

# **EXHIBIT A**

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SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF WESTCHESTER

FILED

APR 30 2001

LEONARD N. SPANO  
COUNTY CLERK

Index No. 96/20517  
COUNTY OF WESTCHESTER

VICKI LOGAN, VIRGINIA A. )  
PHILO, DEBORAH A. SCHEID, )  
GEORGE NIJBOER, JAMES MARINO )  
And DANNY LICUL, )

Plaintiffs, )

vs. )

EMPIRE BLUE CROSS )  
AND BLUE SHIELD, )

Defendant. )  
-----)

VIDEOTAPED DEPOSITION OF

DR. RICHARD SANCHEZ, M.D.

New York, New York

Tuesday, February 23, 1999

Reported by:  
ERICA L. RUGGIERI, RPR  
JOB NO. 86606

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February 23, 1999  
10:17 a.m.

Videotaped Deposition of DR. RICHARD SANCHEZ, M.D., held at the offices of Esquire Deposition Services, 216 East 45th Street, New York, New York, pursuant to Notice, before Erica L. Ruggieri, RPR and Notary Public of the State of New York.

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IT IS HEREBY STIPULATED AND AGREED, by and between the attorneys for the respective parties herein, that filing and sealing be and the same are hereby waived.

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be sworn to and signed before any officer authorized to administer an oath, with the same force and effect as if signed and sworn to before the Court.

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APPEARANCES:

ELKIND, FLYNN & MAURER, P.C.  
Attorneys for Plaintiffs  
11 Martine Avenue  
White Plains, New York 10606  
BY: IRA M. MAURER, ESQ.

PLUNKETT & JAFFE, P.C.  
Attorneys for Defendant  
230 Park Avenue  
New York, New York 10169  
BY: JUSTIN E. DRISCOLL, III, ESQ.

ALSO PRESENT:

MICHAEL FLYNN, ESQ., Elkind, Flynn & Maurer  
MARC T. WIETZKE, ESQ., Elkind, Flynn & Maurer  
JEFFREY CHANCELER, Empire Blue Cross/Blue Shield  
DANIEL HOLMSTOCK, Certified Legal  
Video Specialist

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(Plaintiffs' Sanchez Exhibit 1, copies of personnel file, marked for identification, as of this date.)

THE VIDEOGRAPHER: This is tape No. 1 of the videotape deposition of Dr. Richard Sanchez, M.D., taken by plaintiffs in the matter Vicki Logan, et. al., Plaintiffs, against Empire Blue Cross/Blue Shield, Defendants, in the Supreme Court of the State of New York, County of Westchester, No. 96/20517.

This deposition is being held at the offices of Esquire Deposition Services at 216 East 45th Street, New York, New York on February 23, 1999 at approximately 10:17 a.m..

My name is Daniel Holmstock. I'm from the firm of Esquire Video Services and I am the certified legal video specialist. The court reporter is Mrs. Erica Ruggieri in association with Esquire Deposition Services.

For the record, will counsel please introduce themselves.

1  
 2 MR. MAURER: This is Ira Maurer from  
 3 the law firm of Elkind, Flynn & Maurer  
 4 representing the plaintiffs in this case.  
 5 MR. DRISCOLL: My name is Justin  
 6 Driscoll on behalf of Plunkett & Jaffe,  
 7 P.C., attorneys for Empire Blue Cross/Blue  
 8 Shield.  
 9 THE VIDEOGRAPHER: Will the court  
 10 reporter please swear in the witness.  
 11 RICHARD SANCHEZ, called as a  
 12 witness, having been duly sworn by a Notary  
 13 Public, was examined and testified as  
 14 follows:  
 15 EXAMINATION BY  
 16 MR. MAURER:  
 17 MR. MAURER: All set,  
 18 Mr. Videographer?  
 19 THE VIDEOGRAPHER: All yours.  
 20 Q. Good morning, Dr. Sanchez.  
 21 A. Good morning.  
 22 Q. As you know, my name is Ira Maurer and  
 23 I represent six plaintiffs in a lawsuit that's  
 24 pending in the State Supreme Court in Westchester  
 25 County, New York, who commenced an action against

1 R. Sanchez, M.D.  
 2 Empire Blue Cross/Blue Shield.  
 3 I have asked you to come here today so  
 4 we can ask you some questions to determine what  
 5 you know factually that's relevant to the case.  
 6 Please listen to the questions  
 7 carefully. Wait until we finish our question  
 8 before you start to answer because it's hard for  
 9 the court reporter to take us down speaking  
 10 simultaneously.  
 11 If there's anything that you don't  
 12 understand, please let us know and we'll be happy  
 13 to rephrase or repeat the question.  
 14 Please keep the volume of your voice  
 15 up so we get it clear on the videotape.  
 16 If you need a break for any reason  
 17 because your beeper beeps or you need a visit  
 18 outside to another location for a moment, let us  
 19 know and we will stop.  
 20 A. Understood.  
 21 Q. Could you please tell me your  
 22 educational background, sir?  
 23 A. I went to public schools in Arizona.  
 24 I attended the University of Arizona where I  
 25 received my bachelor of science degree.

1 R. Sanchez, M.D.  
 2 I then went to medical school at the  
 3 University of California, San Francisco, where I  
 4 received my M.D. in 1969.  
 5 I went on to do a three-year pediatric  
 6 residency and internship at Children's Hospital  
 7 of Los Angeles.  
 8 I subsequently received my M.P.H. from  
 9 the University of California, Berkeley, that's a  
 10 Master's in public health. I attended the  
 11 business school at the University of California,  
 12 Irvine.  
 13 I attended one year of law school at  
 14 San Francisco Law School in San Francisco.  
 15 Q. When you did you attend law school,  
 16 Dr. Sanchez?  
 17 A. It was in the late 1980s, in the  
 18 evenings, for a year and a half.  
 19 Q. You did not finish that course?  
 20 A. No, sir.  
 21 Q. Doctor, let me show you what we marked  
 22 before starting the deposition as Plaintiffs'  
 23 Sanchez 1 for identification (handing.)  
 24 Would you be kind enough to look  
 25 through the stack of documents while we go off

1 R. Sanchez, M.D.  
 2 tape and then I'll have some questions for you,  
 3 please.  
 4 MR. MAURER: Off tape.  
 5 THE VIDEOGRAPHER: The time is 10:21  
 6 a.m. and we are going off the record.  
 7 (Witness reviews documents.)  
 8 MR. MAURER: Off the record.  
 9 (Whereupon, there is an off-the-record  
 10 discussion.)  
 11 THE WITNESS: Okay.  
 12 MR. MAURER: On tape.  
 13 THE VIDEOGRAPHER: The time is 10:22  
 14 a.m.. We are back on the record.  
 15 BY MR. MAURER:  
 16 Q. Dr. Sanchez, have you had a chance  
 17 while we were off tape to look through this pile  
 18 of documents marked as Sanchez 1 for ID?  
 19 A. Yes, sir.  
 20 Q. Can you identify what that particular  
 21 exhibit is?  
 22 A. It appears to be copies of my  
 23 personnel file.  
 24 Q. Does that personnel file include a  
 25 copy of your resume as it was current as of the

1 R. Sanchez, M.D.  
 2 time that you submitted it to Empire Blue  
 3 Cross/Blue Shield when you were applying for  
 4 employment with that company?  
 5 A. Yes, it does.  
 6 Q. Could I have the exhibit back, sir.  
 7 (Handing.)  
 8 Q. After you completed your education,  
 9 except for any courses you took while you were  
 10 working, could you please tell us going furthest  
 11 back in time and working forward your history of  
 12 employment?  
 13 A. I practiced -- I did an ambulatory  
 14 fellowship at San Francisco General Hospital in  
 15 1976 and assumed a junior faculty position there  
 16 for a few months and then began a private  
 17 practice of pediatrics that I continued up until  
 18 the late 1980s in San Francisco at Saint Luke's  
 19 Hospital.  
 20 In 1985 the mayor of San Francisco  
 21 appointed me health commissioner of San  
 22 Francisco, a position I held for seven years  
 23 until 1992, and in 1991-'92, I took a position  
 24 with FHP as the medical director for Northern  
 25 California.

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1 R. Sanchez, M.D.  
 2 Q. What is FHP short for?  
 3 A. It's like IBM, it kind of becomes  
 4 FHP. Used to be Family Health Plan when HMO was  
 5 first created in the '70s in California. Now,  
 6 it's HFH. Assumed the position of medical  
 7 director and held that position until coming to  
 8 Empire in 1995. I was eventually the vice  
 9 president of medical affairs and that was  
 10 involvement for all of California for FHP and the  
 11 merger of FHP and Take Care which is another  
 12 large HMO that merged.  
 13 Q. Doctor, are you familiar with the term  
 14 managed care or managed health care?  
 15 A. Yes.  
 16 Q. What is your understanding of the  
 17 term?  
 18 A. Managed care refers to the insurance  
 19 company's or health care provider's activity in  
 20 scrutinizing and assuring health care services to  
 21 its members.  
 22 Q. Generally speaking, when an insurance  
 23 company sells a managed care product to an  
 24 insured does this involve the insurance company  
 25 more in the decision-making process associated

1 R. Sanchez, M.D.  
 2 with evaluation and treatment of the insured?  
 3 MR. DRISCOLL: Objection. Off tape.  
 4 THE VIDEOGRAPHER: The time is 10:26  
 5 a.m.. We are going off the record.  
 6 MR. DRISCOLL: Your objection is just  
 7 leading.  
 8 THE VIDEOGRAPHER: The time is 10:26  
 9 a.m.. We are back on the record.  
 10 BY MR. MAURER:  
 11 Q. Doctor, are you familiar with  
 12 indemnity products that are sold by health  
 13 insurance companies?  
 14 A. Yes.  
 15 Q. Generally speaking, what is an  
 16 indemnity product?  
 17 A. Indemnity product is where either the  
 18 member or the employer pays a premium for that  
 19 employee to access health care services willingly  
 20 anywhere, and there is an awful lot of choice  
 21 involved, there is no constriction of network,  
 22 there's no real UM, utilization management, or  
 23 managed care component to an indemnity product.  
 24 Q. Does the insurance company make any  
 25 decisions regarding the insured's health care in

13

1 R. Sanchez, M.D.  
 2 performing its duties under the plan when you  
 3 have an indemnity plan generally?  
 4 A. Indemnity plans can be underwritten or  
 5 historically underwritten so that there can be in  
 6 some states, in some municipalities, an  
 7 assessment of the health insured's risk.  
 8 Q. What is the difference, generally,  
 9 between an indemnity product and a managed care  
 10 product in layman's terms?  
 11 A. Cost and choice.  
 12 Q. What do you mean?  
 13 A. The indemnity products are much more  
 14 expensive than the managed care products because  
 15 in the long run they cost the insurance company  
 16 more money.  
 17 Choice, the member has much more  
 18 choice in an indemnity product because there's no  
 19 limitation to seek contracted network providers  
 20 or facilities. So an indemnity member would pay  
 21 more money for that product and have more  
 22 choice.  
 23 A managed care member would have less  
 24 premium dollar paid by the member or the employer  
 25 and have less choice.

1 R. Sanchez, M.D.  
 2 Q. Why is it called an indemnity product?  
 3 A. I'm not sure of the derivation of the  
 4 word indemnity.  
 5 Q. Does the insurance company with an  
 6 indemnity product indemnify the insured for  
 7 medical expenses?  
 8 A. Of course.  
 9 Q. Okay. Now, do you have any employment  
 10 history or background prior to your employment  
 11 with Empire Blue Cross/Blue Shield which involved  
 12 you with managed care?  
 13 A. Yes.  
 14 Q. Could you tell us what your background  
 15 is in that regard, please.  
 16 A. My background in managed care started  
 17 in 1982 or '83 when I formed the San Francisco  
 18 IPA, a network of physicians, to contract with  
 19 managed care companies in San Francisco. In  
 20 practice, I was a contractor to many managed care  
 21 organizations. And from 1991-'92 to 1995, before  
 22 I joined FHP, I was vice president of medical  
 23 affairs for FHP, one of the largest Medicare and  
 24 HMOs in the country.  
 25 Q. You mean before you joined Blue

1 R. Sanchez, M.D.  
 2 in your experience?  
 3 A. There was a time in this country when  
 4 the managed care products were very profitable.  
 5 There was also a time in this country where the  
 6 indemnity products were very profitable. So the  
 7 question depends on the timing of the products.  
 8 Q. Let's focus you on 1995, can you  
 9 answer the question based on that year?  
 10 A. In 1995 HMOs throughout the country  
 11 were enjoying an immense amount of profitability.  
 12 Q. That means in comparing managed care  
 13 to indemnity products, which was more profitable  
 14 at that time?  
 15 A. I'm not an indemnity industry expert  
 16 and I don't want to imply that this morning. The  
 17 companies that I was involved in in managed care  
 18 were profitable and there was an awful lot of  
 19 profit taken by the managed care companies  
 20 throughout the '90s, early '90s to the mid-'90s.  
 21 Q. Okay. What were the circumstances of  
 22 your coming to work for Empire Blue Cross/Blue  
 23 Shield?  
 24 A. I was recruited by an executive search  
 25 firm to apply and come to New York and interview

1 R. Sanchez, M.D.  
 2 Cross/Blue Shield?  
 3 A. I'm sorry, before I joined Blue  
 4 Cross/Blue Shield.  
 5 Q. That's Empire Blue Cross/Blue Shield  
 6 of New York?  
 7 A. Correct.  
 8 Q. When it comes to Blue Cross/Blue  
 9 Shield, are there many different Blue Cross/Blue  
 10 Shields around the country?  
 11 A. Oh, yes.  
 12 Q. Are they set up by state? How is it  
 13 set up?  
 14 A. They are set up by regions and  
 15 geography. There's been a lot of merging of  
 16 them. The first thing that occurred is the Blue  
 17 Cross and Blue Shield organizations merged and  
 18 then they set up, there's an umbrella  
 19 organization that provides some oversight over  
 20 the individual Blue Cross/Blue Shield plans.  
 21 Q. Just going back to the comparison I  
 22 was asking you to make between managed care  
 23 products and indemnity products, is one type of  
 24 product more profitable for the insurance  
 25 industry than another type of product, generally,

1 R. Sanchez, M.D.  
 2 for the position and investigate the  
 3 possibilities of me joining the company.  
 4 Q. Your personnel file, which we marked  
 5 as Exhibit 1 for identification, contains a job  
 6 description for the job that you took with Empire  
 7 Blue Cross/Blue Shield which was chief medical  
 8 executive and vice president; is that correct?  
 9 A. Chief medical executive and senior  
 10 vice president.  
 11 Q. Was the position description contained  
 12 in your personnel file, it's three pages in  
 13 length, accurate in terms of what you did at  
 14 Empire when you first went to the company?  
 15 Why don't we go off tape and you can  
 16 take a look at those pages for a moment.  
 17 MR. MAURER: Off tape.  
 18 THE VIDEOGRAPHER: The time is 10:30  
 19 a.m. and we are going off the record.  
 20 (Witness reviews documents.)  
 21 MR. MAURER: On tape, please.  
 22 THE VIDEOGRAPHER: The time is 10:33  
 23 a.m.. We are back on the record.  
 24 BY MR. MAURER:  
 25 Q. Have you had a chance to look at the

1 R. Sanchez, M.D.  
 2 three pages, Doctor?  
 3 A. Correct.  
 4 Q. Is this job description an accurate  
 5 description of the position you took at Empire  
 6 Blue Cross/Blue Shield when you first went there  
 7 to work?  
 8 A. Yes.  
 9 Q. Could I have the documents, please.  
 10 (Handing.)  
 11 Q. Thank you.  
 12 Before you were hired did you meet  
 13 with anyone at Empire Blue Cross/Blue Shield?  
 14 A. Yes.  
 15 Q. Who did you meet with?  
 16 A. I met with Heyward Donigan.  
 17 Q. Who was that?  
 18 A. She is also a senior vice president  
 19 and she was also in charge of the managed care  
 20 for Empire Blue Cross/Blue Shield.  
 21 Q. In the management hierarchy at the  
 22 company where was she in relation to the top of  
 23 the pyramid?  
 24 A. She was at the right hand of the CEO  
 25 of Empire Blue Cross/Blue Shield.

1 R. Sanchez, M.D.  
 2 Q. You met with all those individuals  
 3 before you were hired?  
 4 A. More than once, yes.  
 5 Q. How many times did you meet with the  
 6 chief executive officer and president,  
 7 Dr. Michael Stocker?  
 8 A. I met with Heyward Donigan two or  
 9 three times and I met with Dr. Stocker once or  
 10 twice.  
 11 Q. Did you request any of those meetings  
 12 with Dr. Stocker?  
 13 A. Well, I think that the first one I  
 14 think, as I remember, I was introduced when I  
 15 came to visit and interview there. The second  
 16 one I requested to have a more lengthy discussion  
 17 of my responsibilities and title.  
 18 Q. Did you have to go before the board of  
 19 directors before you were hired?  
 20 A. I didn't have to go to the board. I  
 21 was introduced once I had been selected. The  
 22 board had to approve my position and my salary  
 23 because it was -- it exceeded what they had  
 24 expected to pay for the position and the  
 25 compensation package and it required board

19  
 1 R. Sanchez, M.D.  
 2 Q. Who was that?  
 3 A. The CEO of Empire Blue Cross/Blue  
 4 Shield at the time was Michael Stocker.  
 5 Q. Dr. Michael Stocker?  
 6 A. Yes.  
 7 Q. He was also the president at the time?  
 8 A. I believe that's his title.  
 9 Q. You met with Heyward Donigan. Who  
 10 else did you meet with?  
 11 A. Michael Stocker, Linda Tufo, Michael  
 12 Kent, Gloria Macarthy, Dr. Zemansky. It was a  
 13 battery of people.  
 14 Q. Could you go back, please, and just  
 15 tell us who these people were, what their  
 16 positions were with the company?  
 17 A. Michael Kent was senior vice president  
 18 in charge of human resources. Linda Tufo was  
 19 vice president of human resources in charge of  
 20 managed care. Gloria Macarthy was senior vice  
 21 president in charge of operations. Dr. Martin  
 22 Zemansky, I think is his first name, was the  
 23 acting chief medical officer in Albany. I met  
 24 with -- those are the ones I can recall right off.  
 25 the top of my head.

21  
 1 R. Sanchez, M.D.  
 2 approval.  
 3 Q. I apologize for the intrusion. What  
 4 was the nature of the compensation package that  
 5 you received to go to Empire Blue Cross/Blue  
 6 Shield?  
 7 A. It was a base salary, plus an  
 8 incentive bonus, plus a moving reimbursement  
 9 package and plus an agreement to either purchase  
 10 or sell my home in San Francisco.  
 11 Q. What was the base salary when you  
 12 went?  
 13 A. It wasn't that -- 250,000, I think was  
 14 the base salary and the bonus with the incentive  
 15 compensation was 40 percent of that and the  
 16 relocation package was under 75,000 and the  
 17 agreement to sell the house in San Francisco was  
 18 1.2 million.  
 19 Q. Before you accepted the position and  
 20 were offered the position were you given any  
 21 materials to read by anyone at Empire?  
 22 A. Yes.  
 23 Q. What kind of materials were you given  
 24 to read before you were hired?  
 25 A. The usual personnel and HR collaterals

1 R. Sanchez, M.D.  
 2 and materials.  
 3 Q. What's HR?  
 4 A. Human resources.  
 5 Q. Okay.  
 6 A. Dealing with investment and retirement  
 7 and those kinds of things. In addition, I was  
 8 given copies of two committee or investigative  
 9 reports done on Empire over the preceding four,  
 10 five years. One was by the Nunn commission, as I  
 11 remember, by the Nunn's committee investigating  
 12 all Blue Cross plans in the country and the other  
 13 one was, I think more specific to New York. I  
 14 don't recall the name of them now but there were  
 15 two of them.  
 16 Q. With regard to the Nunn, are you  
 17 referring to Senator Sam Nunn?  
 18 A. Correct.  
 19 Q. That report was a report of his  
 20 subcommittee of the senate?  
 21 A. Yes.  
 22 Q. The other report you said you thought  
 23 was more focused on New York in some way?  
 24 A. Well, as I remember it, and I don't  
 25 recall it, I may have it at home, but it had to

1 R. Sanchez, M.D.  
 2 do, it seemed to me to be more of an attorney  
 3 general or department of insurance review of the  
 4 policies and procedures and activities of Empire  
 5 preceding 1995.  
 6 Q. What do you recall learning from  
 7 reading, first the Nunn report, about the  
 8 activities reported of Empire?  
 9 A. I don't think I can separate from  
 10 where I received what my impression was between  
 11 the two reports so I don't want to try.  
 12 Q. Please just tell me what you can  
 13 recall from both combined as you recall?  
 14 A. I think both reports provided for me  
 15 to have a clear understanding of what I was  
 16 getting into.  
 17 Q. What was the understanding that you  
 18 obtained after looking at those two reports?  
 19 A. That the company had been terribly  
 20 mismanaged and almost criminally mismanaged.  
 21 Q. Why did that become your impression  
 22 after reading the reports? What was there in the  
 23 reports you remember reading that led you to that  
 24 conclusion?  
 25 A. It's absolutely clear that the company

1 R. Sanchez, M.D.  
 2 was mismanaged from a policy point of view, from  
 3 a fiscal point of view. There was very clearly  
 4 some criminal activity that occurred and there  
 5 was fines levied and paid by Empire to  
 6 reestablish its ability to do business in New  
 7 York.  
 8 Q. Was there any reference in either of  
 9 these reports to complaints filed by insureds of  
 10 the company?  
 11 A. Yes.  
 12 Q. With the insurance department in the  
 13 State of New York?  
 14 A. Yes.  
 15 Q. Did the reports indicate any sort of  
 16 quantity of those complaints?  
 17 A. Well, I don't remember the numbers but  
 18 there were an awful large number putting them --  
 19 exceeding other insurers in New York State and  
 20 the level was very high and that was one of the  
 21 things that the committee wanted to address.  
 22 At the end of the report came  
 23 recommendations and settlements and those kinds  
 24 of things and that was one of the issues that  
 25 Empire was going to address as well as the other

1 R. Sanchez, M.D.  
 2 activities that were pointed out in the report.  
 3 Q. I believe you made mention of a fine  
 4 of some sort, what were you referring to?  
 5 A. The Empire Blue Cross had to settle  
 6 with the department of insurance in New York or  
 7 pay a fine for claims issues over the preceding  
 8 half dozen years.  
 9 Q. What was the amount of the fine as  
 10 best you can recall it?  
 11 A. It was approximately a million dollars  
 12 as best I can recall it.  
 13 Q. You also indicated in your earlier  
 14 response some reference to there being evidence  
 15 of criminal conduct in the reports. What were  
 16 you referring to, Dr. Sanchez?  
 17 A. The committee or investigative body  
 18 that had prepared these reports found evidence  
 19 that there was two sets of books kept, financial  
 20 books that were kept and maintained and given to  
 21 regulatory officials and the others reflecting  
 22 the true state of Empire's financial situation.  
 23 Q. Did you learn why those two sets of  
 24 books were maintained by Empire?  
 25 A. No, I never got to talk to the people



1 R. Sanchez, M.D.  
 2 that maintained them.  
 3 Q. Were the two sets of books maintained,  
 4 if you know, for use in making requests for rate  
 5 increases from the State of New York?  
 6 A. They were used, to the best of my  
 7 knowledge, to misrepresent the financial status  
 8 of Empire, either for rate increases or for other  
 9 considerations.  
 10 Q. Was there any reference in the reports  
 11 to any excessiveness in expenditures that took  
 12 place as reported in the report?  
 13 MR. DRISCOLL: Objection. Off tape.  
 14 THE VIDEOGRAPHER: The time is 10:43  
 15 a.m.. We are going off the record.  
 16 MR. DRISCOLL: I object to the leading  
 17 nature of the question.  
 18 THE WITNESS: I'm going to get a  
 19 coffee while you are objecting.  
 20 MR. MAURER: Okay.  
 21 (Whereupon, there is an off-the-record  
 22 discussion.)  
 23 THE VIDEOGRAPHER: The time is 10:44  
 24 a.m.. We are back on the record.  
 25 BY MR. MAURER:

27

1 R. Sanchez, M.D.  
 2 Q. Doctor, did either of the reports you  
 3 reviewed prior to commencing employment with  
 4 Empire make any reference to expenditures at the  
 5 company?  
 6 A. The report was -- yes.  
 7 Q. How was there a reference made to  
 8 expenditures of Empire Blue Cross/Blue Shield?  
 9 A. The report spent a good portion of its  
 10 content revealing what they considered to be  
 11 exorbitant expenditures by the executives of Blue  
 12 Cross/Blue Shield in their day-to-day conduct of  
 13 business.  
 14 Q. Doctor, when were you hired by Empire?  
 15 A. In the spring of 1995.  
 16 Q. When did you actually start work?  
 17 A. In May of 1995.  
 18 Q. Now, according to the position  
 19 description for the chief medical officer  
 20 position you took at Empire, it indicates on the  
 21 first page under Roman numeral one, the chief  
 22 medical officer will facilitate the medical  
 23 management activities to insure that performance  
 24 goals for 1995 are attained. These include --  
 25 Before I get into what it includes,

1 R. Sanchez, M.D.  
 2 what does it mean to "facilitate the medical  
 3 management activities"?  
 4 A. I interpret that as to manage the  
 5 personnel policies and procedures of medical  
 6 management within the company.  
 7 Q. The list then makes reference to the  
 8 following things that were included. Under Roman  
 9 number one, "Establish and achieve corporate  
 10 utilization management targets."  
 11 What's that mean in layman's terms?  
 12 A. That means that the senior staff of  
 13 Empire Blue Cross/Blue Shield would approve  
 14 utilization targets regarding the cost of health  
 15 care and utilization of health care and it would  
 16 be my responsibility to make sure that we met  
 17 those targets.  
 18 Q. Next bulleted item says, "Develop and  
 19 manage catastrophic case management." What does  
 20 that mean?  
 21 A. That refers to the more intense and  
 22 focused management activities, cost of health  
 23 care and utilization and quality of health care  
 24 management focus, on members that have  
 25 catastrophic diseases and high expense costs.

29

1 R. Sanchez, M.D.  
 2 Q. Next item is "develop and manage  
 3 outpatient focused review." What does that mean?  
 4 A. That has to do with trying to bring  
 5 some standardized policies, procedures and  
 6 control of health care costs throughout patient  
 7 services. Those are services delivered in  
 8 doctors' offices and other facilities besides  
 9 hospitals.  
 10 Q. The next item is, "Assure that quality  
 11 assurance goals are met." What is quality  
 12 assurance mean as used in that context?  
 13 A. Quality assurance has to do with  
 14 insuring that the company in its, oversees its  
 15 provider network to assure that members are  
 16 receiving quality health care and sets up  
 17 policies and procedures that are documented by an  
 18 independent review body that we are -- that  
 19 Empire was doing those.  
 20 Q. Skipping down the next bulleted item  
 21 is, "Develop and implement an AIDS disease  
 22 management program." What did that reference  
 23 have to do with --  
 24 A. That goes back to the catastrophic  
 25 disease. That was just one that was identified

1 R. Sanchez, M.D.  
 2 early on.  
 3 Q. Last item under Roman numeral ne,  
 4 "Assessing and continue to improve medical  
 5 policy development and communications."  
 6 A. The company had not done a good job of  
 7 communicating policies and developing system  
 8 policies and implementing them consistently  
 9 throughout their products and that was one of the  
 10 focus of -- one of the charges that I had.  
 11 Q. Roman numeral two indicates, "The  
 12 chief medical officer will participate in the  
 13 strategic planning process to insure that the  
 14 medical viewpoint is represented. He/she will  
 15 also help develop strategies on future products  
 16 including workmen's compensation on Medicare and  
 17 Medicaid products. As integrated delivery  
 18 systems are conceived and developed the chief  
 19 medical officer will participate in all aspects  
 20 including negotiation and management of  
 21 providers."  
 22 What does this paragraph refer to?  
 23 A. It refers to that I would be part of  
 24 the most senior staff at Empire in developing  
 25 policies, procedures and products. I would have

1 R. Sanchez, M.D.  
 2 input into that.  
 3 Q. Roman numeral three states, "The chief  
 4 medical officer will directly manage the ongoing  
 5 activities of the medical directors focusing on  
 6 key staff deliverables and will provide coaching  
 7 and opportunities for career development."  
 8 What did that refer to?  
 9 A. That has to do with my responsibility  
 10 for management and development and recruitment of  
 11 the physicians and nurses that worked in the  
 12 medical management area of Empire Blue Cross/Blue  
 13 Shield.  
 14 Q. The next section, Roman numeral four  
 15 indicates, "Acting as a key outreach resource the  
 16 chief medical officer will insure that Empire is  
 17 represented to the community, providers,  
 18 customers regulators and employees as being," and  
 19 then there's a colon and there's a list.  
 20 Number one: "Passionate about the  
 21 delivery of high-quality cost effective medical  
 22 care."  
 23 What was your understanding of that?  
 24 A. That they wanted an articulate  
 25 spokesman who could communicate Empire's feeling

1 R. Sanchez, M.D.  
 2 about the delivery of health care.  
 3 Q. Second of all: "Competent to deliver  
 4 Empire's medical management performance  
 5 objectives."  
 6 A. That they were looking for someone who  
 7 had a track record and experience and ability to  
 8 deliver on all of the above.  
 9 Q. "Responsive to the concerns of  
 10 patients and providers."  
 11 A. They expected the position to have --  
 12 the incumbent to be able to have a relationship  
 13 and create a relationship that was a good working  
 14 relationship with doctors and members and have  
 15 credibility with those members.  
 16 Q. The next item is: "Sympathetic to the  
 17 needs of the chronically ill."  
 18 A. I think that is pretty  
 19 self-descriptive. They were looking for a  
 20 physician leader who understood the  
 21 complications, not only financial, but of the  
 22 complications in negotiating the health care  
 23 system and achieving a relationship with  
 24 providers in hospitals.  
 25 Q. Skipping down, Roman numeral five,

1 R. Sanchez, M.D.  
 2 "The chief medical officer will have day-to-day  
 3 responsibility for a number of medical activities  
 4 including the following: Provider grievances..."  
 5 What does that refer to?  
 6 A. Providers including hospitals and  
 7 physicians and other facilities can appeal  
 8 reimbursement decisions. They can appeal whether  
 9 they are even allowed to provide the service  
 10 decisions. Those kinds of -- it's a process in  
 11 which they appeal our policies.  
 12 Q. "TQI activities and monitoring."  
 13 A. The company when I was employed was  
 14 embarking upon a total quality program to be  
 15 instituted throughout the company trying to tie  
 16 in the quality goals of the company and I was  
 17 responsible for implementing those activities in  
 18 my decision.  
 19 Q. "Member grievances, policy decisions,  
 20 appeals, sales and provider calls when  
 21 necessary."  
 22 I think those are all pretty  
 23 self-explanatory. Those are all part of what you  
 24 had to do?  
 25 A. Correct.

