **Q.** I'm sorry to interrupt, but this is an area where
6 I would just caution you, if you can avoid it, not to refer
7 to the specific figures; otherwise, I think we'll need to
8 clear the courtroom.
9 MR. ETTINGER: Again, Your Honor, if the witness
10 thinks she needs to refer to it to answer the question --
11 THE COURT: Let me make clear, Dr. Haas-Wilson:
12 If you feel the need to refer to the numbers, we'll clear
13 the courtroom. As I said, there has to be this balance
14 between the public's right to access the courts and the
15 parties' and the nonparties', third parties' interest in
16 preserving confidential and significant essentially trade
17 secrets.
18 So you need to be the guide here or the -- you will be
19 in charge. If you feel the need to refer to numbers, let us
20 know, and we'll clear the courtroom.
21 THE WITNESS: I think I can answer his question.
22 THE COURT: But don't limit yourself. If you feel
23 the need to do it, that's more important. We'll clear the
24 courtroom if need be.
25 Proceed. Go ahead. With that long dialogue or

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1 monologue on my part, perhaps you need to rephrase the
2 question for the witness.
3 BY MR. STEIN:
4 **Q.** Are these the financials of a flailing competitor?
5 **A. These are the financials of a competitor in the**
6 **postacquisition period relative to the preacquisition period**
7 **that show me what was happening to their revenue dollars and**
8 **their net patient revenue per case given the Saltzer**
9 **acquisition.**
10 **What I can't see from this is how different the**
11 **numbers would be at Treasure Valley Hospital if the**
12 **acquisition hadn't taken place. The increase might have**
13 **been even greater had that acquisition not taken place.**
14 **Q.** And does the fact that they might have had done
15 even better than they would absent the acquisition mean that
16 the acquisition is, therefore, anticompetitive?
17 **A. That alone, no.**
18 **Q.** And, Professor Haas-Wilson, the last thing I want
19 to cover to make sure I understand it is this critique you
20 had of -- I think you characterized Dr. Argue's methodology
21 in your attempt to distinguish it from what you did. Do you
22 understand what I'm referring to, generally?
23 **A. Let me just go back a minute to these TVH**
24 **financials. Without giving specific numbers, being**
25 **sensitive that there are others in the room, it's my**

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1 **understanding that TVH is running at a much lower percentage**
2 **capacity than they had been prior to the Saltzer**
3 **acquisition. So there is evidence of harm to TVH.**
4 **And it's also my understanding that, while the**
5 **hospital is doing well, the new surgery center is operating**
6 **at a loss.**
7 **Q.** Let's focus on that for a second. Let's say,
8 hypothetically, a hospital is running at 10 percent
9 capacity, but it is making money hand over fist, it is
10 distributing profits to its investors, its shares are going
11 up every year. Why is the fact that they're operating at a
12 low capacity of concern under the antitrust laws?
13 **A. To the extent they would have been doing even**
14 **better absent the acquisition.**
15 **Q.** And so it's not just a violation of the antitrust
16 laws if Saint Al's Nampa and Treasure Valley Hospital are
17 threatened to be going out of business or not be effective
18 competitors; it's also a violation of the antitrust laws if
19 they're not doing as well financially as they would in the
20 absence of the transaction?
21 **A. That -- that would represent harm.**
22 **Q.** To competition or to the competitors?
23 **A. That would be harm to -- if we're talking about**
24 **TVH doing better absent the transaction, that would be harm**
25 **to TVH, which possibly could mean harm to competition to the**

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1 **extent that TVH is one of the major competitive constraints**
2 **on St. Luke's. So if they were expanding even faster, they**
3 **would be even more of a competitive constraint than they are**
4 **given the acquisition.**
5 **Q.** So the Saltzer transaction is anticompetitive
6 because it makes TVH less of a competitive constraint --
7 strike that.
8 So if the Saltzer transaction results in any loss of
9 business to TVH, it harms competition because it reduces
10 TVH's revenues or makes it more costly for TVH to go out and
11 compete for replacement surgeries; is that fair?
12 **A. I think you're misstating my testimony. I didn't**
13 **say any amount of loss would result in anticompetitive harm.**
14 **That's certainly not what I said.**
15 **Q.** So what is the amount that would result in
16 anticompetitive harm?
17 **A. The amount, certainly, that I showed on some of my**
18 **slides.**
19 **Q.** Meaning, what, 90 -- 90-plus percent?
20 **A. No, no. The loss of Saltzer patients was not**
21 **representative of 90 percent. It was -- I don't remember**
22 **the specific numbers without the exhibits in front of me,**
23 **but for at least one of those outpatient markets that I**
24 **looked at, the loss of Saltzer patients to TVH was certainly**
25 **above what would represent harm in terms of loss of patient**

