EXHIBIT A

SUPREME COURT OF THE STATE OF NEW YORK

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.	Index No. 96/20517

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

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.

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.

APPEARANCES:

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BY: IRA M. MAURER, ESQ.

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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

(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.

MR. MAURER: This is Ira Maurer from the law firm of Elkind, Flynn & Maurer representing the plaintiffs in this case.

MR. DRISCOLL: My name is Justin Driscoll on behalf of Plunkett & Jaffe, P.C., attorneys for Empire Blue Cross/Blue Shield.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

RICHARD SANCHEZ, called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY
MR. MAURER:

MR. MAURER: All set, Mr. Videographer?

THE VIDEOGRAPHER: All yours.

Q. Good morning, Dr. Sanchez.

A. Good morning.

Q. As you know, my name is Ira Maurer and I represent six plaintiffs in a lawsuit that's pending in the State Supreme Court in Westchester County, New York, who commenced an action against

Empire Blue Cross/Blue Shield.

I have asked you to come here today so we can ask you some questions to determine what you know factually that's relevant to the case.

Please listen to the questions carefully. Wait until we finish our question before you start to answer because it's hard for the court reporter to take us down speaking simultaneously.

If there's anything that you don't understand, please let us know and we'll be happy to rephrase or repeat the question.

Please keep the volume of your voice up so we get it clear on the videotape.

If you need a break for any reason because your beeper beeps or you need a visit outside to another location for a moment, let us know and we will stop.

A. Understood.

Q. Could you please tell me your educational background, sir?

A. I went to public schools in Arizona. I attended the University of Arizona where I received my bachelor of science degree.

I then went to medical school at the University of California, San Francisco, where I received my M.D. in 1969.

I went on to do a three-year pediatric residency and internship at Children's Hospital of Los Angeles.

I subsequently received my M.PH. from the University of California, Berkeley, that's a Master's in public health. I attended the business school at the University of California, Irvine.

I attended one year of law school at San Francisco Law School in San Francisco.

Q. When you did you attend law school, Dr. Sanchez?

A. It was in the late 1980s, in the evenings, for a year and a half.

Q. You did not finish that course?

A. No, sir.

Q. Doctor, let me show you what we marked before starting the deposition as Plaintiffs' Sanchez 1 for identification (handing.)

Would you be kind enough to look through the stack of documents while we go off

tape and then I'll have some questions for you, please.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 10:21 a.m. and we are going off the record.

(Witness reviews documents.)

MR. MAURER: Off the record.

(Whereupon, there is an off-the-record discussion.)

THE WITNESS: Okay.

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 10:22 a.m.. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, have you had a chance while we were off tape to look through this pile of documents marked as Sanchez 1 for ID?

A. Yes, sir.

Q. Can you identify what that particular exhibit is?

A. It appears to be copies of my personnel file.

Q. Does that personnel file include a copy of your resume as it was current as of the

time that you submitted it to Empire Blue Cross/Blue Shield when you were applying for employment with that company?

A. Yes, it does.

Q. Could I have the exhibit back, sir.

(Handing.)

Q. After you completed your education, except for any courses you took while you were working, could you please tell us going furthest back in time and working forward your history of employment?

A. I practiced -- I did an ambulatory fellowship at San Francisco General Hospital in 1976 and assumed a junior faculty position there for a few months and then began a private practice of pediatrics that I continued up until the late 1980s in San Francisco at Saint Luke's Hospital.

In 1985 the mayor of San Francisco appointed me health commissioner of San Francisco, a position I held for seven years until 1992, and in 1991-'92, I took a position with FHP as the medical director for Northern California.

Q. What is FHP short for?

A. It's like IBM, it kind of becomes FHP. Used to be Family Health Plan when HMO was first created in the '70s in California. Now, it's HFH. Assumed the position of medical director and held that position until coming to Empire in 1995. I was eventually the vice president of medical affairs and that was involvement for all of California for FHP and the merger of FHP and Take Care which is another large HMO that merged.

Q. Doctor, are you familiar with the term managed care or managed health care?

A. Yes.

Q. What is your understanding of the term?

A. Managed care refers to the insurance company's or health care provider's activity in scrutinizing and assuring health care services to its members.

Q. Generally speaking, when an insurance company sells a managed care product to an insured does this involve the insurance company more in the decision-making process associated

with evaluation and treatment of the insured?

MR. DRISCOLL: Objection. Off tape.

THE VIDEOGRAPHER: The time is 10:26 a.m.. We are going off the record.

MR. DRISCOLL: Your objection is just leading.

THE VIDEOGRAPHER: The time is 10:26 a.m.. We are back on the record.

BY MR. MAURER:

Q. Doctor, are you familiar with indemnity products that are sold by health insurance companies?

A. Yes.

Q. Generally speaking, what is an indemnity product?

A. Indemnity product is where either the member or the employer pays a premium for that employee to access health care services willingly anywhere, and there is an awful lot of choice involved, there is no constriction of network, there's no real UM, utilization management, or managed care component to an indemnity product.

Q. Does the insurance company make any decisions regarding the insured's health care in

performing its duties under the plan when you have an indemnity plan generally?

A. Indemnity plans can be underwritten or historically underwritten so that there can be in some states, in some municipalities, an assessment of the health insured's risk.

Q. What is the difference, generally, between an indemnity product and a managed care product in layman's terms?

A. Cost and choice.

Q. What do you mean?

A. The indemnity products are much more expensive than the managed care products because in the long run they cost the insurance company more money.

Choice, the member has much more choice in an indemnity product because there's no limitation to seek contracted network providers or facilities. So an indemnity member would pay more money for that product and have more choice.

A managed care member would have less premium dollar paid by the member or the employer and have less choice.

R. Sanchez, M.D.

Q. Why is it called an indemnity product?

A. I'm not sure of the derivation of the word indemnity.

Q. Does the insurance company with an indemnity product indemnify the insured for medical expenses?

A. Of course.

Q. Okay. Now, do you have any employment history or background prior to your employment with Empire Blue Cross/Blue Shield which involved you with managed care?

A. Yes.

Q. Could you tell us what your background is in that regard, please.

A. My background in managed care started in 1982 or '83 when I formed the San Francisco IPA, a network of physicians, to contract with managed care companies in San Francisco. In practice, I was a contractor to many managed care organizations. And from 1991-'92 to 1995, before I joined FHP, I was vice president of medical affairs for FHP, one of the largest Medicare and HMOs in the country.

Q. You mean before you joined Blue

R. Sanchez, M.D.

Cross/Blue Shield?

A. I'm sorry, before I joined Blue Cross/Blue Shield.

Q. That's Empire Blue Cross/Blue Shield of New York?

A. Correct.

Q. When it comes to Blue Cross/Blue Shield, are there many different Blue Cross/Blue Shields around the country?

A. Oh, yes.

Q. Are they set up by state? How is it set up?

A. They are set up by regions and geography. There's been a lot of merging of them. The first thing that occurred is the Blue Cross and Blue Shield organizations merged and then they set up, there's an umbrella organization that provides some oversight over the individual Blue Cross/Blue Shield plans.

Q. Just going back to the comparison I was asking you to make between managed care products and indemnity products, is one type of product more profitable for the insurance industry than another type of product, generally,

R. Sanchez, M.D.

in your experience?

A. There was a time in this country when the managed care products were very profitable. There was also a time in this country where the indemnity products were very profitable. So the question depends on the timing of the products.

Q. Let's focus you on 1995, can you answer the question based on that year?

A. In 1995 HMOs throughout the country were enjoying an immense amount of profitability.

Q. That means in comparing managed care to indemnity products, which was more profitable at that time?

A. I'm not an indemnity industry expert and I don't want to imply that this morning. The companies that I was involved in in managed care were profitable and there was an awful lot of profit taken by the managed care companies throughout the '90s, early '90s to the mid-'90s.

Q. Okay. What were the circumstances of your coming to work for Empire Blue Cross/Blue Shield?

A. I was recruited by an executive search firm to apply and come to New York and interview

R. Sanchez, M.D.

for the position and investigate the possibilities of me joining the company.

Q. Your personnel file, which we marked as Exhibit 1 for identification, contains a job description for the job that you took with Empire Blue Cross/Blue Shield which was chief medical executive and vice president; is that correct?

A. Chief medical executive and senior vice president.

Q. Was the position description contained in your personnel file, it's three pages in length, accurate in terms of what you did at Empire when you first went to the company?

Why don't we go off tape and you can take a look at those pages for a moment.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 10:30 a.m. and we are going off the record.

(Witness reviews documents.)

MR. MAURER: On tape, please.

THE VIDEOGRAPHER: The time is 10:33 a.m.. We are back on the record.

BY MR. MAURER:

Q. Have you had a chance to look at the

R. Sanchez, M.D.

three pages, Doctor?

A. Correct.

Q. Is this job description an accurate description of the position you took at Empire Blue Cross/Blue Shield when you first went there to work?

A. Yes.

Q. Could I have the documents, please.

(Handing.)

Q. Thank you.

Before you were hired did you meet with anyone at Empire Blue Cross/Blue Shield?

A. Yes.

Q. Who did you meet with?

A. I met with Heyward Donigan.

Q. Who was that?

A. She is also a senior vice president and she was also in charge of the managed care for Empire Blue Cross/Blue Shield.

Q. In the management hierarchy at the company where was she in relation to the top of the pyramid?

A. She was at the right hand of the CEO of Empire Blue Cross/Blue Shield.

R. Sanchez, M.D.

Q. Who was that?

A. The CEO of Empire Blue Cross/Blue Shield at the time was Michael Stocker.

Q. Dr. Michael Stocker?

A. Yes.

Q. He was also the president at the time?

A. I believe that's his title.

Q. You met with Heyward Donigan. Who else did you meet with?

A. Michael Stocker, Linda Tufo, Michael Kent, Gloria Macarthy, Dr. Zemansky. It was a battery of people.

Q. Could you go back, please, and just tell us who these people were, what their positions were with the company?

A. Michael Kent was senior vice president in charge of human resources. Linda Tufo was vice president of human resources in charge of managed care. Gloria Macarthy was senior vice president in charge of operations. Dr. Martin Zemansky, I think is his first name, was the acting chief medical officer in Albany. I met with -- those are the ones I can recall right off the top of my head.

R. Sanchez, M.D.

Q. You met with all those individuals before you were hired?

A. More than once, yes.

Q. How many times did you meet with the chief executive officer and president, Dr. Michael Stocker?

A. I met with Heyward Donigan two or three times and I met with Dr. Stocker once or twice.

Q. Did you request any of those meetings with Dr. Stocker?

A. Well, I think that the first one I think, as I remember, I was introduced when I came to visit and interview there. The second one I requested to have a more lengthy discussion of my responsibilities and title.

Q. Did you have to go before the board of directors before you were hired?

A. I didn't have to go to the board. I was introduced once I had been selected. The board had to approve my position and my salary because it was -- it exceeded what they had expected to pay for the position and the compensation package and it required board

R. Sanchez, M.D.

approval.

Q. I apologize for the intrusion. What was the nature of the compensation package that you received to go to Empire Blue Cross/Blue Shield?

A. It was a base salary, plus an incentive bonus, plus a moving reimbursement package and plus an agreement to either purchase or sell my home in San Francisco.

Q. What was the base salary when you went?

A. It wasn't that -- 250,000, I think was the base salary and the bonus with the incentive compensation was 40 percent of that and the relocation package was under 75,000 and the agreement to sell the house in San Francisco was 1.2 million.

Q. Before you accepted the position and were offered the position were you given any materials to read by anyone at Empire?

A. Yes.

Q. What kind of materials were you given to read before you were hired?

A. The usual personnel and HR collaterals

and materials.
Q. What's HR?
A. Human resources.
Q. Okay.
A. Dealing with investment and retirement and those kinds of things. In addition, I was given copies of two committee or investigative reports done on Empire over the preceding four, five years. One was by the Nunn commission, as I remember, by the Nunn's committee investigating all Blue Cross plans in the country and the other one was, I think more specific to New York. I don't recall the name of them now but there were two of them.
Q. With regard to the Nunn, are you referring to Senator Sam Nunn?
A. Correct.
Q. That report was a report of his subcommittee of the senate?
A. Yes.
Q. The other report you said you thought was more focused on New York in some way?
A. Well, as I remember it, and I don't recall it, I may have it at home, but it had to

do, it seemed to me to be more of an attorney general or department of insurance review of the policies and procedures and activities of Empire preceding 1995.
Q. What do you recall learning from reading, first the Nunn report, about the activities reported of Empire?
A. I don't think I can separate from where I received what my impression was between the two reports so I don't want to try.
Q. Please just tell me what you can recall from both combined as you recall?
A. I think both reports provided for me to have a clear understanding of what I was getting into.
Q. What was the understanding that you obtained after looking at those two reports?
A. That the company had been terribly mismanaged and almost criminally mismanaged.
Q. Why did that become your impression after reading the reports? What was there in the reports you remember reading that led you to that conclusion?
A. It's absolutely clear that the company

was mismanaged from a policy point of view, from a fiscal point of view. There was very clearly some criminal activity that occurred and there was fines levied and paid by Empire to reestablish its ability to do business in New York.
Q. Was there any reference in either of these reports to complaints filed by insureds of the company?
A. Yes.
Q. With the insurance department in the State of New York?
A. Yes.
Q. Did the reports indicate any sort of quantity of those complaints?
A. Well, I don't remember the numbers but there were an awful large number putting them -- exceeding other insurers in New York State and the level was very high and that was one of the things that the committee wanted to address.
At the end of the report came recommendations and settlements and those kinds of things and that was one of the issues that Empire was going to address as well as the other

activities that were pointed out in the report.
Q. I believe you made mention of a fine of some sort, what were you referring to?
A. The Empire Blue Cross had to settle with the department of insurance in New York or pay a fine for claims issues over the preceding half dozen years.
Q. What was the amount of the fine as best you can recall it?
A. It was approximately a million dollars as best I can recall it.
Q. You also indicated in your earlier response some reference to there being evidence of criminal conduct in the reports. What were you referring to, Dr. Sanchez?
A. The committee or investigative body that had prepared these reports found evidence that there was two sets of books kept, financial books that were kept and maintained and given to regulatory officials and the others reflecting the true state of Empire's financial situation.
Q. Did you learn why those two sets of books were maintained by Empire?
A. No, I never got to talk to the people

that maintained them.

Q. Were the two sets of books maintained, if you know, for use in making requests for rate increases from the State of New York?

A. They were used, to the best of my knowledge, to misrepresent the financial status of Empire, either for rate increases or for other considerations.

Q. Was there any reference in the reports to any excessiveness in expenditures that took place as reported in the report?

MR. DRISCOLL: Objection. Off tape.

THE VIDEOGRAPHER: The time is 10:43 a.m.. We are going off the record.

MR. DRISCOLL: I object to the leading nature of the question.

THE WITNESS: I'm going to get a coffee while you are objecting.

MR. MAURER: Okay.

(Whereupon, there is an off-the-record discussion.)

THE VIDEOGRAPHER: The time is 10:44 a.m.. We are back on the record.

BY MR. MAURER:

what does it mean to "facilitate the medical management activities"?

A. I interpret that as to manage the personnel policies and procedures of medical management within the company.

Q. The list then makes reference to the following things that were included. Under Roman number one, "Establish and achieve corporate utilization management targets."

What's that mean in layman's terms?

A. That means that the senior staff of Empire Blue Cross/Blue Shield would approve utilization targets regarding the cost of health care and utilization of health care and it would be my responsibility to make sure that we met those targets.

Q. Next bulleted item says, "Develop and manage catastrophic case management." What does that mean?

A. That refers to the more intense and focused management activities, cost of health care and utilization and quality of health care management focus, on members that have catastrophic diseases and high expense costs.

Q. Doctor, did either of the reports you reviewed prior to commencing employment with Empire make any reference to expenditures at the company?

A. The report was – yes.

Q. How was there a reference made to expenditures of Empire Blue Cross/Blue Shield?

A. The report spent a good portion of its content revealing what they considered to be exorbitant expenditures by the executives of Blue Cross/Blue Shield in their day-to-day conduct of business.

Q. Doctor, when were you hired by Empire?

A. In the spring of 1995.

Q. When did you actually start work?

A. In May of 1995.

Q. Now, according to the position description for the chief medical officer position you took at Empire, it indicates on the first page under Roman numeral one, the chief medical officer will facilitate the medical management activities to insure that performance goals for 1995 are attained. These include --

Before I get into what it includes,

Q. Next item is "develop and manage outpatient focused review." What does that mean?

A. That has to do with trying to bring some standardized policies, procedures and control of health care costs throughout patient services. Those are services delivered in doctors' offices and other facilities besides hospitals.

Q. The next item is, "Assure that quality assurance goals are met." What is quality assurance mean as used in that context?

A. Quality assurance has to do with insuring that the company in its, oversees its provider network to assure that members are receiving quality health care and sets up policies and procedures that are documented by an independent review body that we are -- that Empire was doing those.

Q. Skipping down the next bulleted item is, "Develop and implement an AIDS disease management program." What did that reference have to do with --

A. That goes back to the catastrophic disease. That was just one that was identified

early on.

Q. Last item under Roman numeral ne, "Assessing and continue to improve medical policy development and communications."

A. The company had not done a good job of communicating policies and developing system policies and implementing them consistently throughout their products and that was one of the focus of -- one of the charges that I had.

Q. Roman numeral two indicates, "The chief medical officer will participate in the strategic planning process to insure that the medical viewpoint is represented. He/she will also help develop strategies on future products including workmen's compensation on Medicare and Medicaid products. As integrated delivery systems are conceived and developed the chief medical officer will participate in all aspects including negotiation and management of providers."

What does this paragraph refer to?

A. It refers to that I would be part of the most senior staff at Empire in developing policies, procedures and products. I would have

input into that.

Q. Roman numeral three states, "The chief medical officer will directly manage the ongoing activities of the medical directors focusing on key staff deliverables and will provide coaching and opportunities for career development."

What did that refer to?

A. That has to do with my responsibility for management and development and recruitment of the physicians and nurses that worked in the medical management area of Empire Blue Cross/Blue Shield.

Q. The next section, Roman numeral four indicates, "Acting as a key outreach resource the chief medical officer will insure that Empire is represented to the community, providers, customers regulators and employees as being," and then there's a colon and there's a list.

Number one: "Passionate about the delivery of high-quality cost effective medical care."

What was your understanding of that?

A. That they wanted an articulate spokesman who could communicate Empire's feeling

about the delivery of health care.

Q. Second of all: "Competent to deliver Empire's medical management performance objectives."

A. That they were looking for someone who had a track record and experience and ability to deliver on all of the above.

Q. "Responsive to the concerns of patients and providers."

A. They expected the position to have -- the incumbent to be able to have a relationship and create a relationship that was a good working relationship with doctors and members and have credibility with those members.

Q. The next item is: "Sympathetic to the needs of the chronically ill."

A. I think that is pretty self-descriptive. They were looking for a physician leader who understood the complications, not only financial, but of the complications in negotiating the health care system and achieving a relationship with providers in hospitals.

Q. Skipping down, Roman numeral five,

"The chief medical officer will have day-to-day responsibility for a number of medical activities including the following: Provider grievances..."

What does that refer to?

A. Providers including hospitals and physicians and other facilities can appeal reimbursement decisions. They can appeal whether they are even allowed to provide the service decisions. Those kinds of -- it's a process in which they appeal our policies.

Q. "TQI activities and monitoring."

A. The company when I was employed was embarking upon a total quality program to be instituted throughout the company trying to tie in the quality goals of the company and I was responsible for implementing those activities in my decision.

Q. "Member grievances, policy decisions, appeals, sales and provider calls when necessary."

I think those are all pretty self-explanatory. Those are all part of what you had to do?