1 R. Sanchez, M.D.  
 2 Q. Okay.  
 3 MR. MAURER: Off tape, please.  
 4 THE VIDEOGRAPHER: The time is 10:53.  
 5 We are going off the record.  
 6 (Whereupon, there is an off-the-record  
 7 discussion.)  
 8 MR. MAURER: Back on tape.  
 9 THE VIDEOGRAPHER: The time is 10:54  
 10 a.m.. We are back on the record.  
 11 BY MR. MAURER:  
 12 Q. Now, under Roman numeral five there  
 13 was a reference to policy decisions. What  
 14 policies are we referring to with that reference?  
 15 A. May I examine?  
 16 (Handing.)  
 17 Q. Roman numeral five, that's a bullet  
 18 there.  
 19 (Witness reviews document.)  
 20 A. That I would have the final approval  
 21 or disapproval of medical policy decisions made  
 22 and final editing of those policies.  
 23 Q. Did you have any -- withdrawn.  
 24 After meeting with the various people  
 25 who you met with before you were hired and having

1 R. Sanchez, M.D.  
 2 A. Over the preceding four or five years  
 3 it had lost more than half its membership.  
 4 Q. How many members are we talking about?  
 5 A. It went from 10 or \$12 million to  
 6 under 5 million. And it had lost those members  
 7 for lots of reasons but it had lost them  
 8 predominantly to managed care competition in New  
 9 York and Blue Cross/Blue Shield leadership had  
 10 been very reticent to realize -- I have to answer  
 11 that phone but I'd like to answer this question.  
 12 MR. MAURER: Sure. Off tape.  
 13 THE VIDEOGRAPHER: The time is 10:57  
 14 a.m.. We are going off the record.  
 15 (Brief recess.)  
 16 THE WITNESS: Can you give me a second  
 17 to turn this thing --  
 18 MR. MAURER: What was the last  
 19 question. Sure.  
 20 MR. MAURER: What was last question?  
 21 (Record read.)  
 22 Q. Do you recall the previous question  
 23 was --  
 24 THE VIDEOGRAPHER: Back on?  
 25 MR. MAURER: Not yet.

1 R. Sanchez, M.D.  
 2 had the opportunity to go before the board of  
 3 directors of Empire Blue Cross/Blue Shield what  
 4 was your understanding, fundamental  
 5 understanding, of what you were being asked to  
 6 accomplish at Empire in the performance of your  
 7 duties?  
 8 A. I was being asked to provide medical  
 9 and clinical leadership to implement managed care  
 10 policies to reduce the cost of health care and to  
 11 provide leadership to a division that was in  
 12 rather disarray.  
 13 Q. Was it just the division that was in  
 14 disarray, was it limited to one division?  
 15 A. There was more than my division in  
 16 disarray but I was responsible for the health  
 17 care and the medical policy division.  
 18 Q. What was the condition of the  
 19 company's business, as you understood it, at the  
 20 time that you were hired?  
 21 A. I don't think there was any question  
 22 it was public and private knowledge that the  
 23 company was in dire straights.  
 24 Q. When you say it was in dire straights,  
 25 why do you say that?

1 R. Sanchez, M.D.  
 2 Q. -- had to do with why did you use the  
 3 phrase dire straights or something to that  
 4 effect.  
 5 MR. MAURER: Let's go back on tape,  
 6 please.  
 7 THE VIDEOGRAPHER: The time is 10:59  
 8 a.m.. We are back on the record.  
 9 BY MR. MAURER:  
 10 Q. Before the interruption, Doctor, you  
 11 were answering my question about why you said  
 12 that the company was in dire straights. Could  
 13 you please continue your answer?  
 14 A. Pardon for the interruption.  
 15 Q. It's okay.  
 16 A. And the lengthy answer. The company.  
 17 was in dire straights for a bunch of things that  
 18 had come together. One is the mismanagement and  
 19 extravagances that occurred prior to my arrival.  
 20 Two, was that the company leadership  
 21 at the board and at the executive leadership had  
 22 failed to recognize the influx of mauaged care  
 23 organizations. They thought that they could  
 24 maintain an indemnity world in a community in  
 25 which the large managed care companies were

1 R. Sanchez, M.D.  
 2 coming in.  
 3 Subsequently, they lost millions of  
 4 members on those managed care organizations  
 5 before they could get a managed care product up  
 6 and running.  
 7 In addition, because they had received  
 8 some state consideration in premium and in  
 9 hospital rates they also had to be the insurance  
 10 company of last resorts. They could not  
 11 underwrite as some of the other companies were  
 12 doing managed care and products, so they ended up  
 13 with a huge population of catastrophically ill  
 14 sicker patients than other managed care  
 15 companies.  
 16 So that when I arrived the cost of  
 17 health care, the medical loss ratio, if you will,  
 18 exceeded the premium dollar collected by many of  
 19 these members. So you put a cost of health care  
 20 that exceeds a premium dollar, you put  
 21 administrative costs together, they were losing  
 22 money on every member they enrolled.  
 23 In addition, they had made a corporate  
 24 decision years ago that they were going to enter  
 25 into the hospital-only business, meaning that

1 R. Sanchez, M.D.  
 2 they would only insure members for the hospital  
 3 care and they had no way of insuring members for  
 4 the professional care, that was given to another  
 5 managed care company. So the company had an  
 6 awful lot of work to do to get back on its feet  
 7 and that's what I would describe simply as dire  
 8 straights.  
 9 Q. Did -- withdrawn.  
 10 Have you ever heard the phrase  
 11 "marching orders"?  
 12 A. Sure.  
 13 Q. Did you receive any marching orders  
 14 from Dr. Stocker before or at the time you were  
 15 hired?  
 16 A. My, if you want to use the term  
 17 marching orders, my responsibilities were clearly  
 18 delineated to me. They were to come in and take  
 19 leadership over the medical division, to reduce  
 20 the cost of health care, to implement a Medicare  
 21 risk product and to bring a clear and consistent  
 22 medical policy to Empire, those were my marching  
 23 orders.  
 24 Q. Did you have any discussions with  
 25 Dr. Stocker or the board of directors regarding

1 R. Sanchez, M.D.  
 2 what steps generally were to be taken to reduce  
 3 the costs of business and increase profitability  
 4 of the company?  
 5 A. In a general way prior to me accepting  
 6 the position and in specific discussions  
 7 throughout my tenure at Empire Blue Cross those  
 8 discussions occurred.  
 9 Q. At the onset of your employment or  
 10 closely after starting work, I'm asking primarily  
 11 at that time period.  
 12 A. I think that we had very, not  
 13 step-by-step, but we had very clear initiatives  
 14 that we were to begin right away. We had those  
 15 discussions, sure.  
 16 Q. Before you implemented any changes in  
 17 the way business was being done at Empire in the  
 18 areas that you were responsible for did you have  
 19 to obtain approval from anyone at the company?  
 20 A. Of course. I mean I am not -- my  
 21 division was not an island. Whatever policy or  
 22 changes that I implemented affected operations,  
 23 it affected legal, it affected all the divisions,  
 24 all the senior vice presidents. So before I  
 25 could implement any of those we discussed them at

1 R. Sanchez, M.D.  
 2 senior staff and the ramifications and everyone  
 3 had to nod their head, otherwise, I would be  
 4 unsuccessful because once I implemented a policy  
 5 it still had to be disseminated, it had to be  
 6 entered in the information systems, it had to get  
 7 to customer service, it had to go to the  
 8 salespeople so they would adequately represent  
 9 the policy to employers. So there was a great  
 10 deal of integration done by necessity.  
 11 Q. Did Dr. Stocker participate in those  
 12 discussion?  
 13 A. Of course.  
 14 Q. Did Heyward Donigan participate in  
 15 those discussions?  
 16 A. Of course.  
 17 Q. Did you have any of those discussions  
 18 with the board of directors as you went along?  
 19 A. We were -- we presented to the board  
 20 of directors on a regular basis.  
 21 Q. Is it an accurate statement then to  
 22 say that Dr. Stocker, the CEO and president, as  
 23 well as the board of directors was kept abreast  
 24 of the changes in practices and procedures that  
 25 you implemented?

1 R. Sanchez, M.D.  
 2 MR. DRISCOLL: Objection. Off tape.  
 3 THE VIDEOGRAPHER: The time is 11:05.  
 4 We are going off the record.  
 5 MR. DRISCOLL: I object to the leading  
 6 nature of the question.  
 7 MR. MAURER: On tape.  
 8 THE VIDEOGRAPHER: The time is 11:05  
 9 a.m.. We are back on the record.  
 10 BY MR. MAURER:  
 11 Q. Was Dr. Stocker kept abreast of the  
 12 changes and practices and procedures that you  
 13 were implementing but were you keeping him  
 14 abreast?  
 15 MR. DRISCOLL: Objection. Off tape.  
 16 THE VIDEOGRAPHER: The time is 11:05  
 17 a.m.. we are going off the record.  
 18 MR. DRISCOLL: I have the same  
 19 objection and have the additional objection  
 20 that it's a compound question.  
 21 MR. MAURER: Back on tape.  
 22 THE VIDEOGRAPHER: The time is 11:05  
 23 a.m. We are back on the record.  
 24 BY MR. MAURER:  
 25 Q. Was Dr. Stocker informed of changes

1 R. Sanchez, M.D.  
 2 and TQA, the quality progress, those kinds of  
 3 things. And once in a while the board might ask  
 4 how we did this or how we were doing that but the  
 5 board does not involve themselves in that.  
 6 Q. Did the board of directors give you  
 7 marching orders of any kind during your  
 8 employment there?  
 9 A. No. The board of directors'  
 10 relationship was with Dr. Stocker not with me.  
 11 He was their chief executive officer.  
 12 Q. What, if anything, did Dr. Stocker  
 13 tell you to do with regard to gaining control  
 14 over the health care costs that Blue Cross/Blue  
 15 Shield was dealing with at the time when you were  
 16 hired or shortly thereafter you were hired?  
 17 A. Well, Dr. Stocker and Heyward Donigan  
 18 were my immediate superiors in this organization  
 19 were both very aware of the exorbitant health  
 20 care costs that Empire Blue Cross/Blue Shield was  
 21 enduring and asked me to implement procedures and  
 22 policies and programs to reduce these costs and  
 23 we did so in a broad array of tactics.  
 24 Q. Dr. Sanchez, I'd like to show you a  
 25 pile of documents that was previously marked for

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 1 R. Sanchez, M.D.  
 2 that you were implementing at Blue Cross/Blue  
 3 Shield before they were implemented?  
 4 A. Yes.  
 5 Q. Who informed him of those changes, the  
 6 nature of the changes?  
 7 A. I informed him, they were discussed as  
 8 about senior staff so that there were two  
 9 mechanisms, either one-on-one meetings with him  
 10 or phone calls that we had regularly or that --  
 11 or senior staff where we had to get the consensus  
 12 of the senior staff to implement any policy  
 13 changes.  
 14 Q. Was the board of directors informed of  
 15 the changes that were being made as they were  
 16 being made?  
 17 A. I think that the board of directors,  
 18 as I remember it, were informed of our progress  
 19 in achieving the large goals that we discussed  
 20 earlier. They did not involve themselves in the  
 21 minutia of the policies and different procedures  
 22 that we were changing or implementing, that was  
 23 not their role.  
 24 So that when we reported to board, we  
 25 reported on our progress in achieving these goals

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 1 R. Sanchez, M.D.  
 2 identification collectively as Plaintiffs'  
 3 Exhibit 1 on 10/14/98 and on the front page it  
 4 says, Empire Blue Cross/Blue Shield Medical  
 5 Management Review, and then it says, Medical  
 6 Management Review, Initial Assessment of  
 7 Capabilities and Recommendations for  
 8 Improvement. It indicates the date October 2nd,  
 9 1995 and the insignia or the logo of Deloitte &  
 10 Touche, LLP. Appears on the bottom right-hand  
 11 corner.  
 12 MR. DRISCOLL: I'd ask to you remove  
 13 the Post-Its, please.  
 14 MR. MAURER: He is not going to look  
 15 through the whole document right now.  
 16 MR. DRISCOLL: May I see it, please.  
 17 (Handing.)  
 18 MR. DRISCOLL: Thank you.  
 19 MR. MAURER: Off tape.  
 20 THE VIDEOGRAPHER: The time is 11:09  
 21 a.m.. We are going off the record.  
 22 MR. DRISCOLL: Off the record.  
 23 (Whereupon, there is an off-the-record  
 24 discussion.)  
 25 MR. MAURER: On tape, please.

1 R. Sanchez, M.D.  
 2 THE VIDEOGRAPHER: The time is 11:11  
 3 a.m.. We are back on the record.  
 4 BY MR. MAURER:  
 5 Q. Dr. Sanchez, just looking at the front  
 6 page of this exhibit, which I'll ask the reporter  
 7 to mark as Plaintiffs' Sanchez Exhibit 2 for  
 8 identification in a moment, are you familiar with  
 9 this particular report, Doctor?  
 10 A. Yes.  
 11 Q. Don't look at the rest of the report  
 12 for the moment, because there are stickers on it  
 13 with my own notations which Counsel would like me  
 14 to remove before you look at it so as not to  
 15 influence you.  
 16 When was the first time that you saw  
 17 this report?  
 18 A. My recollection I saw it right after I  
 19 got there in May or June.  
 20 Q. Who showed it to you?  
 21 A. Heyward Donigan.  
 22 Q. What was your understanding generally  
 23 of why this particular report was requested by  
 24 Empire?  
 25 A. It was requested by Empire to receive

1 R. Sanchez, M.D.  
 2 an objective and third-party evaluation of the  
 3 medical management division and its capabilities,  
 4 its deficiencies, in an effort to, I assume, to  
 5 correct them, to make the necessary corrections.  
 6 Q. Was the information contained in this  
 7 report used by you at all to do any of the job  
 8 you were asked to perform at the company?  
 9 A. Yes.  
 10 Q. Did you discuss the contents of this  
 11 report with the CEO president, Dr. Michael  
 12 Stocker, at any time?  
 13 A. Yes.  
 14 Q. Did you --  
 15 A. Let me -- I don't recall whether it  
 16 was an individual conversation or it was done at  
 17 senior staff but Dr. Stocker knew the contents of  
 18 the report and how I was going to act on  
 19 correcting some of the deficiencies in the  
 20 report.  
 21 MR. DRISCOLL: Objection to that  
 22 response and I move to strike it.  
 23 Q. Dr. Sanchez, was there any discussion  
 24 about the contents of the report with  
 25 Dr. Stocker?

1 R. Sanchez, M.D.  
 2 A. Dr. Stocker was aware of the contents  
 3 of the report and my action plans to correct some  
 4 of the deficiencies identified in the report.  
 5 MR. DRISCOLL: Same objection. Off  
 6 tape.  
 7 THE VIDEOGRAPHER: The time is 11:14  
 8 a.m.. We are going off the record.  
 9 MR. DRISCOLL: I object to the witness  
 10 testifying as to what Dr. Stocker knew or  
 11 didn't know.  
 12 MR. MAURER: On tape.  
 13 THE VIDEOGRAPHER: The time is 11:14  
 14 a.m.. We are back on the record.  
 15 BY MR. MAURER:  
 16 Q. Dr. Sanchez, to your knowledge, did  
 17 Dr. Michael Stocker, the CEO and president of  
 18 Empire, have knowledge of the contents of this  
 19 particular Deloitte & Touche report?  
 20 MR. DRISCOLL: Same objection.  
 21 Q. You can answer.  
 22 A. Yes.  
 23 Q. Why do you say he had knowledge of the  
 24 report, what's the basis for that statement?  
 25 A. Because for me to implement any

1 R. Sanchez, M.D.  
 2 corrections and plans to rectify some of the  
 3 deficiencies identified in the report he would  
 4 have had to approve them.  
 5 Q. Did a discussion of the contents of  
 6 this report take place in the presence of  
 7 Dr. Stocker, to your knowledge?  
 8 A. Yes.  
 9 Q. On how many occasions, once, more than  
 10 once?  
 11 A. I can't tell you whether it was four  
 12 or five but we had regular meetings with the  
 13 senior staff and we had regular individual  
 14 meetings and my activities throughout the day on  
 15 implementing the array of projects that I was  
 16 involved in, I kept him updated on those  
 17 projects, I kept senior staff updated on those  
 18 projects, and when called upon I kept the board  
 19 updated on the global nature of those projects.  
 20 Those were my responsibilities as the senior  
 21 executive of Empire.  
 22 Q. To your knowledge, was there any  
 23 discussion that took place involving the board of  
 24 directors regarding the contents of this  
 25 particular Deloitte & Touche report?

1 R. Sanchez, M.D.  
 2 A. I have no idea about that.  
 3 Q. Did you ever discuss the contents of  
 4 any portion of the Deloitte & Touche report dated  
 5 10/2/95 with any member of the board of directors  
 6 of Empire?  
 7 A. I don't recall any specific  
 8 discussion, no, sir.  
 9 Q. Did Heyward Donigan, your immediate  
 10 supervisor and I think you said the right hand to  
 11 Dr. Stocker, to your knowledge, have any  
 12 knowledge of the contents of this Deloitte &  
 13 Touche report?  
 14 A. Yes, she did.  
 15 Q. Did any discussion about the contents  
 16 of the Deloitte & Touche report take place in the  
 17 presence of Heyward Donigan, to your knowledge?  
 18 A. Yes, those discussions occurred.  
 19 Q. Did she participate in the  
 20 discussions?  
 21 A. Yes.  
 22 Q. By the way, did Dr. Stocker  
 23 participate in the discussions regarding the  
 24 Deloitte & Touche report?  
 25 A. Yes.

1 R. Sanchez, M.D.  
 2 down in Atlanta.  
 3 Q. Did I request the opportunity to meet  
 4 with you?  
 5 A. Yes.  
 6 Q. When I met with you did you agree to  
 7 give a sworn statement which was taken down by a  
 8 court reporter when we met?  
 9 A. Yes.  
 10 Q. Let me show you a transcript of what  
 11 is indicated on the cover as a sworn statement of  
 12 Richard Sanchez, M.D., dated February 17th, 1998,  
 13 about one year ago.  
 14 If you would be kind enough to look at  
 15 this transcript and look at the last page.  
 16 (Handing.)  
 17 Q. Does your signature appear on that  
 18 page?  
 19 A. No.  
 20 Q. I'm sorry, I misspoke about the page.  
 21 As far as you can see, Doctor, is this a complete  
 22 transcript of the sworn statement that you gave  
 23 me about a year ago in Atlanta?  
 24 A. Yes.  
 25 Q. Did you have an opportunity to review

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1 R. Sanchez, M.D.  
 2 MR. MAURER: Why don't I go off tape  
 3 while the reporter marks this as Sanchez  
 4 Exhibit 2 for identification.  
 5 THE VIDEOGRAPHER: The time is 11:17  
 6 a.m.. We are going off the record  
 7 (Sanchez Exhibit 2, Deloitte & Touche  
 8 report, marked for identification, as of  
 9 this date.)  
 10 MR. MAURER: On tape, please.  
 11 THE VIDEOGRAPHER: The time is 11:22  
 12 a.m.. We are back on the record.  
 13 BY MR. MAURER:  
 14 Q. Doctor, before I ask you about the  
 15 Deloitte & Touche report, which is now marked  
 16 Sanchez 2 for identification, I would like to  
 17 digress just for a moment.  
 18 Do you recall the first time you and I  
 19 had contact?  
 20 A. Vaguely.  
 21 Q. Was it about a year ago?  
 22 A. I think it was nine, ten months ago,  
 23 yes.  
 24 Q. Who initiated that contact?  
 25 A. You tracked me down some way, somehow

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1 R. Sanchez, M.D.  
 2 the transcript since the time that you gave the  
 3 sworn statement?  
 4 A. Yes, sir.  
 5 Q. When was the most recent time that you  
 6 had a chance to review the transcript of your  
 7 sworn statement?  
 8 A. I had a chance to review this copy  
 9 that you provided me after the session and the  
 10 last time I read this was last night.  
 11 Q. Doctor, to your knowledge who  
 12 requested, at Empire, who requested the Deloitte  
 13 & Touche medical management review, which is the  
 14 subject of the October 2nd, 1995 report marked as  
 15 Sanchez Exhibit 2 for identification?  
 16 A. It would be the senior staff, the  
 17 senior executives at Empire Blue Cross/Blue  
 18 Shield.  
 19 Q. That included who?  
 20 A. Dr. Stocker and Heyward Donigan.  
 21 Q. Now, back to the actual Deloitte &  
 22 Touche report. I'd like to show you a page  
 23 marked as III-2 which --  
 24 A. Review referring to my sworn  
 25 statement?

1 R. Sanchez, M.D.  
 2 Q. No, we are looking at the Deloitte &  
 3 Touche for now.  
 4 A. Can I put this away now so I don't get  
 5 confused.  
 6 Q. Showing you the particular page which  
 7 has the heading, Financial Impact. Does this  
 8 particular page of the report give an indication  
 9 of whether the company was profitable or losing  
 10 money in the recent past prior to the preparation  
 11 of the report?  
 12 A. This chart shows that since 1991 there  
 13 was only one year where there was a net gain.  
 14 Q. And in 1993, was there a gain or a  
 15 loss?  
 16 A. There was a gain.  
 17 Q. And in 1994, was there a gain or a  
 18 loss?  
 19 A. Between 1993 -- yes, there was a loss.  
 20 Q. Referring you to the page identified  
 21 as III-1 which says financial impact on the top.  
 22 Does this provide information regarding how much  
 23 premium revenue the company had in the recent  
 24 past?  
 25 A. This chart shows from 1991 to 1994

1 R. Sanchez, M.D.  
 2 there was a decline in premium revenue,  
 3 approximately \$2 million.  
 4 Q. Million?  
 5 A. Yes. I think these are millions, two  
 6 million.  
 7 Q. There was a decline of two billion  
 8 dollars?  
 9 A. Right. Sorry, I got my zeros confused  
 10 there.  
 11 Q. So it dropped from 6,929,000,000 in  
 12 1991 down to 4,970,000,000 in 1994?  
 13 A. According to that chart, yes.  
 14 Q. Now, looking at another page there's a  
 15 section under, on page IV-A, page nine, with a  
 16 heading, utilization management process work  
 17 flow, and there's reference here to the  
 18 aggressiveness of nurses. What's that reference  
 19 to in the report?  
 20 MR. DRISCOLL: Objection. Off tape.  
 21 THE VIDEOGRAPHER: The time is 11:29  
 22 a.m.. We are going off the record.  
 23 MR. DRISCOLL: I just like to place on  
 24 the record a general objection to this  
 25 witness who has not authored the report

1 R. Sanchez, M.D.  
 2 testifying as to what the author of the  
 3 report meant when certain information was  
 4 placed on the report.  
 5 MR. MAURER: Let's go back on tape.  
 6 THE VIDEOGRAPHER: The time is 11:30  
 7 a.m.. We are back on the record.  
 8 BY MR. MAURER:  
 9 Q. Doctor, there are two bulleted items  
 10 on this particular page I just made reference to  
 11 IV-A 9. What was your understanding of the first  
 12 bullet which says, "The referral rate for managed  
 13 care products appears somewhat low, which may  
 14 indicate that the RNs are not being as aggressive  
 15 at monitoring care as they are at monitor care"?  
 16 A. My interpretation, the nurses were not  
 17 being as vigilant as they could be in the  
 18 authorization or non-authorizing health care, in  
 19 making health care decisions as per policies of  
 20 Empire.  
 21 Q. The second bulleted item says, "The  
 22 physician denial rate for both indemnity and  
 23 managed care products is only one percent to two  
 24 percent of case intake at Empire. Industries  
 25 standards range from six to eight percent

1 R. Sanchez, M.D.  
 2 indicating the possibility of two lack standards  
 3 of denial."  
 4 What was your understanding of what  
 5 that item meant?  
 6 A. That the physicians were not, compared  
 7 to the national average, supporting the denials  
 8 or decisions of the case management nurses or the  
 9 policies of Empire.  
 10 Q. And on page IV-A 29 there's a bulleted  
 11 item that says, "Nurse referral rates to  
 12 physician reviewers is slightly high and  
 13 physician denial rates are extremely low. In  
 14 addition, appeal rates for denied cases are above  
 15 average."  
 16 What was your understanding of that  
 17 particular item?  
 18 A. There are several parts to that.  
 19 Q. Let's take the first one, nurse  
 20 referral rates to physician reviewers is slightly  
 21 high.  
 22 A. That the nurses in our interpretation  
 23 were not empowered or did not feel empowered or  
 24 were not accustomed to making the difficult  
 25 decisions on their own.



1 R. Sanchez, M.D.  
 2 Q. What were the difficult decisions?  
 3 A. Length of stay, all the  
 4 authorizations, decisions that they were  
 5 responsible for making. So that they would then  
 6 pass these on to the physicians to make.  
 7 Q. The items you just referred to in  
 8 laymen's terms what are we talking about? If a  
 9 patient has prescribed treatment from a  
 10 physician, a treating physician, in what context  
 11 do we consider what you were referring to  
 12 vis-a-vis the prescribed care and decisions that  
 13 were being made?  
 14 MR. DRISCOLL: Objection to the form  
 15 of the question.  
 16 MR. MAURER: It was a terrible  
 17 question. I'll ask it again.  
 18 Q. With regard to the items you just made  
 19 reference to does that have anything to do with  
 20 how insured patients obtained authorization to  
 21 get prescribed treatment?  
 22 A. Yes.  
 23 Q. How does it relate to that?  
 24 A. A provider or physician in many of the  
 25 products at Empire had to have them authorized by

1 R. Sanchez, M.D.  
 2 Q. And the last part was, "In addition,  
 3 appeal rates for denied cases are above  
 4 average."  
 5 What was your understanding of what  
 6 that meant?  
 7 A. That the medical community had figured  
 8 out that all they had to do was appeal this to  
 9 the physician level and it would be approved. So  
 10 they automatically appealed every decision that  
 11 should have been stopped at a lower level.  
 12 Q. Let me show you page IV-A 8 which has  
 13 the subheading of Utilization Management Process  
 14 Work Flow. What is this particular document  
 15 making reference to as you understand it?  
 16 A. This page is a schematic of the flow  
 17 of intake of cases where you have the cases come  
 18 in. There's a pre-certification process and 78  
 19 percent of them are approved and 22 percent are  
 20 not approved and are referred for a physician  
 21 review.  
 22 In the physician review process only  
 23 one or two percent are -- I'm sorry -- 96 percent  
 24 are approved. And then the last box has to do  
 25 with the appeals of the denied cases, that 94

1 R. Sanchez, M.D.  
 2 our case management or utilization nurses in  
 3 Albany. The nurses had policies and procedures  
 4 that they could look up and say yes, this matches  
 5 the policy, we will approve it, no, it doesn't  
 6 match the policy, we will disapprove it, or  
 7 there's no policy for it, let's send it onto a  
 8 medical reviewer and what -- how we interpreted  
 9 that report was that the nurses were not making  
 10 those decisions. There was an excessive amount  
 11 of those that were just being passed through.  
 12 They weren't making the contact and the decision  
 13 at that level and they weren't either used to it  
 14 or didn't have the inclination to do so or  
 15 leadership to do so or support to do so and that  
 16 was something we were going to fix.  
 17 Q. The second part of that sentence on  
 18 this particular page of the Deloitte & Touche  
 19 report was "Physician denial rates are extremely  
 20 low."  
 21 What was your understanding of what  
 22 that meant?  
 23 A. That our physicians would routinely  
 24 approve anything that was appealed to them by the  
 25 provider or referred to them by the nurse.

1 R. Sanchez, M.D.  
 2 percent of them are overturned upon appeal.  
 3 Q. What impact on the financial condition  
 4 of Empire was this particular process, which is  
 5 the subject of IV-A 8, in your view having on the  
 6 company with regard to the percentages that were  
 7 getting passed along the way and how many of the  
 8 cases were getting approved versus denied?  
 9 A. Well, these kinds of percentages would  
 10 reflect a large hemorrhage to the cost of health  
 11 care at Empire Blue Cross/Blue Shield or in any  
 12 company.  
 13 Q. With regard to Empire Blue Cross/Blue  
 14 Shield, why did you say that it reflected a large  
 15 hemorrhage?  
 16 A. Because these rates of approval denial  
 17 were well below the national average of any  
 18 managed care company.  
 19 Q. You are referring to a statistical  
 20 average?  
 21 A. Yes.  
 22 Q. Look at the Roman numeral page 3-6,  
 23 one of the bulleted items says, "HMO denials are  
 24 few and often overturned on appeal." Is that  
 25 referring to what you were just telling us about

1 R. Sanchez, M.D.  
 2 on the previous few sheets that I questioned you  
 3 about?  
 4 A. Yes.  
 5 Q. Then it goes on to say, "The planned  
 6 medical director and physician reviewers are not  
 7 aggressive enough with PCPs or attending  
 8 physicians." What's your understanding of what  
 9 that meant?  
 10 A. That our planned medical directors and  
 11 leadership in the physician area did not have the  
 12 requisite -- I'm trying to think of the right  
 13 word -- ability to confront a physician or  
 14 provider in our community -- in the network to  
 15 deny or recommend an alternative treatment. That  
 16 they would rather just approve them in a  
 17 non-confronting way than provide the leadership  
 18 and ability to deny it or capability to deny it  
 19 as an unnecessary or non-required procedure of  
 20 care.  
 21 Q. Was that impacting on the financial  
 22 status of the company, Empire's company?  
 23 A. Of course.  
 24 Q. Now, Roman numeral, looks like L-15  
 25 under executive summary there is a list of

1 R. Sanchez, M.D.  
 2 recommendations and one of the bulleted items  
 3 says, "The current organizational structure  
 4 places physician reviewers outside the UM  
 5 organization. Physician reviewers do not have  
 6 the tools nor the incentives to aggressively deny  
 7 inappropriate cases."  
 8 First of all, the reference to UM,  
 9 what does that stand for?  
 10 A. Utilization management.  
 11 Q. What is utilization management?  
 12 A. It is the oversight, concurrent and  
 13 prospective concurrent and retrospective  
 14 management of health care for members as it's  
 15 being provided. It entails the authorization of  
 16 services, it entails a review of those services  
 17 as they are performed and also entails a  
 18 retrospective review for appropriateness of  
 19 care. All that comes under the utilization of  
 20 management.  
 21 Q. When you came to Empire Blue Cross was  
 22 there a utilization management area of the  
 23 company?  
 24 A. Yes.  
 25 Q. Where it says, "The current

1 R. Sanchez, M.D.  
 2 organizational structure places physician  
 3 reviewers outside the UM organization," what was  
 4 your understanding of what that meant?  
 5 A. That the bevy of physician reviewers  
 6 existed outside the utilization management  
 7 leadership and department, it was a separate  
 8 entity.  
 9 Q. Did that in your opinion have any  
 10 impact on the financial condition of Empire?  
 11 A. It was something that we corrected.  
 12 Q. Why?  
 13 A. Because we felt that those physicians  
 14 were isolated from the development of policies  
 15 and implementation of policies that were being  
 16 done over in this area and they were over here in  
 17 this area asking to interpret and support  
 18 policies and they were not related.  
 19 In addition, they didn't come up to a  
 20 single leadership position, so there was just no  
 21 leadership. They were rather disparate groups  
 22 and it made no sense that they were separate like  
 23 that so we brought them together.  
 24 Q. Was that separateness contributing in  
 25 your opinion to the losses that Empire was?