1 **base.**
2 Q. I'm sorry. Did you say "the loss of Saltzer
3 patients"?
4 A. **Yes. Those charts I was looking at -- no, no, no.**
5 **No. I'm sorry. I misspoke. Can we look at those exhibits**
6 **again?**
7 Q. Sure. 5090, slide 33. This is General -- this is
8 Neuro+Ortho. And I can put up the previous one if you would
9 like; that's General Surgery.
10 A. **This is -- I misspoke just a second ago. So if**
11 **I'm allowed to strike, I would like to strike.**
12 **This is evidence based on the five**
13 **acquired -- well, the neuro is the two acquired specialty**
14 **practices that do the -- those kinds of surgeries, and the**
15 **other one for all outpatient encounters, that would be for**
16 **the full five specialty practices that were acquired.**
17 MR. STEIN: Okay. I have no further questions at
18 this time, Your Honor.
19 THE COURT: Mr. Ettinger.
20 MR. ETTINGER: Your Honor --
21 THE COURT: Counsel, just so you know, I have to
22 leave right at noon. I have a meeting already that's
23 already under way. And I am hearing grumbling that I'm not
24 there now.
25 MR. ETTINGER: Your Honor, I am going to be very

1 fast. Certainly --
2 THE COURT: I don't mean to preclude you from
3 wrapping this up. The problem is we're not going to be back
4 in session until Monday morning.
5 MR. ETTINGER: Oh, I intend to wrap it up. I
6 don't think the witness will be very happy with me if she
7 has to come back, Your Honor.
8 THE COURT: Boise is lovely this time of year.
9 THE WITNESS: It's far away from Massachusetts.
10 THE COURT: That's true. Western Mass is also
11 beautiful this time of year, probably more so with the
12 leaves changing.
13 Go ahead.
14 THE WITNESS: You should see our fall colors.
15 MR. ETTINGER: Would you pull up paragraph 47 of
16 Professor Haas-Wilson's declaration, Ms. Duke.
17 REDIRECT EXAMINATION
18 BY MR. ETTINGER:
19 Q. Professor Haas-Wilson, Mr. Stein asked you about
20 paragraph 43 of your declaration regarding efficiencies. I
21 just want to show you one --
22 MS. DUKE: Your Honor, we can put that on the --
23 THE COURT: Thank you.
24 BY MR. ETTINGER:
25 Q. I'm sorry. Paragraph 46; I misspoke. I want to

1 show you three paragraphs later in the same section.
2 Did you, in fact, say in your conclusion to this
3 section, quote, "There is no evidence that hospital
4 ownership of physician practices is necessary to achieve
5 efficiencies," close quote?
6 A. **Yes, that is what I wrote.**
7 Q. Mr. Stein also showed you some language from
8 Chapter 7 of your book on the effects of vertical
9 consolidation.
10 MS. DUKE: Your Honor, can you switch over to the
11 ELMO?
12 MR. ETTINGER: Since we don't have this read in,
13 we're going to put it on the ELMO, but I think we want it
14 facing the other way, turned over. All these young kids
15 don't know how to use old technology, Your Honor.
16 MS. DUKE: Right. It's crazy.
17 THE COURT: I thought you were trying to show me
18 the comments by all of the --
19 BY MR. ETTINGER:
20 Q. Let me try to -- is this the last paragraph of
21 Chapter 7 of your book, Professor Haas-Wilson?
22 A. **Yes. The chapter on vertical, yes.**
23 Q. And looking at that last paragraph conclusion, do
24 you say there that "It must be determined for each
25 individual case whether a particular vertical consolidation