A. Correct.

R. Sanchez, M.D.

Q. Okay.

MR. MAURER: Off tape, please.

THE VIDEOGRAPHER: The time is 10:53. We are going off the record.

(Whereupon, there is an off-the-record discussion.)

MR. MAURER: Back on tape.

THE VIDEOGRAPHER: The time is 10:54 a.m.. We are back on the record.

BY MR. MAURER:

Q. Now, under Roman numeral five there was a reference to policy decisions. What policies are we referring to with that reference?

A. May I examine?

(Handing.)

Q. Roman numeral five, that's a bullet there.

(Witness reviews document.)

A. That I would have the final approval or disapproval of medical policy decisions made and final editing of those policies.

Q. Did you have any -- withdrawn.

After meeting with the various people who you met with before you were hired and having

R. Sanchez, M.D.

had the opportunity to go before the board of directors of Empire Blue Cross/Blue Shield what was your understanding, fundamental understanding, of what you were being asked to accomplish at Empire in the performance of your duties?

A. I was being asked to provide medical and clinical leadership to implement managed care policies to reduce the cost of health care and to provide leadership to a division that was in rather disarray.

Q. Was it just the division that was in disarray, was it limited to one division?

A. There was more than my division in disarray but I was responsible for the health care and the medical policy division.

Q. What was the condition of the company's business, as you understood it, at the time that you were hired?

A. I don't think there was any question it was public and private knowledge that the company was in dire straights.

Q. When you say it was in dire straights, why do you say that?

R. Sanchez, M.D.

A. Over the preceding four or five years it had lost more than half its membership.

Q. How many members are we talking about?

A. It went from 10 or $12 million to under 5 million. And it had lost those members for lots of reasons but it had lost them predominantly to managed care competition in New York and Blue Cross/Blue Shield leadership had been very reticent to realize -- I have to answer that phone but I'd like to answer this question.

MR. MAURER: Sure. Off tape.

THE VIDEOGRAPHER: The time is 10:57 a.m.. We are going off the record.

(Brief recess.)

THE WITNESS: Can you give me a second to turn this thing --

MR. MAURER: What was the last question. Sure.

MR. MAURER: What was last question?

(Record read.)

Q. Do you recall the previous question was --

THE VIDEOGRAPHER: Back on?

MR. MAURER: Not yet.

R. Sanchez, M.D.

Q. -- had to do with why did you use the phrase dire straights or something to that effect.

MR. MAURER: Let's go back on tape, please.

THE VIDEOGRAPHER: The time is 10:59 a.m.. We are back on the record.

BY MR. MAURER:

Q. Before the interruption, Doctor, you were answering my question about why you said that the company was in dire straights. Could you please continue your answer?

A. Pardon for the interruption.

Q. It's okay.

A. And the lengthy answer. The company was in dire straights for a bunch of things that had come together. One is the mismanagement and extravagances that occurred prior to my arrival.

Two, was that the company leadership at the board and at the executive leadership had failed to recognize the influx of managed care organizations. They thought that they could maintain an indemnity world in a community in which the large managed care companies were

coming in.

Subsequently, they lost millions of members on those managed care organizations before they could get a managed care product up and running.

In addition, because they had received some state consideration in premium and in hospital rates they also had to be the insurance company of last resorts. They could not underwrite as some of the other companies were doing managed care and products, so they ended up with a huge population of catastrophically ill sicker patients than other managed care companies.

So that when I arrived the cost of health care, the medical loss ratio, if you will, exceeded the premium dollar collected by many of these members. So you put a cost of health care that exceeds a premium dollar, you put administrative costs together, they were losing money on every member they enrolled.

In addition, they had made a corporate decision years ago that they were going to enter into the hospital-only business, meaning that

they would only insure members for the hospital care and they had no way of insuring members for the professional care, that was given to another managed care company. So the company had an awful lot of work to do to get back on its feet and that's what I would describe simply as dire straights.

Q. Did -- withdrawn.

Have you ever heard the phrase "marching orders"?

A. Sure.

Q. Did you receive any marching orders from Dr. Stocker before or at the time you were hired?

A. My, if you want to use the term marching orders, my responsibilities were clearly delineated to me. They were to come in and take leadership over the medical division, to reduce the cost of health care, to implement a Medicare risk product and to bring a clear and consistent medical policy to Empire, those were my marching orders.

Q. Did you have any discussions with Dr. Stocker or the board of directors regarding

what steps generally were to be taken to reduce the costs of business and increase profitability of the company?

A. In a general way prior to me accepting the position and in specific discussions throughout my tenure at Empire Blue Cross those discussions occurred.

Q. At the onset of your employment or closely after starting work, I'm asking primarily at that time period.

A. I think that we had very, not step-by-step, but we had very clear initiatives that we were to begin right away. We had those discussions, sure.

Q. Before you implemented any changes in the way business was being done at Empire in the areas that you were responsible for did you have to obtain approval from anyone at the company?

A. Of course. I mean I am not -- my division was not an island. Whatever policy or changes that I implemented affected operations, it affected legal, it affected all the divisions, all the senior vice presidents. So before I could implement any of those we discussed them at

senior staff and the ramifications and everyone had to nod their head, otherwise, I would be unsuccessful because once I implemented a policy it still had to be disseminated, it had to be entered in the information systems, it had to get to customer service, it had to go to the salespeople so they would adequately represent the policy to employers. So there was a great deal of integration done by necessity.

Q. Did Dr. Stocker participate in those discussion?

A. Of course.

Q. Did Heyward Donigan participate in those discussions?

A. Of course.

Q. Did you have any of those discussions with the board of directors as you went along?

A. We were -- we presented to the board of directors on a regular basis.

Q. Is it an accurate statement then to say that Dr. Stocker, the CEO and president, as well as the board of directors was kept abreast of the changes in practices and procedures that you implemented?

R. Sanchez, M.D.

MR. DRISCOLL: Objection. Off tape.

THE VIDEOGRAPHER: The time is 11:05. We are going off the record.

MR. DRISCOLL: I object to the leading nature of the question.

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 11:05 a.m.. We are back on the record.

BY MR. MAURER:

Q. Was Dr. Stocker kept abreast of the changes and practices and procedures that you were implementing but were you keeping him abreast?

MR. DRISCOLL: Objection. Off tape.

THE VIDEOGRAPHER: The time is 11:05 a.m.. we are going off the record.

MR. DRISCOLL: I have the same objection and have the additional objection that it's a compound question.

MR. MAURER: Back on tape.

THE VIDEOGRAPHER: The time is 11:05 a.m. We are back on the record.

BY MR. MAURER:

Q. Was Dr. Stocker informed of changes

R. Sanchez, M.D.

that you were implementing at Blue Cross/Blue Shield before they were implemented?

A. Yes.

Q. Who informed him of those changes, the nature of the changes?

A. I informed him, they were discussed as about senior staff so that there were two mechanisms, either one-on-one meetings with him or phone calls that we had regularly or that -- or senior staff where we had to get the consensus of the senior staff to implement any policy changes.

Q. Was the board of directors informed of the changes that were being made as they were being made?

A. I think that the board of directors, as I remember it, were informed of our progress in achieving the large goals that we discussed earlier. They did not involve themselves in the minutia of the policies and different procedures that we were changing or implementing, that was not their role.

So that when we reported to board, we reported on our progress in achieving these goals

R. Sanchez, M.D.

and TQA, the quality progress, those kinds of things. And once in a while the board might ask how we did this or how we were doing that but the board does not involve themselves in that.

Q. Did the board of directors give you marching orders of any kind during your employment there?

A. No. The board of directors' relationship was with Dr. Stocker not with me. He was their chief executive officer.

Q. What, if anything, did Dr. Stocker tell you to do with regard to gaining control over the health care costs that Blue Cross/Blue Shield was dealing with at the time when you were hired or shortly thereafter you were hired?

A. Well, Dr. Stocker and Heyward Donigan were my immediate superiors in this organization were both very aware of the exorbitant health care costs that Empire Blue Cross/Blue Shield was enduring and asked me to implement procedures and policies and programs to reduce these costs and we did so in a broad array of tactics.

Q. Dr. Sanchez, I'd like to show you a pile of documents that was previously marked for

R. Sanchez, M.D.

identification collectively as Plaintiffs' Exhibit 1 on 10/14/98 and on the front page it says, Empire Blue Cross/Blue Shield Medical Management Review, and then it says, Medical Management Review, Initial Assessment of Capabilities and Recommendations for Improvement. It indicates the date October 2nd, 1995 and the insignia or the logo of Deloitte & Touche, LLP. Appears on the bottom right-hand corner.

MR. DRISCOLL: I'd ask to you remove the Post-Its, please.

MR. MAURER: He is not going to look through the whole document right now.

MR. DRISCOLL: May I see it, please.

(Handing.)

MR. DRISCOLL: Thank you.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 11:09 a.m.. We are going off the record.

MR. DRISCOLL: Off the record.

(Whereupon, there is an off-the-record discussion.)

MR. MAURER: On tape, please.

R. Sanchez, M.D.

THE VIDEOGRAPHER: The time is 11:11 a.m.. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, just looking at the front page of this exhibit, which I'll ask the reporter to mark as Plaintiffs' Sanchez Exhibit 2 for identification in a moment, are you familiar with this particular report, Doctor?

A. Yes.

Q. Don't look at the rest of the report for the moment, because there are stickers on it with my own notations which Counsel would like me to remove before you look at it so as not to influence you.

When was the first time that you saw this report?

A. My recollection I saw it right after I got there in May or June.

Q. Who showed it to you?

A. Heyward Donigan.

Q. What was your understanding generally of why this particular report was requested by Empire?

A. It was requested by Empire to receive

R. Sanchez, M.D.

an objective and third-party evaluation of the medical management division and its capabilities, its deficiencies, in an effort to, I assume, to correct them, to make the necessary corrections.

Q. Was the information contained in this report used by you at all to do any of the job you were asked to perform at the company?

A. Yes.

Q. Did you discuss the contents of this report with the CEO president, Dr. Michael Stocker, at any time?

A. Yes.

Q. Did you --

A. Let me -- I don't recall whether it was an individual conversation or it was done at senior staff but Dr. Stocker knew the contents of the report and how I was going to act on correcting some of the deficiencies in the report.

MR. DRISCOLL: Objection to that response and I move to strike it.

Q. Dr. Sanchez, was there any discussion about the contents of the report with Dr. Stocker?

R. Sanchez, M.D.

A. Dr. Stocker was aware of the contents of the report and my action plans to correct some of the deficiencies identified in the report.

MR. DRISCOLL: Same objection. Off tape.

THE VIDEOGRAPHER: The time is 11:14 a.m.. We are going off the record.

MR. DRISCOLL: I object to the witness testifying as to what Dr. Stocker knew or didn't know.

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 11:14 a.m.. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, to your knowledge, did Dr. Michael Stocker, the CEO and president of Empire, have knowledge of the contents of this particular Deloitte & Touche report?

MR. DRISCOLL: Same objection.

Q. You can answer.

A. Yes.

Q. Why do you say he had knowledge of the report, what's the basis for that statement?

A. Because for me to implement any

R. Sanchez, M.D.

corrections and plans to rectify some of the deficiencies identified in the report he would have had to approve them.

Q. Did a discussion of the contents of this report take place in the presence of Dr. Stocker, to your knowledge?

A. Yes.

Q. On how many occasions, once, more than once?

A. I can't tell you whether it was four or five but we had regular meetings with the senior staff and we had regular individual meetings and my activities throughout the day on implementing the array of projects that I was involved in, I kept him updated on those projects, I kept senior staff updated on those projects, and when called upon I kept the board updated on the global nature of those projects. Those were my responsibilities as the senior executive of Empire.

Q. To your knowledge, was there any discussion that took place involving the board of directors regarding the contents of this particular Deloitte & Touche report?

R. Sanchez, M.D.

A. I have no idea about that.

Q. Did you ever discuss the contents of any portion of the Deloitte & Touche report dated 10/2/95 with any member of the board of directors of Empire?

A. I don't recall any specific discussion, no, sir.

Q. Did Heyward Donigan, your immediate supervisor and I think you said the right hand to Dr. Stocker, to your knowledge, have any knowledge of the contents of this Deloitte & Touche report?

A. Yes, she did.

Q. Did any discussion about the contents of the Deloitte & Touche report take place in the presence of Heyward Donigan, to your knowledge?

A. Yes, those discussions occurred.

Q. Did she participate in the discussions?

A. Yes.

Q. By the way, did Dr. Stocker participate in the discussions regarding the Deloitte & Touche report?

A. Yes.

R. Sanchez, M.D.

MR. MAURER: Why don't I go off tape while the reporter marks this as Sanchez Exhibit 2 for identification.

THE VIDEOGRAPHER: The time is 11:17 a.m.. We are going off the record

(Sanchez Exhibit 2, Deloitte & Touche report, marked for identification, as of this date.)

MR. MAURER: On tape, please.

THE VIDEOGRAPHER: The time is 11:22 a.m.. We are back on the record.

BY MR. MAURER:

Q. Doctor, before I ask you about the Deloitte & Touche report, which is now marked Sanchez 2 for identification, I would like to digress just for a moment.

Do you recall the first time you and I had contact?

A. Vaguely.

Q. Was it about a year ago?

A. I think it was nine, ten months ago, yes.

Q. Who initiated that contact?

A. You tracked me down some way, somehow

R. Sanchez, M.D.

down in Atlanta.

Q. Did I request the opportunity to meet with you?

A. Yes.

Q. When I met with you did you agree to give a sworn statement which was taken down by a court reporter when we met?

A. Yes.

Q. Let me show you a transcript of what is indicated on the cover as a sworn statement of Richard Sanchez, M.D., dated February 17th, 1998, about one year ago.

If you would be kind enough to look at this transcript and look at the last page.

(Handing.)

Q. Does your signature appear on that page?

A. No.

Q. I'm sorry, I misspoke about the page. As far as you can see, Doctor, is this a complete transcript of the sworn statement that you gave me about a year ago in Atlanta?

A. Yes.

Q. Did you have an opportunity to review

R. Sanchez, M.D.

the transcript since the time that you gave the sworn statement?

A. Yes, sir.

Q. When was the most recent time that you had a chance to review the transcript of your sworn statement?

A. I had a chance to review this copy that you provided me after the session and the last time I read this was last night.

Q. Doctor, to your knowledge who requested, at Empire, who requested the Deloitte & Touche medical management review, which is the subject of the October 2nd, 1995 report marked as Sanchez Exhibit 2 for identification?

A. It would be the senior staff, the senior executives at Empire Blue Cross/Blue Shield.

Q. That included who?

A. Dr. Stocker and Heyward Donigan.

Q. Now, back to the actual Deloitte & Touche report. I'd like to show you a page marked as III-2 which --

A. Review referring to my sworn statement?

R. Sanchez, M.D.

Q. No, we are looking at the Deloitte & Touche for now.

A. Can I put this away now so I don't get confused.

Q. Showing you the particular page which has the heading, Financial Impact. Does this particular page of the report give an indication of whether the company was profitable or losing money in the recent past prior to the preparation of the report?

A. This chart shows that since 1991 there was only one year where there was a net gain.

Q. And in 1993, was there a gain or a loss?

A. There was a gain.

Q. And in 1994, was there a gain or a loss?

A. Between 1993 -- yes, there was a loss.

Q. Referring you to the page identified as III-1 which says financial impact on the top. Does this provide information regarding how much premium revenue the company had in the recent past?

A. This chart shows from 1991 to 1994

R. Sanchez, M.D.

there was a decline in premium revenue, approximately $2 million.

Q. Million?

A. Yes. I think these are millions, two million.

Q. There was a decline of two billion dollars?

A. Right. Sorry, I got my zeros confused there.

Q. So it dropped from 6,929,000,000 in 1991 down to 4,970,000,000 in 1994?

A. According to that chart, yes.

Q. Now, looking at another page there's a section under, on page IV-A, page nine, with a heading, utilization management process work flow, and there's reference here to the aggressiveness of nurses. What's that reference to in the report?

MR. DRISCOLL: Objection. Off tape.

THE VIDEOGRAPHER: The time is 11:29 a.m.. We are going off the record.

MR. DRISCOLL: I just like to place on the record a general objection to this witness who has not authored the report

R. Sanchez, M.D.

testifying as to what the author of the report meant when certain information was placed on the report.

MR. MAURER: Let's go back on tape.

THE VIDEOGRAPHER: The time is 11:30 a.m.. We are back on the record.

BY MR. MAURER:

Q. Doctor, there are two bulleted items on this particular page I just made reference to IV-A 9. What was your understanding of the first bullet which says, "The referral rate for managed care products appears somewhat low, which may indicate that the RNs are not being as aggressive at monitoring care as they are at monitor care"?

A. My interpretation, the nurses were not being as vigilant as they could be in the authorization or non-authorizing health care, in making health care decisions as per policies of Empire.

Q. The second bulleted item says, "The physician denial rate for both indemnity and managed care products is only one percent to two percent of case intake at Empire. Industries standards range from six to eight percent

R. Sanchez, M.D.

indicating the possibility of two lack standards of denial."

What was your understanding of what that item meant?

A. That the physicians were not, compared to the national average, supporting the denials or decisions of the case management nurses or the policies of Empire.

Q. And on page IV-A 29 there's a bulleted item that says, "Nurse referral rates to physician reviewers is slightly high and physician denial rates are extremely low. In addition, appeal rates for denied cases are above average."

What was your understanding of that particular item?

A. There are several parts to that.

Q. Let's take the first one, nurse referral rates to physician reviewers is slightly high.

A. That the nurses in our interpretation were not empowered or did not feel empowered or were not accustomed to making the difficult decisions on their own.

R. Sanchez, M.D.

Q. What were the difficult decisions?

A. Length of stay, all the authorizations, decisions that they were responsible for making. So that they would then pass these on to the physicians to make.

Q. The items you just referred to in laymen's terms what are we talking about? If a patient has prescribed treatment from a physician, a treating physician, in what context do we consider what you were referring to vis-a-vis the prescribed care and decisions that were being made?

MR. DRISCOLL: Objection to the form of the question.

MR. MAURER: It was a terrible question. I'll ask it again.

Q. With regard to the items you just made reference to does that have anything to do with how insured patients obtained authorization to get prescribed treatment?

A. Yes.

Q. How does it relate to that?

A. A provider or physician in many of the products at Empire had to have them authorized by

R. Sanchez, M.D.

our case management or utilization nurses in Albany. The nurses had policies and procedures that they could look up and say yes, this matches the policy, we will approve it, no, it doesn't match the policy, we will disapprove it, or there's no policy for it, let's send it onto a medical reviewer and what -- how we interpreted that report was that the nurses were not making those decisions. There was an excessive amount of those that were just being passed through. They weren't making the contact and the decision at that level and they weren't either used to it or didn't have the inclination to do so or leadership to do so or support to do so and that was something we were going to fix.

Q. The second part of that sentence on this particular page of the Deloitte & Touche report was "Physician denial rates are extremely low."

What was your understanding of what that meant?

A. That our physicians would routinely approve anything that was appealed to them by the provider or referred to them by the nurse.

R. Sanchez, M.D.

Q. And the last part was, "In addition, appeal rates for denied cases are above average."

What was your understanding of what that meant?

A. That the medical community had figured out that all they had to do was appeal this to the physician level and it would be approved. So they automatically appealed every decision that should have been stopped at a lower level.

Q. Let me show you page IV-A 8 which has the subheading of Utilization Management Process Work Flow. What is this particular document making reference to as you understand it?

A. This page is a schematic of the flow of intake of cases where you have the cases come in. There's a pre-certification process and 78 percent of them are approved and 22 percent are not approved and are referred for a physician review.

In the physician review process only one or two percent are -- I'm sorry -- 96 percent are approved. And then the last box has to do with the appeals of the denied cases, that 94

R. Sanchez, M.D.

percent of them are overturned upon appeal.