1 R. Sanchez, M.D.  
 2 A. Yes.  
 3 Q. How?  
 4 A. Because based on the numbers they saw  
 5 no relationship or need or to be part of the team  
 6 that was trying to control health care costs.  
 7 They were a separate entity.  
 8 Q. Where it said, "Physician reviewers do  
 9 no have the tools nor the incentives to  
 10 aggressively deny inappropriate cases," what's  
 11 your understanding of what that meant?  
 12 A. In their isolation they did not have  
 13 the standardized national Millman & Robinson or  
 14 InterQual rules for approval of length of stays  
 15 and policies and general practice of health care  
 16 in the company nor did they have the opportunity  
 17 to work in a collaborative way with the UM nurses  
 18 and people that were doing -- making the initial  
 19 decisions.  
 20 Q. These two names of the policies, could  
 21 you say them again?  
 22 A. InterQual and Millman & Robinson.  
 23 Q. What are those?  
 24 A. Those are large sets of guidelines for  
 25 utilization management that are regionalized for

1 R. Sanchez, M.D.  
 2 every part of the country. For example, if  
 3 someone goes in for a total hip replacement the  
 4 Millman & Robinson guidelines will say that for a  
 5 person 65, you can authorize four days or eight  
 6 days of authorization, and the same thing for a  
 7 gall bladder or pneumonia or whatever.  
 8 Those types of guidelines, tools as  
 9 that refers to, were not being utilized by the  
 10 medical leadership at Empire Blue Cross/Blue  
 11 Shield nor by the nurses. They were utilizing  
 12 their own, what we call home-grown criteria. So  
 13 one of the first things we did was give them a  
 14 set of tools that they could, that were  
 15 nationally recognized, that could support their  
 16 decision on why they had to not approve or would  
 17 approve a procedure.  
 18 Q. What is the nature of the incentives  
 19 that the physician reviewers did not have to  
 20 aggressively deny inappropriate cases?  
 21 A. There was no financial incentives in  
 22 place for them affecting the cost of health care  
 23 allocation.  
 24 Q. In layman's terms what are you talking  
 25 about?

1 R. Sanchez, M.D.  
 2 forget where the cutoff occurred.  
 3 Q. The initial level where authorization  
 4 would be sought from Empire for prescribed care  
 5 would go where, what would be the nature of the  
 6 employee who would get that first-step  
 7 involvement?  
 8 A. It would be a nurse in Albany in our  
 9 utilization management area.  
 10 Q. Would that be someone referred to as a  
 11 caseworker?  
 12 A. Case manager, caseworker, UM, yes.  
 13 Q. Did the caseworkers have supervisors?  
 14 A. Absolutely.  
 15 Q. Did the supervisors, to your  
 16 knowledge, participate in this financial  
 17 incentive program that was instituted at Empire  
 18 to bring about denials of more cases?  
 19 MR. DRISCOLL: Objection to the form  
 20 of the question.  
 21 MR. MAURER: I'll rephrase the  
 22 question.  
 23 Q. What was the intended purpose of  
 24 instituting this incentive goals program at the  
 25 company?

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 1 R. Sanchez, M.D.  
 2 A. That if there were savings from  
 3 services from reducing the cost of health care  
 4 the physician reviewers did not share in any of  
 5 those, there was no incentive for them to have  
 6 that difficult interaction with the physician in  
 7 denying services or not approving services  
 8 because there was no incentive to do that at the  
 9 end of the day the company saved a \$100,000 by  
 10 you appropriately applying the policies and  
 11 procedures of Empire, that showed no reflection  
 12 on his approval, his rating, his compensation or  
 13 his incentive compensation.  
 14 Q. As a result of this report and any  
 15 other background information you brought to the  
 16 company were any incentives for physician  
 17 reviewers put into place at Empire to  
 18 aggressively deny inappropriate cases?  
 19 A. The company and my division  
 20 specifically created an incentive and goals and  
 21 objectives program for the entire company to  
 22 meet. And clearly the reduction in the medical  
 23 loss ratio or cost of health care was, if  
 24 achieved, the incentive compensation would be  
 25 distributed to all supervisors and above, I

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 1 R. Sanchez, M.D.  
 2 A. To reduce the cost of health care, and  
 3 to create an incentive for our nurses and our  
 4 physicians and people that worked in utilization  
 5 management to endure the difficulty of denying or  
 6 not approving health care that was not consistent  
 7 with the policies developed at Empire.  
 8 Q. How were these people supposed to  
 9 reduce the costs of health care so as to qualify  
 10 for this incentive package or program?  
 11 A. They had to first and foremost reduce  
 12 the unnecessary care.  
 13 Q. How?  
 14 A. By not approving procedures and  
 15 procedures and care rendered, considered to be  
 16 rendered, to patients who didn't have the  
 17 diagnosis. For example, you wouldn't approve a  
 18 heart transplant for someone who didn't need a  
 19 heart transplant or you wouldn't approve a hip  
 20 replacement for someone who didn't need a hip  
 21 replacement. There was an awful lot of that  
 22 occurring, you know, unnecessary care being  
 23 delivered to the members at their risk and at  
 24 great cost to the company. So, first and  
 25 foremost, they were to reduce the amount of

1 R. Sanchez, M.D.  
 2 unnecessary care to make sure the diagnosis  
 3 matched the level of care that was being  
 4 recommended by the provider.  
 5 Q. Let me just stop you there for a  
 6 second. To reduce those numbers was it necessary  
 7 for there to be an increase in the number,  
 8 increase in the number of denials that were being  
 9 issued by the case workers?  
 10 A. Yes.  
 11 Q. Okay. Please continue.  
 12 A. Another component was to recommend  
 13 alternatives to care. That if a physician wanted  
 14 to keep someone in the hospital 12 days, the  
 15 caseworker was to suggest alternatives at lower  
 16 costs to that care. If a physician wanted to  
 17 recommend someone staying in a hospital for  
 18 intravenous care, they were instructed to work  
 19 out a home health care where they would receive  
 20 that care at home. So that's another strategy  
 21 that was to be used.  
 22 There was also the strategy of very  
 23 carefully making sure that the policies and  
 24 procedures that were developed matched what the  
 25 benefit was because many, many times we were

1 R. Sanchez, M.D.  
 2 asked to provide a covered benefit that was not a  
 3 covered benefit, so that when that had to be  
 4 denied, whether it was a benefit. You do not get  
 5 a benefit unless you pay for that benefit. If  
 6 the employer did not pay for that benefit the  
 7 member couldn't ask for that in our new policies  
 8 and procedures. We asked them to read strictly  
 9 into what the benefit interpretation was. That  
 10 resulted in what you say denials. So those are  
 11 -- there's a constellation of things these  
 12 people were being asked to do. That is a  
 13 difficult thing for people to do, particularly  
 14 who are not accustomed to do that.  
 15 We created a way to document that and  
 16 we created an incentive compensation program that  
 17 if they did that and we were successful overall  
 18 as a division and as a company that they could  
 19 share in that.  
 20 Q. What did you do to create a way to  
 21 document the increase in denials?  
 22 A. Whenever an alternative or a denial  
 23 was made it was compared, first of all, we had a  
 24 column that said what the procedure or service  
 25 requested was. We then had what was approved or

1 R. Sanchez, M.D.  
 2 suggested or changed. And then there was the  
 3 column for what the savings were by us  
 4 implementing an alternative denial or a different  
 5 course of care. And those services, while not  
 6 solid, I mean you could not say it was 65 or  
 7 64,000, they gave us a general idea of what we  
 8 were saving the company. Those were shared with  
 9 senior leadership throughout the company on a  
 10 regular basis.  
 11 Q. Who made out those forms?  
 12 A. The actual caseworkers, the nurses.  
 13 Q. That would be given to whom?  
 14 A. To their supervisor.  
 15 Q. Would those get summarized in some  
 16 way?  
 17 A. Yes.  
 18 Q. That information was then used by  
 19 upper management where you were to do what?  
 20 MR. DRISCOLL: I object to the leading  
 21 nature of the question.  
 22 Q. Did you use that information in  
 23 performing your duties?  
 24 A. Yes, sir.  
 25 Q. How did you use it?

1 R. Sanchez, M.D.  
 2 A. I used it to evaluate the  
 3 effectiveness of our nurses and doctors in  
 4 implementing the policies and upholding our  
 5 policies and procedures in their success at  
 6 suggesting alternative treatments or therapies  
 7 and whether they were denying uncovered benefits  
 8 or procedures that were not as per our policy.  
 9 I used that to document to my  
 10 superiors the affect that we were having on the  
 11 reduction of cost of health care, which is what I  
 12 was being held responsible for.  
 13 Q. Your superiors meant whom?  
 14 A. Dr. Stocker and Heyward Donigan.  
 15 Q. What about the board of directors?  
 16 A. I was not responsible to the board of  
 17 directors. The board of directors were kept  
 18 informed of my activities through reports,  
 19 regular reports of Dr. Stocker to the board.  
 20 Q. Do the reports that contained  
 21 information about the savings that resulted from  
 22 these denials, was that considered at all as part  
 23 of the incentive program that you've referred to?  
 24 A. Yes.  
 25 Q. How?

1 R. Sanchez, M.D.

2 A. We were to look at these -- the  
3 effectiveness of these nurses and these doctors  
4 in this process to see in a part, I mean, there  
5 was more to it than that, but one of the parts  
6 was clearly in their ability to generate savings  
7 in health care expenditures and so if someone was  
8 successful at that they would have made their  
9 goal of achieving success in that area of their  
10 annual review. There was also other parts of the  
11 annual review that clearly go, you know,  
12 attendant's ability to work with other members,  
13 you know, that kind of thing, that make up a  
14 review, and it adds up to 100 percent. But a  
15 certain percentage was going to be clearly was an  
16 evaluation of how effective they were in the  
17 reduction of health care costs. We had to create  
18 that instrument to be able to do that. We had no  
19 way of knowing it otherwise.

20 Q. Did you participate in this incentive  
21 program?

22 A. You mean me, personally?

23 Q. Yes.

24 A. My goals and my objectives for my  
25 annual review were of a broader nature and they

1 R. Sanchez, M.D.

2 Q. By the way, just while I'm thinking  
3 about it, have you ever heard of the term or  
4 phrase "doctor profiling"?

5 A. Of course.

6 Q. What does it mean or refer to as you  
7 understand it?

8 A. I guess in its most negative sense it  
9 refers to an insurance company keeping track of  
10 the activity and cost that is generated by a  
11 health care provider and its paneled membership.

12 Q. When you arrived at Empire Blue  
13 Cross/Blue Shield, to your knowledge, was the  
14 company engaging in any form of doctor profiling?

15 A. It was called flagging. There were  
16 lots of providers that were flagged and every  
17 claim of there's was reviewed under great  
18 scrutiny.

19 Q. That was in existence when you  
20 arrived?

21 A. Yes.

22 Q. What did it mean for the doctor or  
23 medical service provider to be flagged?

24 A. That meant that every claim submitted  
25 by them was scrutinized for appropriateness, for

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1 R. Sanchez, M.D.

2 were well-documented and I received my annual  
3 review and I received my annual incentive  
4 compensation.

5 Q. In other words, if health care costs  
6 were reduced as a result of the higher issuance  
7 of denials, would that have been reflected in the  
8 evaluation of the performance of your duties to  
9 your knowledge?

10 A. If health care expenditures were  
11 reduced because of the policies and procedures  
12 that I implemented in my division, that would be  
13 a positive for one portion of my annual review  
14 and it would be reflected in a positive way when  
15 I received my incentive compensation.

16 Q. Was there an individual goal in terms  
17 of dollars for the lower level supervisors to  
18 attain?

19 A. I don't recall that there was. You'd  
20 have to talk to their supervisors, how they were  
21 going to evaluate those goals. I was looking at  
22 a percentage reduction, they might have been  
23 looking a dollar reduction per nurse or per  
24 doctor, I don't recall in their individual  
25 objectives and goals.

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1 R. Sanchez, M.D.

2 fraud, for frequency, the actual service was  
3 delivered. It was a great deal of scrutiny that  
4 was brought upon any flagged provider.

5 Q. Why were those flagged providers  
6 flagged to your knowledge?

7 A. The great majority of them, if I  
8 recall, were flagged for what seemed to be  
9 excessive or overbilling or fraudulent billing or  
10 semi-fraudulent billing and for high cost.

11 Q. If a doctor was prescribing a certain  
12 type treatment with greater frequency than what  
13 was generally seen by providers that you dealt  
14 with at the company was that to your knowledge  
15 one basis for flagging that doctor?

16 A. It was but I think it would have had  
17 to have been coupled with providing that service  
18 against our policy, then it would have been, you  
19 know, brought under the criteria for flagging.

20 Q. Did this profiling or flagging  
21 continue to exist during the entire term that you  
22 were with Empire?

23 A. Yes.

24 Q. Now, just to move to another topic for  
25 a moment while it's on my mind. With regard to

1 R. Sanchez, M.D.  
 2 approval of prescribed treatment for insured  
 3 patients, was there any requirement to your  
 4 knowledge at Empire Blue Cross/Blue Shield when  
 5 you arrived there that in order for a prescribed  
 6 therapy to be approved it had to be able to cure  
 7 a condition or disease?  
 8 A. You are asking if there was such a  
 9 policy?  
 10 Q. Yes.  
 11 A. Yes, for certain diagnoses, sure.  
 12 Anything that was considered experimental or not  
 13 proven effective was not a covered benefit.  
 14 Q. In order to be proven effective did it  
 15 have to be capable of curing the patient, was  
 16 that a specific restriction or requirement as you  
 17 understood it?  
 18 A. Curing is more of a layman's term than  
 19 a clinical term. It had to demonstrate  
 20 effectiveness, clinical effectiveness, either in  
 21 the reduction of the symptomatology or an  
 22 elimination of the disease process. If it did  
 23 not show that, it would not be a covered benefit,  
 24 it would be an experimental indication and those  
 25 were approved on a case-by-case basis.

1 R. Sanchez, M.D.  
 2 Q. Based upon a review of the insured's  
 3 patient's chart, among other things?  
 4 A. Chart, doctor, literature.  
 5 Q. In other words, the company when  
 6 considering whether or not to approve a  
 7 prescribed course of treatment for an insured  
 8 patient would consider information from the  
 9 doctor you are saying, the treating doctor?  
 10 A. Absolutely.  
 11 Q. Who prescribed the treatment?  
 12 A. Correct.  
 13 Q. Would consider the case history of the  
 14 insured patient?  
 15 A. Yes, correct.  
 16 Q. Would consider medical literature  
 17 published in the field?  
 18 A. Correct.  
 19 Q. Okay. Did any one of those things in  
 20 and of itself cause Empire to approve or deny  
 21 without consideration of the other areas of  
 22 information that you've told us would be  
 23 considered?  
 24 MR. DRISCOLL: I object to the form of  
 25 that question.

1 R. Sanchez, M.D.  
 2 THE WITNESS: It's good because I  
 3 don't understand it.  
 4 MR. MAURER: I'm sorry. Sometimes I  
 5 do that.  
 6 Q. I'll rephrase the question, Doctor.  
 7 You just made reference to three  
 8 different areas of information that would be  
 9 considered. Were there any other areas that  
 10 would be considered in terms of whether or not to  
 11 approve or deny prescribed treatment?  
 12 A. Well, there was -- there were  
 13 off-the-record things that would be considered  
 14 but nothing, I mean the official policy, that's  
 15 the things we considered. We considered the  
 16 patient's diagnosis, the review of literature,  
 17 whether it was appropriate, and the clinical  
 18 progress and the medical literature whether we  
 19 approved those kinds of things.  
 20 Q. Let me ask you to assume that if the  
 21 literature were to suggest that a prescribed  
 22 course of therapy was still viewed as  
 23 experimental and the information provided by the  
 24 prescribing doctor reflected that the patient had  
 25 received the treatment and had approved in

1 R. Sanchez, M.D.  
 2 symptomatology, would that combined information  
 3 be viewed together so as to make a determination  
 4 as to whether or not the therapy prescribed was  
 5 experimental versus proven?  
 6 MR. DRISCOLL: I object to the  
 7 hypothetical nature of the question.  
 8 Q. You can answer, Doctor.  
 9 A. Sometimes.  
 10 Q. How so?  
 11 A. It would depend on the diagnosis, it  
 12 would depend on the severity of the illness  
 13 involved, whether it was life threatening or not,  
 14 it would likely receive much more attention if it  
 15 were life threatening than if it were something  
 16 of a more cosmetic nature. So all those things  
 17 had to be considered.  
 18 Q. Would it be more likely to be  
 19 considered if it had a high cost?  
 20 MR. DRISCOLL: I object to the leading  
 21 nature of the question.  
 22 Q. Would the cost of prescribed treatment  
 23 be a factor that would be considered in  
 24 determining whether or not prescribed treatment  
 25 would be approved or denied?

1 R. Sanchez, M.D.  
 2 A. Yes.  
 3 Q. Was that true when you got to the  
 4 company?  
 5 A. Yes.  
 6 Q. When you came to the company did you  
 7 take any steps to tighten up the policy of the  
 8 company with regard to what treatment that was  
 9 prescribed by treating doctors would be approved  
 10 or denied?  
 11 A. Yes.  
 12 Q. Was that part of the marching orders  
 13 you received from Dr. Stocker?  
 14 A. From Dr. Stocker and Ms. Donigan, yes.  
 15 Q. Was that intended to have any impact,  
 16 if you recall, on the financial condition of the  
 17 company?  
 18 MR. DRISCOLL: I object to asking the  
 19 witness to speculate about what someone else  
 20 intended.  
 21 Q. If you know. Did you intend it to  
 22 improve the financial condition of the company?  
 23 (Pause.)  
 24 Q. Do you want me to rephrase the  
 25 question?

1 R. Sanchez, M.D.  
 2 A. Yes, please.  
 3 Q. Was the tightening up of these  
 4 policies that governed when prescribed therapy  
 5 would be approved or denied that you implemented  
 6 intended by you to have an impact on the  
 7 financial condition of Empire Blue Cross/Blue  
 8 Shield?  
 9 A. The cost of health care or medical  
 10 loss ratio accounts for 85 to 105 percent of the  
 11 premium dollar. On top of that are  
 12 administrative costs. My responsibility and the  
 13 reason I was brought to Empire was to reduce the  
 14 cost of health care allocation, the medical loss  
 15 ratio, and thereby improving the viability of the  
 16 company.  
 17 Q. Financially?  
 18 A. Of course financially.  
 19 MR. MAURER: Off tape, please.  
 20 THE VIDEOGRAPHER: The time is 12:04  
 21 p.m. and we are off the record.  
 22 MR. DRISCOLL: Can we take a  
 23 five-minute break.  
 24 MR. MAURER: Sure.  
 25 (Whereupon, there is a recess in the

1 R. Sanchez, M.D.  
 2 proceedings.)  
 3 THE VIDEOGRAPHER: The time is 12:16  
 4 p.m. We are back on the record.  
 5 BY MR. MAURER:  
 6 Q. Dr. Sanchez, before I forget, the  
 7 sworn statement that you gave me back on February  
 8 17, 1998, I'd like to mark that as Sanchez  
 9 Exhibit 3 for identification.  
 10 MR. MAURER: If the reporter would be  
 11 kind enough to do so.  
 12 Off tape while we do that.  
 13 THE VIDEOGRAPHER: The time is 12:16  
 14 p.m. and we are going off the record  
 15 (Sanchez Exhibit 3, sworn statement  
 16 given on February 17, 1998, marked for  
 17 identification, as of this date.)  
 18 THE VIDEOGRAPHER: The time is 12:17  
 19 p.m. We are back on the record.  
 20 BY MR. MAURER:  
 21 Q. Dr. Sanchez, is the sworn statement  
 22 that we have marked as Sanchez Exhibit 3, a  
 23 complete copy of the statement you gave me under  
 24 oath a year ago?  
 25 A. Yes, it is.

1 R. Sanchez, M.D.  
 2 Q. Having had the chance to review this  
 3 as recently, I believe, as yesterday, is the  
 4 transcript accurate in terms of the sworn  
 5 testimony that you gave to me on that date  
 6 approximately a year ago?  
 7 A. I believe it is.  
 8 Q. Is there any inaccuracies that need to  
 9 be corrected based on your review yesterday?  
 10 A. No.  
 11 Q. Going back to the Deloitte & Touche  
 12 report, Doctor, on page L-13, it looks likes,  
 13 it's an L, under key findings medical  
 14 management. It says, "There are significant  
 15 improvement opportunities for Empire to more  
 16 effectively manage health care costs" and one of  
 17 the sub-items bulleted is, "Physician reviewers  
 18 internally are not aggressive enough in denying  
 19 cases."  
 20 What's your understanding of what that  
 21 was referring to?  
 22 A. That our physician reviewers lacked  
 23 the will to appropriately deny services.  
 24 Q. The next item says, "Physician  
 25 reviewers denial rates are low negating some of

1 R. Sanchez, M.D.  
 2 the potential effectiveness of managed care."  
 3 The next thing item says, "An increase  
 4 in the physician reviewer denial rate to industry  
 5 norms could reduce claims by \$25 million."  
 6 What was your understanding of what  
 7 those two items were referring to?  
 8 A. That an average denial rate compared  
 9 to industry would have a tremendous rate on  
 10 health cost of health care.  
 11 Q. Now, on page IV-A 15, under  
 12 Utilization Management Process Work Flow Denial  
 13 Rates Continued, it says, "If the physicians took  
 14 a more aggressive stance denying industry  
 15 standard six to eight percent of cases, the  
 16 dollar amount of denied cases could  
 17 conservatively be expected to triple."  
 18 Did you consider that information in  
 19 deciding what course to take in your job  
 20 performance?  
 21 A. Yes.  
 22 Q. With regard to page IV-A 14, is this  
 23 particular chart reflective of the information I  
 24 just asked you about a moment ago from the  
 25 previous page comparing dollars that could be

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 1 R. Sanchez, M.D.  
 2 It was -- there was steps taken to  
 3 create the right leadership and incentive and  
 4 recruit a team that would oversee utilization  
 5 management and the policies and procedures to be  
 6 developed and were implementable.  
 7 There was a creation of the proper  
 8 documentation and incentive, there would be a  
 9 crackdown on fraudulent providers.  
 10 There would be a clarification of some  
 11 of the employer expectations of what they  
 12 interpreted the benefits to be.  
 13 There would be a recontracting of  
 14 provider networks and hospitals.  
 15 There would be an implementation of a  
 16 medical risk product.  
 17 There would be a more of a  
 18 transferring the risk to providers in their  
 19 contracting.  
 20 So there was a constellation of things  
 21 that occurred.  
 22 Q. Did you undertake to have any sort of  
 23 evaluation performed to determine if there were  
 24 any particular areas of health care costs that  
 25 were responsible for the high cost of health care

1 R. Sanchez, M.D.  
 2 saved based upon increased denials?  
 3 A. Yes.  
 4 Q. Look at IV-A 13, Utilization  
 5 Management Process Work Flow Indemnity Products,  
 6 and it says, "Physician denial rates are less  
 7 than one-third of industry standards for  
 8 indemnity products." There is a little bit of a  
 9 graphic or chart there. Would that information  
 10 -- let me just take this Post-it off -- was that  
 11 information considered by you in determining the  
 12 course to take?  
 13 A. Yes.  
 14 Q. Now, in order to make the changes that  
 15 had to be made at Empire Blue Cross to reduce the  
 16 cost of health care what steps did you actually  
 17 take?  
 18 A. Excuse me, I don't want to cough into  
 19 the microphone.  
 20 There was an entire program put into  
 21 effect that implemented many, many steps.  
 22 Specifically, in the cost of health care, it was  
 23 to bring a consistent and implementable set of  
 24 policies for our caseworkers to utilize in their  
 25 evaluation of the appropriateness of care.

1 R. Sanchez, M.D.  
 2 for the company?  
 3 A. Our utilization management leadership  
 4 was asked to identify the high cost diagnoses and  
 5 procedures so that we could focus in on those  
 6 diagnoses and procedures to try to reduce health  
 7 care expenditures in those areas.  
 8 Q. What do you mean by that in layman's  
 9 terms, what do you mean when you say to focus on  
 10 higher cost diagnoses and treatment areas?  
 11 A. That area of managed care is called  
 12 disease management and what it means in layman's  
 13 terms is that we are going to focus on the small  
 14 percentage of diagnoses and procedures that  
 15 account for a huge percentage in health care  
 16 expenditures. If you focus in on those small  
 17 number of diagnoses and procedures, you get a  
 18 much bigger bang for your dollar and you get much  
 19 more of a reduction in the cost of health care  
 20 and we think that that's more important or better  
 21 use of our time than focusing in on the micro  
 22 management of an office visit which is \$80.  
 23 Q. What specifically by way of diagnoses  
 24 did you focus on as the target areas that were  
 25 costing so much money at Empire?



1 R. Sanchez, M.D.

2 A. Diagnoses-wise it was clearly  
3 diabetes, cardiac, cancer, transplants, Lyme  
4 disease, asthma, neonatals were the kind of heavy  
5 hitters that anyone could see at first glance  
6 where the money was going in a disproportionate  
7 way.

8 Q. With regard to Lyme disease is there a  
9 specific area of the treatment of the disease  
10 that caused it to be in that group of high cost  
11 diagnoses?

12 A. Specifically to Lyme disease there was  
13 three areas that caused it to be a  
14 disproportionate expenditure. One, is the very  
15 diagnosis of it, it's very vague, it's very  
16 difficult to diagnose. That caused what we  
17 thought an opportunity to eliminate treatment for  
18 improperly diagnosed cases.

19 The other area was in the  
20 over-treatment and overzealous treatment of a  
21 disease that was difficult to cure and difficult  
22 to document any resolution of the  
23 symptomatology.

24 And then lastly to -- those are the  
25 two that come to mind. I forgot the third one.

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1 R. Sanchez, M.D.

2 Q. Was there any particular kind of  
3 treatment that was determined to be costly with  
4 regard to Lyme disease?

5 A. It was intravenous use of drugs of the  
6 antibiotic Rocephin, R-O-C-E-P-H-I-N, the  
7 intravenous use of that drug and on a very  
8 frequent basis throughout the early course and  
9 sometimes throughout the course of the diagnosis  
10 or suspected diagnosis.

11 Q. Is the intravenous antibiotic  
12 treatment you referred to known sometimes as IV  
13 antibiotic therapy?

14 A. Correct.

15 Q. With regard to the tightening -- did  
16 you say that you tightened up the various  
17 corporate medical policies as part of what you  
18 did?

19 A. Yes.

20 Q. In that regard, did corporate medical  
21 policies which governed what treatment would be  
22 paid for, what testing would be paid for, already  
23 exist when you got to Empire?

24 A. Yes.

25 Q. Did you undertake to have those

1 R. Sanchez, M.D.

2 corporate medical policies that governed the  
3 decisions that were being made by your  
4 caseworkers and doctors so as to have them  
5 upgraded?

6 A. Their corporate medical policies are  
7 an always changing area and they have to be  
8 updated periodically and are when in dire need of  
9 that.

10 Q. Was the cost of health care, or COHC,  
11 a factor that played any part whatsoever in you  
12 having the corporate medical policies that I'm  
13 asking you about revised?

14 A. That would occur with any person  
15 that's required -- any person that had that  
16 responsibility in any insurance company and it  
17 was, of course, I had to consider cost and the  
18 policy. We had to make sure that the policy,  
19 one, was reflective of the diagnosis, and that  
20 the policy implemented the best care available to  
21 that patient.

22 In addition, we wanted to make sure  
23 that that policy also provided a value to the  
24 member and the employer and anyone who was paying  
25 the bill so that we didn't -- so that we took

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1 R. Sanchez, M.D.

2 into consideration if it was going to cost a  
3 million dollars or \$100,000. We wanted to make  
4 sure that the policy brought the quality of care  
5 and was an appropriate use of the financial  
6 resources of the company. That's part and parcel  
7 of what we do.

8 Q. Just to make sure I have got this  
9 clear on the record, is it your testimony that  
10 the corporate medical policies that were used to  
11 determine what diagnostic test and treatment was  
12 paid for was modified or changed at your request  
13 in order to help reduce the cost of health care  
14 at Empire?

15 A. There was a consideration that came  
16 into the development of those policies. That was  
17 one of the considerations.

18 Q. By the way, with regard to the  
19 incentive program that you helped bring into the  
20 company that you talked about earlier, was there  
21 any incentive made available to the outside  
22 medical service providers, the outside doctors,  
23 with regard to helping Empire keep the cost of  
24 health care down?