1 among healthcare firms will make consumers better or worse
2 off"?
3 A. **That's exactly what I wrote, and that is my**
4 **opinion.**
5 THE COURT: Could you leave it on for one -- I'm
6 not sure what "Chicago Skull Blinders" are, but I won't ask
7 since you have limited time. Go ahead. Although I can
8 guess.
9 MR. ETTINGER: If it weren't so tight, Your Honor,
10 I would let her bash the Chicago school.
11 If we could put 1673 and 1674 up very quickly. We can
12 start with -- I want to go from one to the other.
13 BY MR. ETTINGER:
14 Q. Mr. Stein asked you about 1673, about patients
15 with an office visit to a SAMG PCP. Do you recall that,
16 Professor Haas-Wilson? And you have that in the binder
17 Mr. Stein gave you, as well.
18 A. **May I look at it in that? Because I'm having**
19 **trouble seeing it.**
20 Q. Sure.
21 A. **Do you happen to know --**
22 Q. 1673 is the tab.
23 THE COURT: Possibly the large binder.
24 THE WITNESS: It's the one I happen to be at.
25 Okay.

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1 BY MR. ETTINGER:
2 **Q.** And this is cases patients with an office visit to
3 a SAMG PCP and what happened to their cases at Saint Al's.
4 Do you recall being asked about that by Mr. Stein?
5 **A. I do.**
6 **Q.** And look at 1674. Is that patients without an
7 office visit to a SAMG PCP?
8 **A. Yes. That's sensitivity was for only patients who**
9 **had not had an office visit to a SAMG PCP up to 12 months**
10 **prior.**
11 **Q.** Now, Mr. Stein showed you information on Idaho
12 Cardiothoracic and Vascular Associates in particular, did he
13 not?
14 **A. Yes, he did.**
15 **Q.** And do you see there, for patients with a SAMG
16 PCP, their business to -- at Saint Al's went from 56 percent
17 to zero and at St. Luke's from 43 percent to 100 percent?
18 **A. Yes.**
19 **Q.** And if you look at 1674, patients without an
20 office visit to a SAMG PCP, do you see for Idaho
21 Cardiothoracic and Vascular Associates that the cases at
22 Saint Al's went from 31 percent to zero and at St. Luke's
23 from 69 percent to 100 percent?
24 **A. Yes, I do.**
25 **Q.** And so is the pattern you saw for this group as

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1 well as in total the same or different depending on whether
2 the patient had a SAMG PCP?
3 **A. The pattern is the same.**
4 **Q.** And what do you conclude from that?
5 **A. That the expert economist for the hospital, for**
6 **St. Luke's, their alternative explanation cannot explain the**
7 **drop in admissions at Saint Al's.**
8 MR. ETTINGER: No further questions. Thank you.
9 THE COURT: Any recross?
10 MR. STEIN: None, Your Honor.
11 THE COURT: All right. Dr. Haas-Smith [sic],
12 thank you for being here. You will be excused.
13 Plaintiffs, we have ten minutes.
14 MR. POWERS: Your Honor, we have got Dr. Williams
15 here, and we intend to call him as our next witness. Would
16 you like us to start now?
17 THE COURT: Yes, if we can use the ten minutes.
18 Well, Counsel, let me -- let's find out where we are. I
19 know there was a concern on the part of St. Luke's about not
20 concluding the plaintiffs' case today. Have we worked out
21 the timing?
22 If we could recess now and start at 8:30 on Monday and
23 still keep everybody happy, I'm more than delighted to do
24 that.
25 MR. POWERS: Your Honor, the problem we have with

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1 Dr. Williams is if -- we planned on him getting on this
2 morning, realizing the court needed to stop at 12:00. We
3 are going to have to reschedule him probably to a similar
4 time like Dr. Curran next week in the plaintiffs' case.
5 THE COURT: Well, but we can wrap him up in ten
6 minutes?
7 MR. POWERS: We can't do him in ten. We can do
8 him in 20.
9 THE COURT: I can't. I apologize, but we're in a
10 budget crisis.
11 MR. POWERS: I understand, Judge. I'm not
12 complaining. I just -- however you want to do it, Judge.
13 We can start him or we can -- we can bring him back and do
14 him all at once probably next Friday afternoon.
15 THE COURT: I think it would be make more sense to
16 do him all at once. But defendants -- Mr. Bierig.
17 MR. BIERIG: Your Honor, we would prefer that they
18 put on their case Monday morning, if that's possible, so
19 that we can start and have an uninterrupted presentation.
20 MR. POWERS: I can't get Dr. Williams here Monday
21 morning. It's his surgery --
22 THE COURT: As I indicated throughout the trial,
23 there are times when we're just going to have to interrupt.
24 I have allowed obviously St. Luke's to do that by way of
25 conducting direct examination during their cross. Likewise,