Q. What impact on the financial condition of Empire was this particular process, which is the subject of IV-A 8, in your view having on the company with regard to the percentages that were getting passed along the way and how many of the cases were getting approved versus denied?

A. Well, these kinds of percentages would reflect a large hemorrhage to the cost of health care at Empire Blue Cross/Blue Shield or in any company.

Q. With regard to Empire Blue Cross/Blue Shield, why did you say that it reflected a large hemorrhage?

A. Because these rates of approval denial were well below the national average of any managed care company.

Q. You are referring to a statistical average?

A. Yes.

Q. Look at the Roman numeral page 3-6, one of the bulleted items says, "HMO denials are few and often overturned on appeal." Is that referring to what you were just telling us about

on the previous few sheets that I questioned you about?

A. Yes.

Q. Then it goes on to say, "The planned medical director and physician reviewers are not aggressive enough with PCPs or attending physicians." What's your understanding of what that meant?

A. That our planned medical directors and leadership in the physician area did not have the requisite -- I'm trying to think of the right word -- ability to confront a physician or provider in our community -- in the network to deny or recommend an alternative treatment. That they would rather just approve them in a non-confronting way than provide the leadership and ability to deny it or capability to deny it as an unnecessary or non-required procedure of care.

Q. Was that impacting on the financial status of the company, Empire's company?

A. Of course.

Q. Now, Roman numeral, looks like L-15 under executive summary there is a list of

recommendations and one of the bulleted items says, "The current organizational structure places physician reviewers outside the UM organization. Physician reviewers do not have the tools nor the incentives to aggressively deny inappropriate cases."

First of all, the reference to UM, what does that stand for?

A. Utilization management.

Q. What is utilization management?

A. It is the oversight, concurrent and prospective concurrent and retrospective management of health care for members as it's being provided. It entails the authorization of services, it entails a review of those services as they are performed and also entails a retrospective review for appropriateness of care. All that comes under the utilization of management.

Q. When you came to Empire Blue Cross was there a utilization management area of the company?

A. Yes.

Q. Where it says, "The current

organizational structure places physician reviewers outside the UM organization," what was your understanding of what that meant?

A. That the bevy of physician reviewers existed outside the utilization management leadership and department, it was a separate entity.

Q. Did that in your opinion have any impact on the financial condition of Empire?

A. It was something that we corrected.

Q. Why?

A. Because we felt that those physicians were isolated from the development of policies and implementation of policies that were being done over in this area and they were over here in this area asking to interpret and support policies and they were not related.

In addition, they didn't come up to a single leadership position, so there was just no leadership. They were rather disparate groups and it made no sense that they were separate like that so we brought them together.

Q. Was that separateness contributing in your opinion to the losses that Empire was?

A. Yes.

Q. How?

A. Because based on the numbers they saw no relationship or need or to be part of the team that was trying to control health care costs. They were a separate entity.

Q. Where it said, "Physician reviewers do no have the tools nor the incentives to aggressively deny inappropriate cases," what's your understanding of what that meant?

A. In their isolation they did not have the standardized national Millman & Robinson or InterQual rules for approval of length of stays and policies and general practice f health care in the company nor did they have the opportunity to work in a collaborative way with the UM nurses and people that were doing -- making the initial decisions.

Q. These two names of the policies, could you say them again?

A. InterQual and Millman & Robinson.

Q. What are those?

A. Those are large sets of guidelines for utilization management that are regionalized for

R. Sanchez, M.D.

every part of the country. For example, if someone goes in for a total hip replacement the Millman & Robinson guidelines will say that for a person 65, you can authorize four days or eight days of authorization, and the same thing for a gall bladder or pneumonia or whatever.

Those types of guidelines, tools as that refers to, were not being utilized by the medical leadership at Empire Blue Cross/Blue Shield nor by the nurses. They were utilizing their own, what we call home-grown criteria. So one of the first things we did was give them a set of tools that they could, that were nationally recognized, that could support their decision on why they had to not approve or would approve a procedure.

Q. What is the nature of the incentives that the physician reviewers did not have to aggressively deny inappropriate cases?

A. There was no financial incentives in place for them affecting the cost of health care allocation.

Q. In layman's terms what are you talking about?

R. Sanchez, M.D.

A. That if there were savings from services from reducing the cost of health care the physician reviewers did not share in any of those, there was no incentive for them to have that difficult interaction with the physician in denying services or not approving services because there was no incentive to do that at the end of the day the company saved a $100,000 by you appropriately applying the policies and procedures of Empire, that showed no reflection on his approval, his rating, his compensation or his incentive compensation.

Q. As a result of this report and any other background information you brought to the company were any incentives for physician reviewers put into place at Empire to aggressively deny inappropriate cases?

A. The company and my division specifically created an incentive and goals and objectives program for the entire company to meet. And clearly the reduction in the medical loss ratio or cost of health care was, if achieved, the incentive compensation would be distributed to all supervisors and above, I

R. Sanchez, M.D.

forget where the cutoff occurred.

Q. The initial level where authorization would be sought from Empire for prescribed care would go where, what would be the nature of the employee who would get that first-step involvement?

A. It would be a nurse in Albany in our utilization management area.

Q. Would that be someone referred to as a caseworker?

A. Case manager, caseworker, UM, yes.

Q. Did the caseworkers have supervisors?

A. Absolutely.

Q. Did the supervisors, to your knowledge, participate in this financial incentive program that was instituted at Empire to bring about denials of more cases?

MR. DRISCOLL: Objection to the form of the question.

MR. MAURER: I'll rephrase the question.

Q. What was the intended purpose of instituting this incentive goals program at the company?

R. Sanchez, M.D.

A. To reduce the cost of health care, and to create an incentive for our nurses and our physicians and people that worked in utilization management to endure the difficulty of denying or not approving health care that was not consistent with the policies developed at Empire.

Q. How were these people supposed to reduce the costs of health care so as to qualify for this incentive package or program?

A. They had to first and foremost reduce the unnecessary care.

Q. How?

A. By not approving procedures and procedures and care rendered, considered to be rendered, to patients who didn't have the diagnosis. For example, you wouldn't approve a heart transplant for someone who didn't need a heart transplant or you wouldn't approve a hip replacement for someone who didn't need a hip replacement. There was an awful lot of that occurring, you know, unnecessary care being delivered to the members at their risk and at great cost to the company. So, first and foremost, they were to reduce the amount of

unnecessary care to make sure the diagnosis matched the level of care that was being recommended by the provider.

Q. Let me just stop you there for a second. To reduce those numbers was it necessary for there to be an increase in the number, increase in the number of denials that were being issued by the case workers?

A. Yes.

Q. Okay. Please continue.

A. Another component was to recommend alternatives to care. That if a physician wanted to keep someone in the hospital 12 days, the caseworker was to suggest alternatives at lower costs to that care. If a physician wanted to recommend someone staying in a hospital for intravenous care, they were instructed to work out a home health care where they would receive that care at home. So that's another strategy that was to be used.

There was also the strategy of very carefully making sure that the policies and procedures that were developed matched what the benefit was because many, many times we were

asked to provide a covered benefit that was not a covered benefit, so that when that had to be denied, whether it was a benefit. You do not get a benefit unless you pay for that benefit. If the employer did not pay for that benefit the member couldn't ask for that in our new policies and procedures. We asked them to read strictly into what the benefit interpretation was. That resulted in what you say denials. So those are -- there's a constellation of things these people were being asked to do. That is a difficult thing for people to do, particularly who are not accustomed to do that.

We created a way to document that and we created an incentive compensation program that if they did that and we were successful overall as a division and as a company that they could share in that.

Q. What did you do to create a way to document the increase in denials?

A. Whenever an alternative or a denial was made it was compared, first of all, we had a column that said what the procedure or service requested was. We then had what was approved or

suggested or changed. And then there was the column for what the savings were by us implementing an alternative denial or a different course of care. And those services, while not solid, I mean you could not say it was 65 or 64,000, they gave us a general idea of what we were saving the company. Those were shared with senior leadership throughout the company on a regular basis.

Q. Who made out those forms?

A. The actual caseworkers, the nurses.

Q. That would be given to whom?

A. To their supervisor.

Q. Would those get summarized in some way?

A. Yes.

Q. That information was then used by upper management where you were to do what?

MR. DRISCOLL: I object to the leading nature of the question.

Q. Did you use that information in performing your duties?

A. Yes, sir.

Q. How did you use it?

A. I used it to evaluate the effectiveness of our nurses and doctors in implementing the policies and upholding our policies and procedures in their success at suggesting alternative treatments or therapies and whether they were denying uncovered benefits or procedures that were not as per our policy.

I used that to document to my superiors the affect that we were having on the reduction of cost of health care, which is what I was being held responsible for.

Q. Your superiors meant whom?

A. Dr. Stocker and Heyward Donigan.

Q. What about the board of directors?

A. I was not responsible to the board of directors. The board of directors were kept informed of my activities through reports, regular reports of Dr. Stocker to the board.

Q. Do the reports that contained information about the savings that resulted from these denials, was that considered at all as part of the incentive program that you've referred to?

A. Yes.

Q. How?

R. Sanchez, M.D.

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

Q. Did you participate in this incentive program?

A. You mean me, personally?

Q. Yes.

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

R. Sanchez, M.D.

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

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

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

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

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

R. Sanchez, M.D.

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

A. Of course.

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

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

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

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

Q. That was in existence when you arrived?

A. Yes.

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

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

R. Sanchez, M.D.

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

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

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

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

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

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

A. Yes.

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

R. Sanchez, M.D.

approval of prescribed treatment for insured patients, was there any requirement to your knowledge at Empire Blue Cross/Blue Shield when you arrived there that in order for a prescribed therapy to be approved it had to be able to cure a condition or disease?

A. You are asking if there was such a policy?

Q. Yes.

A. Yes, for certain diagnoses, sure. Anything that was considered experimental or not proven effective was not a covered benefit.

Q. In order to be proven effective did it have to be capable of curing the patient, was that a specific restriction or requirement as you understood it?

A. Curing is more of a layman's term than a clinical term. It had to demonstrate effectiveness, clinical effectiveness, either in the reduction of the symptomatology or an elimination of the disease process. If it did not show that, it would not be a covered benefit, it would be an experimental indication and those were approved on a case-by-case basis.

R. Sanchez, M.D.

Q. Based upon a review of the insured's patient's chart, among other things?

A. Chart, doctor, literature.

Q. In other words, the company when considering whether or not to approve a prescribed course of treatment for an insured patient would consider information from the doctor you are saying, the treating doctor?

A. Absolutely.

Q. Who prescribed the treatment?

A. Correct.

Q. Would consider the case history of the insured patient?

A. Yes, correct.

Q. Would consider medical literature published in the field?

A. Correct.

Q. Okay. Did any one of those things in and of itself cause Empire to approve or deny without consideration of the other areas of information that you've told us would be considered?

MR. DRISCOLL: I object to the form of that question.

R. Sanchez, M.D.

THE WITNESS: It's good because I don't understand it.

MR. MAURER: I'm sorry. Sometimes I do that.

Q. I'll rephrase the question, Doctor.

You just made reference to three different areas of information that would be considered. Were there any other areas that would be considered in terms of whether or not to approve or deny prescribed treatment?

A. Well, there was -- there were off-the-record things that would be considered but nothing, I mean the official policy, that's the things we considered. We considered the patient's diagnosis, the review of literature, whether it was appropriate, and the clinical progress and the medical literature whether we approved those kinds of things.

Q. Let me ask you to assume that if the literature were to suggest that a prescribed course of therapy was still viewed as experimental and the information provided by the prescribing doctor reflected that the patient had received the treatment and had approved in

R. Sanchez, M.D.

symptomatology, would that combined information be viewed together so as to make a determination as to whether or not the therapy prescribed was experimental versus proven?

MR. DRISCOLL: I object to the hypothetical nature of the question.

Q. You can answer, Doctor.

A. Sometimes.

Q. How so?

A. It would depend on the diagnosis, it would depend on the severity of the illness involved, whether it was life threatening or not, it would likely receive much more attention if it were life threatening than if it were something of a more cosmetic nature. So all those things had to be considered.

Q. Would it be more likely to be considered if it had a high cost?

MR. DRISCOLL: I object to the leading nature of the question.

Q. Would the cost of prescribed treatment be a factor that would be considered in determining whether or not prescribed treatment would be approved or denied?

R. Sanchez, M.D.

A. Yes.

Q. Was that true when you got to the company?

A. Yes.

Q. When you came to the company did you take any steps to tighten up the policy of the company with regard to what treatment that was prescribed by treating doctors would be approved or denied?

A. Yes.

Q. Was that part of the marching orders you received from Dr. Stocker?

A. From Dr. Stocker and Ms. Donigan, yes.

Q. Was that intended to have any impact, if you recall, on the financial condition of the company?

MR. DRISCOLL: I object to asking the witness to speculate about what someone else intended.

Q. If you know. Did you intend it to improve the financial condition of the company?

(Pause.)

Q. Do you want me to rephrase the question?

R. Sanchez, M.D.

A. Yes, please.

Q. Was the tightening up of these policies that governed when prescribed therapy would be approved or denied that you implemented intended by you to have an impact on the financial condition of Empire Blue Cross/Blue Shield?

A. The cost of health care or medical loss ratio accounts for 85 to 105 percent of the premium dollar. On top of that are administrative costs. My responsibility and the reason I was brought to Empire was to reduce the cost of health care allocation, the medical loss ratio, and thereby improving the viability of the company.

Q. Financially?

A. Of course financially.

MR. MAURER: Off tape, please.

THE VIDEOGRAPHER: The time is 12:04 p.m. and we are off the record.

MR. DRISCOLL: Can we take a five-minute break.

MR. MAURER: Sure.

(Whereupon, there is a recess in the

R. Sanchez, M.D.

proceedings.)

THE VIDEOGRAPHER: The time is 12:16 p.m. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, before I forget, the sworn statement that you gave me back on February 17, 1998, I'd like to mark that as Sanchez Exhibit 3 for identification.

MR. MAURER: If the reporter would be kind enough to do so.

Off tape while we do that.

THE VIDEOGRAPHER: The time is 12:16 p.m. and we are going off the record

(Sanchez Exhibit 3, sworn statement given on February 17, 1998, marked for identification, as of this date.)

THE VIDEOGRAPHER: The time is 12:17 p.m. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, is the sworn statement that we have marked as Sanchez Exhibit 3, a complete copy of the statement you gave me under oath a year ago?

A. Yes, it is.

R. Sanchez, M.D.

Q. Having had the chance to review this as recently, I believe, as yesterday, is the transcript accurate in terms of the sworn testimony that you gave to me on that date approximately a year ago?

A. I believe it is.

Q. Is there any inaccuracies that need to be corrected based on your review yesterday?

A. No.

Q. Going back to the Deloitte & Touche report, Doctor, on page L-13, it looks likes, it's an L, under key findings medical management. It says, "There are significant improvement opportunities for Empire to more effectively manage health care costs" and one of the sub-items bulleted is, "Physician reviewers internally are not aggressive enough in denying cases."

What's your understanding of what that was referring to?

A. That our physician reviewers lacked the will to appropriately deny services.

Q. The next item says, "Physician reviewers denial rates are low negating some of

R. Sanchez, M.D.

the potential effectiveness of managed care."

The next thing item says, "An increase in the physician reviewer denial rate to industry norms could reduce claims by $25 million."

What was your understanding of what those two items were referring to?

A. That an average denial rate compared to industry would have a tremendous rate on health cost of health care.

Q. Now, on page IV-A 15, under Utilization Management Process Work Flow Denial Rates Continued, it says, "If the physicians took a more aggressive stance denying industry standard six to eight percent of cases, the dollar amount of denied cases could conservatively be expected to triple."

Did you consider that information in deciding what course to take in your job performance?

A. Yes.

Q. With regard to page IV-A 14, is this particular chart reflective of the information I just asked you about a moment ago from the previous page comparing dollars that could be

R. Sanchez, M.D.

saved based upon increased denials?

A. Yes.

Q. Look at IV-A 13, Utilization Management Process Work Flow Indemnity Products, and it says, "Physician denial rates are less than one-third of industry standards for indemnity products." There is a little bit of a graphic or chart there. Would that information – let me just take this Post-it off – was that information considered by you in determining the course to take?

A. Yes.

Q. Now, in order to make the changes that had to be made at Empire Blue Cross to reduce the cost of health care what steps did you actually take?

A. Excuse me, I don't want to cough into the microphone.

There was an entire program put into effect that implemented many, many steps. Specifically, in the cost of health care, it was to bring a consistent and implementable set of policies for our caseworkers to utilize in their evaluation of the appropriateness of care.

R. Sanchez, M.D.

It was -- there was steps taken to create the right leadership and incentive and recruit a team that would oversee utilization management and the policies and procedures to be developed and were implementable.

There was a creation of the proper documentation and incentive, there would be a crackdown on fraudulent providers.

There would be a clarification of some of the employer expectations of what they interpreted the benefits to be.

There would be a recontracting of provider networks and hospitals.

There would be an implementation of a medical risk product.

There would be a more of a transferring the risk to providers in their contracting.

So there was a constellation of things that occurred.

Q. Did you undertake to have any sort of evaluation performed to determine if there were any particular areas of health care costs that were responsible for the high cost of health care

R. Sanchez, M.D.

for the company?

A. Our utilization management leadership was asked to identify the high cost diagnoses and procedures so that we could focus in on those diagnoses and procedures to try to reduce health care expenditures in those areas.

Q. What do you mean by that in layman's terms, what do you mean when you say to focus on higher cost diagnoses and treatment areas?

A. That area of managed care is called disease management and what it means in layman's terms is that we are going to focus on the small percentage of diagnoses and procedures that account for a huge percentage in health care expenditures. If you focus in on those small number of diagnoses and procedures, you get a much bigger bang for your dollar and you get much more of a reduction in the cost of health care and we think that that's more important or better use of our time than focusing in on the micro management of an office visit which is $80.

Q. What specifically by way of diagnoses did you focus on as the target areas that were costing so much money at Empire?

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

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

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

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

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

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

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

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

A. Correct.

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

A. Yes.

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

A. Yes.

Q. Did you undertake to have those

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

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

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

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

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

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

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

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

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

A. Yes.

R. Sanchez, M.D.

Q. What was done in that regard?

A. In the re-contracting of our providers for risk products, the lock-in HMO, the managed care products, the Medicare risk products, they were to share in an -- they were to receive an incentive compensation for any reduction in savings of the cost of health care that Empire realized.

Q. Just to put this in terms that are clear, was there any incentive for these outside doctors that you just referred to, to keep the number of expensive diagnostic tests that they prescribed down to a certain level or number?

A. Yes.

Q. Was that in existence when you got to Empire or something that you helped to bring in?

A. Something I helped to bring in.

Q. Was the goal of reducing the cost of health care for the company a fact in factor in your deciding to bring that particular program of incentives for outside doctors into existence?

A. I was hired to implement risk contracting. One of the aspects was to implement a risk contract with our providers and so it was

R. Sanchez, M.D.

clear to me that that was one of the expectations. It wasn't the only expectation and one of the only aspects of my job, but clearly to recontract our physician network into risk contracts in which they shared an incentive compensation at the end of the day if we had reduced health care costs that was part of the plan.

Q. I have been asking you some questions about corporate medical policy. What are we talking about, could you explain it to the jury what you are referring to?

A. Corporate medical policy has to do with the, in a very narrow sense, has to do with that I was responsible, has to do with having the correct policies for the interpretation of benefits so that the rest of our operation can pay the claim appropriately. That's a corporate medical policy.