25 A. Yes.

1 R. Sanchez, M.D.  
 2 Q. What was done in that regard?  
 3 A. In the re-contracting of our providers  
 4 for risk products, the lock-in HMO, the managed  
 5 care products, the Medicare risk products, they  
 6 were to share in an -- they were to receive an  
 7 incentive compensation for any reduction in  
 8 savings of the cost of health care that Empire  
 9 realized.  
 10 Q. Just to put this in terms that are  
 11 clear, was there any incentive for these outside  
 12 doctors that you just referred to, to keep the  
 13 number of expensive diagnostic tests that they  
 14 prescribed down to a certain level or number?  
 15 A. Yes.  
 16 Q. Was that in existence when you got to  
 17 Empire or something that you helped to bring in?  
 18 A. Something I helped to bring in.  
 19 Q. Was the goal of reducing the cost of  
 20 health care for the company a fact in factor in  
 21 your deciding to bring that particular program of  
 22 incentives for outside doctors into existence?  
 23 A. I was hired to implement risk  
 24 contracting. One of the aspects was to implement  
 25 a risk contract with our providers and so it was

1 R. Sanchez, M.D.  
 2 clear to me that that was one of the  
 3 expectations. It wasn't the only expectation and  
 4 one of the only aspects of my job, but clearly to  
 5 recontract our physician network into risk  
 6 contracts in which they shared an incentive  
 7 compensation at the end of the day if we had  
 8 reduced health care costs that was part of the  
 9 plan.  
 10 Q. I have been asking you some questions  
 11 about corporate medical policy. What are we  
 12 talking about, could you explain it to the jury  
 13 what you are referring to?  
 14 A. Corporate medical policy has to do  
 15 with the, in a very narrow sense, has to do with  
 16 that I was responsible, has to do with having the  
 17 correct policies for the interpretation of  
 18 benefits so that the rest of our operation can  
 19 pay the claim appropriately. That's a corporate  
 20 medical policy.  
 21 For example, if you need a gall  
 22 bladder surgery, or you think you need it, we  
 23 have a corporate medical policy on gall bladder  
 24 surgery. That policy would include to make sure  
 25 that the diagnosis is appropriate, to make sure

1 R. Sanchez, M.D.  
 2 what you have tried up to the point you are  
 3 recommending surgery is appropriate and then to  
 4 recommend the appropriate care intervention,  
 5 whether that is surgery or done laparoscopy,  
 6 whether it's done inpatient or outpatient.  
 7 So that someone who wanted to come in  
 8 and give chemotherapy for a gall bladder would  
 9 not be able to pass the scrutiny of our corporate  
 10 policy.  
 11 Q. Let me show you an exhibit, previously  
 12 marked as Plaintiffs' Golonka, G-O-L-O-N-K-A, No.  
 13 1 of 2/10/98 which we will mark as Plaintiffs'  
 14 Sanchez 4 for identification.  
 15 This says on the top, Empire Blue  
 16 Cross/Blue Shield Managed Care Medical Guideline  
 17 Topic Treatment of Lyme Disease.  
 18 MR. MAURER: If the court reporter  
 19 would be kind enough to put a sticker on it  
 20 I'll ask you to go off tape for a moment.  
 21 THE VIDEOGRAPHER: The time is 12:34  
 22 p.m.  
 23 This completes tape No. 1 of the  
 24 videotape deposition of Dr. Richard  
 25 Sanchez.

1 R. Sanchez, M.D.  
 2 (Sanchez Exhibit 4, document entitled  
 3 Empire Blue Cross/Blue Shield Managed Care-  
 4 Medical Guideline, Topic: Treatment of Lyme  
 5 disease, marked for identification, as of  
 6 this date.)  
 7 THE VIDEOGRAPHER: The time is 12:36  
 8 p.m.  
 9 This is tape No. 2 of the videotape  
 10 deposition of Dr. Richard Sanchez, M.D..  
 11 BY MR. MAURER:  
 12 Q. I see that two exhibits from the  
 13 Golonka deposition were connected so I have  
 14 separated them.  
 15 Sanchez Exhibit 4 is a two-page  
 16 document which is dated and signed 10/1/90.  
 17 Dr. Sanchez, would you take a look at  
 18 this particular exhibit. Can you identify what  
 19 this particular document is?  
 20 A. It is a medical policy for the managed  
 21 care guidelines for Lyme disease, for the  
 22 treatment of Lyme disease.  
 23 Q. Is this a corporate medical policy as  
 24 we have been referring to it?  
 25 A. Yes, it is.

1 R. Sanchez, M.D.  
 2 Q. Who would typically receive a copy of  
 3 that corporate medical policy at Empire?  
 4 A. Our case managers, our doctors, the  
 5 chief medical officer would have a lot to do with  
 6 editing this and producing this final copy. At  
 7 one point they would be shared with our senior  
 8 staff but they don't write these.  
 9 Q. Have you had a chance to read this  
 10 particular corporate medical policy on Lyme  
 11 disease prior to today?  
 12 A. Yes.  
 13 Q. Based upon your knowledge of what is  
 14 contained in this particular corporate medical  
 15 policy on Lyme disease do you consider this to be  
 16 a fair corporate medical policy on Lyme disease  
 17 when it was put into place back in 1990?  
 18 A. Yes.  
 19 Q. Thank you, Doctor.  
 20 Now, with regard to the diagnosis of  
 21 Lyme disease, what is your understanding as to  
 22 how Lyme disease is diagnosed?  
 23 A. The diagnosis usually starts with a  
 24 type of viral syndrome symptomatology including a  
 25 fever, aches, headache and a characteristic skin

1 R. Sanchez, M.D.  
 2 Q. Is that an antibody test that was used  
 3 in the early '90s and is still used today in the  
 4 diagnosis of Lyme disease?  
 5 A. Yes.  
 6 Q. Are you familiar with the IFA test,  
 7 Immunofluorescent Assay test?  
 8 A. Yes.  
 9 Q. Is that also a test that is used to  
 10 diagnose Lyme disease?  
 11 A. Can be, yes.  
 12 Q. If those tests are done and the test  
 13 comes back positive, would it then be typical, as  
 14 far as you know, to then do a confirmatory  
 15 Western Immuno-Blot test?  
 16 A. That's usually the order of the test.  
 17 They are general and they become more specific.  
 18 Q. In 1990, did the corporate medical  
 19 policy on Lyme disease used at Empire, which is  
 20 Sanchez 4 for identification, would I be correct  
 21 that that particular policy did not require a  
 22 positive serology with both the ELISA and a  
 23 confirmatory Western Blot in order to get  
 24 approval from Empire Blue Cross for independent  
 25 intravenous treatment?

1 R. Sanchez, M.D.  
 2 rash surrounding the tick bite that transmits the  
 3 bacteria to the patient. It is then followed by  
 4 some variable -- by a variable process that could  
 5 lead to connective tissue disorders and heart  
 6 disease and at one point there is a seral  
 7 conversion that allows the diagnosis to be more  
 8 accurate which you can actually detect the  
 9 antibodies to the bacteria in the patient's  
 10 serum.  
 11 Q. Now, with regard to testing, to your  
 12 knowledge what specific tests have been generally  
 13 used to diagnosis Lyme disease?  
 14 A. It's an antibody, it's called a  
 15 Western Blot. It is an antibody titer taken from  
 16 the patient's serum looking for specific  
 17 antibodies to the bacteria. If you have them,  
 18 then you've been exposed to the disease. If you  
 19 have high titers of those antibodies, you have an  
 20 acute exposure. If you have decreasing titers,  
 21 then you have response to the treatment or the  
 22 disease is self-limited or disappearing.  
 23 Q. Are you familiar with the ELISA test,  
 24 E-L-I-S-A?  
 25 A. Yes.

1 R. Sanchez, M.D.  
 2 MR. DRISCOLL: I object and would like  
 3 to go off tape.  
 4 THE VIDEOGRAPHER: The time is 12:41  
 5 p.m. We are going off the record.  
 6 MR. DRISCOLL: The objection is that  
 7 Dr. Sanchez was not at Empire in 1990 and  
 8 unless you are going to ask him whether he's  
 9 had an opportunity to review the document  
 10 you've marked and he's gotten some  
 11 understanding of it based upon this review  
 12 here today, then I don't see how you can ask  
 13 him about Empire's policies in 1990.  
 14 MR. MAURER: I asked him that two  
 15 minutes ago, Justice. That he read it.  
 16 MR. MAURER: Yes. And he said he did.  
 17 Q. Is that correct, Doctor?  
 18 A. I read it in 1995 in reviewing our  
 19 updated policy.  
 20 Q. Did you read it again yesterday at my  
 21 request?  
 22 A. Yes.  
 23 MR. DRISCOLL: The objection is  
 24 withdrawn.  
 25 MR. MAURER: On tape.

1 R. Sanchez, M.D.  
 2 THE VIDEOGRAPHER: The time is 12:42  
 3 p.m. We are back on the record.  
 4 BY MR. MAURER:  
 5 Q. Doctor, I'll repeat the question.  
 6 Would I be correct that the 1990  
 7 corporate medical policy on Lyme disease, which  
 8 we marked as Sanchez 4 for identification, did  
 9 not require that a patient have both a positive  
 10 ELISA test and confirmatory positive Western  
 11 Immuno-Blot test in order to qualify for approval  
 12 of prescribed intravenous antibiotic therapy for  
 13 Lyme disease?  
 14 A. Yes.  
 15 MR. MAURER: Let's mark as Plaintiffs'  
 16 Sanchez Exhibit 5, a memorandum from Marvin  
 17 B. Blitz, M.D., vice president medical  
 18 policy and research on the subject of Lyme  
 19 disease, oral and intravenous, dated August  
 20 30, 1993 and previously marked for  
 21 identification as Plaintiffs' 2 on  
 22 11/17/97.  
 23 Off tape.  
 24 THE VIDEOGRAPHER: The time is 12:43  
 25 p.m. We are going off the record.

1 R. Sanchez, M.D.  
 2 (Plaintiffs' Sanchez Exhibit 5,  
 3 memorandum from Marvin B. Blitz, M.D., on  
 4 the subject of Lyme disease oral and  
 5 intravenous, dated August 30, 1993, marked  
 6 for identification, as of this date.)  
 7 Q. Doctor, you requested the opportunity  
 8 while we were off tape to look at this particular  
 9 exhibit?  
 10 A. I just did.  
 11 Q. No, I didn't know if the reporter had  
 12 the request. I wanted to document your request.  
 13 A. Yes.  
 14 Q. Please feel free before we go on  
 15 tape:  
 16 (Witness reads document.)  
 17 MR. MAURER: On tape, please.  
 18 THE VIDEOGRAPHER: The time is 12:45  
 19 p.m. We are back on the record.  
 20 BY MR. MAURER:  
 21 Q. While we were off tape did you request  
 22 to be able to read through the '93 corporate Lyme  
 23 policy?  
 24 A. Yes.  
 25 Q. Did you do so?

1 R. Sanchez, M.D.  
 2 A. Yes, sir.  
 3 Q. Had you seen this particular two-page  
 4 document prior to today?  
 5 A. Yes.  
 6 Q. When for the first time,  
 7 approximately?  
 8 A. 1995. Again, a year ago when you took  
 9 my sworn statement and last night or yesterday  
 10 and today.  
 11 Q. Incidentally, I didn't ask you, but  
 12 while we are bringing it up, did you and I meet  
 13 for any period of time prior to today to discuss  
 14 your deposition, this particular deposition for  
 15 trial?  
 16 A. We met yesterday.  
 17 Q. For how long?  
 18 A. An hour and a half.  
 19 Q. Did you review materials at that time?  
 20 A. Yes.  
 21 Q. What materials did you review?  
 22 A. I reviewed my personnel folder, I  
 23 reviewed these three policies and I reviewed my  
 24 sworn statement.  
 25 Q. Did you look at any portion of the

1 R. Sanchez, M.D.  
 2 Deloitte & Touche report?  
 3 A. No, I did not. I didn't look at that.  
 4 Q. Now, returning to Sanchez Exhibit 5,,  
 5 the 1993 corporate Lyme disease policy from  
 6 Empire, there's some reference to code numbers on  
 7 the bottom of the first page. Do you see what  
 8 I'm referring to?  
 9 A. Correct.  
 10 Q. What is that?  
 11 A. These code numbers refer to the  
 12 diagnosis.  
 13 Q. Was there a particular reason why  
 14 those code numbers started to be used at Empire  
 15 with regard to the diagnosis of Lyme disease?  
 16 A. Yes.  
 17 Q. What's your understanding of the  
 18 reason?  
 19 A. The intent of this memorandum was to  
 20 make sure that all those new diagnoses identified  
 21 by this code number would suspend.  
 22 Q. Why?  
 23 A. For medical review.  
 24 Q. Why?  
 25 A. To assure that the treatment was

1 R. Sanchez, M.D.  
 2 authorized prior to forwarding it for payment.  
 3 Q. Why?  
 4 A. Because prior to that the treatment  
 5 was being paid for without that kind of review.  
 6 Q. Were these code numbers put into a  
 7 computer system at Empire, if you know?  
 8 A. Yes, they were.  
 9 Q. Did the use of this code number for  
 10 Lyme disease flag a Lyme disease case as  
 11 something that all payments should stop until a  
 12 review had taken place?  
 13 A. It would have been impossible to  
 14 process the claim any further until a medical  
 15 reviewer intervened.  
 16 Q. Was that built into the system?  
 17 A. Yes.  
 18 Q. Now, I have an additional document of  
 19 the date of August 18th, 1993 which consisted of  
 20 five pages on Lyme disease treatment from  
 21 Dr. Blitz to Harold Sandler.  
 22 Who is Harold Sandler, do you know?  
 23 A. Harold Sandler, as I recall, I thought  
 24 there were two people named Sandler, but the  
 25 Sandler I recall had to do with underwriting and

1 R. Sanchez, M.D.  
 2 involve different parts of the body. I'd like to  
 3 ask you a little bit more about that.  
 4 Have you ever heard of the term  
 5 "disseminated disease" with reference to Lyme  
 6 disease?  
 7 A. Yes.  
 8 Q. What's your understanding of the  
 9 method by which the organism that causes Lyme  
 10 disease disseminates in the human body?  
 11 A. The dissemination of any infection,  
 12 including Lyme disease, throughout the body  
 13 occurs when the bacterial spread of the virus or  
 14 the disease goes beyond where it was introduced  
 15 or attacks various systems that would normally  
 16 not be involved.  
 17 For example, in tuberculosis you may  
 18 contract the Tuberculin Bacillus by breathing it  
 19 in the subway. The dissemination would be that  
 20 you actually developed a brain abscess of  
 21 bacteria, so that that's the dissemination of the  
 22 disease, or the bone.  
 23 Q. With reference to Lyme, how does the  
 24 organism spread within the human body?  
 25 A. It would be the same process, the body

1 R. Sanchez, M.D.  
 2 also in operations and claims area.  
 3 Q. Attached to this five-page document  
 4 there is an Exhibit 1, Lyme disease statement of  
 5 medical necessity, Exhibit 2, decision guide for  
 6 Lyme disease, IV treatment payment, which is  
 7 followed by a memorandum to Ellen Rothstein from  
 8 Dr. Blitz dated August 3, '93, and a final page,  
 9 pre-authorization for IV treatment of Lyme  
 10 disease.  
 11 MR. MAURER: Why don't we mark  
 12 collectively as Sanchez Exhibit 6. We will  
 13 go off tape.  
 14 THE VIDEOGRAPHER: The time is 12:50  
 15 p.m. And we are going off the record.  
 16 (Plaintiffs' Sanchez Exhibit 6,  
 17 collection of documents, marked for  
 18 identification, as of this date.)  
 19 MR. MAURER: On tape.  
 20 THE VIDEOGRAPHER: The time is 12:50  
 21 p.m. We are back on the record.  
 22 BY MR. MAURER:  
 23 Q. Doctor, you made reference in response  
 24 to an earlier question a few minutes ago to some  
 25 of the various ways that Lyme disease could

1 R. Sanchez, M.D.  
 2 itself does not limit the area of attack of the  
 3 bacterium and it could disseminate onto cartilage  
 4 and the heart and other areas.  
 5 Q. Does it travel in a particular system  
 6 of the body?  
 7 A. It's assumed to be in the blood  
 8 system.  
 9 Q. So once the organism that causes Lyme  
 10 disease gets into the blood system, it could  
 11 disseminate or spread throughout the body, is  
 12 that what you are saying?  
 13 A. If not taken care of by the body's  
 14 immune system or the appropriate antibody or in  
 15 some cases the disease is self-limited and never  
 16 goes any further.  
 17 Q. What's your understanding of how  
 18 quickly or how soon the organism that cause Lyme  
 19 disease can get into the blood stream and start  
 20 to disseminate into the body?  
 21 A. It could be days to weeks.  
 22 Q. I'd like to show you Sanchez Exhibit 6  
 23 and I'll give you a moment to look through it one  
 24 more time before I ask you a question out of  
 25 fairness so the information is fresh in your

1 R. Sanchez, M.D.  
 2 mind.  
 3 MR. MAURER: Let's go off tape while  
 4 you look at the document.  
 5 THE VIDEOGRAPHER: The time is 12:53  
 6 p.m. and we are going off the record.  
 7 (Witness reviews exhibit.)  
 8 MR. MAURER: I guess after we finish  
 9 with this exhibit we will take a lunch  
 10 break. It's 1:00.  
 11 MR. CHANCELER: You have more after  
 12 lunch?  
 13 MR. MAURER: Yes. We are getting  
 14 there.  
 15 On tape.  
 16 THE VIDEOGRAPHER: The time is 12:55  
 17 p.m. We are back on the record.  
 18 BY MR. MAURER:  
 19 Q. Have you had a chance to look at  
 20 Exhibit 6, Doctor?  
 21 A. Yes.  
 22 Q. Had you seen this particular document  
 23 before today?  
 24 A. Yes.  
 25 Q. Did you see it in '95?

1 R. Sanchez, M.D.  
 2 A. Yes.  
 3 Q. Did you see it when you undertook to  
 4 have corporate medical policies changed?  
 5 A. Yes.  
 6 Q. Did you review it yesterday?  
 7 A. Yes.  
 8 Q. Doctor, what's your understanding, if  
 9 you have an understanding, as to how fast the  
 10 Lyme bacteria, the bacteria that causes Lyme  
 11 disease, can disseminate or spread from the  
 12 location of the tick bite to the brain?  
 13 A. In -- it can be as short as a week and  
 14 as long as six weeks.  
 15 Q. Is there, to your knowledge, any  
 16 advantage to treating Lyme disease with  
 17 intravenous antibiotics as opposed to oral  
 18 antibiotics?  
 19 A. Are you asking me that with knowledge  
 20 now or knowledge in '95?  
 21 Q. I'm asking you based on your  
 22 understanding of the subject currently.  
 23 A. My understanding of the subject  
 24 currently is that the intravenous administration  
 25 aggressive very early on in any suspected

1 R. Sanchez, M.D.  
 2 dissemination of the disease is the appropriate  
 3 choice.  
 4 Q. Have you ever heard of the blood brain  
 5 barrier?  
 6 A. Sure.  
 7 Q. Were you aware of what that was in  
 8 '95?  
 9 A. Yes, sir.  
 10 Q. In 1995, what was your understanding  
 11 as to whether or not oral and intravenous  
 12 antibiotics, either or, were capable of  
 13 penetrating the blood brain barrier?  
 14 A. Oral agents poorly, intravenous agents  
 15 much more successful.  
 16 Q. In the treatment of Lyme disease what  
 17 was knowledge in 1995 when the new corporate  
 18 medical policies came into being with regard to  
 19 the appropriateness of use of intravenous  
 20 antibiotics to treat Lyme disease where central  
 21 nervous system involvement was believed to exist?  
 22 A. Where central nervous system  
 23 involvement was believed to exist in conjunction  
 24 with the timing it was an appropriate utilization  
 25 of medication -- it was an appropriate regimen.

1 R. Sanchez, M.D.  
 2 Q. What do you mean by timing?  
 3 A. That our policy when I arrived and our  
 4 understanding of the disease from the experts  
 5 that we, and review of the literature, was that  
 6 the first line of treatment for an early  
 7 infection, less than six weeks, was an oral  
 8 administration of antibiotics.  
 9 Q. If a patient was the recipient of an  
 10 appropriate dose of oral antibiotics early on  
 11 after the onset of the infection and appeared to  
 12 have evidence of central nervous system  
 13 involvement, what was your understanding with  
 14 regard to the appropriateness of treatment with  
 15 intravenous antibiotics within that first  
 16 six-week period?  
 17 A. It was our policy to not approve  
 18 those.  
 19 Q. Are you aware of any particular  
 20 scientific or medical reason or literature that  
 21 supported the conclusion that it was appropriate  
 22 not to treat with intravenous antibiotics if it  
 23 was 42 days or less from the date on onset of the  
 24 condition?  
 25 A. That was the existing policy when I

1 R. Sanchez, M.D.  
 2 arrived at Empire.  
 3 Q. My question is: Are you aware of any  
 4 medical or scientific justification for that  
 5 policy, to restrict approval of IV antibiotic  
 6 treatment to patients who were at least 42 days  
 7 or more out from the onset of their Lyme disease  
 8 condition?  
 9 A. No.  
 10 MR. MAURER: Since it's 1:00 why don't  
 11 we break now for lunch and then we will come  
 12 back. Off tape, please.  
 13 THE VIDEOGRAPHER: The time is 1:00  
 14 p.m. We are going off the record.  
 15 (Luncheon recess taken at 1:00 p.m.)  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25

1 R. Sanchez, M.D.  
 2 Q. As far as you know what was the  
 3 rationale for selecting the 42-day period of time  
 4 for the section that I just read from the  
 5 corporate Lyme disease policy from 1993?  
 6 A. It's an arbitrary number, six times  
 7 seven is 42, it's six weeks, and that's just the  
 8 way we tended to divide up courses of treatment,  
 9 ten days, 14 days, four weeks, six weeks, nothing  
 10 magical or scientific about it.  
 11 MR. MAURER: I'd like to mark as  
 12 Plaintiffs' Sanchez Exhibit 7 for ID, the  
 13 Empire Blue Cross/Blue Shield medical policy  
 14 on Lyme disease dated December 8th, 1995.  
 15 Why don't we go off tape to mark it.  
 16 THE VIDEOGRAPHER: The time is 1402  
 17 p.m.. We are going off the record  
 18 (Plaintiffs' Sanchez Exhibit 7, Empire  
 19 Blue Cross/Blue Shield medical policy on  
 20 Lyme disease dated December 8th, 1995,  
 21 marked for identification, as of this date.)  
 22 THE VIDEOGRAPHER: The time is 1403  
 23 and we are back on the record.  
 24 BY MR. MAURER:  
 25 Q. Dr. Sanchez, let me show what I have

1  
 2 AFTERNOON SESSION  
 3 (Time noted: 2:00 p.m.)  
 4 RICHARD SANCHEZ, resumed and  
 5 testified as follows:  
 6 CONTINUED EXAMINATION  
 7 BY MR. MAURER:  
 8 THE VIDEOGRAPHER: The time is 2:00  
 9 p.m. we are back on the record.  
 10 Q. Good afternoon, Doctor.  
 11 With reference to the 1993 corporate  
 12 Lyme disease policy that I was asking you about  
 13 before and specifically with reference to what is  
 14 stated on the third page under policy, let's see,  
 15 under the section B, history, it says, "Date of  
 16 onset. If 42 days or less from start of  
 17 treatment it is early disease and IV infusion is  
 18 to be denied."  
 19 My question to you is, first of all,  
 20 did you discuss the corporate Lyme disease policy  
 21 at all with Dr. Blitz?  
 22 A. I discussed all the policies with him  
 23 at one point or another so this would have been  
 24 one of them. I don't remember the specific  
 25 conversations regarding that.

1 R. Sanchez, M.D.  
 2 marked for identification as Plaintiffs' Sanchez  
 3 7 for identification.  
 4 The first question is: Have you seen  
 5 this particular document before?  
 6 A. Yes, I have seen this particular  
 7 document before.  
 8 Q. Did you see it in 1995?  
 9 A. Yes.  
 10 Q. Have you seen it since then?  
 11 A. Yes.  
 12 Q. Did you see it yesterday?  
 13 A. Yes.  
 14 Q. Okay. Could I have it for a moment,  
 15 please.  
 16 (Handing.)  
 17 Q. Doctor, referring to page 13 of this  
 18 particular exhibit, Sanchez 7, there's a table  
 19 two, Summary of Indications for IV antibiotics.  
 20 It says, "For all the following, three conditions  
 21 must be satisfied. One, characteristic  
 22 exposure/epidemiologic and early localized  
 23 disease history."  
 24 What was your understanding of what  
 25 that meant?

1 R. Sanchez, M.D.  
 2 A. That there would have to be a  
 3 recollection of the possible exposure to tick  
 4 bite, that the person actually remembers the tick  
 5 bite or that there's a manifestation on the skin  
 6 of the tick bite and Lyme disease.  
 7 Q. Number two, positive Lyme serology  
 8 concerned with Western Immuno-Blot. What was  
 9 your understanding of what that meant?  
 10 A. That the patient would have to have  
 11 antibody evidence of exposure to the organism.  
 12 Q. Does this specifically when referring  
 13 to positive Lyme serology refer to a positive  
 14 ELISA?  
 15 A. Yes.  
 16 Q. Confirm with Western Immuno-Blot.  
 17 Does that mean a positive Western Immuno-Blot  
 18 test?  
 19 A. Correct.  
 20 Q. So does number two there require both  
 21 a positive ELISA and a positive Western Blot  
 22 test?  
 23 A. Yes.  
 24 Q. No. 3, exclusion of other common  
 25 medical illness that could explain clinical

1 R. Sanchez, M.D.  
 2 findings.  
 3 A. Correct.  
 4 Q. So based upon what is stated here on  
 5 page 13 of the 1995 Empire Blue Cross/Blue Shield  
 6 corporate medical policy on Lyme disease, no  
 7 insured patient who is insured with Empire would  
 8 qualify for approval of prescribed IV antibiotic  
 9 therapy if they did not have both the positive  
 10 ELISA and positive Western Blot test?  
 11 A. As per the policy, yes.  
 12 Q. This policy was actually put into  
 13 effect when you were at Empire; is that correct?  
 14 A. Right.  
 15 Q. Was this one of the corporate medical  
 16 policies that was revised as part of the overall  
 17 project that you've already told us about?  
 18 A. That's correct.  
 19 Q. With reference to these new corporate  
 20 medical policies that you put into effect after  
 21 you went to Empire, did these policies reflect  
 22 the same information or did they differ from the  
 23 kinds of guidelines that you told us about that  
 24 were in the InterQual and Millman & Robertson?  
 25 A. They were reflected much the same

1 R. Sanchez, M.D.  
 2 information. They are a little different in that  
 3 the Millman & Robertson and InterQual are more  
 4 procedure-related, length of stay-related than  
 5 corporate policies that do more to interpret  
 6 benefits. So these are a little different, they  
 7 are not apples and oranges, apple and apples,  
 8 apples and oranges.  
 9 Q. Now, with regard to these new  
 10 corporate medical policies that you brought into  
 11 effect at Empire, did you have any expectation --  
 12 or what expectation did you have, if any, as to  
 13 any impact the new corporate policy would have  
 14 with regard to the ability of insured patients  
 15 being able to get treated for diagnosed Lyme  
 16 disease?  
 17 A. Our expectation was that we would be  
 18 able to prevent the unnecessary treatment of, the  
 19 unnecessary and expensive treatment, with people  
 20 of early Lyme disease that could have been  
 21 treated orally or, two, or misdiagnosed Lyme  
 22 disease. There was at that time a rather  
 23 hysterical environment of people in that part of  
 24 the state or country that Lyme disease was being  
 25 over-diagnosed and therefore being over-treated

1 R. Sanchez, M.D.  
 2 so the policies were made to curb that.  
 3 Q. Did you when you brought in the new  
 4 corporate medical policy on Lyme disease in  
 5 December 1995, were you familiar with Dr. Raymond  
 6 Dattwyler from the Stony Brook, New York Lyme  
 7 clinic?  
 8 A. I'm familiar with his work.  
 9 Q. With regard to the work you were  
 10 familiar with were you familiar with his work  
 11 regarding sero-negative Lyme patients?  
 12 A. Yes.  
 13 Q. What's your understanding of what a  
 14 sero-negative is?  
 15 A. It's a patient who demonstrates no  
 16 antibody development or demonstrable antibody  
 17 development but has indeed contracted the disease  
 18 and is manifesting symptoms and pathology of the  
 19 organism without an immune response.  
 20 Q. In December of 1995 when you adopted  
 21 the new corporate medical policy on Lyme disease  
 22 did you have that information about sero-negative  
 23 Lyme patients?  
 24 A. Yes.  
 25 Q. You were aware of it?



1 R. Sanchez, M.D.  
 2 A. Correct.  
 3 Q. Did you have any expectation at the  
 4 time that you adopted the new corporate medical  
 5 policy on Lyme disease that there would be any  
 6 patients who were insured with Empire who had  
 7 Lyme disease who would not be able to meet the  
 8 criteria contained in the policy, the corporate  
 9 medical policy?  
 10 A. Could you ask that question again.  
 11 Q. You want it read back by the reporter  
 12 or would you like me to rephrase it?  
 13 A. I would like you to clarify it for me.  
 14 Q. Is there a particular part that you  
 15 didn't understand so I know what to focus on?  
 16 A. The part of my expectation of patients  
 17 that had the diagnosis.  
 18 Q. Sure. When you adopted the new  
 19 corporate medical policy on Lyme disease did you  
 20 anticipate that there would be some insured  
 21 patients who actually had Lyme disease who did  
 22 not meet the new criteria for diagnosis of Lyme  
 23 disease that you adopted and therefore would not  
 24 be able to get approval for prescribed treatment  
 25 from Empire?