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1 I will require we do it at a time that is not disruptive of
2 a witness of St. Luke's, so you'll need to coordinate that.
3 But I would rather hear the testimony all at once.
4 Because if I hear part of it now and part of it next Friday,
5 I will never be able to connect the two very easily. Why
6 don't we just recess, then, until Monday morning.
7 Counsel, I would again encourage you to work out issues
8 concerning depositions so that I could perhaps just --
9 Ms. Gearhart, would you publish very quickly the
10 depositions that we have already alluded to or read into the
11 record.
12 THE CLERK: The depositions of Jeff Taylor, Peter
13 LaFleur, Gary Fletcher, Jim Souza, Erik Heggland, and Jon
14 Schott are published.
15 (Depositions of Jeff Taylor, Peter LaFleur,
16 Gary Fletcher, Jim Souza, Erik Heggland, and
17 Jon Schott published.)
18 THE COURT: Now, Mr. Bierig?
19 MR. BIERIG: Yes. I just wanted to inquire of the
20 court whether the plan is for us to begin, that is
21 defendants to begin, at 8:30 or whether they're planning to
22 put on their video depositions in the morning.
23 THE COURT: That's why I was inquiring. If you
24 can work out where I can watch the video depositions -- if I
25 had them by tomorrow, I could review them all over the

1 weekend.
2 MS. DUKE: That's what Mr. Stein and I were
3 discussing. And we're going to try to coordinate a way to
4 get an FTP site up and going for you so that you could do
5 that with the depositions that are remaining.
6 THE COURT: However you work it out with the
7 technology is fine. The only thing is make sure that I have
8 access to the exhibits that are being referred to because
9 the exhibit numbers don't match to the trial exhibits.
10 MS. DUKE: Right.
11 THE COURT: And I don't have time to try to figure
12 that out.
13 MS. DUKE: Yes.
14 MR. BIERIG: Then, Your Honor, our understanding
15 is 8:30, we will begin our case Monday morning.
16 MR. ETTINGER: Your Honor, we may have some issues
17 with exhibits to deal with, and we can maybe try to do that
18 offline, but we're not ready to close our case quite yet.
19 THE COURT: I'm not -- you know, I certainly think
20 the defendants can -- can begin even if there is still
21 some -- I think it's more of a question of scheduling than
22 closing. But my sense is that you will be able to start
23 with some cleanup matters that you can work out over the
24 weekend.
25 I'll be accessible through Mr. Metcalf. If any issue

1 arises that I need to resolve, he will have my cell phone
2 number, and I can be available anytime over the weekend.
3 And tomorrow I'm at our district conference along with
4 Mr. Sinclair in Coeur d'Alene tomorrow and will make myself
5 available for that. All right?
6 MR. BIERIG: Thank you, Your Honor.
7 THE COURT: We'll be in recess.
8 (Court recessed at 11:53 a.m.)
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1 REPORTER'S CERTIFICATE
2
3
4
5 I, Tamara I. Hohenleitner, Official
6 Court Reporter, County of Ada, State of Idaho,
7 hereby certify:
8 That I am the reporter who transcribed
9 the proceedings had in the above-entitled action
10 in machine shorthand and thereafter the same was
11 reduced into typewriting under my direct
12 supervision; and
13 That the foregoing transcript contains a
14 full, true, and accurate record of the proceedings
15 had in the above and foregoing cause, which was
16 heard at Boise, Idaho.
17 IN WITNESS WHEREOF, I have hereunto set
18 my hand October 4, 2013.
19
20
21
22 -s-
Tamara I. Hohenleitner
23 Official Court Reporter
CSR No. 619
24
25