For example, if you need a gall bladder surgery, or you think you need it, we have a corporate medical policy on gall bladder surgery. That policy would include to make sure that the diagnosis is appropriate, to make sure

R. Sanchez, M.D.

what you have tried up to the point you are recommending surgery is appropriate and then to recommend the appropriate care intervention, whether that is surgery or done laparoscopy, whether it's done inpatient or outpatient.

So that someone who wanted to come in and give chemotherapy for a gall bladder would not be able to pass the scrutiny of our corporate policy.

Q. Let me show you an exhibit, previously marked as Plaintiffs' Golonka, G-O-L-O-N-K-A, No. 1 of 2/10/98 which we will mark as Plaintiffs' Sanchez 4 for identification.

This says on the top, Empire Blue Cross/Blue Shield Managed Care Medical Guideline Topic Treatment of Lyme Disease.

MR. MAURER: If the court reporter would be kind enough to put a sticker on it I'll ask you to go off tape for a moment.

THE VIDEOGRAPHER: The time is 12:34 p.m.

This completes tape No. 1 of the videotape deposition of Dr. Richard Sanchez.

R. Sanchez, M.D.

(Sanchez Exhibit 4, document entitled Empire Blue Cross/Blue Shield Managed Care-Medical Guideline, Topic: Treatment of Lyme disease, marked for identification, as of this date.)

THE VIDEOGRAPHER: The time is 12:36 p.m.

This is tape No. 2 of the videotape deposition of Dr. Richard Sanchez, M.D..

BY MR. MAURER:

Q. I see that two exhibits from the Golonka deposition were connected so I have separated them.

Sanchez Exhibit 4 is a two-page document which is dated and signed 10/1/90.

Dr. Sanchez, would you take a look at this particular exhibit. Can you identify what this particular document is?

A. It is a medical policy for the managed care guidelines for Lyme disease, for the treatment of Lyme disease.

Q. Is this a corporate medical policy as we have been referring to it?

A. Yes, it is.

R. Sanchez, M.D.

Q. Who would typically receive a copy of that corporate medical policy at Empire?

A. Our case managers, our doctors, the chief medical officer would have a lot to do with editing this and producing this final copy. At one point they would be shared with our senior staff but they don't write these.

Q. Have you had a chance to read this particular corporate medical policy on Lyme disease prior to today?

A. Yes.

Q. Based upon your knowledge of what is contained in this particular corporate medical policy on Lyme disease do you consider this to be a fair corporate medical policy on Lyme disease when it was put into place back in 1990?

A. Yes.

Q. Thank you, Doctor.

Now, with regard to the diagnosis of Lyme disease, what is your understanding as to how Lyme disease is diagnosed?

A. The diagnosis usually starts with a type of viral syndrome symptomatology including a fever, aches, headache and a characteristic skin

R. Sanchez, M.D.

rash surrounding the tick bite that transmits the bacteria to the patient. It is then followed by some variable -- by a variable process that could lead to connective tissue disorders and heart disease and at one point there is a seral conversion that allows the diagnosis to be more accurate which you can actually detect the antibodies to the bacteria in the patient's serum.

Q. Now, with regard to testing, to your knowledge what specific tests have been generally used to diagnosis Lyme disease?

A. It's an antibody, it's called a Western Blot. It is an antibody titer taken from the patient's serum looking for specific antibodies to the bacteria. If you have them, then you've been exposed to the disease. If you have high titers of those antibodies, you have an acute exposure. If you have decreasing titers, then you have response to the treatment or the disease is self-limited or disappearing.

Q. Are you familiar with the ELISA test, E-L-I-S-A?

A. Yes.

R. Sanchez, M.D.

Q. Is that an antibody test that was used in the early '90s and is still used today in the diagnosis of Lyme disease?

A. Yes.

Q. Are you familiar with the IFA test, Immunofluorescent Assay test?

A. Yes.

Q. Is that also a test that is used to diagnose Lyme disease?

A. Can be, yes.

Q. If those tests are done and the test comes back positive, would it then be typical, as far as you know, to then do a confirmatory Western Immuno-Blot test?

A. That's usually the order of the test. They are general and they become more specific.

Q. In 1990, did the corporate medical policy on Lyme disease used at Empire, which is Sanchez 4 for identification, would I be correct that that particular policy did not require a positive serology with both the ELISA and a confirmatory Western Blot in order to get approval from Empire Blue Cross for independent intravenous treatment?

R. Sanchez, M.D.

MR. DRISCOLL: I object and would like to go off tape.

THE VIDEOGRAPHER: The time is 12:41 p.m. We are going off the record.

MR. DRISCOLL: The objection is that Dr. Sanchez was not at Empire in 1990 and unless you are going to ask him whether he's had an opportunity to review the document you've marked and he's gotten some understanding of it based upon this review here today, then I don't see how you can ask him about Empire's policies in 1990.

MR. MAURER: I asked him that two minutes ago, Justice. That he read it.

MR. MAURER: Yes. And he said he did.

Q. Is that correct, Doctor?

A. I read it in 1995 in reviewing our updated policy.

Q. Did you read it again yesterday at my request?

A. Yes.

MR. DRISCOLL: The objection is withdrawn.

MR. MAURER: On tape.

R. Sanchez, M.D.

THE VIDEOGRAPHER: The time is 12:42 p.m. We are back on the record.

BY MR. MAURER:

Q. Doctor, I'll repeat the question. Would I be correct that the 1990 corporate medical policy on Lyme disease, which we marked as Sanchez 4 for identification, did not require that a patient have both a positive ELISA test and confirmatory positive Western Immuno-Blot test in order to qualify for approval of prescribed intravenous antibiotic therapy for Lyme disease?

A. Yes.

MR. MAURER: Let's mark as Plaintiffs' Sanchez Exhibit 5, a memorandum from Marvin B. Blitz, M.D., vice president medical policy and research on the subject of Lyme disease, oral and intravenous, dated August 30, 1993 and previously marked for identification as Plaintiffs' 2 on 11/17/97.

Off tape.

THE VIDEOGRAPHER: The time is 12:43 p.m. We are going off the record.

R. Sanchez, M.D.

(Plaintiffs' Sanchez Exhibit 5, memorandum from Marvin B. Blitz, M.D., on the subject of Lyme disease oral and intravenous, dated August 30, 1993, marked for identification, as of this date.)

Q. Doctor, you requested the opportunity while we were off tape to look at this particular exhibit?

A. I just did.

Q. No, I didn't know if the reporter had the request. I wanted to document your request.

A. Yes.

Q. Please feel free before we go on tape.

(Witness reads document.)

MR. MAURER: On tape, please.

THE VIDEOGRAPHER: The time is 12:45 p.m. We are back on the record.

BY MR. MAURER:

Q. While we were off tape did you request to be able to read through the '93 corporate Lyme policy?

A. Yes.

Q. Did you do so?

R. Sanchez, M.D.

A. Yes, sir.

Q. Had you seen this particular two-page document prior to today?

A. Yes.

Q. When for the first time, approximately?

A. 1995. Again, a year ago when you took my sworn statement and last night or yesterday and today.

Q. Incidentally, I didn't ask you, but while we are bringing it up, did you and I meet for any period of time prior to today to discuss your deposition, this particular deposition for trial?

A. We met yesterday.

Q. For how long?

A. An hour and a half.

Q. Did you review materials at that time?

A. Yes.

Q. What materials did you review?

A. I reviewed my personnel folder, I reviewed these three policies and I reviewed my sworn statement.

Q. Did you look at any portion of the

R. Sanchez, M.D.

Deloitte & Touche report?

A. No, I did not. I didn't look at that.

Q. Now, returning to Sanchez Exhibit 5,, the 1993 corporate Lyme disease policy from Empire, there's some reference to code numbers on the bottom of the first page. Do you see what I'm referring to?

A. Correct.

Q. What is that?

A. These code numbers refer to the diagnosis.

Q. Was there a particular reason why those code numbers started to be used at Empire with regard to the diagnosis of Lyme disease?

A. Yes.

Q. What's your understanding of the reason?

A. The intent of this memorandum was to make sure that all those new diagnoses identified by this code number would suspend.

Q. Why?

A. For medical review.

Q. Why?

A. To assure that the treatment was

authorized prior to forwarding it for payment.
Q. Why?
A. Because prior to that the treatment was being paid for without that kind of review.
Q. Were these code numbers put into a computer system at Empire, if you know?
A. Yes, they were.
Q. Did the use of this code number for Lyme disease flag a Lyme disease case as something that all payments should stop until a review had taken place?
A. It would have been impossible to process the claim any further until a medical reviewer intervened.
Q. Was that built into the system?
A. Yes.
Q. Now, I have an additional document of the date of August 18th, 1993 which consisted of five pages on Lyme disease treatment from Dr. Blitz to Harold Sandler.
Who is Harold Sandler, do you know?
A. Harold Sandler, as I recall, I thought there were two people named Sandler, but the Sandler I recall had to do with underwriting and

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

involve different parts of the body. I'd like to ask you a little bit more about that.
Have you ever heard of the term "disseminated disease" with reference to Lyme disease?
A. Yes.
Q. What's your understanding of the method by which the organism that causes Lyme disease disseminates in the human body?
A. The dissemination of any infection, including Lyme disease, throughout the body occurs when the bacterial spread of the virus or the disease goes beyond where it was introduced or attacks various systems that would normally not be involved.
For example, in tuberculosis you may contract the Tuberculin Bacillus by breathing it in the subway. The dissemination would be that you actually developed a brain abscess of bacteria, so that that's the dissemination of the disease, or the bone.
Q. With reference to Lyme, how does the organism spread within the human body?
A. It would be the same process, the body

itself does not limit the area of attack of the bacterium and it could disseminate onto cartilage and the heart and other areas.
Q. Does it travel in a particular system of the body?
A. It's assumed to be in the blood system.
Q. So once the organism that causes Lyme disease gets into the blood system, it could disseminate or spread throughout the body, is that what you are saying?
A. If not taken care of by the body's immune system or the appropriate antibody or in some cases the disease is self-limited and never goes any further.
Q. What's your understanding of how quickly or how soon the organism that cause Lyme disease can get into the blood stream and start to disseminate into the body?
A. It could be days to weeks.
Q. I'd like to show you Sanchez Exhibit 6 and I'll give you a moment to look through it one more time before I ask you a question out of fairness so the information is fresh in your

mind.

MR. MAURER: Let's go off tape while you look at the document.

THE VIDEOGRAPHER: The time is 12:53 p.m. and we are going off the record.

(Witness reviews exhibit.)

MR. MAURER: I guess after we finish with this exhibit we will take a lunch break. It's 1:00.

MR. CHANCELER: You have more after lunch?

MR. MAURER: Yes. We are getting there.

On tape.

THE VIDEOGRAPHER: The time is 12:55 p.m. We are back on the record.

BY MR. MAURER:

Q. Have you had a chance to look at Exhibit 6, Doctor?

A. Yes.

Q. Had you seen this particular document before today?

A. Yes.

Q. Did you see it in '95?

A. Yes.

Q. Did you see it when you undertook to have corporate medical policies changed?

A. Yes.

Q. Did you review it yesterday?

A. Yes.

Q. Doctor, what's your understanding, if you have an understanding, as to how fast the Lyme bacteria, the bacteria that causes Lyme disease, can disseminate or spread from the location of the tick bite to the brain?

A. In -- it can be as short as a week and as long as six weeks.

Q. Is there, to your knowledge, any advantage to treating Lyme disease with intravenous antibiotics as opposed to oral antibiotics?

A. Are you asking me that with knowledge now or knowledge in '95?

Q. I'm asking you based on your understanding of the subject currently.

A. My understanding of the subject currently is that the intravenous administration aggressive very early on in any suspected

dissemination of the disease is the appropriate choice.

Q. Have you ever heard of the blood brain barrier?

A. Sure.

Q. Were you aware of what that was in '95?

A. Yes, sir.

Q. In 1995, what was your understanding as to whether or not oral and intravenous antibiotics, either or, were capable of penetrating the blood brain barrier?

A. Oral agents poorly, intravenous agents much more successful.

Q. In the treatment of Lyme disease what was knowledge in 1995 when the new corporate medical policies came into being with regard to the appropriateness of use of intravenous antibiotics to treat Lyme disease where central nervous system involvement was believed to exist?

A. Where central nervous system involvement was believed to exist in conjunction with the timing it was an appropriate utilization of medication -- it was an appropriate regimen.

Q. What do you mean by timing?

A. That our policy when I arrived and our understanding of the disease from the experts that we, and review of the literature, was that the first line of treatment for an early infection, less than six weeks, was an oral administration of antibiotics.

Q. If a patient was the recipient of an appropriate dose of oral antibiotics early on after the onset of the infection and appeared to have evidence of central nervous system involvement, what was your understanding with regard to the appropriateness of treatment with intravenous antibiotics within that first six-week period?

A. It was our policy to not approve those.

Q. Are you aware of any particular scientific or medical reason or literature that supported the conclusion that it was appropriate not to treat with intravenous antibiotics if it was 42 days or less from the date on onset of the condition?

A. That was the existing policy when I

R. Sanchez, M.D.
arrived at Empire.
Q. My question is: Are you aware of any medical or scientific justification for that policy, to restrict approval of IV antibiotic treatment to patients who were at least 42 days or more out from the onset of their Lyme disease condition?
A. No.
MR. MAURER: Since it's 1:00 why don't we break now for lunch and then we will come back. Off tape, please.
THE VIDEOGRAPHER: The time is 1:00 p.m. We are going off the record.
(Luncheon recess taken at 1:00 p.m.)

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

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

R. Sanchez, M.D.
marked for identification as Plaintiffs' Sanchez 7 for identification.
The first question is: Have you seen this particular document before?
A. Yes, I have seen this particular document before.
Q. Did you see it in 1995?
A. Yes.
Q. Have you seen it since then?
A. Yes.
Q. Did you see it yesterday?
A. Yes.
Q. Okay. Could I have it for a moment, please.
(Handing.)
Q. Doctor, referring to page 13 of this particular exhibit, Sanchez 7, there's a table two, Summary of Indications for IV antibiotics. It says, "For all the following, three conditions must be satisfied. One, characteristic exposure/epidemiologic and early localized disease history."
What was your understanding of what that meant?

R. Sanchez, M.D.

A. That there would have to be a recollection of the possible exposure to tick bite, that the person actually remembers the tick bite or that there's a manifestation on the skin of the tick bite and Lyme disease.

Q. Number two, positive Lyme serology concerned with Western Immuno-Blot. What was your understanding of what that meant?

A. That the patient would have to have antibody evidence of exposure to the organism.

Q. Does this specifically when referring to positive Lyme serology refer to a positive ELISA?

A. Yes.

Q. Confirm with Western Immuno-Blot. Does that mean a positive Western Immuno-Blot test?

A. Correct.

Q. So does number two there require both a positive ELISA and a positive Western Blot test?

A. Yes.

Q. No. 3, exclusion of other common medical illness that could explain clinical

R. Sanchez, M.D.

findings.

A. Correct.

Q. So based upon what is stated here on page 13 of the 1995 Empire Blue Cross/Blue Shield corporate medical policy on Lyme disease, no insured patient who is insured with Empire would qualify for approval of prescribed IV antibiotic therapy if they did not have both the positive ELISA and positive Western Blot test?

A. As per the policy, yes.

Q. This policy was actually put into effect when you were at Empire; is that correct?

A. Right.

Q. Was this one of the corporate medical policies that was revised as part of the overall project that you've already told us about?

A. That's correct.

Q. With reference to these new corporate medical policies that you put into effect after you went to Empire, did these policies reflect the same information or did they differ from the kinds of guidelines that you told us about that were in the InterQual and Millman & Robertson?

A. They were reflected much the same

R. Sanchez, M.D.

information. They are a little different in that the Millman & Robertson and InterQual are more procedure-related, length of stay-related than corporate policies that do more to interpret benefits. So these are a little different, they are not apples and oranges, apple and apples, apples and oranges.

Q. Now, with regard to these new corporate medical policies that you brought into effect at Empire, did you have any expectation -- or what expectation did you have, if any, as to any impact the new corporate policy would have with regard to the ability of insured patients being able to get treated for diagnosed Lyme disease?

A. Our expectation was that we would be able to prevent the unnecessary treatment of, the unnecessary and expensive treatment, with people of early Lyme disease that could have been treated orally or, two, or misdiagnosed Lyme disease. There was at that time a rather hysterical environment of people in that part of the state or country that Lyme disease was being over-diagnosed and therefore being over-treated

R. Sanchez, M.D.

so the policies were made to curb that.

Q. Did you when you brought in the new corporate medical policy on Lyme disease in December 1995, were you familiar with Dr. Raymond Dattwyler from the Stony Brook, New York Lyme clinic?

A. I'm familiar with his work.

Q. With regard to the work you were familiar with were you familiar with his work regarding sero-negative Lyme patients?

A. Yes.

Q. What's your understanding of what a sero-negative is?

A. It's a patient who demonstrates no antibody development or demonstrable antibody development but has indeed contracted the disease and is manifesting symptoms and pathology of the organism without an immune response.

Q. In December of 1995 when you adopted the new corporate medical policy on Lyme disease did you have that information about sero-negative Lyme patients?

A. Yes.

Q. You were aware of it?

R. Sanchez, M.D.

A. Correct.

Q. Did you have any expectation at the time that you adopted the new corporate medical policy on Lyme disease that there would be any patients who were insured with Empire who had Lyme disease who would not be able to meet the criteria contained in the policy, the corporate medical policy?

A. Could you ask that question again.

Q. You want it read back by the reporter or would you like me to rephrase it?

A. I would like you to clarify it for me.

Q. Is there a particular part that you didn't understand so I know what to focus on?

A. The part of my expectation of patients that had the diagnosis.

Q. Sure. When you adopted the new corporate medical policy on Lyme disease did you anticipate that there would be some insured patients who actually had Lyme disease who did not meet the new criteria for diagnosis of Lyme disease that you adopted and therefore would not be able to get approval for prescribed treatment from Empire?

R. Sanchez, M.D.

A. The short answer is yes. Let me elaborate. What we knew and expected was that there were people that prior to implementing this policy would have been diagnosed to have Lyme disease. We tightened up the definition and diagnosis and documentation of those people that had Lyme disease fully understanding that there would be people who thought they had Lyme disease or had been treated to have Lyme disease or were sero-negative were not going to meet the criteria.

Q. You knew that were some people who were sero-negative who still had the disease who would not be able to meet the criteria?

A. According to Dr. Dattwyler there were a couple dozen in his study. We had no evidence of how many of those that there our members but had one of those patients been our members, he would have qualified for treatment.

Q. Did you have any knowledge at the time you adopted this new corporate medical policy in December 1995 that required there to be a positive serology with confirmatory Western Blot in order to qualify for IV antibiotic therapy as

R. Sanchez, M.D.

to what percentage of the Lyme disease patient community was sero-negative?

A. We thought that it was a very insignificant percentage.

Q. Did Empire do any research or investigation to determine whether or not any of the medical literature reported on the percentage of Lyme disease patients who were sero-negative before adopting the new policy in December 1995?

A. We did no research, we reviewed the literature and consulted infectious disease experts in community and from that generated a policy. So we got input from lots of sources, CDC, people in the community and then we created a policy.

Q. Did you disbelieve the information contained in Dr. Dattwyler's research that he published regarding sero-negativity at the time or prior to the time you adopted the new corporate medical policy on Lyme disease?

A. It was early research. It was a very small group of patients and we assumed it was insignificant.

Q. Did you contact Dr. Dattwyler or did

R. Sanchez, M.D.

you or anyone else to your knowledge at Empire contact Dr. Dattwyler or anyone he was working with at Stony Brook to question him about his research on sero-negativity and Lyme?

A. To my knowledge, no.

Q. Did Empire have the view that if you didn't meet the criteria in any of its corporate medical policies for any given disease or condition that you didn't have the disease or condition?