1 R. Sanchez, M.D.  
 2 to what percentage of the Lyme disease patient  
 3 community was sero-negative?  
 4 A. We thought that it was a very  
 5 insignificant percentage.  
 6 Q. Did Empire do any research or  
 7 investigation to determine whether or not any of  
 8 the medical literature reported on the percentage  
 9 of Lyme disease patients who were sero-negative  
 10 before adopting the new policy in December 1995?  
 11 A. We did no research, we reviewed the  
 12 literature and consulted infectious disease  
 13 experts in community and from that generated a  
 14 policy. So we got input from lots of sources,  
 15 CDC, people in the community and then we created  
 16 a policy.  
 17 Q. Did you disbelieve the information  
 18 contained in Dr. Dattwyler's research that he  
 19 published regarding sero-negativity at the time  
 20 or prior to the time you adopted the new  
 21 corporate medical policy on Lyme disease?  
 22 A. It was early research. It was a very  
 23 small group of patients and we assumed it was  
 24 insignificant.  
 25 Q. Did you contact Dr. Dattwyler or did

1 R. Sanchez, M.D.  
 2 A. The short answer is yes. Let me  
 3 elaborate. What we knew and expected was that  
 4 there were people that prior to implementing this  
 5 policy would have been diagnosed to have Lyme  
 6 disease. We tightened up the definition and  
 7 diagnosis and documentation of those people that  
 8 had Lyme disease fully understanding that there  
 9 would be people who thought they had Lyme disease  
 10 or had been treated to have Lyme disease or were  
 11 sero-negative were not going to meet the  
 12 criteria.  
 13 Q. You knew that were some people who  
 14 were sero-negative who still had the disease who  
 15 would not be able to meet the criteria?  
 16 A. According to Dr. Dattwyler there were  
 17 a couple dozen in his study. We had no evidence  
 18 of how many of those that there our members but  
 19 had one of those patients been our members, he  
 20 would have qualified for treatment.  
 21 Q. Did you have any knowledge at the time  
 22 you adopted this new corporate medical policy in  
 23 December 1995 that required there to be a  
 24 positive serology with confirmatory Western Blot  
 25 in order to qualify for IV antibiotic therapy as

1 R. Sanchez, M.D.  
 2 you or anyone else to your knowledge at Empire  
 3 contact Dr. Dattwyler or anyone he was working  
 4 with at Stony Brook to question him about his  
 5 research on sero-negativity and Lyme?  
 6 A. To my knowledge, no.  
 7 Q. Did Empire have the view that if you  
 8 didn't meet the criteria in any of its corporate  
 9 medical policies for any given disease or  
 10 condition that you didn't have the disease or  
 11 condition?  
 12 A. Correct.  
 13 Q. Was the cost of health care and  
 14 reducing the cost of health care for Empire a  
 15 factor in adopting the new corporate medical  
 16 policies that you brought in to play at Empire?  
 17 A. Yes.  
 18 MR. MAURER: Off tape.  
 19 THE VIDEOGRAPHER: The time is 1414.  
 20 We are going off the record.  
 21 (Whereupon, there is an off-the-record  
 22 discussion.)  
 23 THE VIDEOGRAPHER: The time is 1415.  
 24 We are back on the record.  
 25 BY MR. MAURER:

1 R. Sanchez, M.D.  
 2 Q. I'm not sure I asked this question,  
 3 forgive me if I'm repeating myself. I just want  
 4 to make sure I cover this point.  
 5 When the corporate medical policies  
 6 were adopted that you brought in when you came  
 7 into Empire did you have any expectation that  
 8 there would be patients, not just Lyme disease  
 9 patients, but patients in each of the disease or  
 10 conditioned areas that were the subject of these  
 11 new corporate medical policies who did not meet  
 12 the criteria in the policies who still had the  
 13 condition or disease that was the subject of any  
 14 given policy?  
 15 A. What is the question? You made a  
 16 statement. Did I have any expectation?  
 17 Q. That there would be some people that  
 18 didn't meet the criteria who still had the  
 19 disease or condition that the corporate medical  
 20 policy covered?  
 21 A. Of course. May I elaborate?  
 22 Q. Sure.  
 23 A. For example, there was a time when we  
 24 would consider transplantation of bone marrow in  
 25 a woman with advanced breast cancer. On our

1 R. Sanchez, M.D.  
 2 review of the literature showed that this was  
 3 experimental in the latter stages. We rewrote  
 4 the corporate policy so that we made it only a  
 5 benefit or coverable expense in the earlier  
 6 stages. When you rewrite that kind of policy or  
 7 procedure, you know full well you have people  
 8 with breast cancer in advanced stages that no  
 9 longer have a benefit for that coverage, so you  
 10 would be naive to think they don't exist anymore  
 11 or that are not going to get treated, they have  
 12 the disease but they no longer candidates for the  
 13 benefit.  
 14 Q. The motivation for doing that with  
 15 these different corporate medical policies was  
 16 what?  
 17 A. There were several. First, and  
 18 foremost, there was no scientific evidence that  
 19 it changed the outcome. In the example I just  
 20 cited that women still died, there was no  
 21 scientific evidence in that.  
 22 Secondly, and importantly, but not as  
 23 important as that, is that this was a huge  
 24 expense for the company to provide this care for  
 25 something that was futile, there was no evidence

1 R. Sanchez, M.D.  
 2 that it was going to help, or more importantly it  
 3 was being inappropriately applied to a  
 4 misdiagnosis.  
 5 Q. While you are on that particular  
 6 subject and that condition, were you aware of any  
 7 evidence to support the conclusion that what was  
 8 called experimental treatment in that particular  
 9 condition was a condition where the patient still  
 10 could have their life extended if not saved?  
 11 MR. DRISCOLL: I object to the form of  
 12 that question.  
 13 Q. Did you understand the question,  
 14 Doctor?  
 15 A. No. Would you repeat it for me,  
 16 please.  
 17 Q. Sure. You said earlier, to  
 18 paraphrase, that the people were going to die  
 19 even if they got the treatment and therefore it  
 20 was considered experimental; is that correct?  
 21 A. Correct.  
 22 Q. Earlier on today I asked you if it  
 23 would be experimental even if there wasn't a cure  
 24 but there was some benefit and you, I believe  
 25 told me, that if there was a medical benefit then

1 R. Sanchez, M.D.  
 2 it might not be considered experimental; is that  
 3 true?  
 4 A. A medical improvement, an improvement  
 5 in the long-term course of the disease, either  
 6 interrupting the destruction or the disease  
 7 process or accelerating a cure.  
 8 Q. Now, with regard to the breast cancer  
 9 you were just talking about, where this treatment  
 10 was considered experimental and you modified the  
 11 corporate policy as you told us, did you have any  
 12 knowledge of the fact that some people had their  
 13 life extended if they received the treatment even  
 14 if they ultimately died, did you know that?  
 15 A. Yes.  
 16 MR. MAURER: Off tape.  
 17 THE VIDEOGRAPHER: The time is 1419.  
 18 We are going off the record.  
 19 (Whereupon, there is an off-the-record  
 20 discussion.)  
 21 MR. MAURER: On tape.  
 22 THE VIDEOGRAPHER: The time is 1420.  
 23 We are back on the record.  
 24 BY MR. MAURER:  
 25 Q. By the way, if a patient was denied

1 R. Sanchez, M.D.  
 2 authorization for treatment because they didn't  
 3 meet the criterion in one of these new corporate  
 4 medical policies that you adopted at Empire and  
 5 they self paid for the treatment and the treating  
 6 physician submitted a subsequent letter of  
 7 medical necessity requesting approval for further  
 8 treatment and that letter of medical necessity  
 9 was coupled with information that showed that the  
 10 patient benefitted, they improved but were not  
 11 cured as a result of the treatment they paid for  
 12 that you denied, would that information be  
 13 considered in determining whether or not the  
 14 treatment was experimental with the next  
 15 application that the doctor made for approval?  
 16 A. Sometimes.  
 17 Q. And sometimes not?  
 18 A. Mostly not.  
 19 Q. Why not, why mostly not?  
 20 A. Because we were still wrestling with  
 21 whether the diagnosis was appropriate, whether  
 22 the improvement was for spontaneous remission of  
 23 another disease or that there may have been some  
 24 palliative affect of the treatment but there was  
 25 no real -- there was not going to be a change in

1 R. Sanchez, M.D.  
 2 the course from our evidence -- from our  
 3 research.  
 4 Q. Now, if somebody had a denial given to  
 5 them for prescribed intravenous antibiotic  
 6 treatment of Lyme disease was there an appeal  
 7 process that existed generally?  
 8 A. Yes, it was that one we discussed very  
 9 early this morning.  
 10 Q. Eventually would that appeal, if there  
 11 continued to be denials, lead to a review by a  
 12 doctor within the company?  
 13 A. Yes.  
 14 Q. These were salaried doctors who worked  
 15 for Empire?  
 16 A. Correct.  
 17 Q. Were those salaried doctors that  
 18 worked for Empire required to use any particular  
 19 criteria in deciding whether or not to reverse  
 20 the denial or sustain the denial of the  
 21 prescribed IV therapy?  
 22 A. They were required to use Empire's  
 23 medical policies and either the InterQual  
 24 standard or the Millman & Robertson standards  
 25 that we used.

1 R. Sanchez, M.D.  
 2 In addition, we expected of them to  
 3 have a knowledge of the literature and in many  
 4 cases if it was their own specialty, to be  
 5 experts or semi-experts in the disease that we  
 6 were asking them to review.  
 7 Q. Does that mean that you expected these  
 8 internal doctors to have any sort of substantial  
 9 experience in diagnosing and treating Lyme  
 10 disease?  
 11 A. No.  
 12 Q. So if they were an infectious disease  
 13 doctor by training is that what you meant?  
 14 A. Yes.  
 15 Q. Sometimes were the reviews conducted  
 16 at Empire's request by outside consultants who  
 17 were not employed full-time as salaried  
 18 physicians internally but worked as outside  
 19 consultants?  
 20 A. Yes. And we were moving more toward  
 21 that before I left.  
 22 Q. With regard to those particular  
 23 doctors was it necessary for those doctors to  
 24 have experience in, substantial experience in  
 25 diagnosis and treatment of Lyme disease for

1 R. Sanchez, M.D.  
 2 Empire, to ask them to do such a review?  
 3 A. The panel of our experts was limited  
 4 to the major specialties, for example,  
 5 cardiology, infectious disease, rheumatology. We  
 6 expected that these luminaries in their field  
 7 would be sufficiently versed in the treatment of  
 8 Lyme disease just as they were in the treatment  
 9 of Polio, tuberculosis or other infectious  
 10 diseases. Was it a Lyme disease expert that was  
 11 selected, no.  
 12 Q. So the outside consulting doctor who  
 13 Empire would occasionally send files to where a  
 14 denial of IV antibiotic therapy for Lyme disease  
 15 was appealed, those doctors were just like the  
 16 internal doctors, they could be an infectious  
 17 disease doctor but they didn't necessarily have  
 18 to be experienced in diagnosis and treatment of  
 19 Lyme disease; is that correct?  
 20 A. They were general specialists in their  
 21 large field of expertise infectious diseases.  
 22 They were practicing or held academic positions  
 23 or were renowned in areas of infectious disease.  
 24 They were clearly a cut above our internal  
 25 doctors -- two cuts above our internal doctors

1 R. Sanchez, M.D.  
 2 who first reviewed the case or would have denied  
 3 it.  
 4 Q. With regard to the hiring of staff, I  
 5 believe early on today you said that one of the  
 6 things you had to do was bring in new staff to  
 7 work with you in making any changes that were  
 8 necessary at Empire.  
 9 A. Correct.  
 10 Q. What kinds of experts did you bring in  
 11 to work with you?  
 12 A. I brought people who were actually  
 13 experienced in the management and operation of  
 14 utilization management and medical affairs in  
 15 managed care organizations.  
 16 Q. Did that include a woman named Zenobia  
 17 Collins-Johnson?  
 18 A. Yes. Zenobia Collins-Johnson I  
 19 selected to be the vice president of utilization  
 20 management. Her credentials are impeccable in  
 21 that area. She had responsibility for millions  
 22 of members in California. She has a Master's,  
 23 she has an MBA. She also is a very good  
 24 clinician and did an outstanding job prior to  
 25 coming to Empire and did an outstanding job at

1 R. Sanchez, M.D.  
 2 Empire.  
 3 Q. Have you continued to work with  
 4 Zenobia Collins-Johnson since you departed  
 5 Empire?  
 6 A. No, I have not. I keep in touch with  
 7 her but I have not had the opportunity to put her  
 8 on in the salaried position or position where she  
 9 could work with me again. I would not hesitate  
 10 to do so.  
 11 Q. What was the title that Zenobia had?  
 12 A. Vice president of utilization. She  
 13 was a vice president in the company in the  
 14 officer or director, delegation, whatever that  
 15 is. I think it was utilization management, I'm  
 16 not sure.  
 17 Q. What again does utilization management  
 18 have to do with at Empire?  
 19 A. It has to do with assuring the  
 20 quality, the appropriateness and the expenditure  
 21 of cost of health care for our members.  
 22 Q. Have you ever heard of the group of  
 23 people that you brought in referred to as the  
 24 "California posse"?  
 25 A. Sure.

1 R. Sanchez, M.D.  
 2 Q. What was your understanding of why  
 3 that was used, California posse, to describe the  
 4 group?  
 5 A. At Empire it was a rather derogatory  
 6 term used to indite some of the team that came  
 7 from California because California was where all  
 8 this expertise existed. So when we sought to put  
 9 a team together we brought people in with that  
 10 experience. Could have been from Tennessee, if  
 11 they had been at the forefront, but anyone in  
 12 health care knows that managed care is in its  
 13 most evolved and sophisticated form in  
 14 California.  
 15 So when we sought out people with  
 16 experience to do what the senior management at  
 17 Empire wanted to accomplish we went to  
 18 California. If that had existed in New York, we  
 19 would have selected from New York. When it did  
 20 not and we have these people making rather  
 21 significant changes that derogatory term came up.  
 22 Q. Did you have any problem with any part  
 23 of Zenobia Collins-Johnson's performance of her  
 24 assigned duties while she was here at Empire?  
 25 A. No. I think she clearly was very

1 R. Sanchez, M.D.  
 2 loyal to me, to the company and carried on the  
 3 trying to meet the objectives and the goals that  
 4 were given to her and her responsibility.  
 5 Q. Just digressing for a moment and going  
 6 back to something we've touched on. With regard  
 7 to the issue of the number of denials, the rate  
 8 of denials that were being issued by in-house  
 9 physicians at Empire, did you personally speak to  
 10 any of the in-house doctors about that subject?  
 11 A. Yes.  
 12 Q. What did you speak about?  
 13 A. I told them that their contribution  
 14 was -- I told them that their success in helping  
 15 us control the cost of health care was almost  
 16 nonexistent.  
 17 Q. What else did you tell them?  
 18 A. That they had to improve their  
 19 contribution.  
 20 Q. Did you give them -- did you say  
 21 anything to them about what would happen, if  
 22 anything, if they didn't improve?  
 23 A. They knew that it would be part of  
 24 that evaluation and their evaluation would affect  
 25 their compensation and their longevity in the

1 R. Sanchez, M.D.  
 2 position.  
 3 MR. DRISCOLL: I object to that and  
 4 move to strike the answer as nonresponsive.  
 5 Q. Did you make any specific statement to  
 6 the doctors about their future at the company if  
 7 they didn't change the denial rate?  
 8 A. Yes.  
 9 Q. What did you say?  
 10 A. I said that it had to come within  
 11 national standard or they wouldn't be around.  
 12 Q. Meaning what?  
 13 A. They would not be employed at Empire.  
 14 Q. Did you terminate any doctors in that  
 15 regard?  
 16 A. We terminated several doctors.  
 17 Q. Did you terminate any doctors for the  
 18 reason that they did not modify their approach to  
 19 the issuance of denials as requested?  
 20 A. It was, as I said, that part of it was  
 21 in context of an overall evaluation so it was  
 22 that plus other portions of their objectives and  
 23 their evaluation that would have been contributed  
 24 to their termination.  
 25 Many of them resigned, by the way.

1 R. Sanchez, M.D.  
 2 behavior and it never been expected of them  
 3 before. It was a new day and a new team and a  
 4 new mission and they were uncomfortable with  
 5 that.  
 6 Q. Now, before you adopted these new  
 7 corporate medical policies affecting these  
 8 various serious disease and illness groups, did  
 9 Empire do any investigation and research to look  
 10 at insured patients' records to determine the  
 11 impact that the changes may or may not have on  
 12 the patient's abilities to get treatment, in  
 13 other words, did you consider the chart  
 14 information of the patients or was it limited to  
 15 other information like a statistical data you've  
 16 told me about?  
 17 A. It was the latter. On appeal the  
 18 chart information would be looked at but not  
 19 before that, no, and there was no research done  
 20 prior to the end of that policy, to the  
 21 formulation of the policy, no.  
 22 Q. So what was considered was the  
 23 statistical analysis, for example, that  
 24 information contained in the Deloitte & Touche  
 25 report, among other things?

1 R. Sanchez, M.D.  
 2 Q. Did any of them tell you the reasons  
 3 why they resigned?  
 4 A. Sure.  
 5 Q. Did any of them complain to you about  
 6 the new approaches that you were taking to the  
 7 jobs that they had?  
 8 A. Yes.  
 9 Q. What did they complain about?  
 10 A. They complained that they really  
 11 didn't have the stomach, heart or will to  
 12 implement the policies or the Millman & Robertson  
 13 guidelines.  
 14 Q. Did they say why they didn't have the  
 15 stomach, or will, I forget the third word that  
 16 you said?  
 17 A. Stomach, heart or will.  
 18 Q. Did they tell you why they didn't have  
 19 the stomach, heart or will to implement these  
 20 policies?  
 21 A. You have to realize this was a major,  
 22 to use a term that's overused, paradigm ship for  
 23 these guys.  
 24 Q. When means?  
 25 A. They weren't used to that kind of

1 R. Sanchez, M.D.  
 2 A. That was part of it but there was a  
 3 review of the literature, there was review of  
 4 what was current, there was review of how to  
 5 diagnose the problem, there was review of the  
 6 treatment and all of those modalities.  
 7 All of that went into the policy in  
 8 addition to cost but did you say did we sit there  
 9 and look at the patients and review their records  
 10 to see what kind of impact that would have on  
 11 those patients, no.  
 12 Q. Doctor, at the time that you  
 13 implemented these new business approaches at  
 14 Empire to reduce the health care costs did you  
 15 believe or did you have any opinion as to whether  
 16 or not there was anything wrong with the system  
 17 you were bringing in?  
 18 A. I think the misgivings that I had were  
 19 not that these weren't appropriate managed care  
 20 policies and principals. I mean I thought they  
 21 were not different than other entities' mature  
 22 managed care.  
 23 Q. Did you have any problem with the --  
 24 A. Let me finish.  
 25 Q. I'm sorry.

1 R. Sanchez, M.D.  
 2 A. The misgivings that I had, Mr. Maurer,  
 3 were two. One, that could we -- did the company  
 4 have the stomach, will and heart to implement  
 5 these. I mean, we are already being perceived as  
 6 the California posse taking over, we were  
 7 complicating people's, you know, the way they  
 8 used to do things, we were expecting more out of  
 9 people. So the misgiving I had is was I creating  
 10 something that we thought could work but putting  
 11 it in front of an organization that could not  
 12 implement it. That was a misgiving I had.  
 13 Two, I had a concern about the uniform  
 14 way we would apply this. I had significant  
 15 misgivings about that.  
 16 Q. What do you mean?  
 17 A. Those were the two areas that caused  
 18 me some concern.  
 19 Q. What was it about the uniform  
 20 application of these new programs and procedures  
 21 that concerned you?  
 22 A. This is difficult. That no matter how  
 23 effective we thought the policy or process might  
 24 affect the company positively and no matter how  
 25 much evidence that if that policy were supported

1 R. Sanchez, M.D.  
 2 by the company, that there would always be some  
 3 exceptions or exceptions made and that for me is  
 4 a position -- it was a misgiving, a concern that  
 5 I had.  
 6 Q. What do you mean about there being  
 7 exceptions made? Did the company uniformly apply  
 8 all the new procedures and policies that you  
 9 brought in to all insureds and all medical  
 10 service providers?  
 11 A. No.  
 12 Q. Can you elaborate, please.  
 13 A. That to almost any policy or procedure  
 14 that had been implemented or had been implemented  
 15 there would be some exceptions made.  
 16 Q. Can you give me some examples of what  
 17 you are referring to?  
 18 A. I don't have any Lyme disease  
 19 examples.  
 20 Q. I'm not asking just about Lyme  
 21 disease, I'd like to know about its affect on all  
 22 insureds if you can respond on that level.  
 23 A. Empire was and is a very big insurer  
 24 of the citizens of New York. And its employer  
 25 groups who pay the premium dollars, whether they

1 R. Sanchez, M.D.  
 2 are there government or the unions or the large  
 3 Empire groups, and the board members all have,  
 4 pardon me, I'm trying to select my words  
 5 carefully, constituencies, so that people that  
 6 were more influential could go around the appeal  
 7 process and those processes and have things  
 8 covered that people with less influence could  
 9 have hoped to.  
 10 Q. Can you tell me how this actually  
 11 would work in your experience at Empire, give me  
 12 examples of how somebody with influence would be  
 13 able to circumvent the corporate medical policy  
 14 and get something approved that the policy wasn't  
 15 supposed to cover?  
 16 A. If an important client or labor leader  
 17 or member of a board, our board, or a large  
 18 hospital client would bring pressure to bear upon  
 19 the senior leadership of Empire we would create  
 20 an exception or what we call, I think they called  
 21 it off contract or something, and the benefit  
 22 would be covered.  
 23 Q. Did you ever speak to Dr. Michael  
 24 Stocker about this or did he ever speak to you  
 25 about it?

1 R. Sanchez, M.D.  
 2 A. Of course.  
 3 Q. Well, what can you tell me what you  
 4 discussed, can you give me examples, please?  
 5 A. There was -- there were two sets of  
 6 discussions. One in which he would call me to  
 7 tell me of the intervention of some politician or  
 8 labor leader or member of the board that we were  
 9 to, you know, take special precautions with this  
 10 member or this case.  
 11 The other is and when I gave him a  
 12 heads up, that we were denying services on very  
 13 controversial case or influential person, to give  
 14 him a warning that there might be pressure coming  
 15 in. So those were the context of which we had  
 16 that discussion.  
 17 Q. Well --  
 18 A. I don't think that those are unusual  
 19 discussions that a CEO would have with the chief  
 20 medical officer of an insurance. Company, I  
 21 think those are common every day, not every day,  
 22 thank God, but they are part of the job.  
 23 Q. Let me ask you this, Dr. Sanchez, with  
 24 regard to, for example, politicians are you  
 25 saying there were times when politicians, elected

1 R. Sanchez, M.D.  
 2 officials, contacted Empire and requested that a  
 3 certain medical service or certain medical  
 4 service provider have payments made that would  
 5 not otherwise have been made under the new  
 6 corporate medical policies?  
 7 A. Yes.  
 8 Q. Can you name any politicians, elected  
 9 officials, who did that, can you think of any  
 10 senators, for example?  
 11 A. I can recall them invoking the name of  
 12 a very important political leader in New York.  
 13 Q. Who?  
 14 A. Suffice it to say they are elected  
 15 officials. Remember, Empire is a public, not a  
 16 public, almost a public institution that has been  
 17 granted many favors and considerations by the  
 18 Department of Insurance and Department of Health  
 19 and the senate and assembly and the governor's  
 20 office over the last ten or fifteen years and to  
 21 try to keep it a viable entity for the people of  
 22 New York.  
 23 Q. Dr. Sanchez, excuse me, but I asked  
 24 you a simple question. Can you please name the  
 25 elected officials that you mentioned from New

1 R. Sanchez, M.D.  
 2 whatever that position is, intervened at one  
 3 point on a case and we were involved but, you  
 4 know.  
 5 Q. Dr. Sanchez, when you were informed by  
 6 Dr. Stocker, the head of Empire, that Senator  
 7 D'Amato had contacted him and requested that some  
 8 benefit be paid for some subscriber or  
 9 subscribers who were insured by Empire, did you  
 10 say anything in response to him to offer any  
 11 opposition?  
 12 A. Yes.  
 13 Q. What do you recall saying in  
 14 substance, if not verbatim?  
 15 A. The general gist was I was always  
 16 against settling these because the history of  
 17 Empire had been that we had always been -- we had  
 18 always caved in on those. That I thought we were  
 19 on sound scientific ground, that I thought we had  
 20 taken the high road and for us to respond was a  
 21 disservice not only in a financial sense but an  
 22 ethical sense to the rest of our membership.  
 23 Q. What do you mean by that?  
 24 A. Because we were denying services to  
 25 the person who had no influence and we were

1 R. Sanchez, M.D.  
 2 York who you specifically recall having their  
 3 names mentioned to you?  
 4 A. One is the former Senator D'Amato.  
 5 Q. Alfonse D'Amato?  
 6 A. Who intervened on behalf of patients  
 7 not once but several times who would come to his  
 8 office.  
 9 Q. And who told you that?  
 10 A. Dr. Stocker.  
 11 Q. Dr. Michael Stocker, the CEO  
 12 president, told you that Senator Alfonse D'Amato  
 13 had intervened and requested that payments be  
 14 made?  
 15 A. That the benefit be approved.  
 16 Q. Do you need to answer that beep,  
 17 Doctor?  
 18 A. No.  
 19 Q. Who else do you recall besides Senator  
 20 D'Amato?  
 21 A. I have been out of New York but it was  
 22 the leader I think of the New York senate or  
 23 assembly and as soon as I recall those names I  
 24 could tell you. One of them, the president of  
 25 the senate or the speaker of the assembly,

1 R. Sanchez, M.D.  
 2 approving it to the person that did. That is an  
 3 ethical issue that gave me misgivings very early  
 4 on. What I'm saying is I communicated that in a  
 5 subtle way as I could so I think that's an answer  
 6 to your question.  
 7 Q. I think you mentioned that possibly  
 8 some union officials were among the group who got  
 9 this different kind of treatment. Do you recall  
 10 any specific labor officials?  
 11 A. No, I don't have that recollection.  
 12 Q. What about celebrities, do you recall  
 13 any celebrities who got different treatment  
 14 because of pressure that was brought in?  
 15 A. No.  
 16 Q. Were separate records kept with regard  
 17 to these insured patients or medical service --  
 18 let's just limit it to the insured patients. Did  
 19 the company keep separate records or separate  
 20 files for those individuals who had the political  
 21 connections or clout?  
 22 A. Not that I know of. To the extent  
 23 that occurred it occurred with certain large  
 24 employer groups or unions that in the process of  
 25 selling the account they were promised extra

1 R. Sanchez, M.D.  
 2 contractual things beyond the benefits that were  
 3 provided some other account so that those extra  
 4 contractual, I think was the word that was used,  
 5 were pretty rampant when I got there and what I  
 6 asked Dr. Stocker to do immediately was allow me  
 7 to sign off on those and we were starting to do  
 8 that. So that a member of those special accounts  
 9 was somehow made known either through the  
 10 computer system or the flagging system because  
 11 they were accustomed to receiving benefits  
 12 different than the package sold here.  
 13 Q. Were there any people insured by  
 14 Empire while you were at Empire whose records or  
 15 files were notated or flagged in some way to  
 16 indicate that payment of prescribed treatment was  
 17 not to be questioned at Empire?  
 18 A. Besides those extra contractals that  
 19 flowed through without any question, those were  
 20 the only ones that I was aware of.  
 21 MR. MAURER: Off tape.  
 22 THE VIDEOGRAPHER: The time is 1449.  
 23 We are going off the record.  
 24 (Whereupon, there is a recess in the  
 25 proceedings.)

1 R. Sanchez, M.D.  
 2 THE VIDEOGRAPHER: The time is 1456.  
 3 We are back on the record.  
 4 BY MR. MAURER:  
 5 Q. Dr. Sanchez, I believe you mentioned  
 6 there were board members who were given this  
 7 special treatment in terms of coverage; is that  
 8 correct?  
 9 A. Correct.  
 10 Q. What board members are you referring  
 11 to, are you referring to Empire board members or  
 12 board members outside Empire?  
 13 A. These were considerations given to  
 14 families of Empire board members.  
 15 Q. So members of the board of directors,  
 16 their family, there were instances that you  
 17 recall where individuals were paid for treatment  
 18 that was not covered or to be covered under the  
 19 corporate medical policies in effect for those  
 20 board members' families, is that what you are  
 21 saying?  
 22 A. In one instance, yes, that I can  
 23 recall.  
 24 Q. Who was that board member?  
 25 A. I would have to look at the board. I

1 R. Sanchez, M.D.  
 2 don't remember the board member. It was a board  
 3 member whose spouse had fractured an ankle and  
 4 somehow ended up in a facility that wasn't one of  
 5 our approved facilities and was there for longer  
 6 than she should have been and I got a call from  
 7 Dr. Stocker to approve that care.  
 8 Q. How much did that cost the company,  
 9 approximately, that you would not have paid or  
 10 incurred as a health cost under the corporate  
 11 medical policy in effect, approximately?  
 12 A. Less than \$20,000. It wasn't -- I  
 13 don't remember it being an exorbitant amount.  
 14 Q. You told me about individuals who got  
 15 special treatment. Were there medical service  
 16 providers who received special treatment?  
 17 A. Yes. There were like facilities and  
 18 those.  
 19 Q. Tell me about those facilities,  
 20 please, identify them, please.  
 21 A. The one that comes to mind -- these  
 22 have nothing to do with Lyme disease.  
 23 Q. I'm asking you questions about how  
 24 Empire paid for medical care for individuals or  
 25 paid for services rendered to medical service

1 R. Sanchez, M.D.  
 2 providers in terms of the general public now,  
 3 Doctor. I'm not limiting it to Lyme disease.  
 4 A. Empire was always under a lot of  
 5 pressure to pay for services that were either  
 6 denied or we didn't think were appropriate and  
 7 delivered to a facility or ER and there was an  
 8 awful lot of pressure from us from those  
 9 administrators and the one example that comes to  
 10 mind is a hospital called Calvary.  
 11 Q. Was it a hospital?  
 12 A. Yes, it's a hospital.  
 13 Q. What's the nature of the facility?  
 14 A. It's a hospice.  
 15 Q. What's the difference between a  
 16 hospice and a hospital?  
 17 A. Well, in both, in a hospital you can  
 18 provide different levels of care, from ICU care  
 19 to cardiac care, to medical surgical care, to  
 20 outpatient care, to long-term care, to hospice  
 21 care and at Calvary is a hospital that bills, at  
 22 the time billed Empire for acute care for hospice  
 23 care level of services.  
 24 Q. How did you treat those bills that  
 25 were submitted?



1 R. Sanchez, M.D.  
2 A. Well, after months and months of  
3 investigation and tallying up the millions of  
4 dollars that were overpaid, we tried to recoup  
5 them, we tried to stop the patients from ending  
6 up there and we then tried to renegotiate a  
7 hospice rate for what clearly is a hospice  
8 hospital.  
9 Q. And what happened?  
10 A. The administrator of Calvary contacted  
11 his local politicians and they influenced our  
12 senior management to resume paying them for the  
13 acute level of care.  
14 Q. Who are you talking about in terms of  
15 senior management?  
16 A. It was Dr. Stocker.  
17 Q. Did you discuss with Dr. Stocker the  
18 fact that Calvary hospice had billed Empire and  
19 was billing Empire at intensive --  
20 A. No, acute rates.  
21 Q. -- at acute rates for hospice  
22 services?  
23 A. Yes, sure.  
24 Q. What did you tell them should be done?  
25 A. Two things -- three things. One, that

1 R. Sanchez, M.D.  
2 we should go back and recoup that money as we  
3 would any provider that overcharged us; two, that  
4 we should limit the admission of our members, we  
5 should redirect them to other hospices. There  
6 were a lot of hospices that charge appropriately  
7 and deliver the hospice care, the same time they  
8 were delivering there, and that we should  
9 consider negotiating a hospice rate for them so  
10 that we could continue to use them if it was such  
11 an attractive hospital to our members.  
12 Q. How much money was this costing  
13 Empire, this paying for hospice care at a more  
14 expensive rate?  
15 A. It was very, very expensive.  
16 Q. How much?  
17 A. In the millions of dollars.  
18 Q. Millions?  
19 A. Yes.  
20 Q. What did Dr. Stocker tell to you do  
21 about this?  
22 A. Back off.  
23 Q. Did he say why?  
24 A. That they had -- there was no specific  
25 why except that there could be no why. I mean it

1 R. Sanchez, M.D.  
2 was just a political decision that was made.  
3 Q. Was it appropriate to make payments at  
4 that rate under the corporate medical policies  
5 and the contracts that were in effect?  
6 A. No. It was inappropriate.  
7 Q. You told Stocker that?  
8 A. He knew that.  
9 Q. Did you tell him that?  
10 A. Yes.  
11 Q. How many times did you tell him?  
12 A. This particular example the reason is  
13 because these were lengthy conversations.  
14 Q. Where did they take place, where were  
15 you and Dr. Stocker when you spoke to him about  
16 it?  
17 A. Actually, I think, and if my memory  
18 recalls, these occurred in his office but as I  
19 recall we actually took Dr. Stocker to Calvary  
20 and we took a tour.  
21 Q. Who else was there with you?  
22 A. Me. And I don't know who else was  
23 there but I remember that Dr. Stocker and I'm  
24 recollecting that we went to Calvary to see what  
25 the services were, to actually look in the beds

1 R. Sanchez, M.D.  
2 and we went over there to look. Now, I may be  
3 mistaken about that but the conversations took  
4 place in his office.  
5 Q. Was this discussed at all with the  
6 board of directors to your knowledge?  
7 A. I don't know that. Not on my part.  
8 Q. Where is Calvary?  
9 A. It's in the Bronx.  
10 Q. Do you recall who the politician or  
11 politicians were that Calvary contacted which  
12 then contacted Dr. Stocker?  
13 A. The name Valone comes to mind.  
14 Q. Peter Valone?  
15 A. He was head of the assembly or senate  
16 or one of the bodies.  
17 Q. Peter Valone?  
18 A. Yes. That's why as I recall made the  
19 call on behalf of Calvary.  
20 Q. So let me ask you this: Between the  
21 insured members of Empire Blue Cross, meaning the  
22 people who were insured by the company --  
23 A. Let me interrupt you. I don't think  
24 that there's anything wrong with a politician on  
25 behalf of his constituents intervening in a

1 R. Sanchez, M.D.  
 2 policy dispute.  
 3 Q. Do you think there's anything wrong  
 4 with Dr. Stocker telling you to apply the  
 5 policies and procedures of Blue Cross/Blue Shield  
 6 in a way so that people who don't have influence  
 7 don't get paid in certain instances while people  
 8 who have influence did get the payments that they  
 9 weren't supposed to get?  
 10 A. I have already said I had great  
 11 problems with that, okay. At the same time,  
 12 Dr. Stocker had to make a business decision and a  
 13 political decision and those decisions, whatever  
 14 was going on in his head, were not consistent  
 15 with the way I would have arrived at a decision.  
 16 But I do not think that if I were an elected  
 17 politician for me to intervene on what I  
 18 considered an unfair policy on behalf of a  
 19 constituent is inappropriate.  
 20 Q. But you thought that it was the  
 21 policies that you had placed in effect were  
 22 reasonable, didn't you?  
 23 A. They were not only reasonable, I  
 24 thought they were going to keep alive a very  
 25 valuable asset for New York.