A. Correct.

Q. Was the cost of health care and reducing the cost of health care for Empire a factor in adopting the new corporate medical policies that you brought in to play at Empire?

A. Yes.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 1414. We are going off the record.

(Whereupon, there is an off-the-record discussion.)

THE VIDEOGRAPHER: The time is 1415. We are back on the record.

BY MR. MAURER:

Q. I'm not sure I asked this question, forgive me if I'm repeating myself. I just want to make sure I cover this point.

When the corporate medical policies were adopted that you brought in when you came into Empire did you have any expectation that there would be patients, not just Lyme disease patients, but patients in each of the disease or conditioned areas that were the subject of these new corporate medical policies who did not meet the criteria in the policies who still had the condition or disease that was the subject of any given policy?

A. What is the question? You made a statement. Did I have any expectation?

Q. That there would be some people that didn't meet the criteria who still had the disease or condition that the corporate medical policy covered?

A. Of course. May I elaborate?

Q. Sure.

A. For example, there was a time when we would consider transplantation of bone marrow in a woman with advanced breast cancer. On our

review of the literature showed that this was experimental in the latter stages. We rewrote the corporate policy so that we made it only a benefit or coverable expense in the earlier stages. When you rewrite that kind of policy or procedure, you know full well you have people with breast cancer in advanced stages that no longer have a benefit for that coverage, so you would be naive to think they don't exist anymore or that are not going to get treated, they have the disease but they no longer candidates for the benefit.

Q. The motivation for doing that with these different corporate medical policies was what?

A. There were several. First, and foremost, there was no scientific evidence that it changed the outcome. In the example I just cited that women still died, there was no scientific evidence in that.

Secondly, and importantly, but not as important as that, is that this was a huge expense for the company to provide this care for something that was futile, there was no evidence

that it was going to help, or more importantly it was being inappropriately applied to a misdiagnosis.

Q. While you are on that particular subject and that condition, were you aware of any evidence to support the conclusion that what was called experimental treatment in that particular condition was a condition where the patient still could have their life extended if not saved?

MR. DRISCOLL: I object to the form of that question.

Q. Did you understand the question, Doctor?

A. No. Would you repeat it for me, please.

Q. Sure. You said earlier, to paraphrase, that the people were going to die even if they got the treatment and therefore it was considered experimental; is that correct?

A. Correct.

Q. Earlier on today I asked you if it would be experimental even if there wasn't a cure but there was some benefit and you, I believe told me, that if there was a medical benefit then

it might not be considered experimental; is that true?

A. A medical improvement, an improvement in the long-term course of the disease, either interrupting the destruction or the disease process or accelerating a cure.

Q. Now, with regard to the breast cancer you were just talking about, where this treatment was considered experimental and you modified the corporate policy as you told us, did you have any knowledge of the fact that some people had their life extended if they received the treatment even if they ultimately died, did you know that?

A. Yes.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 1419. We are going off the record.

(Whereupon, there is an off-the-record discussion.)

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 1420. We are back on the record.

BY MR. MAURER:

Q. By the way, if a patient was denied

R. Sanchez, M.D.

authorization for treatment because they didn't meet the criterion in one of these new corporate medical policies that you adopted at Empire and they self paid for the treatment and the treating physician submitted a subsequent letter of medical necessity requesting approval for further treatment and that letter of medical necessity was coupled with information that showed that the patient benefitted, they improved but were not cured as a result of the treatment they paid for that you denied, would that information be considered in determining whether or not the treatment was experimental with the next application that the doctor made for approval?

A. Sometimes.

Q. And sometimes not?

A. Mostly not.

Q. Why not, why mostly not?

A. Because we were still wrestling with whether the diagnosis was appropriate, whether the improvement was for spontaneous remission of another disease or that there may have been some palliative affect of the treatment but there was no real -- there was not going to be a change in

R. Sanchez, M.D.

the course from our evidence -- from our research.

Q. Now, if somebody had a denial given to them for prescribed intravenous antibiotic treatment of Lyme disease was there an appeal process that existed generally?

A. Yes, it was that one we discussed very early this morning.

Q. Eventually would that appeal, if there continued to be denials, lead to a review by a doctor within the company?

A. Yes.

Q. These were salaried doctors who worked for Empire?

A. Correct.

Q. Were those salaried doctors that worked for Empire required to use any particular criteria in deciding whether or not to reverse the denial or sustain the denial of the prescribed IV therapy?

A. They were required to use Empire's medical policies and either the InterQual standard or the Millman & Robertson standards that we used.

R. Sanchez, M.D.

In addition, we expected of them to have a knowledge of the literature and in many cases if it was their own specialty, to be experts or semi-experts in the disease that we were asking them to review.

Q. Does that mean that you expected these internal doctors to have any sort of substantial experience in diagnosing and treating Lyme disease?

A. No.

Q. So if they were an infectious disease doctor by training is that what you meant?

A. Yes.

Q. Sometimes were the reviews conducted at Empire's request by outside consultants who were not employed full-time as salaried physicians internally but worked as outside consultants?

A. Yes. And we were moving more toward that before I left.

Q. With regard to those particular doctors was it necessary for those doctors to have experience in, substantial experience in diagnosis and treatment of Lyme disease for

R. Sanchez, M.D.

Empire, to ask them to do such a review?

A. The panel of our experts was limited to the major specialties, for example, cardiology, infectious disease, rheumatology. We expected that these luminaries in their field would be sufficiently versed in the treatment of Lyme disease just as they were in the treatment of Polio, tuberculosis or other infectious diseases. Was it a Lyme disease expert that was selected, no.

Q. So the outside consulting doctor who Empire would occasionally send files to where a denial of IV antibiotic therapy for Lyme disease was appealed, those doctors were just like the internal doctors, they could be an infectious disease doctor but they didn't necessarily have to be experienced in diagnosis and treatment of Lyme disease; is that correct?

A. They were general specialists in their large field of expertise infectious diseases. They were practicing or held academic positions or were renowned in areas of infectious disease. They were clearly a cut above our internal doctors -- two cuts above our internal doctors

who first reviewed the case or would have denied it.

Q. With regard to the hiring of staff, I believe early on today you said that one of the things you had to do was bring in new staff to work with you in making any changes that were necessary at Empire.

A. Correct.

Q. What kinds of experts did you bring in to work with you?

A. I brought people who were actually experienced in the management and operation of utilization management and medical affairs in managed care organizations.

Q. Did that include a woman named Zenobia Collins-Johnson?

A. Yes. Zenobia Collins-Johnson I selected to be the vice president of utilization management. Her credentials are impeccable in that area. She had responsibility for millions of members in California. She has a Master's, she has an MBA. She also is a very good clinician and did an outstanding job prior to coming to Empire and did an outstanding job at

Empire.

Q. Have you continued to work with Zenobia Collins-Johnson since you departed Empire?

A. No, I have not. I keep in touch with her but I have not had the opportunity to put her on in the salaried position or position where she could work with me again. I would not hesitate to do so.

Q. What was the title that Zenobia had?

A. Vice president of utilization. She was a vice president in the company in the officer or director, delegation, whatever that is. I think it was utilization management, I'm not sure.

Q. What again does utilization management have to do with at Empire?

A. It has to do with assuring the quality, the appropriateness and the expenditure of cost of health care for our members.

Q. Have you ever heard of the group of people that you brought in referred to as the "California posse"?

A. Sure.

Q. What was your understanding of why that was used, California posse, to describe the group?

A. At Empire it was a rather derogatory term used to indite some of the team that came from California because California was where all this expertise existed. So when we sought to put a team together we brought people in with that experience. Could have been from Tennessee, if they had been at the forefront, but anyone in health care knows that managed care is in its most evolved and sophisticated form in California.

So when we sought out people with experience to do what the senior management at Empire wanted to accomplish we went to California. If that had existed in New York, we would have selected from New York. When it did not and we have these people making rather significant changes that derogatory term came up.

Q. Did you have any problem with any part of Zenobia Collins-Johnson's performance of her assigned duties while she was here at Empire?

A. No. I think she clearly was very

loyal to me, to the company and carried on the trying to meet the objectives and the goals that were given to her and her responsibility.

Q. Just digressing for a moment and going back to something we've touched on. With regard to the issue of the number of denials, the rate of denials that were being issued by in-house physicians at Empire, did you personally speak to any of the in-house doctors about that subject?

A. Yes.

Q. What did you speak about?

A. I told them that their contribution was -- I told them that their success in helping us control the cost of health care was almost nonexistent.

Q. What else did you tell them?

A. That they had to improve their contribution.

Q. Did you give them -- did you say anything to them about what would happen, if anything, if they didn't improve?

A. They knew that it would be part of that evaluation and their evaluation would affect their compensation and their longevity in the

R. Sanchez, M.D.

position.

MR. DRISCOLL: I object to that and move to strike the answer as nonresponsive.

Q. Did you make any specific statement to the doctors about their future at the company if they didn't change the denial rate?

A. Yes.

Q. What did you say?

A. I said that it had to come within national standard or they wouldn't be around.

Q. Meaning what?

A. They would not be employed at Empire.

Q. Did you terminate any doctors in that regard?

A. We terminated several doctors.

Q. Did you terminate any doctors for the reason that they did not modify their approach to the issuance of denials as requested?

A. It was, as I said, that part of it was in context of an overall evaluation so it was that plus other portions of their objectives and their evaluation that would have been contributed to their termination.

Many of them resigned, by the way.

R. Sanchez, M.D.

Q. Did any of them tell you the reasons why they resigned?

A. Sure.

Q. Did any of them complain to you about the new approaches that you were taking to the jobs that they had?

A. Yes.

Q. What did they complain about?

A. They complained that they really didn't have the stomach, heart or will to implement the policies or the Millman & Robertson guidelines.

Q. Did they say why they didn't have the stomach, or will, I forget the third word that you said?

A. Stomach, heart or will.

Q. Did they tell you why they didn't have the stomach, heart or will to implement these policies?

A. You have to realize this was a major, to use a term that's overused, paradigm ship for these guys.

Q. When means?

A. They weren't used to that kind of

R. Sanchez, M.D.

behavior and it never been expected of them before. It was a new day and a new team and a new mission and they were uncomfortable with that.

Q. Now, before you adopted these new corporate medical policies affecting these various serious disease and illness groups, did Empire do any investigation and research to look at insured patients' records to determine the impact that the changes may or may not have on the patient's abilities to get treatment, in other words, did you consider the chart information of the patients or was it limited to other information like a statistical data you've told me about?

A. It was the latter. On appeal the chart information would be looked at but not before that, no, and there was no research done prior to the end of that policy, to the formulation of the policy, no.

Q. So what was considered was the statistical analysis, for example, that information contained in the Deloitte & Touche report, among other things?

R. Sanchez, M.D.

A. That was part of it but there was a review of the literature, there was review of what was current, there was review of how to diagnose the problem, there was review of the treatment and all of those modalities.

All of that went into the policy in addition to cost but did you say did we sit there and look at the patients and review their records to see what kind of impact that would have on those patients, no.

Q. Doctor, at the time that you implemented these new business approaches at Empire to reduce the health care costs did you believe or did you have any opinion as to whether or not there was anything wrong with the system you were bringing in?

A. I think the misgivings that I had were not that these weren't appropriate managed care policies and principals. I mean I thought they were not different than other entities' mature managed care.

Q. Did you have any problem with the --

A. Let me finish.

Q. I'm sorry.

A. The misgivings that I had, Mr. Maurer, were two. One, that could we -- did the company have the stomach, will and heart to implement these. I mean, we are already being perceived as the California posse taking over, we were complicating people's, you know, the way they used to do things, we were expecting more out of people. So the misgiving I had is was I creating something that we thought could work but putting it in front of an organization that could not implement it. That was a misgiving I had.

Two, I had a concern about the uniform way we would apply this. I had significant misgivings about that.

Q. What do you mean?

A. Those were the two areas that caused me some concern.

Q. What was it about the uniform application of these new programs and procedures that concerned you?

A. This is difficult. That no matter how effective we thought the policy or process might affect the company positively and no matter how much evidence that if that policy were supported

by the company, that there would always be some exceptions or exceptions made and that for me is a position -- it was a misgiving, a concern that I had.

Q. What do you mean about there being exceptions made? Did the company uniformly apply all the new procedures and policies that you brought in to all insureds and all medical service providers?

A. No.

Q. Can you elaborate, please.

A. That to almost any policy or procedure that had been implemented or had been implemented there would be some exceptions made.

Q. Can you give me some examples of what you are referring to?

A. I don't have any Lyme disease examples.

Q. I'm not asking just about Lyme disease, I'd like to know about its affect on all insureds if you can respond on that level.

A. Empire was and is a very big insurer of the citizens of New York. And its employer groups who pay the premium dollars, whether they

are there government or the unions or the large Empire groups, and the board members all have, pardon me, I'm trying to select my words carefully, constituencies, so that people that were more influential could go around the appeal process and those processes and have things covered that people with less influence could have hoped to.

Q. Can you tell me how this actually would work in your experience at Empire, give me examples of how somebody with influence would be able to circumvent the corporate medical policy and get something approved that the policy wasn't supposed to cover?

A. If an important client or labor leader or member of a board, our board, or a large hospital client would bring pressure to bear upon the senior leadership of Empire we would create an exception or what we call, I think they called it off contract or something, and the benefit would be covered.

Q. Did you ever speak to Dr. Michael Stocker about this or did he ever speak to you about it?

A. Of course.

Q. Well, what can you tell me what you discussed, can you give me examples, please?

A. There was -- there were two sets of discussions. One in which he would call me to tell me of the intervention of some politician or labor leader or member of the board that we were to, you know, take special precautions with this member or this case.

The other is and when I gave him a heads up, that we were denying services on very controversial case or influential person, to give him a warning that there might be pressure coming in. So those were the context of which we had that discussion.

Q. Well --

A. I don't think that those are unusual discussions that a CEO would have with the chief medical officer of an insurance. Company, I think those are common every day, not every day, thank God, but they are part of the job.

Q. Let me ask you this, Dr. Sanchez, with regard to, for example, politicians are you saying there were times when politicians, elected

R. Sanchez, M.D.

officials, contacted Empire and requested that a certain medical service or certain medical service provider have payments made that would not otherwise have been made under the new corporate medical policies?

A. Yes.

Q. Can you name any politicians, elected officials, who did that, can you think of any senators, for example?

A. I can recall them invoking the name of a very important political leader in New York.

Q. Who?

A. Suffice it to say they are elected officials. Remember, Empire is a public, not a public, almost a public institution that has been granted many favors and considerations by the Department of Insurance and Department of Health and the senate and assembly and the governor's office over the last ten or fifteen years and to try to keep it a viable entity for the people of New York.

Q. Dr. Sanchez, excuse me, but I asked you a simple question. Can you please name the elected officials that you mentioned from New

R. Sanchez, M.D.

York who you specifically recall having their names mentioned to you?

A. One is the former Senator D'Amato.

Q. Alfonse D'Amato?

A. Who intervened on behalf of patients not once but several times who would come to his office.

Q. And who told you that?

A. Dr. Stocker.

Q. Dr. Michael Stocker, the CEO president, told you that Senator Alfonse D'Amato had intervened and requested that payments be made?

A. That the benefit be approved.

Q. Do you need to answer that beep, Doctor?

A. No.

Q. Who else do you recall besides Senator D'Amato?

A. I have been out of New York but it was the leader I think of the New York senate or assembly and as soon as I recall those names I could tell you. One of them, the president of the senate or the speaker of the assembly,

R. Sanchez, M.D.

whatever that position is, intervened at one point on a case and we were involved but, you know.

Q. Dr. Sanchez, when you were informed by Dr. Stocker, the head of Empire, that Senator D'Amato had contacted him and requested that some benefit be paid for some subscriber or subscribers who were insured by Empire, did you say anything in response to him to offer any opposition?

A. Yes.

Q. What do you recall saying in substance, if not verbatim?

A. The general gist was I was always against settling these because the history of Empire had been that we had always been -- we had always caved in on those. That I thought we were on sound scientific ground, that I thought we had taken the high road and for us to respond was a disservice not only in a financial sense but an ethical sense to the rest of our membership.

Q. What do you mean by that?

A. Because we were denying services to the person who had no influence and we were

R. Sanchez, M.D.

approving it to the person that did. That is an ethical issue that gave me misgivings very early on. What I'm saying is I communicated that in a subtle way as I could so I think that's an answer to your question.

Q. I think you mentioned that possibly some union officials were among the group who got this different kind of treatment. Do you recall any specific labor officials?

A. No, I don't have that recollection.

Q. What about celebrities, do you recall any celebrities who got different treatment because of pressure that was brought in?

A. No.

Q. Were separate records kept with regard to these insured patients or medical service -- let's just limit it to the insured patients. Did the company keep separate records or separate files for those individuals who had the political connections or clout?

A. Not that I know of. To the extent that occurred it occurred with certain large employer groups or unions that in the process of selling the account they were promised extra

contractual things beyond the benefits that were provided some other account so that those extra contractual, I think was the word that was used, were pretty rampant when I got there and what I asked Dr. Stocker to do immediately was allow me to sign off on those and we were starting to do that. So that a member of those special accounts was somehow made known either through the computer system or the flagging system because they were accustomed to receiving benefits different than the package sold here.

Q. Were there any people insured by Empire while you were at Empire whose records or files were notated or flagged in some way to indicate that payment of prescribed treatment was not to be questioned at Empire?

A. Besides those extra contractuals that flowed through without any question, those were the only ones that I was aware of.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 1449. We are going off the record.

(Whereupon, there is a recess in the proceedings.)

THE VIDEOGRAPHER: The time is 1456. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, I believe you mentioned there were board members who were given this special treatment in terms of coverage; is that correct?

A. Correct.

Q. What board members are you referring to, are you referring to Empire board members or board members outside Empire?

A. These were considerations given to families of Empire board members.

Q. So members of the board of directors, their family, there were instances that you recall where individuals were paid for treatment that was not covered or to be covered under the corporate medical policies in effect for those board members' families, is that what you are saying?

A. In one instance, yes, that I can recall.

Q. Who was that board member?

A. I would have to look at the board. I

don't remember the board member. It was a board member whose spouse had fractured an ankle and somehow ended up in a facility that wasn't one of our approved facilities and was there for longer than she should have been and I got a call from Dr. Stocker to approve that care.

Q. How much did that cost the company, approximately, that you would not have paid or incurred as a health cost under the corporate medical policy in effect, approximately?

A. Less than $20,000. It wasn't -- I don't remember it being an exorbitant amount.

Q. You told me about individuals who got special treatment. Were there medical service providers who received special treatment?

A. Yes. There were like facilities and those.

Q. Tell me about those facilities, please, identify them, please.

A. The one that comes to mind -- these have nothing to do with Lyme disease.

Q. I'm asking you questions about how Empire paid for medical care for individuals or paid for services rendered to medical service

providers in terms of the general public now, Doctor. I'm not limiting it to Lyme disease.

A. Empire was always under a lot of pressure to pay for services that were either denied or we didn't think were appropriate and delivered to a facility or ER and there was an awful lot of pressure from us from those administrators and the one example that comes to mind is a hospital called Calvary.

Q. Was it a hospital?

A. Yes, it's a hospital.

Q. What's the nature of the facility?

A. It's a hospice.

Q. What's the difference between a hospice and a hospital?

A. Well, in both, in a hospital you can provide different levels of care, from ICU care to cardiac care, to medical surgical care, to outpatient care, to long-term care, to hospice care and at Calvary is a hospital that bills, at the time billed Empire for acute care for hospice care level of services.

Q. How did you treat those bills that were submitted?

A. Well, after months and months of investigation and tallying up the millions of dollars that were overpaid, we tried to recoup them, we tried to stop the patients from ending up there and we then tried to renegotiate a hospice rate for what clearly is a hospice hospital.

Q. And what happened?

A. The administrator of Calvary contacted his local politicians and they influenced our senior management to resume paying them for the acute level of care.

Q. Who are you talking about in terms of senior management?

A. It was Dr. Stocker.

Q. Did you discuss with Dr. Stocker the fact that Calvary hospice had billed Empire and was billing Empire at intensive --

A. No, acute rates.

Q. -- at acute rates for hospice services?

A. Yes, sure.

Q. What did you tell them should be done?

A. Two things -- three things. One, that

we should go back and recoup that money as we would any provider that overcharged us; two, that we should limit the admission of our members, we should redirect them to other hospices. There were a lot of hospices that charge appropriately and deliver the hospice care, the same time they were delivering there, and that we should consider negotiating a hospice rate for them so that we could continue to use them if it was such an attractive hospital to our members.

Q. How much money was this costing Empire, this paying for hospice care at a more expensive rate?

A. It was very, very expensive.

Q. How much?

A. In the millions of dollars.

Q. Millions?

A. Yes.

Q. What did Dr. Stocker tell to you do about this?

A. Back off.

Q. Did he say why?

A. That they had -- there was no specific why except that there could be no why. I mean it

was just a political decision that was made.

Q. Was it appropriate to make payments at that rate under the corporate medical policies and the contracts that were in effect?

A. No. It was inappropriate.

Q. You told Stocker that?

A. He knew that.

Q. Did you tell him that?

A. Yes.

Q. How many times did you tell him?

A. This particular example the reason is because these were lengthy conversations.

Q. Where did they take place, where were you and Dr. Stocker when you spoke to him about it?

A. Actually, I think, and if my memory recalls, these occurred in his office but as I recall we actually took Dr. Stocker to Calvary and we took a tour.

Q. Who else was there with you?

A. Me. And I don't know who else was there but I remember that Dr. Stocker and I'm recollecting that we went to Calvary to see what the services were, to actually look in the beds

and we went over there to look. Now, I may be mistaken about that but the conversations took place in his office.

Q. Was this discussed at all with the board of directors to your knowledge?

A. I don't know that. Not on my part.

Q. Where is Calvary?

A. It's in the Bronx.

Q. Do you recall who the politician or politicians were that Calvary contacted which then contacted Dr. Stocker?

A. The name Valone comes to mind.

Q. Peter Valone?

A. He was head of the assembly or senate or one of the bodies.

Q. Peter Valone?

A. Yes. That's why as I recall made the call on behalf of Calvary.

Q. So let me ask you this: Between the insured members of Empire Blue Cross, meaning the people who were insured by the company --

A. Let me interrupt you. I don't think that there's anything wrong with a politician on behalf of his constituents intervening in a

policy dispute.

Q. Do you think there's anything wrong with Dr. Stocker telling you to apply the policies and procedures of Blue Cross/Blue Shield in a way so that people who don't have influence don't get paid in certain instances while people who have influence did get the payments that they weren't supposed to get?

A. I have already said I had great problems with that, okay. At the same time, Dr. Stocker had to make a business decision and a political decision and those decisions, whatever was going on in his head, were not consistent with the way I would have arrived at a decision. But I do not think that if I were an elected politician for me to intervene on what I considered an unfair policy on behalf of a constituent is inappropriate.

Q. But you thought that it was the policies that you had placed in effect were reasonable, didn't you?

A. They were not only reasonable, I thought they were going to keep alive a very valuable asset for New York.

Q. Empire Blue Cross/Blue Shield?

A. Yes.

Q. Between the people you've told me about, the members of the board of directors of Empire, the various individuals who got this special treatment from Empire as well as the medical service providers like Calvary and others who got the special treatment, how much money are we talking about in terms of what it cost Empire as a result of this diverse approach to running the Empire business?

A. I think the big six or big eight, whatever you call it, big six report, and any reasonable person we are talking in this situation millions of dollars.

Q. As a result of the changes you brought into the company after you came to Empire Blue Cross/Blue Shield did Empire save money?

A. Yes.

Q. How much money?

A. From our calculations on our own medical economics kind of unit that we put in depending on the product we saved anywhere between five and fifteen percent of health care

costs that had formally been expended in those products.

Q. Per year?

A. Sure.

Q. So you are --

A. It was an 18-month year probability before we got them all done.

Q. You are talking percentages of a little less than seven billion down to four point something billion dollar amount, is that what you are saying?

A. We reduced the medical loss ratio or the health care expenditure, depending on the product, anywhere between five and fifteen percent. And that was what we called low hanging fruit because it was easily done with just a slight correction in the attitude and in the policies. That was still not enough to turn around Empire's fortunes, they still had a long way to go but it was a start in the right direction.

Q. You left Empire Blue Cross/Blue Shield at some point; is that correct?

A. I left in September of 1996, I

believe.

Q. Prior to leaving did any changes take place in your responsibilities at Empire?

A. Yes.

Q. What changes took place?

A. The areas of medical management, Medicare and chief medical executive those areas were removed and I was placed in charge of the medical services organization.

Q. Did you consider that a demotion?

A. Of course.

Q. How did you feel about it?

A. I was devastated.

Q. Is that -- is any of feelings that you experienced as a result of that demotion causing you to testify about anything that you've testified about here today, is it motivating you in any way?

A. I'm here this afternoon because you said if I didn't show up, I'd be subpoenaed and I'm here to tell you the truth as I recollect it. I have put what happened to me and my people and what I brought to Empire behind me. I'm three years out. It is not something that I lose

R. Sanchez, M.D.

any sleep over anymore.

Q. What happened --

A. If you had not contacted me I would not have given you, New York or Empire a second thought. And as soon as we are finished, I hope that I don't have to ever have to sit down and talk about these things again.

Q. You made reference to what happened to you and the other people, I assume you are referring to the people in the California posse, am I correct?

A. Correct.

Q. What happened to you that you just referred to?

A. Well, not only the Zenobia and Daniel.

Q. Daniel who?

A. Daniel Naranjo, N-A-R-A-N-J-O, Zenobia, my pharmacy director.

Q. Who?

A. I'm blanking on her name. Jerry Adams our Medicare vice president, they were all fired. In fact, Heyward Donigan was fired right after I was so there was a complete cleansing of the managed care area, purge.

R. Sanchez, M.D.

Q. Would it be fair to characterize the group that came in in this California posse as cost cutters in terms of their expertise?

A. I think it would be fair to characterize them as very experienced managers of care of HMO executives and people who could manage care and part of that was clearly their cost -- ability to bring cost savings to an HMO.

Q. Are you aware of the reason why you were demoted?

A. No, I'm not. I asked not only Heyward Donigan who came in for maternity leave to do it I asked Dr. Stocker, I asked our legal counsel at the time, I asked our HR people and the only thing Heyward said was that this had been in the offing for several months and she just had not gotten around to it until she had to come back from maternity leave to do it.

Q. You looked at your personnel file which is Sanchez Exhibit 1 for identification. Is there one shred of information in this entire file that tells you why you were demoted?

A. No. I looked and there isn't.

Q. Did you try to find out from

R. Sanchez, M.D.

Dr. Stocker?

A. I tried Dr. Stocker and Heyward Donigan.

Q. How many times did you try?

A. Three times in a tearful meeting, two times in an anger meeting. These were several meetings that we had over that tumultuous two-week time I told them that I, in good faith, could not accept that demotion. They had created to me a humiliating workplace environment but they would never tell me why.

Q. Were you given a severance package with some compensation at the time that you left the company?

A. Yes.

Q. How much money did you receive in lump sum either in one or multiple payments?

A. I didn't receive any in lump sum.

Q. In total how much did you receive?

A. It was three months.

Q. In total how much did you get?

A. Three times 25,000 a month, maybe $75,000.

Q. Dr. Sanchez, prior to coming here

R. Sanchez, M.D.

today did I inquire of you by telephone if you would be able to come to court in White Plains in the state supreme court in May when this case is ready to start trial?

A. Yes, you did.

Q. What did you tell me with regard to your availability?

A. I told you it would be unlikely, that I have not only a vacation scheduled but I have engagements in the consulting company that I'm working at.

Q. You work where presently?

A. I work in Dallas, Texas.

Q. Where do you live?

A. Dallas, Texas.

Q. How much traveling do you have to do as part of your current job?

A. I'm on the road three or four days a week.

Q. Incidentally, have I compensated you in any way for your testimony?

A. No.

Q. Have I paid for your transportation or your hotel stay?

R. Sanchez, M.D.

A. No.

Q. Other than paying for lunch yesterday and today is that it in terms of what you received from me?

A. That's correct.

MR. MAURER: I have no further questions on direct examination. Do you want to take a brief recess?

MR. DRISCOLL: Fine.

MR. MAURER: Off tape.

THE VIDEOGRAPHER: The time is 1515. We are going off the record.

(Whereupon, there is a recess in the proceedings.)

THE VIDEOGRAPHER: The time is 1524. We are back on the record.

CROSS EXAMINATION

BY MR. DRISCOLL:

Q. Good afternoon, Dr. Sanchez. My name is Justin Driscoll. I represent Empire Blue Cross/Blue Shield. I'm going to be asking you some questions. If you don't understand the question, please feel free to tell me and I'll try to rephrase it.

R. Sanchez, M.D.

First of all, could I see what you brought with you to the deposition today.

MR. DRISCOLL: We can go off tape while I look through that.

THE VIDEOGRAPHER: The time is 1525. We are off the record.

MR. MAURER: Do these materials have anything to do with the lawsuit?

THE WITNESS: No.

MR. MAURER: This is work-related?

THE WITNESS: Yes. Hand scratchings as I take phone messages.

MR. DRISCOLL: Is there anything else in the folder other than what you've given me?

(Pause.)

MR. DRISCOLL: Thank you. Back on tape.

THE VIDEOGRAPHER: The time is 1526. We are back on the record.

BY MR. DRISCOLL:

Q. Dr. Sanchez, after having reviewed the materials that you've brought with you I see there is one page here which is a fax cover

R. Sanchez, M.D.

sheet. I'd like to show you that and ask if you can identify it?

A. Uh-hum.

Q. What is that?

A. This has to do with my deposition.

Q. Who is it from?

A. It's from Zenobia Collins-Johnson.

Q. When is it dated?

A. January 12th.

Q. Of what year?

A. 1999.

MR. DRISCOLL: I'd like to have that marked as Defendant's A Sanchez A.

(Defendant's Sanchez Exhibit A, fax cover sheet, marked for identification, as of this date.)

Q. Forgive me if I fail to make note of it but I didn't hear you say what you are currently doing?

A. I'm a health care consultant.

Q. For whom?

A. I'm an independent contractor.

Q. What is the name of the company?

A. Aztlan Health Care Consulting Group.

R. Sanchez, M.D.

Q. How long have you been employed by Aztlan Health Care?

A. It's a corporation I have had for, it started in California. I've refiled it in Dallas when I moved there.

Q. When was it incorporated in California?

A. In the 1992, very early, maybe even earlier.

Q. So is that a company that continued to do business while you were employed by Empire?

A. No.

Q. How many employees does the company have?

A. One, me.

Q. Currently. Has that been true since 1992 when it was formed?

A. Yes.

Q. Can you describe for me the type of work that Aztlan does?

A. Health care consulting.

Q. What do you mean by that, sir?

A. Managed care consulting. It's like a Coopers & Lybrand or Ernst & Young.

R. Sanchez, M.D.

Q. Am I correct then that you are retained by companies on a project-by-project basis to consult?

A. Correct.

Q. Can you tell me some of the companies that you've consulted for?

A. Most recently the Pace Group in Dallas, Texas.

Q. What is the Pace Group?

A. It is a health care consulting company.

Q. What did do you for that?

A. I did an NCQA audit of an HMO in Grand Rapids, Michigan.

Q. You said before in response to my question that the company was not doing business during the period of time that you were employed by Empire. When did it recommence its business activity?

A. In January of this year, maybe December.

Q. January of 1999?

A. Uh-hum.

Q. What did you do between the time that

R. Sanchez, M.D.

you left the employ of Empire and January of 1999 when you recommenced the business of Aztlan Health Care?

A. I left Empire and worked for a year as the chief executive officer of New York Doctors MSO, an MSO that was forming in Queens, New York.

Q. What is an MSO?

A. Management services organization.

Q. What type of work does an MSO do?

A. It's the infrastructure of a group of physicians or hospitals that take risk contracts from HMOs.

Q. When you say take risk contract, to adopt Mr. Maurer's language, can you put that in layman's terms for me, please?

A. That means that your organization of physicians is willing to take prospective payment and manage care within that prospective payment and thereby taking the risk of over-utilization. To do that they need a management services organization that would provide the infrastructure to pay claims, do utilization management and concurrent review MSO is what I formed in Queens.

R. Sanchez, M.D.

Q. Would that be the equivalent of a health care factor?

A. I don't know what a health care factor.

Q. Fact of taking somebody else's receivables and taking responsibility for collecting those receivables, is it something like that?

A. No, not at all.

Q. How long did you work for that entity?

A. About a year.

Q. What was your title there?

A. President and chief executive officer.

Q. Was that a company that you formed or had they been in business prior to your arrival?

A. They incorporated and been prior to that.

Q. What did do you after you left their employ?

A. I went to Physicians Health Corporation, a PPM company, in Atlanta.

Q. What did do you for them?

A. I did their risk contracting for their specialty physician networks throughout the

R. Sanchez, M.D.

country.

Q. How long did you do that?

A. About a year.

Q. What was your title there?

A. Senior vice president of the corporation and I was president and CEO of the subsidiary called PHC Physician Networks.

Q. Did the business of the subsidiary differ at all from the business of the parent?

A. Yes.

Q. How so?

A. The parent was a physician practice management company that bought the assets of physician practices throughout the country and acquired large oncology and outpatient surgery centers or built them. The subsidiary had to do with bringing revenue for managing risk contracts on behalf of providers.

Q. Could you explain for me what managing risk contracts involves?

A. That means we take -- we, the physician we represent or have a contact with, take a per member, per month capitalization from the HMO and that they are now on the hook for

R. Sanchez, M.D.

Q. So in spite of the fact that he had mentioned to you that he couldn't subpoena you, you decided to cooperate in any event, is that true?

MR. MAURER: Objection. Off tape.

THE VIDEOGRAPHER: The time is 1539. We are going off the record.

MR. MAURER: I think this line of question is argumentative in nature and repetitious and now you are repeating your questions so I object for those reasons and others.

MR. DRISCOLL: Do you have the question in mind, sir -- on tape, please.

THE VIDEOGRAPHER: The time is 1539. We are back on the record.

BY MR. DRISCOLL:

Q. Do you have the question in mind, sir?

A. No.

MR. DRISCOLL: Could you read back the question, please, the last question.

Could you go off tape, please.

THE VIDEOGRAPHER: The time is 1539. We are going off the record.

R. Sanchez, M.D.

(Record read.)

A. Yes.

MR. MAURER: Are we back on tape?

MR. DRISCOLL: On tape, please.

THE VIDEOGRAPHER: The time is 1541. We are back on the record

BY MR. DRISCOLL:

MR. DRISCOLL: Could you read the last question back, please.

(Record read.)

A. Yes.

Q. Getting back for a moment to your employment history, what was the reason for your leaving the New York doctors job that you referred to?

A. The opportunity came up to be -- to develop an equity interest in a new physician practice management company and the venture capitalists that were putting the company together asked me to take a senior management position with an equity position in the new company. It was a better opportunity.

Q. What were the reasons for the departure from the job that followed that job?

R. Sanchez, M.D.

A. In Atlanta?

Q. Yes.

A. The PPM industry or over the 18 months that I was there in the last six months took a big dive and it was very difficult for us to raise venture capitol, so that the senior executives of the company, of which I was a part, decided that we would focus in on oncology and limit our resources in the other areas which was the subsidiary that I was leading and I said that's fine, I still have a lot of stock in the company and I wanted to continue my managed care activities so I looked for a managed care opportunity.

Q. Getting back to your initial discussions regarding this case, you mentioned that there were a couple of conversations over a period of time and eventually you said that you would help; is that right?

A. I don't recall the conversation. I recall that I agreed to a sworn statement.

Q. Did any documents get forwarded to you at any time during that period from the first conversation with Mr. Maurer until you decided to

R. Sanchez, M.D.

give a sworn statement?

A. You mean -- could you be more specific.

Q. Documents regarding this case, were any documents regarding this case where your employment with Empire Blue Cross/Blue Shield get forwarded to you --

A. No.

Q. -- during that period of time?

A. These were phone conversations.

Q. You didn't review any documents before you gave the sworn statement?

A. Review any documents before I gave the sworn statement. I don't recall that I did. I think that was, it was done in Atlanta and with a transcriptionist or a recorder with that. During the sworn statement I think documents, as I recall, documents were handed to me and I looked and she stopped recording and I reviewed the documents.

Q. In between that period of time when you first learned of this case and the time you gave your sworn statement, did you reach out to any either current or former employees of Empire

R. Sanchez, M.D.

taking risk for the provision of all of the services that member would need.

Q. What did do you after you left the employ of that company?

A. I moved to -- I went to Europe and I looked around for a job and I wanted to move west and I got as far as Dallas.

Q. How long of a period of time elapsed between the time you left the employ of this most recent company that you've been discussing and the time that you found your next employment?

A. Two months.

Q. What was that next employment?

A. It was the self-employment, my self-employment. I decided to form a consulting.

Q. Your current employment?

A. Uh-hum.

Q. So that brings us up to date?

A. Correct.

Q. When did you first become aware of Ira Maurer?

A. When he called me about a year ago.

Q. Were you expecting his call when he called?

R. Sanchez, M.D.

A. No, sir.

Q. What did he say to you in that conversation?

A. He said -- he introduced himself as an attorney and that he was representing clients who had a suit against Empire for the care covered by Empire on behalf of these clients of his.

Q. What did you say?

A. I said that's interesting. Why do you want to talk to me.

Q. What was his response?

A. His response was that as chief medical officer of Empire Blue Cross/Blue Shield, that it was under my watch that many of the policies that affected his clients were implemented or changed or --

Q. Did he tell you how he had come to learn of your identity and whereabouts?

A. No.

Q. Did he mention that he had been speaking with any other former Empire employees at that time?

A. He said he had spoken with other employees, I forget who he had spoken to but I don't know how he got my name.

Q. Do you know whether he had spoken with Ms. Collins-Johnson at the time, whether he told you he had?

A. I don't think he had, no.

Q. What did you do next as far as your contact with plaintiffs' counsel after that conversation?

A. He asked me if I would talk to him and I said I didn't feel the need to talk to him, I resisted it. This was, of course, behind me. I didn't want to be part of whatever the suit was. He convinced me that, over another phone call or two, that if I didn't take time to do this in a cooperative way that I would be subpoenaed.

Q. Did he mention to you that you were outside the subpoena range of the court that the case was filed in?

A. I'm not sure what that means. He gave me some -- I don't know what that means.

Q. Did he mention to you that he was unable legally to subpoena you as long as you were in Atlanta or outside the geographic area that the lawsuit was pending?

R. Sanchez, M.D.

A. He discussed something to that effect, I don't recall what it was. I don't understand the legal terms of it.

Q. He did say something to you about that and you decided to go forward and cooperate in any event?

A. I had nothing to hide about our policies or procedures and I chose to give my statement rather than be subpoenaed. I thought that was -- on my terms and in my backyard which is Atlanta.

Q. I thought you just said that he had said words to the effect that he could not subpoena you.

MR. MAURER: Note my objection to the arguing.

A. He did. I mean I was not -- you are asking me if I was outside this subpoena. We did have a discussion of how he was going to subpoena me and get me from Atlanta and all those things, but in spite of that I said I would cooperate rather than try to resist any kind of formal requirement of my testimony and that I would rather do it on my own terms and my own schedule.

to discuss the sworn statement or your plan to give a sworn statement?