1 R. Sanchez, M.D.  
 2 Q. Empire Blue Cross/Blue Shield?  
 3 A. Yes.  
 4 Q. Between the people you've told me  
 5 about, the members of the board of directors of  
 6 Empire, the various individuals who got this  
 7 special treatment from Empire as well as the  
 8 medical service providers like Calvary and others  
 9 who got the special treatment, how much money are  
 10 we talking about in terms of what it cost Empire  
 11 as a result of this diverse approach to running  
 12 the Empire business?  
 13 A. I think the big six or big eight,  
 14 whatever you call it, big six report, and any  
 15 reasonable person we are talking in this  
 16 situation millions of dollars.  
 17 Q. As a result of the changes you brought  
 18 into the company after you came to Empire Blue  
 19 Cross/Blue Shield did Empire save money?  
 20 A. Yes.  
 21 Q. How much money?  
 22 A. From our calculations on our own  
 23 medical economics kind of unit that we put in  
 24 depending on the product we saved anywhere  
 25 between five and fifteen percent of health care

1 R. Sanchez, M.D.  
 2 costs that had formally been expended in those  
 3 products.  
 4 Q. Per year?  
 5 A. Sure.  
 6 Q. So you are --  
 7 A. It was an 18-month year probability  
 8 before we got them all done.  
 9 Q. You are talking percentages of a  
 10 little less than seven billion down to four point  
 11 something billion dollar amount, is that what you  
 12 are saying?  
 13 A. We reduced the medical loss ratio or  
 14 the health care expenditure, depending on the  
 15 product, anywhere between five and fifteen  
 16 percent. And that was what we called low hanging  
 17 fruit because it was easily done with just a  
 18 slight correction in the attitude and in the  
 19 policies. That was still not enough to turn  
 20 around Empire's fortunes, they still had a long  
 21 way to go but it was a start in the right  
 22 direction.  
 23 Q. You left Empire Blue Cross/Blue Shield  
 24 at some point; is that correct?  
 25 A. I left in September of 1996, I

1 R. Sanchez, M.D.  
 2 believe.  
 3 Q. Prior to leaving did any changes take  
 4 place in your responsibilities at Empire?  
 5 A. Yes.  
 6 Q. What changes took place?  
 7 A. The areas of medical management,  
 8 Medicare and chief medical executive those areas  
 9 were removed and I was placed in charge of the  
 10 medical services organization.  
 11 Q. Did you consider that a demotion?  
 12 A. Of course.  
 13 Q. How did you feel about it?  
 14 A. I was devastated.  
 15 Q. Is that -- is any of feelings that you  
 16 experienced as a result of that demotion causing  
 17 you to testify about anything that you've  
 18 testified about here today, is it motivating you  
 19 in any way?  
 20 A. I'm here this afternoon because you  
 21 said if I didn't show up, I'd be subpoenaed and  
 22 I'm here to tell you the truth as I recollect  
 23 it. I have put what happened to me and my people  
 24 and what I brought to Empire behind me. I'm  
 25 three years out. It is not something that I lose

1 R. Sanchez, M.D.  
 2 any sleep over anymore.  
 3 Q. What happened --  
 4 A. If you had not contacted me I would  
 5 not have given you, New York or Empire a second  
 6 thought. And as soon as we are finished, I hope  
 7 that I don't have to ever have to sit down and  
 8 talk about these things again.  
 9 Q. You made reference to what happened to  
 10 you and the other people, I assume you are  
 11 referring to the people in the California posse,  
 12 am I correct?  
 13 A. Correct.  
 14 Q. What happened to you that you just  
 15 referred to?  
 16 A. Well, not only the Zenobia and Daniel.  
 17 Q. Daniel who?  
 18 A. Daniel Naranjo, N-A-R-A-N-J-O,  
 19 Zenobia, my pharmacy director.  
 20 Q. Who?  
 21 A. I'm blanking on her name. Jerry Adams  
 22 our Medicare vice president, they were all  
 23 fired. In fact, Heyward Donigan was fired right  
 24 after I was so there was a complete cleansing of  
 25 the managed care area, purge.

1 R. Sanchez, M.D.  
 2 Q. Would it be fair to characterize the  
 3 group that came in in this California posse as  
 4 cost cutters in terms of their expertise?  
 5 A. I think it would be fair to  
 6 characterize them as very experienced managers of  
 7 care of HMO executives and people who could  
 8 manage care and part of that was clearly their  
 9 cost -- ability to bring cost savings to an HMO.  
 10 Q. Are you aware of the reason why you  
 11 were demoted?  
 12 A. No, I'm not. I asked not only Heyward  
 13 Donigan who came in for maternity leave to do it  
 14 I asked Dr. Stocker, I asked our legal counsel at  
 15 the time, I asked our HR people and the only  
 16 thing Heyward said was that this had been in the  
 17 offing for several months and she just had not  
 18 gotten around to it until she had to come back  
 19 from maternity leave to do it.  
 20 Q. You looked at your personnel file  
 21 which is Sanchez Exhibit 1 for identification.  
 22 Is there one shred of information in this entire  
 23 file that tells you why you were demoted?  
 24 A. No. I looked and there isn't.  
 25 Q. Did you try to find out from

1 R. Sanchez, M.D.  
 2 Dr. Stocker?  
 3 A. I tried Dr. Stocker and Heyward  
 4 Donigan.  
 5 Q. How many times did you try?  
 6 A. Three times in a tearful meeting, two  
 7 times in an anger meeting. These were several  
 8 meetings that we had over that tumultuous  
 9 two-week time I told them that I, in good faith,  
 10 could not accept that demotion. They had created  
 11 to me a humiliating workplace environment but  
 12 they would never tell me why.  
 13 Q. Were you given a severance package  
 14 with some compensation at the time that you left  
 15 the company?  
 16 A. Yes.  
 17 Q. How much money did you receive in lump  
 18 sum either in one or multiple payments?  
 19 A. I didn't receive any in lump sum.  
 20 Q. In total how much did you receive?  
 21 A. It was three months.  
 22 Q. In total how much did you get?  
 23 A. Three times 25,000 a month, maybe  
 24 \$75,000.  
 25 Q. Dr. Sanchez, prior to coming here

1 R. Sanchez, M.D.  
 2 today did I inquire of you by telephone if you  
 3 would be able to come to court in White Plains in  
 4 the state supreme court in May when this case is  
 5 ready to start trial?  
 6 A. Yes, you did.  
 7 Q. What did you tell me with regard to  
 8 your availability?  
 9 A. I told you it would be unlikely, that  
 10 I have not only a vacation scheduled but I have  
 11 engagements in the consulting company that I'm  
 12 working at.  
 13 Q. You work where presently?  
 14 A. I work in Dallas, Texas.  
 15 Q. Where do you live?  
 16 A. Dallas, Texas.  
 17 Q. How much traveling do you have to do  
 18 as part of your current job?  
 19 A. I'm on the road three or four days a  
 20 week.  
 21 Q. Incidentally, have I compensated you  
 22 in any way for your testimony?  
 23 A. No.  
 24 Q. Have I paid for your transportation or  
 25 your hotel stay?

1 R. Sanchez, M.D.  
 2 A. No.  
 3 Q. Other than paying for lunch yesterday  
 4 and today is that it in terms of what you  
 5 received from me?  
 6 A. That's correct.  
 7 MR. MAURER: I have no further  
 8 questions on direct examination. Do you  
 9 want to take a brief recess?  
 10 MR. DRISCOLL: Fine.  
 11 MR. MAURER: Off tape.  
 12 THE VIDEOGRAPHER: The time is 1515.  
 13 We are going off the record.  
 14 (Whereupon, there is a recess in the  
 15 proceedings.)  
 16 THE VIDEOGRAPHER: The time is 1524.  
 17 We are back on the record.  
 18 CROSS EXAMINATION  
 19 BY MR. DRISCOLL:  
 20 Q. Good afternoon, Dr. Sanchez. My name  
 21 is Justin Driscoll. I represent Empire Blue  
 22 Cross/Blue Shield. I'm going to be asking you  
 23 some questions. If you don't understand the  
 24 question, please feel free to tell me and I'll  
 25 try to rephrase it.

1 R. Sanchez, M.D.  
 2 First of all, could I see what you  
 3 brought with you to the deposition today.  
 4 MR. DRISCOLL: We can go off tape  
 5 while I look through that.  
 6 THE VIDEOGRAPHER: The time is 1525.  
 7 We are off the record.  
 8 MR. MAURER: Do these materials have  
 9 anything to do with the lawsuit?  
 10 THE WITNESS: No.  
 11 MR. MAURER: This is work-related?  
 12 THE WITNESS: Yes. Hand scratchings  
 13 as I take phone messages.  
 14 MR. DRISCOLL: Is there anything else  
 15 in the folder other than what you've given  
 16 me?  
 17 (Pause.)  
 18 MR. DRISCOLL: Thank you. Back on  
 19 tape.  
 20 THE VIDEOGRAPHER: The time is 1526.  
 21 We are back on the record.  
 22 BY MR. DRISCOLL:  
 23 Q. Dr. Sanchez, after having reviewed the  
 24 materials that you've brought with you I see  
 25 there is one page here which is a fax cover

1 R. Sanchez, M.D.  
 2 sheet. I'd like to show you that and ask if you  
 3 can identify it?  
 4 A. Uh-hum.  
 5 Q. What is that?  
 6 A. This has to do with my deposition.  
 7 Q. Who is it from?  
 8 A. It's from Zenobia Collins-Johnson.  
 9 Q. When is it dated?  
 10 A. January 12th.  
 11 Q. Of what year?  
 12 A. 1999.  
 13 MR. DRISCOLL: I'd like to have that  
 14 marked as Defendant's A Sanchez A.  
 15 (Defendant's Sanchez Exhibit A, fax  
 16 cover sheet, marked for identification, as  
 17 of this date.)  
 18 Q. Forgive me if I fail to make note of  
 19 it but I didn't hear you say what you are  
 20 currently doing?  
 21 A. I'm a health care consultant.  
 22 Q. For whom?  
 23 A. I'm an independent contractor.  
 24 Q. What is the name of the company?  
 25 A. Aztlan Health Care Consulting Group.

1 R. Sanchez, M.D.  
 2 Q. How long have you been employed by  
 3 Aztlan Health Care?  
 4 A. It's a corporation I have had for, it  
 5 started in California. I've refiled it in Dallas  
 6 when I moved there.  
 7 Q. When was it incorporated in  
 8 California?  
 9 A. In the 1992, very early, maybe even  
 10 earlier.  
 11 Q. So is that a company that continued to  
 12 do business while you were employed by Empire?  
 13 A. No.  
 14 Q. How many employees does the company  
 15 have?  
 16 A. One, me.  
 17 Q. Currently. Has that been true since  
 18 1992 when it was formed?  
 19 A. Yes.  
 20 Q. Can you describe for me the type of  
 21 work that Aztlan does?  
 22 A. Health care consulting.  
 23 Q. What do you mean by that, sir?  
 24 A. Managed care consulting. It's like a  
 25 Coopers & Lybrand or Ernst & Young.

1 R. Sanchez, M.D.  
 2 Q. Am I correct then that you are  
 3 retained by companies on a project-by-project  
 4 basis to consult?  
 5 A. Correct.  
 6 Q. Can you tell me some of the companies  
 7 that you've consulted for?  
 8 A. Most recently the Pace Group in  
 9 Dallas, Texas.  
 10 Q. What is the Pace Group?  
 11 A. It is a health care consulting  
 12 company.  
 13 Q. What did you do for that?  
 14 A. I did an NCQA audit of an HMO in Grand  
 15 Rapids, Michigan.  
 16 Q. You said before in response to my  
 17 question that the company was not doing business  
 18 during the period of time that you were employed  
 19 by Empire. When did it recommence its business  
 20 activity?  
 21 A. In January of this year, maybe  
 22 December.  
 23 Q. January of 1999?  
 24 A. Uh-hum.  
 25 Q. What did you do between the time that

1 R. Sanchez, M.D.  
 2 Q. Would that be the equivalent of a  
 3 health care factor?  
 4 A. I don't know what a health care  
 5 factor.  
 6 Q. Fact of taking somebody else's  
 7 receivables and taking responsibility for  
 8 collecting those receivables, is it something  
 9 like that?  
 10 A. No, not at all.  
 11 Q. How long did you work for that entity?  
 12 A. About a year.  
 13 Q. What was your title there?  
 14 A. President and chief executive officer.  
 15 Q. Was that a company that you formed or  
 16 had they been in business prior to your arrival?  
 17 A. They incorporated and been prior to  
 18 that.  
 19 Q. What did do you after you left their  
 20 employ?  
 21 A. I went to Physicians Health  
 22 Corporation, a PPM company, in Atlanta.  
 23 Q. What did do you for them?  
 24 A. I did their risk contracting for their  
 25 specialty physician networks throughout the

1 R. Sanchez, M.D.  
 2 you left the employ of Empire and January of 1999  
 3 when you recommenced the business of Aztlan  
 4 Health Care?  
 5 A. I left Empire and worked for a year as  
 6 the chief executive officer of New York Doctors  
 7 MSO, an MSO that was forming in Queens, New York.  
 8 Q. What is an MSO?  
 9 A. Management services organization.  
 10 Q. What type of work does an MSO do?  
 11 A. It's the infrastructure of a group of  
 12 physicians or hospitals that take risk contracts  
 13 from HMOs.  
 14 Q. When you say take risk contract, to  
 15 adopt Mr. Maurer's language, can you put that in  
 16 layman's terms for me, please?  
 17 A. That means that your organization of  
 18 physicians is willing to take prospective payment  
 19 and manage care within that prospective payment  
 20 and thereby taking the risk of over-utilization.  
 21 To do that they need a management services  
 22 organization that would provide the  
 23 infrastructure to pay claims, do utilization  
 24 management and concurrent review MSO is what I  
 25 formed in Queens.

1 R. Sanchez, M.D.  
 2 country.  
 3 Q. How long did you do that?  
 4 A. About a year.  
 5 Q. What was your title there?  
 6 A. Senior vice president of the  
 7 corporation and I was president and CEO of the  
 8 subsidiary called PHC Physician Networks.  
 9 Q. Did the business of the subsidiary  
 10 differ at all from the business of the parent?  
 11 A. Yes.  
 12 Q. How so?  
 13 A. The parent was a physician practice  
 14 management company that bought the assets of  
 15 physician practices throughout the country and  
 16 acquired large oncology and outpatient surgery  
 17 centers or built them. The subsidiary had to do  
 18 with bringing revenue for managing risk contracts  
 19 on behalf of providers.  
 20 Q. Could you explain for me what managing  
 21 risk contracts involves?  
 22 A. That means we take -- we, the  
 23 physician we represent or have a contact with,  
 24 take a per member, per month capitalization from  
 25 the HMO and that they are now on the hook for

1 R. Sanchez, M.D.  
 2 Q. So in spite of the fact that he had  
 3 mentioned to you that he couldn't subpoena you,  
 4 you decided to cooperate in any event, is that  
 5 true?  
 6 MR. MAURER: Objection. Off tape.  
 7 THE VIDEOGRAPHER: The time is 1539.  
 8 We are going off the record.  
 9 MR. MAURER: I think this line of  
 10 question is argumentative in nature and  
 11 repetitious and now you are repeating your  
 12 questions so I object for those reasons and  
 13 others.  
 14 MR. DRISCOLL: Do you have the  
 15 question in mind, sir -- on tape, please.  
 16 THE VIDEOGRAPHER: The time is 1539.  
 17 We are back on the record.  
 18 BY MR. DRISCOLL:  
 19 Q. Do you have the question in mind, sir?  
 20 A. No.  
 21 MR. DRISCOLL: Could you read back the  
 22 question, please, the last question.  
 23 Could you go off tape, please.  
 24 THE VIDEOGRAPHER: The time is 1539.  
 25 We are going off the record.

1 R. Sanchez, M.D.  
 2 (Record read.)  
 3 A. Yes.  
 4 MR. MAURER: Are we back on tape?  
 5 MR. DRISCOLL: On tape, please.  
 6 THE VIDEOGRAPHER: The time is 1541.  
 7 We are back on the record  
 8 BY MR. DRISCOLL:  
 9 MR. DRISCOLL: Could you read the last  
 10 question back, please.  
 11 (Record read.)  
 12 A. Yes.  
 13 Q. Getting back for a moment to your  
 14 employment history, what was the reason for your  
 15 leaving the New York doctors job that you  
 16 referred to?  
 17 A. The opportunity came up to be -- to  
 18 develop an equity interest in a new physician  
 19 practice management company and the venture  
 20 capitalists that were putting the company  
 21 together asked me to take a senior management  
 22 position with an equity position in the new  
 23 company. It was a better opportunity.  
 24 Q. What were the reasons for the  
 25 departure from the job that followed that job?

1 R. Sanchez, M.D.  
 2 A. In Atlanta?  
 3 Q. Yes.  
 4 A. The PPM industry or over the 18 months  
 5 that I was there in the last six months took a  
 6 big dive and it was very difficult for us to  
 7 raise venture capitol, so that the senior  
 8 executives of the company, of which I was a part,  
 9 decided that we would focus in on oncology and  
 10 limit our resources in the other areas which was  
 11 the subsidiary that I was leading and I said  
 12 that's fine, I still have a lot of stock in the  
 13 company and I wanted to continue my managed care  
 14 activities so I looked for a managed care  
 15 opportunity.  
 16 Q. Getting back to your initial  
 17 discussions regarding this case, you mentioned  
 18 that there were a couple of conversations over a  
 19 period of time and eventually you said that you  
 20 would help; is that right?  
 21 A. I don't recall the conversation. I  
 22 recall that I agreed to a sworn statement.  
 23 Q. Did any documents get forwarded to you  
 24 at any time during that period from the first  
 25 conversation with Mr. Maurer until you decided to

1 R. Sanchez, M.D.  
 2 give a sworn statement?  
 3 A. You mean -- could you be more  
 4 specific.  
 5 Q. Documents regarding this case, were  
 6 any documents regarding this case where your  
 7 employment with Empire Blue Cross/Blue Shield get  
 8 forwarded to you --  
 9 A. No.  
 10 Q. -- during that period of time?  
 11 A. These were phone conversations.  
 12 Q. You didn't review any documents before  
 13 you gave the sworn statement?  
 14 A. Review any documents before I gave the  
 15 sworn statement. I don't recall that I did. I  
 16 think that was, it was done in Atlanta and with a  
 17 transcriptionist or a recorder with that. During  
 18 the sworn statement I think documents, as I  
 19 recall, documents were handed to me and I looked  
 20 and she stopped recording and I reviewed the  
 21 documents.  
 22 Q. In between that period of time when  
 23 you first learned of this case and the time you  
 24 gave your sworn statement, did you reach out to  
 25 any either current or former employees of Empire

1 R. Sanchez, M.D.  
 2 taking risk for the provision of all of the  
 3 services that member would need.  
 4 Q. What did do you after you left the  
 5 employ of that company?  
 6 A. I moved to -- I went to Europe and I  
 7 looked around for a job and I wanted to move west  
 8 and I got as far as Dallas.  
 9 Q. How long of a period of time elapsed  
 10 between the time you left the employ of this most  
 11 recent company that you've been discussing and  
 12 the time that you found your next employment?  
 13 A. Two months.  
 14 Q. What was that next employment?  
 15 A. It was the self-employment, my  
 16 self-employment. I decided to form a consulting.  
 17 Q. Your current employment?  
 18 A. Uh-hum.  
 19 Q. So that brings us up to date?  
 20 A. Correct.  
 21 Q. When did you first become aware of Ira  
 22 Maurer?  
 23 A. When he called me about a year ago.  
 24 Q. Were you expecting his call when he  
 25 called?

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1 R. Sanchez, M.D.  
 2 A. No, sir.  
 3 Q. What did he say to you in that  
 4 conversation?  
 5 A. He said -- he introduced himself as an  
 6 attorney and that he was representing clients who  
 7 had a suit against Empire for the care covered by  
 8 Empire on behalf of these clients of his.  
 9 Q. What did you say?  
 10 A. I said that's interesting. Why do you  
 11 want to talk to me.  
 12 Q. What was his response?  
 13 A. His response was that as chief medical  
 14 officer of Empire Blue Cross/Blue Shield, that it  
 15 was under my watch that many of the policies that  
 16 affected his clients were implemented or changed  
 17 or --  
 18 Q. Did he tell you how he had come to  
 19 learn of your identity and whereabouts?  
 20 A. No.  
 21 Q. Did he mention that he had been  
 22 speaking with any other former Empire employees  
 23 at that time?  
 24 A. He said he had spoken with other  
 25 employees, I forget who he had spoken to but I

1 R. Sanchez, M.D.  
 2 don't know how he got my name.  
 3 Q. Do you know whether he had spoken with  
 4 Ms. Collins-Johnson at the time, whether he told  
 5 you he had?  
 6 A. I don't think he had, no.  
 7 Q. What did you do next as far as your  
 8 contact with plaintiffs' counsel after that  
 9 conversation?  
 10 A. He asked me if I would talk to him and  
 11 I said I didn't feel the need to talk to him, I  
 12 resisted it. This was, of course, behind me. I  
 13 didn't want to be part of whatever the suit was.  
 14 He convinced me that, over another phone call or  
 15 two, that if I didn't take time to do this in a  
 16 cooperative way that I would be subpoenaed.  
 17 Q. Did he mention to you that you were  
 18 outside the subpoena range of the court that the  
 19 case was filed in?  
 20 A. I'm not sure what that means. He gave  
 21 me some -- I don't know what that means.  
 22 Q. Did he mention to you that he was  
 23 unable legally to subpoena you as long as you  
 24 were in Atlanta or outside the geographic area  
 25 that the lawsuit was pending?

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1 R. Sanchez, M.D.  
 2 A. He discussed something to that effect,  
 3 I don't recall what it was. I don't understand  
 4 the legal terms of it.  
 5 Q. He did say something to you about that  
 6 and you decided to go forward and cooperate in  
 7 any event?  
 8 A. I had nothing to hide about our  
 9 policies or procedures and I chose to give my  
 10 statement rather than be subpoenaed. I thought  
 11 that was -- on my terms and in my backyard which  
 12 is Atlanta.  
 13 Q. I thought you just said that he had  
 14 said words to the effect that he could not  
 15 subpoena you.  
 16 MR. MAURER: Note my objection to the  
 17 arguing.  
 18 A. He did. I mean I was not -- you are  
 19 asking me if I was outside this subpoena. We did  
 20 have a discussion of how he was going to subpoena  
 21 me and get me from Atlanta and all those things,  
 22 but in spite of that I said I would cooperate  
 23 rather than try to resist any kind of formal  
 24 requirement of my testimony and that I would  
 25 rather do it on my own terms and my own schedule.

1 R. Sanchez, M.D.  
 2 to discuss the sworn statement or your plan to  
 3 give a sworn statement?  
 4 A. Yes.  
 5 Q. Who did you reach out to?  
 6 A. Only one person.  
 7 Q. Who was that?  
 8 A. Zenobia.  
 9 Q. When was that?  
 10 A. I don't remember. I called her right  
 11 after Maurer contacted me. I called her to  
 12 refresh my memory before the sworn statement, I  
 13 called her and he we exchanged comments back and  
 14 forth. So she's was my right-hand person. I  
 15 depended on her to refresh my memory over a lot  
 16 of things that we implemented and worked on  
 17 together.  
 18 Q. Were any documents exchanged between  
 19 you and Ms. Collins-Johnson prior to your giving  
 20 the sworn statement?  
 21 A. No.  
 22 Q. Did you have any documents in your  
 23 possession that you had retained from your  
 24 service at Empire that you reviewed?  
 25 A. No.

1 R. Sanchez, M.D.  
 2 Q. Did you reach out to Mr. Maurer or did  
 3 Mr. Maurer reach out to you either prior to the  
 4 time you gave your sworn statement to discuss the  
 5 substance of your sworn statement?  
 6 A. No. I knew that we were going to talk  
 7 about policies and we were going to talk about --  
 8 other than that I mean I knew that that was the  
 9 gist of why they were interested in me doing a  
 10 sworn statement.  
 11 Q. Did that have something to do with  
 12 Lyme disease?  
 13 A. Oh, yes. He told me that in the first  
 14 ten seconds of the conversation.  
 15 Q. What did he tell you?  
 16 A. That he represented members that had  
 17 Lyme disease.  
 18 Q. Did he talk at all about Empire's  
 19 policy with respect to Lyme disease?  
 20 A. He said that that was the basis of his  
 21 lawsuit.  
 22 Q. Did he tell you what his clients'  
 23 contentions were with respect to the Empire Lyme  
 24 disease policy?  
 25 A. I don't know that to date.

1 R. Sanchez, M.D.  
 2 Q. Did you discuss with anyone prior to  
 3 giving your sworn statement what your testimony  
 4 would be in that sworn statement?  
 5 A. No. I mean I talked to Zenobia so she  
 6 refreshed my memory on lots of things but I  
 7 didn't know where this was going. I didn't know  
 8 what it was limited to so we discussed a full  
 9 range of what we did there over that 18 months  
 10 and exchanged lots of conversations but I had no  
 11 idea, and to this date, I don't know who his  
 12 clients are, each of them singularly.  
 13 Q. How many conversations did you have  
 14 with Ms. Collins-Johnson between the time you  
 15 first learned of the case and the time you gave  
 16 your sworn statement?  
 17 A. We speak about twice a week.  
 18 Q. Would you have spoken at the rate of  
 19 twice a week, Doctor, during that period of time  
 20 that I just referred to?  
 21 A. Regarding this case I don't remember.  
 22 We talk about an awful lot of things besides  
 23 this.  
 24 Q. Do you remember how much time passed  
 25 between the time that you first learned of this

1 R. Sanchez, M.D.  
 2 case and the time you gave your sworn statement?  
 3 A. It was maybe a month, six weeks.  
 4 Q. Would you -- withdrawn.  
 5 Would it be fair to say you spoke at  
 6 least twice a week with Ms. Collins-Johnson  
 7 during that six-week period?  
 8 A. We speak regularly, once or twice a  
 9 week, yes.  
 10 Q. That would have been true during that  
 11 period of time as well?  
 12 A. It will be true way after this case is  
 13 disposed of.  
 14 Q. You mentioned that some kind of  
 15 materials were exchanged; do you remember what  
 16 kind of materials were exchanged?  
 17 A. I exchanged resumes, we exchanged how  
 18 I recollected different programs, those kinds of  
 19 things.  
 20 Q. Which resumes were exchanged?  
 21 A. I gave her mine, she gave me hers.  
 22 Q. Were any resumes exchanged that had  
 23 anything to do with this particular case?  
 24 A. No.  
 25 Q. Were any documents exchanged that had



1 R. Sanchez, M.D.  
 2 anything to do with this case during the period  
 3 of time from when you first learned of the case  
 4 until the time that you gave your sworn  
 5 statement?  
 6 A. No.  
 7 Q. Did anyone tell you some of the issues  
 8 that you were going to be asked about during your  
 9 sworn statement?  
 10 A. Other than it was going to be about my  
 11 stewardship of the medical policy, no.  
 12 Q. Was there any mention of what  
 13 particular aspects of the medical policy were  
 14 going to be discussed?  
 15 A. I got the gist that it was going to be  
 16 something regarding our Lyme disease policy and  
 17 our catastrophic policies.  
 18 Q. Did Ms. Collins-Johnson mention to you  
 19 at any time that she was going to give a sworn  
 20 statement in this case?  
 21 A. I found that out later on that she was  
 22 going to be interviewed by Mr. Maurer.  
 23 Q. Was that before or after she gave the  
 24 sworn statement?  
 25 A. I think it was -- I don't recollect

1 R. Sanchez, M.D.  
 2 A. They were my recollections.  
 3 Q. Were they recollections that she had  
 4 helped you make?  
 5 A. In some cases I'm sure, you know, put  
 6 the timing and those things. I wanted to be as  
 7 accurate and truthful as I could on my sworn  
 8 statement and I saw no reason -- perhaps maybe  
 9 you are indicating there is some reason that I  
 10 shouldn't have contacted her -- but I saw no  
 11 reason that I could not to insure the integrity  
 12 of my sworn statements that I could not refresh  
 13 my memory.  
 14 Q. Did Ms. Collins-Johnson indicate to  
 15 you that she was communicating with any former  
 16 Empire employees?  
 17 A. No.  
 18 Q. How about current Empire employees,  
 19 did she mention to you that she had been in  
 20 contact with any current Empire employees?  
 21 A. I don't think there's anybody left  
 22 that we know.  
 23 Q. After the time that you gave your  
 24 sworn statement when was the next time that you  
 25 had any contact with Mr. Maurer or anyone from

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 1 R. Sanchez, M.D.  
 2 completely but I think it was before she said she  
 3 was going to speak to Mr. Maurer.  
 4 Q. Did you talk at all with her about  
 5 what her testimony would be in the sworn  
 6 statement?  
 7 A. No. I mean -- the reasons we spoke  
 8 were about lots of social issues and political  
 9 issues. We have worked together an awful long  
 10 time and my conversations to her regarding this  
 11 was for me to refresh her memory. Her memory,  
 12 maybe because she's younger or brighter, is much  
 13 better than mine, although I had nothing to  
 14 refresh her memory or contribute but she did  
 15 refresh my memory.  
 16 Q. Is it accurate to say then that some  
 17 of the things that you testified to in your sworn  
 18 statement were based upon conversations that took  
 19 place with Ms. Collins-Johnson?  
 20 A. I'm sorry, repeat the question.  
 21 MR. MAURER: Objection to form.  
 22 Q. Were some of the things that you said  
 23 in your sworn statement based upon your  
 24 recollection that had been prompted by  
 25 conversations with Ms. Collins-Johnson?