A. Yes.

Q. Who did you reach out to?

A. Only one person.

Q. Who was that?

A. Zenobia.

Q. When was that?

A. I don't remember. I called her right after Maurer contacted me. I called her to refresh my memory before the sworn statement, I called her and he we exchanged comments back and forth. So she's was my right-hand person. I depended on her to refresh my memory over a lot of things that we implemented and worked on together.

Q. Were any documents exchanged between you and Ms. Collins-Johnson prior to your giving the sworn statement?

A. No.

Q. Did you have any documents in your possession that you had retained from your service at Empire that you reviewed?

A. No.

Q. Did you reach out to Mr. Maurer or did Mr. Maurer reach out to you either prior to the time you gave your sworn statement to discuss the substance of your sworn statement?

A. No. I knew that we were going to talk about policies and we were going to talk about -- other than that I mean I knew that that was the gist of why they were interested in me doing a sworn statement.

Q. Did that have something to do with Lyme disease?

A. Oh, yes. He told me that in the first ten seconds of the conversation.

Q. What did he tell you?

A. That he represented members that had Lyme disease.

Q. Did he talk at all about Empire's policy with respect to Lyme disease?

A. He said that that was the basis of his lawsuit.

Q. Did he tell you what his clients' contentions were with respect to the Empire Lyme disease policy?

A. I don't know that to date.

Q. Did you discuss with anyone prior to giving your sworn statement what your testimony would be in that sworn statement?

A. No. I mean I talked to Zenobia so she refreshed my memory on lots of things but I didn't know where this was going. I didn't know what it was limited to so we discussed a full range of what we did there over that 18 months and exchanged lots of conversations but I had no idea, and to this date, I don't know who his clients are, each of them singularly.

Q. How many conversations did you have with Ms. Collins-Johnson between the time you first learned of the case and the time you gave your sworn statement?

A. We speak about twice a week.

Q. Would you have spoken at the rate of twice a week, Doctor, during that period of time that I just referred to?

A. Regarding this case I don't remember. We talk about an awful lot of things besides this.

Q. Do you remember how much time passed between the time that you first learned of this

case and the time you gave your sworn statement?

A. It was maybe a month, six weeks.

Q. Would you -- withdrawn.

Would it be fair to say you spoke at least twice a week with Ms. Collins-Johnson during that six-week period?

A. We speak regularly, once or twice a week, yes.

Q. That would have been true during that period of time as well?

A. It will be true way after this case is disposed of.

Q. You mentioned that some kind of materials were exchanged; do you remember what kind of materials were exchanged?

A. I exchanged resumes, we exchanged how I recollected different programs, those kinds of things.

Q. Which resumes were exchanged?

A. I gave her mine, she gave me hers.

Q. Were any resumes exchanged that had anything to do with this particular case?

A. No.

Q. Were any documents exchanged that had

R. Sanchez, M.D.

anything to do with this case during the period of time from when you first learned of the case until the time that you gave your sworn statement?

A. No.

Q. Did anyone tell you some of the issues that you were going to be asked about during your sworn statement?

A. Other than it was going to be about my stewardship of the medical policy, no.

Q. Was there any mention of what particular aspects of the medical policy were going to be discussed?

A. I got the gist that it was going to be something regarding our Lyme disease policy and our catastrophic policies.

Q. Did Ms. Collins-Johnson mention to you at any time that she was going to give a sworn statement in this case?

A. I found that out later on that she was going to be interviewed by Mr. Maurer.

Q. Was that before or after she gave the sworn statement?

A. I think it was -- I don't recollect

R. Sanchez, M.D.

completely but I think it was before she said she was going to speak to Mr. Maurer.

Q. Did you talk at all with her about what her testimony would be in the sworn statement?

A. No. I mean -- the reasons we spoke were about lots of social issues and political issues. We have worked together an awful long time and my conversations to her regarding this was for me to refresh her memory. Her memory, maybe because she's younger or brighter, is much better than mine, although I had nothing to refresh her memory or contribute but she did refresh my memory.

Q. Is it accurate to say then that some of the things that you testified to in your sworn statement were based upon conversations that took place with Ms. Collins-Johnson?

A. I'm sorry, repeat the question.

MR. MAURER: Objection to form.

Q. Were some of the things that you said in your sworn statement based upon your recollection that had been prompted by conversations with Ms. Collins-Johnson?

R. Sanchez, M.D.

A. They were my recollections.

Q. Were they recollections that she had helped you make?

A. In some cases I'm sure, you know, put the timing and those things. I wanted to be as accurate and truthful as I could on my sworn statement and I saw no reason -- perhaps maybe you are indicating there is some reason that I shouldn't have contacted her -- but I saw no reason that I could not to insure the integrity of my sworn statements that I could not refresh my memory.

Q. Did Ms. Collins-Johnson indicate to you that she was communicating with any former Empire employees?

A. No.

Q. How about current Empire employees, did she mention to you that she had been in contact with any current Empire employees?

A. I don't think there's anybody left that we know.

Q. After the time that you gave your sworn statement when was the next time that you had any contact with Mr. Maurer or anyone from

R. Sanchez, M.D.

his office?

A. Right before -- the week before trying to schedule this meeting.

Q. Within the last few weeks?

A. He sent me a copy of my sworn statement. After that I thought you all would settle it or whatever but I didn't receive any further contact until he told me that this was coming close to trial and you needed me to be available for a deposition. I said, wait a minute, I thought the sworn statement would have sufficed and he said no, that I needed to be part of the deposition and he would schedule that as soon as possible but certainly wanted to do it before the end of March. So I would assume sometime during that period, December, January. It took us a while to schedule this date.

Q. Between the period of time that you had that conversation regarding scheduling of this deposition and today have you had occasion to speak with Mr. Maurer or any representatives of his office?

A. Except for the lunch yesterday. I have never met the other two representatives.

Q. Did you call them to tell him that you were in town?
A. No.
Q. When did you schedule the lunch?
A. The lunch was scheduled when they called my office. I told them I would be available on the early part of this week, that's when the luncheon was scheduled.
Q. When did that conversation take place?
A. Two weeks ago.
Q. Did anything else take place in that conversation other than setting up a lunch date?
A. No.
Q. Was any material sent to you at any time during the time that you took your sworn statement until the time that you spoke a couple weeks ago?
A. At the receipt of the sworn statement and receipt of a document requesting my personnel file, release of my personnel file that was signed and sent.
Q. Is that it, is that everything?
A. (Witness nods.)
Q. You said you had this lunch

yesterday. What took place at the lunch?
A. We discussed what the process would be like today.
Q. Did you talk at all about the questions that you were going to be asked?
A. No.
Q. Not at all?
A. We were going to be discussing the policies, how I implemented them, the Ernst & Young report --
Q. The Deloitte & Touche report?
A. I'm sorry, the Deloitte & Touche, and the personnel record.
Q. So those were the areas that were indicated to be subject of the testimony today?
A. Correct.
Q. Was there any discussion about what would be asked within the context of those different areas?
A. Not specifically but I don't recall.
Q. What about with respect to the Deloitte & Touche report and circumstances surrounding that report, did that come up at the lunch?

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

BY MR. DRISCOLL:
Q. Dr. Sanchez, did anybody show you a copy of report at the lunch yesterday?
A. No.
Q. So the first time you saw it was when --
A. He might have had it in his briefcase but he never handed it to me for a review.
Q. Was there any discussion about the contents of the report?
A. I knew the contents of the report.
Q. So the answer was no there was no discussion about the contents of the report?
A. Except that he would be asking me about it, that he had finally obtained a copy and it would come up today.
Q. Were there any questions posed to you, and by that I mean practice questions, during the lunch or at any time up until today?
A. No.
Q. Did you indicate what any of your answers would be to any of the questions that were asked of you that -- that would be asked of you?

R. Sanchez, M.D.

A. I don't believe. My consistent message was it would be to my best recollection and the truth.

Q. What other subjects were discussed at the lunch other than the Deloitte & Touche report?

A. The process, the punctuation, that this would be my last involvement in this, that I really didn't want it to go on any further. I wanted to put it behind me and I wasn't happy to be here and those things and I hoped this would end, this would be it, and that given the opportunity for both sides to depose me that that should be it.

Q. You testified earlier that in addition to the report there was some discussion about Empire's policies and procedures; is that right?

A. Yes. Those that occurred over the preceding phone conversations and the sworn statement and yesterday that I would be asked to recall my contribution and give my opinion about the policy at Empire.

Q. Were any documents other than the Deloitte & Touche report, which you've said was

R. Sanchez, M.D.

not shown to you at lunch, were any other documents shown to you at lunch?

A. Those policies that we referenced earlier, the 1990, 1993 and 1995.

Q. The Lyme disease policies?

A. The Lyme disease policies.

Q. Anything other than those three documents?

A. Not that I recall.

Q. Were there any discussions between the period of time of yesterday's lunch and your testimony today?

A. No.

Q. So you didn't speak at all last night or this morning before your testimony began?

A. He called me at 10:00 a.m. when I was late, he called me on my cell phone and asked where I was. I told him I was in a cab on my way here.

Q. When was the last time you spoke with Ms. Collins-Johnson?

A. I think it was probably yesterday.

Q. What was the substance of that conversation?

R. Sanchez, M.D.

A. That I had given her name to a headhunter that was going to call her and that she should take the call.

Q. Was there any discussion of your testimony today?

A. I told her that I was here and that I was going to do the deposition today.

Q. Did she talk to you at all about her scheduled deposition?

A. No.

Q. She didn't mention that at all?

A. No.

Q. You testified earlier that one of the things that you were going to be asked to do when you came to Empire was to go be "passionate about high-quality care" responsive to the concern of patients and providers and sympathetic to the needs of the chronically ill.

Do you believe that you were all those things during the period of time that you were with Empire, don't you?

A. Yes.

Q. You've talked about the tabulation of denials and keeping track of denials. Are you

R. Sanchez, M.D.

aware of any process whereby denials are tabulated for Medicare purposes?

A. No.

MR. MAURER: Excuse me, Justin, your microphone isn't on.

MR. DRISCOLL: Thank you.

Q. During the early days of your discussions with Mr. Maurer about the case prior to the time of your sworn statement as opposed to your testimony today, did you speak at all to Jeffrey Chanceler of Empire?

A. Jeffrey called me within a few days or weeks after I spoke to Mr. Maurer.

Q. He asked you whether he could speak to you as well, didn't he?

A. He asked if he could represent me and he asked if he could -- he didn't ask to speak with me.

Q. Did he ask you if he could participate in a sworn statement?

A. Not to me, no.

Q. Did he ask you if you would --

A. I assumed he would be there but he wasn't. It didn't matter to me whether he was

there or not, I didn't want his representation.
Q. Isn't it a fact, sir, that you told him that you would speak with him as long as it was okay with Mr. Maurer?
A. I think what I said is you need to ask Mr. Maurer if he wants you present at the sworn statement. It didn't matter to me.
Q. Did he ask you what you were going to say in your sworn statement?
A. Jeffrey did.
Q. He did?
A. No, I don't recall that, no.
Q. Isn't it a fact, sir, that in that conversation you told him that you hated Mike Stocker?
A. No, that's not true.
Q. Isn't also a fact that you told him that Mike Stocker had taken money from you by not paying your bonus?
A. No, that's absolutely wrong.
Q. Is it --
A. What I did say is that I thought that I was treated very unfavorably with corporate counsel in the room who should have been looking

out for me and the company and that I didn't trust corporate counsel to ever represent me again and that's what he was trying to do. He was trying to represent me in this action and I said no, thank you, I have had my full -- my fill of the way you've represented me and I didn't think I was treated fairly and he understood that. That's all that was about.
Q. Isn't it also a fact that you told him that you hated Empire?
A. No.
MR. DRISCOLL: I'd like to have marked as Defendant's B, a document entitled Separation Agreement and General Release. I'd like to go off tape as the reporter marks that document.
MR. MAURER: It's already in the personnel file.
THE VIDEOGRAPHER: The time is 1609. We are going off the record.
(Defendant's Exhibit B, document entitled Separation Agreement and General Release, marked for identification, as of this date.)

MR. DRISCOLL: On the record, off the tape. Let the record just reflect that this document is also contained in the personnel file that was previously marked.
Back on tape.
THE VIDEOGRAPHER: The time is 1611. We are back on the record.
BY MR. DRISCOLL:
Q. Dr. Sanchez, I'd like to show you what's been marked as Defendant's Exhibit B and ask you if you can identify that document?
A. Uh-hum. It's the separation agreement when I left Empire.
Q. Is that your signature on the last page of the document?
A. Yes.
Q. You testified in your direct examination that you were paid a sum of money in connection with the separation from the company or severance. Is the amount set forth in paragraph four the amount that you received?
A. Yes.
Q. You said before that you are not being compensated at all by plaintiffs' counsel for

your presence here today?
A. No, I'm not.
Q. Are you up here on other business?
A. Yes, I am.
Q. You've testified as to your understanding of the policies regarding intravenous antibiotic treatment of Lyme disease; is that right?
A. That's correct.
Q. Do you consider yourself an expert in Lyme disease?
A. No, I do not.
Q. Do you know enough about it to know that there is a dispute within the medical community as to the efficacy of antibiotic therapy beyond 30 days?
A. I knew at the time in 1995 that there was a dispute among the efficacy.
Q. There was a substantial amount of literature, was there not, that IV antibiotic therapy beyond 30 days was not efficacious?
A. That's correct.
Q. That was one of things that you considered in putting together the Lyme disease

R. Sanchez, M.D.

policy?
A. That's correct.
Q. Intravenous antibiotic therapy is risky, is it not?
A. There are some risks, yes.
Q. Some of those risks would be an infection at the entry port; is that correct?
A. Correct.
Q. There are also side affects or possible risks with respect to colitis; is that true?
A. Yes, to the antibiotic, yes.
Q. And with respect to the one drug that you mentioned earlier Rocephin, there's potential risk of gall bladder problems with respect to that treatment, is there not?
A. Those are rarer risks and anaphylaxis or allergic reactions or super infections with other microbes but, yes, there's risks.
Q. The other things that you just mentioned are they additional risks that might be caused by intravenous antibiotic therapy?
A. Yes.
Q. Isn't it a fact that in determining

R. Sanchez, M.D.

whether to prescribe intravenous antibiotic therapy one would weigh the risks associated with that therapy against the potential benefit of that therapy?
A. One would.
Q. If there was no proven benefit to the therapy and that was coupled with risk the physician would err on the side of not prescribing the therapy due to the risk and the unproven benefit?
A. In any therapeutic intervention you also weigh the risk and the benefit. The benefits have to outweigh the risks.
Q. Now, at the time that you put together the Lyme disease policy, and I think you said it was sometime in 1995, you believe that to be the right approach to the treatment of Lyme disease, did you not?
A. We believed it to be a workable approach. I mean right is a, you know, I don't know if it's a religious term or not. We thought it was a sensible approach.
Q. You wouldn't have put together a policy that was -- that ran counter to the things

R. Sanchez, M.D.

that you described initially that you were going to do when you came to Empire?
A. No, I wouldn't have.
Q. By that I meant the three items that you had mentioned, the high quality -- passionate about high-quality care, responsive to concerns of patients and providers and sympathetic to the needs of the chronically ill. You wouldn't have put together a policy that was inconsistent with those three things?
A. No, we would not.
Q. You said that you were familiar with Ms. Collins-Johnson and her employment at Empire and that you were happy with her service; is that right?
A. Yes.
Q. Were you aware of an issue that occurred with respect to her use of her secretary for baby-sitting?
A. No.
Q. You were not aware of that?
A. I was not aware of that.
Q. She never told you anything about that?

R. Sanchez, M.D.

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

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

Q. Isn't it true that one of the things you considered was where Empire stood vis-a-vis the rest of the industry?
A. Sure. You use those benchmarks to compare your success.
Q. So you agree then --
A. That was our mind, it was a personal goal.
Q. I understand. One of the things that you considered was the fact that Empire's costs were, to use your language in this answer, very, very high; is that right?
A. Correct.
Q. You also went to on to say on page 12 that the denials by medical directors were way, way below the national average. That was also something that you considered?
A. Correct.
Q. This was part of your plan, to bring better utilization and quality care to your members; is that right?
A. It was part of the plan, yes.
Q. Part of that plan?
A. Yes.

Q. One of the things you also wanted to consider and did consider was whether your policies stood up to, as you described it, scientific scrutiny; is that right?
A. Correct.
Q. By scientific scrutiny you mean looking at what the medical literature is, the peer review literature, and making sure that whatever Empire does is consistent with that literature?
A. Consistent with the consensus of the research and literature. You cannot in a topic as controversial as Lyme disease or bone marrow transplant for breast patients get consistent medical literature. You try to arrive at a consensus and you try to create a policy that's defensible within the literature and research that exists.
Q. One of the things that you are looking at, of course, I would think would be what the consensus was of the medical community in the literature?
A. One of the factors you would take is the standard of practice in the community.

Q. That would involve looking at what the consensus of the medical opinion was in the community; is that right?
A. Yes. The way physicians practice in that community, yes, it's one of the factors you consider.
Q. Would it also include taking into consideration the consensus of studies on a particular topic?
A. Yes, sir.
Q. Those are things that you considered in putting together the Lyme disease policy?
A. Correct.
Q. Going for a moment to this question of the incentive compensation that you referred to in your direct examination. It's not your testimony, is it, that people receive some benefit for denying a particular claim?
A. Not a particular claim, no.
Q. Isn't it true that what the incentive compensation program was about was trying to broaden the participation of people in the bottom line performance of the company?
A. That's true.

R. Sanchez, M.D.

Q. And you said, I think, certain senior management people and at certain levels, not everybody, but certain levels of the employment structure at the company would participate in some way in the bottom line performance of the company?

A. The bottom line performance of the company was one of the criteria for a segment of several segments on which your evaluation and your incentive compensation was based. So you had to predetermine everyone that was an executive or manager and above or director and above, I forget where the cutoff was, knew that x percentage of their base salary would be eligible for incentive compensation. That x percentage, you never received 100 percent of that because it was impossible to meet almost all the criteria at a hundred percent, you might only get 50 percent on A, 100 percent on B and only 30 percent on C. You could have received up to, in my case, 40 percent, you received less because maybe the company didn't meet its overall goals. So there were a lot of factors that were formulated, taken into account in that, but the reduction and the

R. Sanchez, M.D.

cost of health care was one of them.

Q. But when someone reviewed a claim they weren't incentivised to deny that claim based on the incentive program?

A. They were incentivised to make sure that before they approved of that claim it met medical policy guidelines, and the diagnosis was appropriate and the therapy was appropriate and that it matched our new criteria from InterQual or Millman & Robertson. They knew that adherence to those things was part of what we were going to look at in the year evaluation of that.

Q. What you are saying is they were incentivised to discover inappropriate or medically unnecessary claims?

A. Correct, for sure.

MR. DRISCOLL: Off tape for a moment.

THE VIDEOGRAPHER: The time is 1630. We are off the record.

(Whereupon, there is a recess in the proceedings.)

THE VIDEOGRAPHER: The time is 1633. We are back on the record.

BY MR. DRISCOLL:

R. Sanchez, M.D.

Q. Dr. Sanchez, you were referring before to certain instances where the larger clients may have come to the company and asked for some variation, I guess, of the policy and that Empire went ahead and approved those variations. Is that something known as an extra-contractual payment?

A. I think the extra-contractual payment is different. The extra contractual that you are referring to has to do with a policy -- a process in which you go back to the employer and say, you know, we have one of your employees asking for this, it's not a covered benefit. The employer has a right to go into an extra contractual and say I'll pay for it and you just bill me for it, I'm going to cover it, it's a valued employee, it's a service. There are those. That's not what I was referring to.