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 1 R. Sanchez, M.D.  
 2 his office?  
 3 A. Right before -- the week before  
 4 trying to schedule this meeting.  
 5 Q. Within the last few weeks?  
 6 A. He sent me a copy of my sworn  
 7 statement. After that I thought you all would  
 8 settle it or whatever but I didn't receive any  
 9 further contact until he told me that this was  
 10 coming close to trial and you needed me to be  
 11 available for a deposition. I said, wait a  
 12 minute, I thought the sworn statement would have  
 13 sufficed and he said no, that I needed to be part  
 14 of the deposition and he would schedule that as  
 15 soon as possible but certainly wanted to do it  
 16 before the end of March. So I would assume  
 17 sometime during that period, December, January.  
 18 It took us a while to schedule this date.  
 19 Q. Between the period of time that you  
 20 had that conversation regarding scheduling of  
 21 this deposition and today have you had occasion  
 22 to speak with Mr. Maurer or any representatives  
 23 of his office?  
 24 A. Except for the lunch yesterday. I  
 25 have never met the other two representatives.

1 R. Sanchez, M.D.  
 2 Q. Did you call them to tell him that you  
 3 were in town?  
 4 A. No.  
 5 Q. When did you schedule the lunch?  
 6 A. The lunch was scheduled when they  
 7 called my office. I told them I would be  
 8 available on the early part of this week, that's  
 9 when the luncheon was scheduled.  
 10 Q. When did that conversation take place?  
 11 A. Two weeks ago.  
 12 Q. Did anything else take place in that  
 13 conversation other than setting up a lunch date?  
 14 A. No.  
 15 Q. Was any material sent to you at any  
 16 time during the time that you took your sworn  
 17 statement until the time that you spoke a couple  
 18 weeks ago?  
 19 A. At the receipt of the sworn statement  
 20 and receipt of a document requesting my personnel  
 21 file, release of my personnel file that was  
 22 signed and sent.  
 23 Q. Is that it, is that everything?  
 24 A. (Witness nods.)  
 25 Q. You said you had this lunch

1 R. Sanchez, M.D.  
 2 yesterday. What took place at the lunch?  
 3 A. We discussed what the process would be  
 4 like today.  
 5 Q. Did you talk at all about the  
 6 questions that you were going to be asked?  
 7 A. No.  
 8 Q. Not at all?  
 9 A. We were going to be discussing the  
 10 policies, how I implemented them, the Ernst &  
 11 Young report --  
 12 Q. The Deloitte & Touche report?  
 13 A. I'm sorry, the Deloitte & Touche, and  
 14 the personnel record.  
 15 Q. So those were the areas that were  
 16 indicated to be subject of the testimony today?  
 17 A. Correct.  
 18 Q. Was there any discussion about what  
 19 would be asked within the context of those  
 20 different areas?  
 21 A. Not specifically but I don't recall.  
 22 Q. What about with respect to the  
 23 Deloitte & Touche report and circumstances  
 24 surrounding that report, did that come up at the  
 25 lunch?

1 R. Sanchez, M.D.  
 2 A. We discussed the report, why it was  
 3 commissioned and how it was used and our policy.  
 4 Q. You told him what your testimony would  
 5 be on that subject?  
 6 A. I told him what the report was used  
 7 for at Empire in a general sense. The first time  
 8 I have looked at the detail of the report was  
 9 just a few minutes ago, when I actually looked at  
 10 the report. I have not been privy to it since  
 11 1995.  
 12 Q. The report was discussed and you  
 13 talked a little bit about what your testimony  
 14 would be with respect to that report?  
 15 A. The report was discussed as to its  
 16 role in creating medical policy.  
 17 MR. DRISCOLL: Off tape.  
 18 THE VIDEOGRAPHER: The time is 1557.  
 19 This completes tape No. 2 of the videotaped  
 20 deposition of Dr. Richard Sanchez, M.D.  
 21 (Whereupon, there is a recess in the  
 22 proceedings.)  
 23 THE VIDEOGRAPHER: The time is 1600.  
 24 This is tape No. 3 of the videotaped  
 25 deposition of Dr. Richard Sanchez, M.D..

1 R. Sanchez, M.D.  
 2 BY MR. DRISCOLL:  
 3 Q. Dr. Sanchez, did anybody show you a  
 4 copy of report at the lunch yesterday?  
 5 A. No.  
 6 Q. So the first time you saw it was  
 7 when --  
 8 A. He might have had it in his briefcase  
 9 but he never handed it to me for a review.  
 10 Q. Was there any discussion about the  
 11 contents of the report?  
 12 A. I knew the contents of the report.  
 13 Q. So the answer was no there was no  
 14 discussion about the contents of the report?  
 15 A. Except that he would be asking me  
 16 about it, that he had finally obtained a copy and  
 17 it would come up today.  
 18 Q. Were there any questions posed to you,  
 19 and by that I mean practice questions, during the  
 20 lunch or at any time up until today?  
 21 A. No.  
 22 Q. Did you indicate what any of your  
 23 answers would be to any of the questions that  
 24 were asked of you that -- that would be asked of  
 25 you?

1 R. Sanchez, M.D.  
 2 A. I don't believe. My consistent  
 3 message was it would be to my best recollection  
 4 and the truth.  
 5 Q. What other subjects were discussed at  
 6 the lunch other than the Deloitte & Touche  
 7 report?  
 8 A. The process, the punctuation, that  
 9 this would be my last involvement in this, that I  
 10 really didn't want it to go on any further. I  
 11 wanted to put it behind me and I wasn't happy to  
 12 be here and those things and I hoped this would  
 13 end, this would be it, and that given the  
 14 opportunity for both sides to depose me that that  
 15 should be it.  
 16 Q. You testified earlier that in addition  
 17 to the report there was some discussion about  
 18 Empire's policies and procedures; is that right?  
 19 A. Yes. Those that occurred over the  
 20 preceding phone conversations and the sworn  
 21 statement and yesterday that I would be asked to  
 22 recall my contribution and give my opinion about  
 23 the policy at Empire.  
 24 Q. Were any documents other than the  
 25 Deloitte & Touche report, which you've said was

1 R. Sanchez, M.D.  
 2 A. That I had given her name to a  
 3 headhunter that was going to call her and that  
 4 she should take the call.  
 5 Q. Was there any discussion of your  
 6 testimony today?  
 7 A. I told her that I was here and that I  
 8 was going to do the deposition today.  
 9 Q. Did she talk to you at all about her  
 10 scheduled deposition?  
 11 A. No.  
 12 Q. She didn't mention that at all?  
 13 A. No.  
 14 Q. You testified earlier that one of the  
 15 things that you were going to be asked to do when  
 16 you came to Empire was to go be "passionate about  
 17 high-quality care" responsive to the concern of  
 18 patients and providers and sympathetic to the  
 19 needs of the chronically ill.  
 20 Do you believe that you were all those  
 21 things during the period of time that you were  
 22 with Empire, don't you?  
 23 A. Yes.  
 24 Q. You've talked about the tabulation of  
 25 denials and keeping track of denials. Are you

1 R. Sanchez, M.D.  
 2 not shown to you at lunch, were any other  
 3 documents shown to you at lunch?  
 4 A. Those policies that we referenced  
 5 earlier, the 1990, 1993 and 1995.  
 6 Q. The Lyme disease policies?  
 7 A. The Lyme disease policies.  
 8 Q. Anything other than those three  
 9 documents?  
 10 A. Not that I recall.  
 11 Q. Were there any discussions between the  
 12 period of time of yesterday's lunch and your  
 13 testimony today?  
 14 A. No.  
 15 Q. So you didn't speak at all last night  
 16 or this morning before your testimony began?  
 17 A. He called me at 10:00 a.m. when I was  
 18 late, he called me on my cell phone and asked  
 19 where I was. I told him I was in a cab on my way  
 20 here.  
 21 Q. When was the last time you spoke with  
 22 Ms. Collins-Johnson?  
 23 A. I think it was probably yesterday.  
 24 Q. What was the substance of that  
 25 conversation?

1 R. Sanchez, M.D.  
 2 aware of any process whereby denials are  
 3 tabulated for Medicare purposes?  
 4 A. No.  
 5 MR. MAURER: Excuse me, Justin, your  
 6 microphone isn't on.  
 7 MR. DRISCOLL: Thank you.  
 8 Q. During the early days of your  
 9 discussions with Mr. Maurer about the case prior  
 10 to the time of your sworn statement as opposed to  
 11 your testimony today, did you speak at all to  
 12 Jeffrey Chancellor of Empire?  
 13 A. Jeffrey called me within a few days or  
 14 weeks after I spoke to Mr. Maurer.  
 15 Q. He asked you whether he could speak to  
 16 you as well, didn't he?  
 17 A. He asked if he could represent me and  
 18 he asked if he could -- he didn't ask to speak  
 19 with me.  
 20 Q. Did he ask you if he could participate  
 21 in a sworn statement?  
 22 A. Not to me, no.  
 23 Q. Did he ask you if you would --  
 24 A. I assumed he would be there but he  
 25 wasn't. It didn't matter to me whether he was

1 R. Sanchez, M.D.  
 2 there or not, I didn't want his representation.  
 3 Q. Isn't it a fact, sir, that you told  
 4 him that you would speak with him as long as it  
 5 was okay with Mr. Maurer?  
 6 A. I think what I said is you need to ask  
 7 Mr. Maurer if he wants you present at the sworn  
 8 statement. It didn't matter to me.  
 9 Q. Did he ask you what you were going to  
 10 say in your sworn statement?  
 11 A. Jeffrey did.  
 12 Q. He did?  
 13 A. No, I don't recall that, no.  
 14 Q. Isn't it a fact, sir, that in that  
 15 conversation you told him that you hated Mike  
 16 Stocker?  
 17 A. No, that's not true.  
 18 Q. Isn't also a fact that you told him  
 19 that Mike Stocker had taken money from you by not  
 20 paying your bonus?  
 21 A. No, that's absolutely wrong.  
 22 Q. Is it --  
 23 A. What I did say is that I thought that  
 24 I was treated very unfavorably with corporate  
 25 counsel in the room who should have been looking

1 R. Sanchez, M.D.  
 2 out for me and the company and that I didn't  
 3 trust corporate counsel to ever represent me  
 4 again and that's what he was trying to do. He  
 5 was trying to represent me in this action and I  
 6 said no, thank you, I have had my full -- my fill  
 7 of the way you've represented me and I didn't  
 8 think I was treated fairly and he understood  
 9 that. That's all that was about.  
 10 Q. Isn't it also a fact that you told him  
 11 that you hated Empire?  
 12 A. No.  
 13 MR. DRISCOLL: I'd like to have marked  
 14 as Defendant's B, a document entitled  
 15 Separation Agreement and General Release.  
 16 I'd like to go off tape as the reporter  
 17 marks that document.  
 18 MR. MAURER: It's already in the  
 19 personnel file.  
 20 THE VIDEOGRAPHER: The time is 1609.  
 21 We are going off the record.  
 22 (Defendant's Exhibit B, document  
 23 entitled Separation Agreement and General  
 24 Release, marked for identification, as of  
 25 this date.)

1 R. Sanchez, M.D.  
 2 MR. DRISCOLL: On the record, off the  
 3 tape. Let the record just reflect that this  
 4 document is also contained in the personnel  
 5 file that was previously marked.  
 6 Back on tape.  
 7 THE VIDEOGRAPHER: The time is 1611.  
 8 We are back on the record.  
 9 BY MR. DRISCOLL:  
 10 Q. Dr. Sanchez, I'd like to show you  
 11 what's been marked as Defendant's Exhibit B and  
 12 ask you if you can identify that document?  
 13 A. Uh-hum. It's the separation agreement  
 14 when I left Empire.  
 15 Q. Is that your signature on the last  
 16 page of the document?  
 17 A. Yes.  
 18 Q. You testified in your direct  
 19 examination that you were paid a sum of money in  
 20 connection with the separation from the company  
 21 or severance. Is the amount set forth in  
 22 paragraph four the amount that you received?  
 23 A. Yes.  
 24 Q. You said before that you are not being  
 25 compensated at all by plaintiffs' counsel for

1 R. Sanchez, M.D.  
 2 your presence here today?  
 3 A. No, I'm not.  
 4 Q. Are you up here on other business?  
 5 A. Yes, I am.  
 6 Q. You've testified as to your  
 7 understanding of the policies regarding  
 8 intravenous antibiotic treatment of Lyme disease;  
 9 is that right?  
 10 A. That's correct.  
 11 Q. Do you consider yourself an expert in  
 12 Lyme disease?  
 13 A. No, I do not.  
 14 Q. Do you know enough about it to know  
 15 that there is a dispute within the medical  
 16 community as to the efficacy of antibiotic  
 17 therapy beyond 30 days?  
 18 A. I knew at the time in 1995 that there  
 19 was a dispute among the efficacy.  
 20 Q. There was a substantial amount of  
 21 literature, was there not, that IV antibiotic  
 22 therapy beyond 30 days was not efficacious?  
 23 A. That's correct.  
 24 Q. That was one of things that you  
 25 considered in putting together the Lyme disease

1 R. Sanchez, M.D.  
 2 policy?  
 3 A. That's correct.  
 4 Q. Intravenous antibiotic therapy is  
 5 risky, is it not?  
 6 A. There are some risks, yes.  
 7 Q. Some of those risks would be an  
 8 infection at the entry port; is that correct?  
 9 A. Correct.  
 10 Q. There are also side affects or  
 11 possible risks with respect to colitis; is that  
 12 true?  
 13 A. Yes, to the antibiotic, yes.  
 14 Q. And with respect to the one drug that  
 15 you mentioned earlier Rocephin, there's potential  
 16 risk of gall bladder problems with respect to  
 17 that treatment, is there not?  
 18 A. Those are rarer risks and anaphylaxis  
 19 or allergic reactions or super infections with  
 20 other microbes but, yes, there's risks.  
 21 Q. The other things that you just  
 22 mentioned are they additional risks that might be  
 23 caused by intravenous antibiotic therapy?  
 24 A. Yes.  
 25 Q. Isn't it a fact that in determining

1 R. Sanchez, M.D.  
 2 that you described initially that you were going  
 3 to do when you came to Empire?  
 4 A. No, I wouldn't have.  
 5 Q. By that I meant the three items that  
 6 you had mentioned, the high quality -- passionate  
 7 about high-quality care, responsive to concerns  
 8 of patients and providers and sympathetic to the  
 9 needs of the chronically ill. You wouldn't have  
 10 put together a policy that was inconsistent with  
 11 those three things?  
 12 A. No, we would not.  
 13 Q. You said that you were familiar with  
 14 Ms. Collins-Johnson and her employment at Empire  
 15 and that you were happy with her service; is that  
 16 right?  
 17 A. Yes.  
 18 Q. Were you aware of an issue that  
 19 occurred with respect to her use of her secretary  
 20 for baby-sitting?  
 21 A. No.  
 22 Q. You were not aware of that?  
 23 A. I was not aware of that.  
 24 Q. She never told you anything about  
 25 that?

1 R. Sanchez, M.D.  
 2 whether to prescribe intravenous antibiotic  
 3 therapy one would weigh the risks associated with  
 4 that therapy against the potential benefit of  
 5 that therapy?  
 6 A. One would.  
 7 Q. If there was no proven benefit to the  
 8 therapy and that was coupled with risk the  
 9 physician would err on the side of not  
 10 prescribing the therapy due to the risk and the  
 11 unproven benefit?  
 12 A. In any therapeutic intervention you  
 13 also weigh the risk and the benefit. The  
 14 benefits have to outweigh the risks.  
 15 Q. Now, at the time that you put together  
 16 the Lyme disease policy, and I think you said it  
 17 was sometime in 1995, you believe that to be the  
 18 right approach to the treatment of Lyme disease,  
 19 did you not?  
 20 A. We believed it to be a workable  
 21 approach. I mean right is a, you know, I don't  
 22 know if it's a religious term or not. We thought  
 23 it was a sensible approach.  
 24 Q. You wouldn't have put together a  
 25 policy that was -- that ran counter to the things

1 R. Sanchez, M.D.  
 2 A. She never told me anything about it.  
 3 No one at Empire -- I was her supervisor, no one  
 4 told me. She told me later on.  
 5 Q. She did tell you?  
 6 A. Yes.  
 7 Q. What did she say?  
 8 A. That they were trying to accuse her of  
 9 lots of dastardly things and something had come  
 10 up regarding that but it was never brought to my  
 11 attention, any misuse of personnel. It might  
 12 have occurred after I left, too.  
 13 Q. I'd like to show you the statement  
 14 that you gave previously that was marked on your  
 15 direct examination.  
 16 MR. DRISCOLL: Off tape, please.  
 17 THE VIDEOGRAPHER: The time is 1619  
 18 and we are off the record.  
 19 (Whereupon, there is a recess in the  
 20 proceedings.)  
 21 THE VIDEOGRAPHER: The time is 1622  
 22 and we are back on the record.  
 23 BY MR. DRISCOLL:  
 24 Q. Dr. Sanchez, do you have before you  
 25 what was marked as Sanchez 3?

1 R. Sanchez, M.D.  
 2 A. Correct.  
 3 Q. Is that the sworn statement that you  
 4 gave in Atlanta sometime prior to today?  
 5 A. Correct.  
 6 Q. Directing your attention to page 12 of  
 7 the statement, actually, we're going to have to  
 8 start at the bottom of page 11. Do you see the  
 9 bottom of page 11 where you say, "Cost of health  
 10 care, providing actual medical services to the  
 11 member of Blue Cross/Blue Shield had historically  
 12 been very, very high and was out of step with the  
 13 premiums and was out of step with what he,"  
 14 meaning Dr. Stocker, I believe, from the first  
 15 part of your answer, "felt to be the rest of the  
 16 country."  
 17 Is it true that one of the things that  
 18 you were interested in doing was bringing  
 19 Empire's much higher costs down to where you  
 20 thought they should be; is that right?  
 21 A. No. My charge was to bring Empire's  
 22 cost into a range where the company would be  
 23 profitable. Profitability is not determined by  
 24 me, it's determined by investors and the board  
 25 and my supervisors.

1 R. Sanchez, M.D.  
 2 Q. Isn't it true that one of the things  
 3 you considered was where Empire stood vis-a-vis  
 4 the rest of the industry?  
 5 A. Sure. You use those benchmarks to  
 6 compare your success.  
 7 Q. So you agree then --  
 8 A. That was our mind, it was a personal  
 9 goal.  
 10 Q. I understand. One of the things that  
 11 you considered was the fact that Empire's costs  
 12 were, to use your language in this answer, very,  
 13 very high; is that right?  
 14 A. Correct.  
 15 Q. You also went to on to say on page 12  
 16 that the denials by medical directors were way,  
 17 way below the national average. That was also  
 18 something that you considered?  
 19 A. Correct.  
 20 Q. This was part of your plan, to bring  
 21 better utilization and quality care to your  
 22 members; is that right?  
 23 A. It was part of the plan, yes.  
 24 Q. Part of that plan?  
 25 A. Yes.

1 R. Sanchez, M.D.  
 2 Q. One of the things you also wanted to  
 3 consider and did consider was whether your  
 4 policies stood up to, as you described it,  
 5 scientific scrutiny; is that right?  
 6 A. Correct.  
 7 Q. By scientific scrutiny you mean  
 8 looking at what the medical literature is, the  
 9 peer review literature, and making sure that  
 10 whatever Empire does is consistent with that  
 11 literature?  
 12 A. Consistent with the consensus of the  
 13 research and literature. You cannot in a topic  
 14 as controversial as Lyme disease or bone marrow  
 15 transplant for breast patients get consistent  
 16 medical literature. You try to arrive at a  
 17 consensus and you try to create a policy that's  
 18 defensible within the literature and research  
 19 that exists.  
 20 Q. One of the things that you are looking  
 21 at, of course, I would think would be what the  
 22 consensus was of the medical community in the  
 23 literature?  
 24 A. One of the factors you would take is  
 25 the standard of practice in the community.

1 R. Sanchez, M.D.  
 2 Q. That would involve looking at what the  
 3 consensus of the medical opinion was in the  
 4 community; is that right?  
 5 A. Yes. The way physicians practice in  
 6 that community, yes, it's one of the factors you  
 7 consider.  
 8 Q. Would it also include taking into  
 9 consideration the consensus of studies on a  
 10 particular topic?  
 11 A. Yes, sir.  
 12 Q. Those are things that you considered  
 13 in putting together the Lyme disease policy?  
 14 A. Correct.  
 15 Q. Going for a moment to this question of  
 16 the incentive compensation that you referred to  
 17 in your direct examination. It's not your  
 18 testimony, is it, that people receive some  
 19 benefit for denying a particular claim?  
 20 A. Not a particular claim, no.  
 21 Q. ...Isn't it true that what the incentive  
 22 compensation program was about was trying to  
 23 broaden the participation of people in the bottom  
 24 line performance of the company?  
 25 A. That's true.

1 R. Sanchez, M.D.  
 2 Q. And you said, I think, certain senior  
 3 management people and at certain levels, not  
 4 everybody, but certain levels of the employment  
 5 structure at the company would participate in  
 6 some way in the bottom line performance of the  
 7 company?  
 8 A. The bottom line performance of the  
 9 company was one of the criteria for a segment of  
 10 several segments on which your evaluation and  
 11 your incentive compensation was based. So you  
 12 had to predetermine everyone that was an  
 13 executive or manager and above or director and  
 14 above, I forget where the cutoff was, knew that x  
 15 percentage of their base salary would be eligible  
 16 for incentive compensation. That x percentage,  
 17 you never received 100 percent of that because it  
 18 was impossible to meet almost all the criteria at  
 19 a hundred percent, you might only get 50 percent  
 20 on A, 100 percent on B and only 30 percent on C.  
 21 You could have received up to, in my case, 40  
 22 percent, you received less because maybe the  
 23 company didn't meet its overall goals. So there  
 24 were a lot of factors that were formulated, taken  
 25 into account in that, but the reduction and the

1 R. Sanchez, M.D.  
 2 cost of health care was one of them.  
 3 Q. But when someone reviewed a claim they  
 4 weren't incentivised to deny that claim based on  
 5 the incentive program?  
 6 A. They were incentivised to make sure  
 7 that before they approved of that claim it met  
 8 medical policy guidelines, and the diagnosis was  
 9 appropriate and the therapy was appropriate and  
 10 that it matched our new criteria from InterQual  
 11 or Millman & Robertson. They knew that adherence  
 12 to those things was part of what we were going to  
 13 look at in the year evaluation of that.  
 14 Q. What you are saying is they were  
 15 incentivised to discover inappropriate or  
 16 medically unnecessary claims?  
 17 A. Correct, for sure.  
 18 MR. DRISCOLL: Off tape for a moment.  
 19 THE VIDEOGRAPHER: The time is 1630.  
 20 We are off the record.  
 21 (Whereupon, there is a recess in the  
 22 proceedings.)  
 23 THE VIDEOGRAPHER: The time is 1633.  
 24 We are back on the record.  
 25 BY MR. DRISCOLL:

1 R. Sanchez, M.D.  
 2 Q. Dr. Sanchez, you were referring before  
 3 to certain instances where the larger clients may  
 4 have come to the company and asked for some  
 5 variation, I guess, of the policy and that Empire  
 6 went ahead and approved those variations. Is  
 7 that something known as an extra-contractual  
 8 payment?  
 9 A. I think the extra-contractual payment  
 10 is different. The extra contractual that you are  
 11 referring to has to do with a policy -- a process  
 12 in which you go back to the employer and say, you  
 13 know, we have one of your employees asking for  
 14 this, it's not a covered benefit. The employer  
 15 has a right to go into an extra contractual and  
 16 say I'll pay for it and you just bill me for it,  
 17 I'm going to cover it, it's a valued employee,  
 18 it's a service. There are those. That's not  
 19 what I was referring to.  
 20 Q. So --  
 21 A. What I was referring to was direct  
 22 pressure to go around medical policy or claims  
 23 policy and pay claims where the benefit wasn't  
 24 covered. We were not going to get compensation  
 25 later from the employer in the extra-contractual

1 R. Sanchez, M.D.  
 2 process that I just described.  
 3 Q. You know that to be true of the  
 4 instances that you mentioned, that the employer  
 5 or whether it was an union or a company, they did  
 6 not contribute in any way toward the payment of  
 7 the benefit that they sought?  
 8 A. Yes. There's no way they could have.  
 9 Q. Why is that?  
 10 A. Because we compensated the provider,  
 11 the hospital, the physician. We cut a check to  
 12 them and everything was square. There was no way  
 13 to rebill them for whatever we did in that  
 14 accommodation.  
 15 Q. Isn't it a fact, sir, that when Empire  
 16 is approached on an extra-contractual basis  
 17 Empire will go ahead and perhaps make a variation  
 18 because the money is coming from the employer as  
 19 opposed to Empire?  
 20 A. That's correct. In that  
 21 extra-contractual process there is an  
 22 understanding that the employer will make up and  
 23 pay it. I don't know how effective that was in  
 24 going back and collecting it, I never saw that.  
 25 We in medical management didn't like that, that

1 R. Sanchez, M.D.  
 2 that would occur. But that's a different process  
 3 than what I was describing.  
 4 Q. Thank you.  
 5 What would you have done if you  
 6 learned that treatment that was covered by the  
 7 policy and medically necessary was being denied?  
 8 MR. MAURER: Objection. Off tape.  
 9 THE VIDEOGRAPHER: The time is 1637.  
 10 We are going off the record.  
 11 MR. MAURER: It calls for  
 12 speculation.  
 13 MR. DRISCOLL: If he can answer it.  
 14 MR. MAURER: On tape.  
 15 THE VIDEOGRAPHER: The time is 1637  
 16 and we are back on the record.  
 17 BY MR. DRISCOLL:  
 18 A. If it was a covered benefit we were  
 19 obligated to pay for it and we were obligated to  
 20 insist that our providers provide the service as  
 21 we could enforce the contract.  
 22 Q. So that if you learned that somebody  
 23 was denying treatment in that situation that  
 24 would be inconsistent with medical policy; isn't  
 25 that right?

1 R. Sanchez, M.D.  
 2 A. It would be inconsistent with our  
 3 whole contract with the employer.  
 4 Q. So if you learned that you would  
 5 report that person or see it to that that person  
 6 was disciplined in some way?  
 7 MR. MAURER: Same objection.  
 8 A. Yes.  
 9 Q. Dr. Sanchez, the statement that Empire  
 10 during your time there ruthlessly disregarded the  
 11 consequences of its decisions, that's a false  
 12 statement, isn't it?  
 13 A. Where is that statement?  
 14 Q. I just gave it to you. Would that  
 15 have been a false statement?  
 16 A. Did I make that statement?  
 17 Q. No. Would that have been false?  
 18 A. I'm sorry.  
 19 Q. Ruthlessly disregarded the  
 20 consequences of its decisions, that's a false  
 21 statement, isn't it?  
 22 A. It's a stronger statement than I would  
 23 say.  
 24 Q. That would mean in your view it would  
 25 be false; isn't that right?

1 R. Sanchez, M.D.  
 2 MR. MAURER: Objection. Asked and  
 3 answered.  
 4 A. You have to give me in the context.  
 5 You have given me a phrase within the context of  
 6 I don't know what the discussion was.  
 7 Q. Would that be an appropriate  
 8 characterization of what you were doing while you  
 9 were at Empire?  
 10 MR. MAURER: Same objection.  
 11 A. Ruthlessly disregarding the  
 12 consequences of my --  
 13 Q. -- of your decisions.  
 14 A. If you are asking me was my conduct at  
 15 Empire describable by ruthlessly disregarding the  
 16 consequences of my decision, I would deny that.  
 17 Q. The statement that Empire during your  
 18 period there put costs ahead of patients' health,  
 19 that would be false, too, wouldn't it?  
 20 A. We were -- we had a contractual  
 21 obligation to pay for benefits covered by  
 22 employers and we had an obligation to create a  
 23 policy so that we could compensate the providers  
 24 for the covered benefits to our members.  
 25 To the extent that there were

1 R. Sanchez, M.D.  
 2 conditions or diagnoses or services requested  
 3 that were not covered benefits, we denied those.  
 4 We denied them and we denied them. They may  
 5 claim that their health suffered or their very  
 6 lives suffered. They weren't a covered benefit,  
 7 it wasn't in our medical policy and the employer  
 8 had not paid the premium for that benefit, that's  
 9 the way we interpreted that.  
 10 Q. What you were looking to ferret out  
 11 was in your period of time at Empire was payment  
 12 for services that were not covered benefits;  
 13 isn't that right?  
 14 A. Not covered benefits or being applied  
 15 to the wrong diagnoses?  
 16 MR. DRISCOLL: I'd like to have marked  
 17 as Defendant's C, I believe, a document  
 18 entitled General Release. I'd like to go  
 19 off tape while the reporter marks that  
 20 document.  
 21 THE VIDEOGRAPHER: The time is 1643.  
 22 We are going off the record.  
 23 (Defendant's Sanchez Exhibit C,  
 24 document entitled General Release, marked  
 25 for identification, as of this date.)



1 R. Sanchez, M.D.  
 2 MR. DRISCOLL: Back on tape, please.  
 3 THE VIDEOGRAPHER: The time is 1642.  
 4 We are back on the record.  
 5 BY MR. DRISCOLL:  
 6 Q. Dr. Sanchez, I show you what's been  
 7 marked as Defendant's C. Can you identify that,  
 8 please?  
 9 A. This is a general -- this is a release  
 10 of me being named in a suit by Dan Licul,  
 11 L-I-C-U-L.  
 12 Q. Are there releases for the other  
 13 plaintiffs in this case as well?  
 14 A. Yes, sir.  
 15 Q. Can you tell me the circumstances  
 16 surrounding this release?  
 17 A. I was very reticent to cooperate, I  
 18 didn't want to cooperate. I wanted this behind  
 19 me and I didn't want to give a sworn statement  
 20 that was going to extract something that would  
 21 put me in jeopardy of being sued by his clients  
 22 so I asked for a release.  
 23 Q. Hasn't your sworn statement already  
 24 been given at the time you had the release  
 25 executed?

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1 R. Sanchez, M.D.  
 2 A. No.  
 3 Q. Let me show you --  
 4 A. My agreement was to get that release,  
 5 I don't remember --  
 6 Q. Let me show you Sanchez 3 and  
 7 Defendant's C and perhaps that would refresh your  
 8 recollection as to the sequence of events.  
 9 A. Uh-hum. The agreement to get the  
 10 release was before I wrote this, before I did the  
 11 sworn statement. The actual collection of it  
 12 might have occurred afterward but I took  
 13 Mr. Maurer at his word and his clients.  
 14 Q. So he promised you that if you gave  
 15 the sworn statement you would get the release?  
 16 A. No, sir. I promised -- I extracted an  
 17 agreement that I would not give a sworn statement  
 18 unless I could get the releases, that's the  
 19 order. I gave the sworn statement, I asked for  
 20 the releases, they were in the process. Because  
 21 one of them, I think he said one of them was out  
 22 of town or something and he could not get them  
 23 all but he did in the process over the next few  
 24 weeks give them to me.  
 25 Q. So you gave the sworn statement?

1 R. Sanchez, M.D.  
 2 without at least one of the releases?  
 3 A. I don't think I had any of them in my  
 4 hand. I'm a pretty trusting fellow.  
 5 MR. DRISCOLL: Off tape for a moment,  
 6 please.  
 7 THE VIDEOGRAPHER: The time is 1645.  
 8 We are going off the record.  
 9 (Whereupon, there is a recess in the  
 10 proceedings.)  
 11 MR. DRISCOLL: Back on tape, please.  
 12 THE VIDEOGRAPHER: The time is 1647.  
 13 We are back on the record.  
 14 BY MR. DRISCOLL:  
 15 Q. Dr. Sanchez, you referred earlier to  
 16 certain coding practice that took place, I think  
 17 in your direct testimony you were talking about  
 18 coding of Lyme disease claims.  
 19 Isn't it true sir, that there were  
 20 codes affixed to all types of claims, all types  
 21 of procedures, not just Lyme disease-related  
 22 procedures?  
 23 A. Yes.  
 24 Q. This question of this suspension of  
 25 codes related to Lyme disease treatment, that

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1 R. Sanchez, M.D.  
 2 suspension was implemented because Empire was  
 3 experiencing medically unnecessary and  
 4 experimental treatments with respect to Lyme  
 5 disease claims; isn't that also correct?  
 6 A. The new codes were implemented to be  
 7 sure that there was physician review of any new  
 8 Lyme disease diagnoses and request for treatment  
 9 as per that policy that you are referencing and  
 10 the whole impetus to change the policy was that  
 11 we were incurring extraordinary costs for the  
 12 treatment of Lyme disease.  
 13 Q. Isn't it also true you were  
 14 experiencing that cost on claims that were  
 15 frequently for services that Empire believed were  
 16 medically unnecessary or experimental treatments?  
 17 A. Correct.  
 18 Q. So it wasn't a code assigned to simply  
 19 identify and slow down Lyme disease cases just  
 20 because they were Lyme disease as opposed to some  
 21 other illness, it was because Empire was  
 22 experiencing a problem in the handling of Lyme  
 23 disease claims?  
 24 A. Lyme disease was selected because it  
 25 was one of the high costs claims that

1 R. Sanchez, M.D.  
 2 precipitated a lot of costs in claims and those  
 3 were flagged to make sure that the scrutiny was  
 4 brought upon those claims to make sure they  
 5 didn't adhere to policy and the diagnosis was  
 6 correct.  
 7 Q. So Empire was experiencing cost within  
 8 the context of claims that under its policy many  
 9 times were medically unnecessary or experimental  
 10 in nature?  
 11 A. It was our opinion, yes.  
 12 Q. In fact, you used the phrase  
 13 "overzealous treatment" as something that was  
 14 associated with Lyme disease treatment; isn't  
 15 that correct?  
 16 A. Correct.  
 17 Q. Sir, there was nothing arbitrary at  
 18 all about Empire's Lyme disease policy; isn't  
 19 that right?  
 20 A. I used the term arbitrary when we were  
 21 talking the 42 days.  
 22 Q. That's not arbitrary at all, is it,  
 23 that's a number that was based on medical review  
 24 and peer literature that you said you  
 25 considered?

1 R. Sanchez, M.D.  
 2 MR. MAURER: Objection.  
 3 Q. Isn't that right?  
 4 A. The number -- in my use of the word  
 5 arbitrary means that it could have been 40 days  
 6 or 45 days, and if you look at treatment  
 7 modalities are divided up into weeks and we had  
 8 to pick one and we had to pick one that seemed to  
 9 match the literature and everybody else on what  
 10 the definition of early disease and late disease  
 11 and we picked that at around six weeks. When you  
 12 could classify a Lyme disease person in the early  
 13 stages as opposed to into the late stages.  
 14 Q. Then you would agree with me that it  
 15 was not simply picked out of the sky, it was  
 16 based upon the medical literature that you  
 17 reviewed?  
 18 MR. MAURER: Objection. Asked and  
 19 answered.  
 20 A. As I said, whether it was 42 days or  
 21 45 was what I meant that made it arbitrary.  
 22 Somewhere in the six-week period we had to  
 23 define.  
 24 Q. You didn't pick a year or two years?  
 25 A. No. The course of the disease tends

1 R. Sanchez, M.D.  
 2 to move it into a month period and beyond a month  
 3 period so in that range.  
 4 Q. Now, this California posse that you  
 5 referred to that included a relative of yours;  
 6 did it not?  
 7 A. No, sir.  
 8 Q. Was there someone that was part of  
 9 your staff at Empire that you were related to?  
 10 A. No, sir.  
 11 Q. No one?  
 12 A. No. ?  
 13 MR. DRISCOLL: Off tape for a moment,  
 14 please.  
 15 THE VIDEOGRAPHER: The time is 1652.  
 16 We are going off the record.  
 17 MR. DRISCOLL: Back on tape for a  
 18 moment.  
 19 THE WITNESS: Wait a minute there was  
 20 one, not on my staff.  
 21 THE VIDEOGRAPHER: The time is 1653.  
 22 We are back on the record.  
 23 BY MR. DRISCOLL:  
 24 Q. Did you want to clarify your answer?  
 25 A. Yes, I did. There was no one related

1 R. Sanchez, M.D.  
 2 me. There was a brother-in-law that was brought  
 3 from California as part of Jerry Adam's team.  
 4 That was a tag team that we had together at FHP.  
 5 I had nothing to do with his hiring and bringing  
 6 him to board. That's the only -- if you consider  
 7 that a relative .  
 8 Q. I know you have to break for a  
 9 conference call at this point.  
 10 A. It won't take very long and I  
 11 appreciate your consideration in this. I'll be  
 12 glad to come back.  
 13 MR. DRISCOLL: Could we go off tape,  
 14 please.  
 15 THE VIDEOGRAPHER: The time is 1653.  
 16 We are going off the record.  
 17 (Whereupon, there is a recess in the  
 18 proceedings.)  
 19 MR. DRISCOLL: Back on tape, please.  
 20 THE VIDEOGRAPHER: The time is 1704.  
 21 We are back on the record.  
 22 BY MR. DRISCOLL:  
 23 Q. Dr. Sanchez, in response to one of  
 24 Mr. Maurer's questions I believe you said that  
 25 Empire did not do any investigation to determine

1 R. Sanchez, M.D.  
 2 what impact changes would have on patients and  
 3 didn't review chart information on these  
 4 particular patients that were in the Empire pool  
 5 at the time, correct?  
 6 A. Correct.  
 7 Q. Isn't it a fact that one of the  
 8 principal reasons why that would not have been  
 9 done was because any claims made under the new  
 10 policy would be examined by claims personnel and  
 11 if the claim was denied and it went for review  
 12 there would be a review of the medical chart at  
 13 that time?  
 14 A. Mr. Driscoll, I understood the  
 15 question was did we do any research in looking  
 16 into the clinical care of these patients up until  
 17 the modification of the policy and I answered no,  
 18 we did not. We didn't -- I think he was asking  
 19 did we consider the impact on the patients by  
 20 reviewing and investigating doing research on  
 21 those patient charts, we did not. You are  
 22 absolutely correct and in going forward they  
 23 would all pop in because on appeal we would get  
 24 all that information.  
 25 MR. DRISCOLL: Thank you very much. I

1 R. Sanchez, M.D.  
 2 proceedings.)  
 3 MR. MAURER: Back on tape and record.  
 4 THE VIDEOGRAPHER: The time is 1708.  
 5 We are back on the record.  
 6 BY MR. MAURER:  
 7 Q. Dr. Sanchez, with regard to review of  
 8 insured patient's medical charts, did such a  
 9 review normally take place at Empire before there  
 10 was a denial followed by an appeal?  
 11 A. Before there was a denial?  
 12 Q. Yes.  
 13 A. No, no.  
 14 Q. With regard to the use of the computer  
 15 codes and the automatic suspension that would  
 16 take place with the Lyme disease as a result of  
 17 some of the changes you brought in, would I be  
 18 correct that this was something that applied in  
 19 some instances but this is not something that  
 20 happened across the board; is that correct?  
 21 A. Could you rephrase the question. I'm  
 22 sorry, Mr. Maurer, it's been a long day.  
 23 Q. I'm sorry, I have a habit of sometimes  
 24 not making sense especially at the end of the  
 25 day, I apologize.

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 1 R. Sanchez, M.D.  
 2 have no further questions.  
 3 REDIRECT EXAMINATION  
 4 BY MR. MAURER:  
 5 MR. MAURER: This is Ira Maurer on  
 6 re-direct.  
 7 Q. Your last response, Doctor, has to be  
 8 considered, doesn't it, in the context that the  
 9 fact that not all insured patients will go  
 10 through the appeal process, true?  
 11 A. Absolutely, that is true.  
 12 Q. So the review of the charts would not  
 13 take place for all cases where there was a denial  
 14 issued, correct?  
 15 A. That's correct. It would have to be  
 16 the squeaky wheel either by a physician or  
 17 member.  
 18 MR. MAURER: There's a call for  
 19 Mr. Driscoll. Let's go off tape for a  
 20 moment.  
 21 MR. DRISCOLL: Off tape and off  
 22 record, please.  
 23 THE VIDEOGRAPHER: The time is 1706  
 24 and we are off the record.  
 25 (Whereupon, there is a recess in the

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 1 R. Sanchez, M.D.  
 2 With regard to the use of computer  
 3 codes to identify and flag Lyme disease under the  
 4 new procedures that you brought in to Empire, you  
 5 told us that that would result in an immediate  
 6 suspension of payment of any claims until there  
 7 was a review of the file; is that correct?  
 8 A. Correct.  
 9 Q. That happened with other high cost  
 10 illnesses; is that true?  
 11 A. It happened with anything that we  
 12 wanted it to happen. It could happen with a  
 13 certain provider that we thought was suspicious  
 14 that was overbilling us or fraudulent. It could  
 15 happen with a certain clinic or lab that we  
 16 thought so. We could put those flags on any that  
 17 claim through.  
 18 If you recall, the policy was written  
 19 so as to from going forward new diagnoses would  
 20 hit this code and it would then flag and come out  
 21 and it couldn't be processed or paid until it  
 22 came out. That was the intention of that new  
 23 flag. And for Lyme disease, those codes started  
 24 on whatever date it referenced there moving  
 25 forward.

1 R. Sanchez, M.D.  
 2 Q. So this happened with some but not all  
 3 claims. Only the selected ones?  
 4 A. Only those that were referenced in the  
 5 letter. New Lyme disease cases was the sentence  
 6 we used.  
 7 Q. You also used other flagging codes for  
 8 other high cost items as a way of controlling the  
 9 high costs; is that correct?  
 10 A. We spent an awful lot of time working  
 11 with our case management and utilization nurses  
 12 to pay attention to the high cost diagnoses and I  
 13 don't know if they were all formally flagged but  
 14 they knew clearly before they approved an \$80,000  
 15 procedure that it was one of those that we were  
 16 going to scrutinize.  
 17 Q. Now, you were being asked some  
 18 questions by Mr. Driscoll about the use of  
 19 incentives, I think he used the word  
 20 incentivised, whether or not employees were  
 21 incentivised.  
 22 A. That's a new verb in managed care  
 23 language.  
 24 Q. I'm not familiar with that one.  
 25 Let me ask you this: As part of the

1 R. Sanchez, M.D.  
 2 policies and procedures that you implemented at  
 3 Empire was there as part of this incentive a  
 4 situation where the caseworkers and the doctors  
 5 at Empire had this incentive to deny intravenous  
 6 antibiotic therapy where there was no positive  
 7 ELISA coupled with a positive Western Blot test,  
 8 was that part of the incentive program  
 9 indirectly?  
 10 A. They -- indirectly, I mean if you put  
 11 the word indirectly in there, adverb or  
 12 adjective, indirectly, of course, if they were  
 13 able to weed out inappropriate or overzealous or  
 14 over-utilized care and save on Lyme disease, what  
 15 the benefits we were providing, those types of  
 16 Lyme disease diagnoses, it would have reflected  
 17 in a lower cost of health care and would have  
 18 been part of the factor that we took in to their  
 19 incentive compensation.  
 20 MR. MAURER: Off tape, please.  
 21 THE VIDEOGRAPHER: The time is 1712.  
 22 We are going off the record.  
 23 MR. DRISCOLL: Are you looking for  
 24 something I marked?  
 25 MR. MAURER: No, I just want to look

1 R. Sanchez, M.D.  
 2 at the language for one second.  
 3 MR. MAURER: On tape.  
 4 THE VIDEOGRAPHER: The time is 1714.  
 5 We are back on the record.  
 6 BY MR. MAURER:  
 7 Q. Dr. Sanchez, you were asked questions  
 8 by Mr. Driscoll regarding what I asked you  
 9 earlier about the 42-day cutoff, the measure from  
 10 date of onset. Do you remember those areas?  
 11 A. Correct.  
 12 Q. I believe you told me earlier in  
 13 direct examination that a Lyme disease patient  
 14 could have disseminated Lyme disease within a  
 15 matter of days to weeks within the onset of the  
 16 illness, correct?  
 17 A. What I said is it is possible in some  
 18 patients that they have a very rapid progression.  
 19 Q. That's documented in the literature,  
 20 correct?  
 21 A. I believe it is, yes.  
 22 Q. That's literature you were aware of  
 23 before the '95 policy was adopted on Lyme  
 24 disease, correct?  
 25 A. I can't tell you when I became aware

1 R. Sanchez, M.D.  
 2 of that.  
 3 Q. Well, if you have a patient who is  
 4 insured with Empire who had clinical evidence  
 5 supportive of the conclusion that the patient was  
 6 suffering from disseminated disease less than 42  
 7 days from the onset of the illness, your  
 8 corporate medical policy on Lyme required the  
 9 issuance of a denial for IV therapy that was  
 10 prescribed by a treating physician; is that  
 11 correct?  
 12 A. That was correct. He was first to  
 13 undergo an oral course of antibiotics because our  
 14 interpretation of the literature that that was  
 15 the appropriate first Lyme course.  
 16 Q. I'm sorry, I said '95 but that was the  
 17 '93, August '93 one that I was referring to; is  
 18 that correct?  
 19 A. That's '93, yes.  
 20 Q. Okay. Well, if you have a patient  
 21 with disseminated disease who is less than 42  
 22 days out from the onset of his illness and you  
 23 have a corporate medical policy that requires a  
 24 denial of a request for treatment with  
 25 intravenous antibiotics, wouldn't you consider

1 R. Sanchez, M.D.  
 2 that in all reasonableness to be an overzealous  
 3 denial?  
 4 A. You know, I think any time we deny  
 5 care the provider or the member would say that  
 6 it's an overzealous denial but that's because  
 7 they didn't get what they wanted so.  
 8 Q. So if you rigidly adhere to a  
 9 corporate policy that says no IV earlier than 42  
 10 days out from the onset of the illness even  
 11 though there was clinical evidence that  
 12 demonstrated that the patient had a disease would  
 13 you think that's appropriate?  
 14 A. What would occur -- no, the short  
 15 answer is no. What would occur is we would  
 16 expect an appeal.  
 17 Q. Would you conclude that the issuance  
 18 of the denial consistent with the Empire Blue  
 19 Cross Lyme policy that no IV earlier than 42 days  
 20 from the onset of illness, that using such a  
 21 standard, rigidly adherent to such a standard,  
 22 was arbitrary, especially given the fact that the  
 23 42 days was arbitrary based on what you told us  
 24 earlier, would you agree with that?  
 25 A. I would say that regardless of the

1 R. Sanchez, M.D.  
 2 Q. You gave something but you took back  
 3 something, didn't you?  
 4 (Pause.)  
 5 Q. You became flexible on one hand but on  
 6 the other hand there was an inflexibility that  
 7 was created, wasn't there?  
 8 A. Yes.  
 9 Q. Now, with regard to the therapy risks  
 10 that Mr. Driscoll asked you about, when someone  
 11 is treated with IV antibiotic therapy for Lyme  
 12 disease you mentioned several different things  
 13 that you are concerned about as a physician.  
 14 Would you also have been concerned  
 15 about the risk that a patient with disseminated  
 16 Lyme disease where the bacteria has penetrated  
 17 the blood brain barrier could result in permanent  
 18 brain damage if untreated with appropriate  
 19 antibiotic therapy, was that something that was  
 20 considered?  
 21 A. In that situation, hypothetically that  
 22 you just described, the risks of the intravenous  
 23 therapy would have been outweighed by the  
 24 potential benefits or the imminent danger to the  
 25 patient. As I said, we calculate that risk

1 R. Sanchez, M.D.  
 2 policy that we implemented for Lyme disease or  
 3 any other there were going to be cases or  
 4 situations in which the member or the physician  
 5 would consider it overzealous or arbitrary.  
 6 Q. My question was: Would you agree that  
 7 it's arbitrary to deny authorization for IV where  
 8 there's clinical evidence that the patient has  
 9 disseminated disease based solely upon the 42-day  
 10 period specified in Empire's Lyme corporate  
 11 medical policy? That's the question.  
 12 A. I considered that true and we modified  
 13 the policy in '95 to allow some flexibility in  
 14 the use of dissemination.  
 15 Q. But at the same time while allowing  
 16 some flexibility that way you also increased the  
 17 inflexibility, didn't you, by requiring that  
 18 there be both a positive ELISA test or  
 19 Immunofluorescent Assay test combined with a  
 20 positive confirmatory Western Blot test; isn't  
 21 that true?  
 22 A. That's true.  
 23 Q. So you gave with one hand but you took  
 24 with the other, true?  
 25 A. That's your expression.

1 R. Sanchez, M.D.  
 2 versus benefit every time we entertain or approve  
 3 a therapeutic regimen.  
 4 Q. Let's focus on this for a moment  
 5 then. What study was done by Empire or what  
 6 study did Empire research which showed the  
 7 percentage of Lyme disease sufferers who would go  
 8 on to develop disseminated Lyme disease involving  
 9 the central nervous system and specifically the  
 10 brain which resulted in evidence on diagnostic  
 11 studies that there was a lesion or evidence of  
 12 abnormal blood flow of the brain?  
 13 MR. DRISCOLL: Objection to the form  
 14 of the question.  
 15 A. There was no study done by Empire.  
 16 Q. Before adopting these corporate  
 17 medical policies; is that correct?  
 18 A. Empire was not in the habit of doing  
 19 clinical research. It was our process was to  
 20 take the clinical research and review of the  
 21 literature and try to create a sensible policy.  
 22 Q. Before determining that the risks  
 23 outweighed the benefits with IV antibiotics in  
 24 certain circumstances, as you just testified to  
 25 it, did you consider that some people would

1 R. Sanchez, M.D.  
 2 develop permanent brain damage, if they didn't  
 3 get proper antibiotic IV therapy, was that  
 4 considered by Empire before adopting the  
 5 corporate medical policy on Lyme disease?  
 6 A. No.  
 7 Q. Did you ask -- withdrawn.  
 8 Were you aware that Lyme disease when  
 9 disseminated can affect the nervous system of the  
 10 heart and cause an arrhythmia or heart block?  
 11 A. Of course.  
 12 Q. And did you give any consideration to  
 13 the risks associated with failure to treat second  
 14 or third degree heart block with intravenous  
 15 antibiotic therapy in terms of the potential for  
 16 a fatal failure of the heart resulting from that  
 17 lack of treatment with IV therapy?  
 18 A. Our review of the literature and the  
 19 consensus opinion of the infectious disease  
 20 experts that we consulted, we interpreted as  
 21 consistent with our implementing our policy which  
 22 was we thought a sensible policy. We clearly  
 23 knew or any reasonable person would know as with  
 24 any policy that some patients would not fit the  
 25 classic policy or definition. We expected those

1 R. Sanchez, M.D.  
 2 to rise up through the appellate system and  
 3 therefore not fall through the cracks.  
 4 Q. People -- you've already told me a few  
 5 moments ago that you also expected that not  
 6 everyone would appeal from the denials, true?  
 7 A. That's true with any population.  
 8 Q. There was some sort of a statistical  
 9 analysis of that at Empire, wasn't there, that  
 10 was considered as part of the overall changes  
 11 that took place when you came in?  
 12 A. I think that -- no, there was no -- I  
 13 mean it is common knowledge and it's assumed that  
 14 any time you put any type of barrier up or hurdle  
 15 or obstacle depending on your terminology for  
 16 someone receiving a questionable benefit or care,  
 17 that once that obstacle is up there are certain  
 18 people that will fight to get over it and appeal,  
 19 there are other people that will accept it and  
 20 not appeal. That's common sense. We all know  
 21 that.  
 22 Q. What you just said is also true of  
 23 some Lyme disease patients who suffer from Lyme  
 24 encephalopathy with cognitive deficits who might  
 25 not be up to, health-wise, going through the

1 R. Sanchez, M.D.  
 2 process of an appeal; isn't that true?  
 3 A. Yes.  
 4 Q. Did you do anything before  
 5 implementing the corporate medical policies that  
 6 you've told us about to determine how physicians  
 7 in the community, the clinicians who are treating  
 8 Lyme disease out in the field, were practicing in  
 9 terms of how they were treating Lyme disease?  
 10 A. We knew from their claims activity how  
 11 they were treating Lyme disease and we thought it  
 12 was inappropriate. So part of our policies are  
 13 meant to educate physicians on the appropriate  
 14 ways to diagnosis and treat, they are kind of  
 15 guidelines as we say. So that we were very well  
 16 with the general activity, very familiar with the  
 17 general activity, based on the claims activity  
 18 that we received. I think our policy addressed  
 19 it in the way a physician would have to work up a  
 20 patient to make up the proper diagnosis and what  
 21 we considered a sensible way to begin therapeutic  
 22 intervention.  
 23 Q. When you were questioned by  
 24 Mr. Driscoll before on cross examination I  
 25 believe you indicated or he asked you about

1 R. Sanchez, M.D.  
 2 whether or not you would discipline an employee  
 3 if they denied a benefit to an insured. Do you  
 4 recall that?  
 5 A. Yes.  
 6 Q. How many times in your tenure at  
 7 Empire Blue Cross did you discipline an employee  
 8 who denied a benefit to an insured?  
 9 A. Denied?  
 10 Q. Yes, denied.  
 11 MR. DRISCOLL: Object to the form of  
 12 the question just because it leaves part of  
 13 my question out.  
 14 A. I don't recall.  
 15 Q. Do you recall ever doing it?  
 16 A. No, sir.  
 17 MR. MAURER: Off tape, off record.  
 18 THE VIDEOGRAPHER: The time is 1726.  
 19 We are going off the record.  
 20 (Whereupon, there is a recess in the  
 21 proceedings.)  
 22 MR. MAURER: On tape on record.  
 23 THE VIDEOGRAPHER: The time is 1727.  
 24 We are back on the record.  
 25 BY MR. MAURER:

1 R. Sanchez, M.D.  
 2 Q. With regard to the question about your  
 3 being sympathetic to the chronically ill and that  
 4 being part of what your job description called  
 5 for, do you recall that area?  
 6 A. Uh-hum. It's part of the job  
 7 description that was written by I imagine the  
 8 human resources department at Empire, yes.  
 9 Q. You've already told us today that  
 10 there are some -- you knew when you first came to  
 11 Empire that there were some patients who have  
 12 Lyme disease according to Dr. Dattwyler who have  
 13 negative serologies; is that correct?  
 14 A. We knew that Dr. Dattwyler had  
 15 identified a small study of those, yes.  
 16 Q. And --  
 17 A. And those patients existed in the  
 18 universe of Lyme disease patients.  
 19 Q. And if those patients were denied  
 20 treatment because they did not meet the criteria  
 21 of a positive ELISA and a Western Blot, you knew  
 22 that if they still had the Lyme disease anyway  
 23 that they were going to get sicker because they  
 24 weren't treated, true, yes or no, sir?  
 25 A. We knew that those patients had an

1 R. Sanchez, M.D.  
 2 some cases and some cases it's a more indolent  
 3 progression.  
 4 Q. Okay. Since you knew that Lyme  
 5 disease can be progressive in nature you were  
 6 therefore aware, were you not, that denying  
 7 treatment to some Lyme disease patients thinking  
 8 well, we will catch the ones that truly have Lyme  
 9 on the appeal, first of all, there's a  
 10 fundamental problem with that because you knew  
 11 that some people wouldn't appeal, right, isn't  
 12 that true, you've already told me that?  
 13 A. That's common sense.  
 14 Q. And, second of all, you know that  
 15 those people are sick and they are waiting for  
 16 the appeal to be handled and the appeal can take  
 17 some period of time, true?  
 18 A. It takes a finite amount of time, yes.  
 19 Q. That finite time varied tremendously,  
 20 didn't it, couldn't it range anywhere from weeks  
 21 to months to years in some cases?  
 22 A. I believe our appellate process was  
 23 much quicker than that in that in the cases of  
 24 catastrophic illness and those that the process  
 25 took much less in months or years and it was

1 R. Sanchez, M.D.  
 2 appellate route to receive treatment if they  
 3 could make the compelling case that they were  
 4 sero-negative but had the disease, which is, you  
 5 know, I think not a formidable but there has to  
 6 be that clinical history and the progression and  
 7 the response to this all has to be documented in  
 8 the clinical chart.  
 9 At that point there's a process in  
 10 which that appeal could have been overturned and  
 11 we would have approved it and that's how we slept  
 12 with ourselves, that these patients were not  
 13 going to get initial treatment, these rare  
 14 patients were not getting initial treatment at  
 15 the first part of this, that there was still a  
 16 route by which the doctor and the patient could  
 17 appeal the decision.  
 18 Q. You knew that the disease is not a  
 19 static one, that it continues to progress when  
 20 not treated, didn't you, talking about Lyme  
 21 disease?  
 22 A. Lyme disease is a great masquerader,  
 23 so it's difficult to distinguish between other  
 24 diseases and it is progressive and it does seem  
 25 to go through plateaus, rapid dissemination in

1 R. Sanchez, M.D.  
 2 within weeks.  
 3 Q. Really. Are you aware of anyone who  
 4 took -- any cases where it took more than weeks  
 5 to go through the appeal process and reverse the  
 6 denial if appropriate?  
 7 A. No, I'm not. I'm assuming from the --  
 8 from the process of the steps that are involved  
 9 in the appellate process that this was a matter  
 10 of weeks and not months.  
 11 Q. If it took months would you think that  
 12 that approach was sympathetic to the chronically  
 13 ill if, in fact, the patient actually had the  
 14 disease and had to wait that long?  
 15 A. No.  
 16 Q. Doctor, how much of a bonus did you  
 17 receive from Empire for the first year that you  
 18 were there which I guess was the calendar year  
 19 1995?  
 20 A. I don't recall the number.  
 21 Q. Your best estimate.  
 22 A. \$40,000.  
 23 MR. MAURER: I have no further  
 24 questions. Thank you, Doctor.  
 25 MR. DRISCOLL: Off tape for a moment,

1 R. Sanchez, M.D.  
 2 please.  
 3 THE VIDEOGRAPHER: The time is 1732.  
 4 We are going off the record.  
 5 (Whereupon, there is a recess in the  
 6 proceedings.)  
 7 THE VIDEOGRAPHER: The time is 1735  
 8 and we are back on the record.  
 9 BY MR. DRISCOLL:  
 10 Q. Dr. Sanchez, Mr. Maurer just spent  
 11 some time with you on the question of the impact  
 12 of the appeal process and what period of time  
 13 that took. Isn't it also -- isn't it true, sir,  
 14 that there was also something called a  
 15 pre-approval process for doctors to seek  
 16 pre-approval for intravenous antibiotic therapy?  
 17 A. Yes, yes, there was.  
 18 Q. If a doctor made a sufficient showing  
 19 at that point in time and submitted materials  
 20 than Empire might authorize the IV therapy at  
 21 that time?  
 22 A. Yes.  
 23 MR. DRISCOLL: I have no further  
 24 questions.  
 25 MR. MAURER: I have nothing further.

1 R. Sanchez, M.D.  
 2 MR. DRISCOLL: Thank you for your  
 3 time,, Doctor.  
 4 THE VIDEOGRAPHER: The time is 1736 on  
 5 February 23, 1999. This completes the  
 6 videotape deposition of Dr. Richard Sanchez  
 7 M.D.  
 8 MR. MAURER: Off record.  
 9 (Time noted: 5:36 p.m.)  
 10  
 11  
 12 \_\_\_\_\_  
 13 DR. RICHARD SANCHEZ, M.D.  
 14  
 15 Subscribed and sworn to before me  
 16 this day of 1999.  
 17 \_\_\_\_\_  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25

1  
 2 CERTIFICATE  
 3 STATE OF NEW YORK )  
 4 ) ss.:  
 5 COUNTY OF NEW YORK )  
 6  
 7 I, ERICA L. RUGGIERI, a Registered  
 8 Professional Reporter and Notary Public  
 9 within and for the State of New York, do  
 10 hereby certify:  
 11 That DR. RICHARD SANCHEZ, M.D., the  
 12 witness whose deposition is hereinbefore set  
 13 forth, was duly sworn by me and that such  
 14 deposition is a true record of the testimony  
 15 given by such witness.  
 16 I further certify that I am not  
 17 related to any of the parties to this action  
 18 by blood or marriage; and that I am in no  
 19 way interested in the outcome of this  
 20 matter.  
 21 IN WITNESS WHEREOF, I have hereunto  
 22 set my hand this 9th day of March, 1999.  
 23  
 24 \_\_\_\_\_  
 25 ERICA L. RUGGIERI, RPR

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