Q. So --

A. What I was referring to was direct pressure to go around medical policy or claims policy and pay claims where the benefit wasn't covered. We were not going to get compensation later from the employer in the extra-contractual

R. Sanchez, M.D.

process that I just described.

Q. You know that to be true of the instances that you mentioned, that the employer or whether it was an union or a company, they did not contribute in any way toward the payment of the benefit that they sought?

A. Yes. There's no way they could have.

Q. Why is that?

A. Because we compensated the provider, the hospital, the physician. We cut a check to them and everything was square. There was no way to rebill them for whatever we did in that accommodation.

Q. Isn't it a fact, sir, that when Empire is approached on an extra-contractual basis Empire will go ahead and perhaps make a variation because the money is coming from the employer as opposed to Empire?

A. That's correct. In that extra-contractual process there is an understanding that the employer will make up and pay it. I don't know how effective that was in going back and collecting it, I never saw that. We in medical management didn't like that, that

R. Sanchez, M.D.

that would occur. But that's a different process than what I was describing.

Q. Thank you.

What would you have done if you learned that treatment that was covered by the policy and medically necessary was being denied?

MR. MAURER: Objection. Off tape.

THE VIDEOGRAPHER: The time is 1637. We are going off the record.

MR. MAURER: It calls for speculation.

MR. DRISCOLL: If he can answer it.

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 1637 and we are back on the record.

BY MR. DRISCOLL:

A. If it was a covered benefit we were obligated to pay for it and we were obligated to insist that our providers provide the service as we could enforce the contract.

Q. So that if you learned that somebody was denying treatment in that situation that would be inconsistent with medical policy; isn't that right?

R. Sanchez, M.D.

A. It would be inconsistent with our whole contract with the employer.

Q. So if you learned that you would report that person or see it to that that person was disciplined in some way?

MR. MAURER: Same objection.

A. Yes.

Q. Dr. Sanchez, the statement that Empire during your time there ruthlessly disregarded the consequences of its decisions, that's a false statement, isn't it?

A. Where is that statement?

Q. I just gave it to you. Would that have been a false statement?

A. Did I make that statement?

Q. No. Would that have been false?

A. I'm sorry.

Q. Ruthlessly disregarded the consequences of its decisions, that's a false statement, isn't it?

A. It's a stronger statement than I would say.

Q. That would mean in your view it would be false; isn't that right?

R. Sanchez, M.D.

MR. MAURER: Objection. Asked and answered.

A. You have to give me in the context. You have given me a phrase within the context of I don't know what the discussion was.

Q. Would that be an appropriate characterization of what you were doing while you were at Empire?

MR. MAURER: Same objection.

A. Ruthlessly disregarding the consequences of my --

Q. -- of your decisions.

A. If you are asking me was my conduct at Empire describable by ruthlessly disregarding the consequences of my decision, I would deny that.

Q. The statement that Empire during your period there put costs ahead of patients' health, that would be false, too, wouldn't it?

A. We were -- we had a contractual obligation to pay for benefits covered by employers and we had an obligation to create a policy so that we could compensate the providers for the covered benefits to our members.

To the extent that there were

R. Sanchez, M.D.

conditions or diagnoses or services requested that were not covered benefits, we denied those. We denied them and we denied them. They may claim that their health suffered or their very lives suffered. They weren't a covered benefit, it wasn't in our medical policy and the employer had not paid the premium for that benefit, that's the way we interpreted that.

Q. What you were looking to ferret out was in your period of time at Empire was payment for services that were not covered benefits; isn't that right?

A. Not covered benefits or being applied to the wrong diagnoses?

MR. DRISCOLL: I'd like to have marked as Defendant's C, I believe, a document entitled General Release. I'd like to go off tape while the reporter marks that document.

THE VIDEOGRAPHER: The time is 1643. We are going off the record.

(Defendant's Sanchez Exhibit C, document entitled General Release, marked for identification, as of this date.)

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

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

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

R. Sanchez, M.D.
suspension was implemented because Empire was experiencing medically unnecessary and experimental treatments with respect to Lyme disease claims; isn't that also correct?
A. The new codes were implemented to be sure that there was physician review of any new Lyme disease diagnoses and request for treatment as per that policy that you are referencing and the whole impetus to change the policy was that we were incurring extraordinary costs for the treatment of Lyme disease.
Q. Isn't it also true you were experiencing that cost on claims that were frequently for services that Empire believed were medically unnecessary or experimental treatments?
A. Correct.
Q. So it wasn't a code assigned to simply identify and slow down Lyme disease cases just because they were Lyme disease as opposed to some other illness, it was because Empire was experiencing a problem in the handling of Lyme disease claims?
A. Lyme disease was selected because it was one of the high costs claims that

R. Sanchez, M.D.

precipitated a lot of costs in claims and those were flagged to make sure that the scrutiny was brought upon those claims to make sure they didn't adhere to policy and the diagnosis was correct.

Q. So Empire was experiencing cost within the context of claims that under its policy many times were medically unnecessary or experimental in nature?

A. It was our opinion, yes.

Q. In fact, you used the phrase "overzealous treatment" as something that was associated with Lyme disease treatment; isn't that correct?

A. Correct.

Q. Sir, there was nothing arbitrary at all about Empire's Lyme disease policy; isn't that right?

A. I used the term arbitrary when we were talking the 42 days.

Q. That's not arbitrary t all, is it, that's a number that was based on medical review and peer literature that you said you considered?

R. Sanchez, M.D.

MR. MAURER: Objection.

Q. Isn't that right?

A. The number -- in my use of the word arbitrary means that it could have been 40 days or 45 days, and if you look at treatment modalities are divided up into weeks and we had to pick one and we had to pick one that seemed to match the literature and everybody else on what the definition of early disease and late disease and we picked that at around six weeks. When you could classify a Lyme disease person in the early stages as opposed to into the late stages.

Q. Then you would agree with me that it was not simply picked out of the sky, it was based upon the medical literature that you reviewed?

MR. MAURER: Objection. Asked and answered.

A. As I said, whether it was 42 days or 45 was what I meant that made it arbitrary. Somewhere in the six-week period we had to define.

Q. You didn't pick a year or two years?

A. No. The course of the disease tends

R. Sanchez, M.D.

to move it into a month period and beyond a month period so in that range.

Q. Now, this California posse that you referred to that included a relative of yours, did it not?

A. No, sir.

Q. Was there someone that was part of your staff at Empire that you were related to?

A. No, sir.

Q. No one?

A. No. ?

MR. DRISCOLL: Off tape for a moment, please.

THE VIDEOGRAPHER: The time is 1652. We are going off the record.

MR. DRISCOLL: Back on tape for a moment.

THE WITNESS: Wait a minute there was one, not on my staff.

THE VIDEOGRAPHER: The time is 1653. We are back on the record.

BY MR. DRISCOLL:

Q. Did you want to clarify your answer?

A. Yes, I did. There was no one related

R. Sanchez, M.D.

me. There was a brother-in-law that was brought from California as part of Jerry Adam's team. That was a tag team that we had together at FHP. I had nothing to do with his hiring and bringing him to board. That's the only -- if you consider that a relative .

Q. I know you have to break for a conference call at this point.

A. It won't take very long and I appreciate your consideration in this. I'll be glad to come back.

MR. DRISCOLL: Could we go off tape, please.

THE VIDEOGRAPHER: The time is 1653. We are going off the record.

(Whereupon, there is a recess in the proceedings.)

MR. DRISCOLL: Back on tape, please.

THE VIDEOGRAPHER: The time is 1704. We are back on the record.

BY MR. DRISCOLL:

Q. Dr. Sanchez, in response to one of Mr. Maurer's questions I believe you said that Empire did not do any investigation to determine

R. Sanchez, M.D.

what impact changes would have on patients and didn't review chart information on these particular patients that were in the Empire pool at the time, correct?

A. Correct.

Q. Isn't it a fact that one of the principal reasons why that would not have been done was because any claims made under the new policy would be examined by claims personnel and if the claim was denied and it went for review there would be a review of the medical chart at that time?

A. Mr. Driscoll, I understood the question was did we do any research in looking into the clinical care of these patients up until the modification of the policy and I answered no, we did not. We didn't -- I think he was asking did we consider the impact on the patients by reviewing and investigating doing research on those patient charts, we did not. You are absolutely correct and in going forward they would all pop in because on appeal we would get all that information.

MR. DRISCOLL: Thank you very much. I

R. Sanchez, M.D.

have no further questions.

REDIRECT EXAMINATION

BY MR. MAURER:

MR. MAURER: This is Ira Maurer on re-direct.

Q. Your last response, Doctor, has to be considered, doesn't it, in the context that the fact that not all insured patients will go through the appeal process, true?

A. Absolutely, that is true.

Q. So the review of the charts would not take place for all cases where there was a denial issued, correct?

A. That's correct. It would have to be the squeaky wheel either by a physician or member.

MR. MAURER: There's a call for Mr. Driscoll. Let's go off tape for a moment.

MR. DRISCOLL: Off tape and off record, please.

THE VIDEOGRAPHER: The time is 1706 and we are off the record.

(Whereupon, there is a recess in the

R. Sanchez, M.D.

proceedings.)

MR. MAURER: Back on tape and record.

THE VIDEOGRAPHER: The time is 1708. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, with regard to review of insured patient's medical charts, did such a review normally take place at Empire before there was a denial followed by an appeal?

A. Before there was a denial?

Q. Yes.

A. No, no.

Q. With regard to the use of the computer codes and the automatic suspension that would take place with the Lyme disease as a result of some of the changes you brought in, would I be correct that this was something that applied in some instances but this is not something that happened across the board; is that correct?

A. Could you rephrase the question. I'm sorry, Mr. Maurer, it's been a long day.

Q. I'm sorry, I have a habit of sometimes not making sense especially at the end of the day, I apologize.

R. Sanchez, M.D.

With regard to the use of computer codes to identify and flag Lyme disease under the new procedures that you brought in to Empire, you told us that that would result in an immediate suspension of payment of any claims until there was a review of the file; is that correct?

A. Correct.

Q. That happened with other high cost illnesses; is that true?

A. It happened with anything that we wanted it to happen. It could happen with a certain provider that we thought was suspicious that was overbilling us or fraudulent. It could happen with a certain clinic or lab that we thought so. We could put those flags on any that claim through.

If you recall, the policy was written so as to from going forward new diagnoses would hit this code and it would then flag and come out and it couldn't be processed or paid until it came out. That was the intention of that new flag. And for Lyme disease, those codes started on whatever date it referenced there moving forward.

Q. So this happened with some but not all claims. Only the selected ones?

A. Only those that were referenced in the letter. New Lyme disease cases was the sentence we used.

Q. You also used other flagging codes for other high cost items as a way of controlling the high costs; is that correct?

A. We spent an awful lot of time working with our case management and utilization nurses to pay attention to the high cost diagnoses and I don't know if they were all formally flagged but they knew clearly before they approved an $80,000 procedure that it was one of those that we were going to scrutinize.

Q. Now, you were being asked some questions by Mr. Driscoll about the use of incentives, I think he used the word incentivised, whether or not employees were incentivised.

A. That's a new verb in managed care language.

Q. I'm not familiar with that one.

Let me ask you this: As part of the

policies and procedures that you implemented at Empire was there as part of this incentive a situation where the caseworkers and the doctors at Empire had this incentive to deny intravenous antibiotic therapy where there was no positive ELISA coupled with a positive Western Blot test, was that part of the incentive program indirectly?

A. They -- indirectly, I mean if you put the word indirectly in there, adverb or adjective, indirectly, of course, if they were able to weed out inappropriate or overzealous or over-utilized care and save on Lyme disease, what the benefits we were providing, those types of Lyme disease diagnoses, it would have reflected in a lower cost of health care and would have been part of the factor that we took in to their incentive compensation.

MR. MAURER: Off tape, please.

THE VIDEOGRAPHER: The time is 1712. We are going off the record.

MR. DRISCOLL: Are you looking for something I marked?

MR. MAURER: No, I just want to look

at the language for one second.

MR. MAURER: On tape.

THE VIDEOGRAPHER: The time is 1714. We are back on the record.

BY MR. MAURER:

Q. Dr. Sanchez, you were asked questions by Mr. Driscoll regarding what I asked you earlier about the 42-day cutoff, the measure from date of onset. Do you remember those areas?

A. Correct.

Q. I believe you told me earlier in direct examination that a Lyme disease patient could have disseminated Lyme disease within a matter of days to weeks within the onset of the illness, correct?

A. What I said is it is possible in some patients that they have a very rapid progression.

Q. That's documented in the literature, correct?

A. I believe it is, yes.

Q. That's literature you were aware of before the '95 policy was adopted on Lyme disease, correct?

A. I can't tell you when I became aware

of that.

Q. Well, if you have a patient who is insured with Empire who had clinical evidence supportive of the conclusion that the patient was suffering from disseminated disease less than 42 days from the onset of the illness, your corporate medical policy on Lyme required the issuance of a denial for IV therapy that was prescribed by a treating physician; is that correct?

A. That was correct. He was first to undergo an oral course of antibiotics because our interpretation of the literature that that was the appropriate first Lyme course.

Q. I'm sorry, I said '95 but that was the '93, August '93 one that I was referring to; is that correct?

A. That's '93, yes.

Q. Okay. Well, if you have a patient with disseminated disease who is less than 42 days out from the onset of his illness and you have a corporate medical policy that requires a denial of a request for treatment with intravenous antibiotics, wouldn't you consider

that in all reasonableness to be an overzealous denial?

A. You know, I think any time we deny care the provider or the member would say that it's an overzealous denial but that's because they didn't get what they wanted so.

Q. So if you rigidly adhere to a corporate policy that says no IV earlier than 42 days out from the onset of the illness even though there was clinical evidence that demonstrated that the patient had a disease would you think that's appropriate?

A. What would occur -- no, the short answer is no. What would occur is we would expect an appeal.

Q. Would you conclude that the issuance of the denial consistent with the Empire Blue Cross Lyme policy that no IV earlier than 42 days from the onset of illness, that using such a standard, rigidly adherent to such a standard, was arbitrary, especially given the fact that the 42 days was arbitrary based on what you told us earlier, would you agree with that?

A. I would say that regardless of the

policy that we implemented for Lyme disease or any other there were going to be cases or situations in which the member or the physician would consider it overzealous or arbitrary.

Q. My question was: Would you agree that it's arbitrary to deny authorization for IV where there's clinical evidence that the patient has disseminated disease based solely upon the 42-day period specified in Empire's Lyme corporate medical policy? That's the question.

A. I considered that true and we modified the policy in '95 to allow some flexibility in the use of dissemination.

Q. But at the same time while allowing some flexibility that way you also increased the inflexibility, didn't you, by requiring that there be both a positive ELISA test or Immunofluorescent Assay test combined with a positive confirmatory Western Blot test; isn't that true?

A. That's true.

Q. So you gave with one hand but you took with the other, true?

A. That's your expression.

Q. You gave something but you took back something, didn't you?

(Pause.)

Q. You became flexible on one hand but on the other hand there was an inflexibility that was created, wasn't there?

A. Yes.

Q. Now, with regard to the therapy risks that Mr. Driscoll asked you about, when someone is treated with IV antibiotic therapy for Lyme disease you mentioned several different things that you are concerned about as a physician.

Would you also have been concerned about the risk that a patient with disseminated Lyme disease where the bacteria has penetrated the blood brain barrier could result in permanent brain damage if untreated with appropriate antibiotic therapy, was that something that was considered?

A. In that situation, hypothetically that you just described, the risks of the intravenous therapy would have been outweighed by the potential benefits or the imminent danger to the patient. As I said, we calculate that risk

versus benefit every time we entertain or approve a therapeutic regimen.

Q. Let's focus on this for a moment then. What study was done by Empire or what study did Empire research which showed the percentage of Lyme disease sufferers who would go on to develop disseminated Lyme disease involving the central nervous system and specifically the brain which resulted in evidence on diagnostic studies that there was a lesion or evidence of abnormal blood flow of the brain?

MR. DRISCOLL: Objection to the form of the question.

A. There was no study done by Empire.

Q. Before adopting these corporate medical policies; is that correct?

A. Empire was not in the habit of doing clinical research. It was our process was to take the clinical research and review of the literature and try to create a sensible policy.

Q. Before determining that the risks outweighed the benefits with IV antibiotics in certain circumstances, as you just testified to it, did you consider that some people would

R. Sanchez, M.D.

develop permanent brain damage, if they didn't get proper antibiotic IV therapy, was that considered by Empire before adopting the corporate medical policy on Lyme disease?

A. No.

Q. Did you ask -- withdrawn.

Were you aware that Lyme disease when disseminated can affect the nervous system of the heart and cause an arrythmia or heart block?

A. Of course.

Q. And did you give any consideration to the risks associated with failure to treat second or third degree heart block with intravenous antibiotic therapy in terms of the potential for a fatal failure of the heart resulting from that lack of treatment with IV therapy?

A. Our review of the literature and the consensus opinion of the infectious disease experts that we consulted, we interpreted as consistent with our implementing our policy which was we thought a sensible policy. We clearly knew or any reasonable person would know as with any policy that some patients would not fit the classic policy or definition. We expected those

R. Sanchez, M.D.

to rise up through the appellate system and therefore not fall through the cracks.

Q. People -- you've already told me a few moments ago that you also expected that not everyone would appeal from the denials, true?

A. That's true with any population.

Q. There was some sort of a statistical analysis of that at Empire, wasn't there, that was considered as part of the overall changes that took place when you came in?

A. I think that -- no, there was no -- I mean it is common knowledge and it's assumed that any time you put any type of barrier up or hurdle or obstacle depending on your terminology for someone receiving a questionable benefit or care, that once that obstacle is up there are certain people that will fight to get over it and appeal, there are other people that will accept it and not appeal. That's common sense. We all know that.

Q. What you just said is also true of some Lyme disease patients who suffer from Lyme encephalopathy with cognitive deficits who might not be up to, health-wise, going through the

R. Sanchez, M.D.

process of an appeal; isn't that true?

A. Yes.

Q. Did you do anything before implementing the corporate medical policies that you've told us about to determine how physicians in the community, the clinicians who are treating Lyme disease out in the field, were practicing in terms of how they were treating Lyme disease?

A. We knew from their claims activity how they were treating Lyme disease and we thought it was inappropriate. So part of our policies are meant to educate physicians on the appropriate ways to diagnosis and treat, they are kind of guidelines as we say. So that we were very well with the general activity, very familiar with the general activity, based on the claims activity that we received. I think our policy addressed it in the way a physician would have to work up a patient to make up the proper diagnosis and what we considered a sensible way to begin therapeutic intervention.

Q. When you were questioned by Mr. Driscoll before on cross examination I believe you indicated or he asked you about

R. Sanchez, M.D.

whether or not you would discipline an employee if they denied a benefit to an insured. Do you recall that?

A. Yes.

Q. How many times in your tenure at Empire Blue Cross did you discipline an employee who denied a benefit to an insured?

A. Denied?

Q. Yes, denied.

MR. DRISCOLL: Object to the form of the question just because it leaves part of my question out.

A. I don't recall.

Q. Do you recall ever doing it?

A. No, sir.

MR. MAURER: Off tape, off record.

THE VIDEOGRAPHER: The time is 1726. We are going off the record.

(Whereupon, there is a recess in the proceedings.)

MR. MAURER: On tape on record.

THE VIDEOGRAPHER: The time is 1727. We are back on the record.

BY MR. MAURER:

R. Sanchez, M.D.

Q. With regard to the question about your being sympathetic to the chronically ill and that being part of what your job description called for, do you recall that area?

A. Uh-hum. It's part of the job description that was written by I imagine the human resources department at Empire, yes.

Q. You've already told us today that there are some -- you knew when you first came to Empire that there were some patients who have Lyme disease according to Dr. Dattwyler who have negative serologies; is that correct?

A. We knew that Dr. Dattwyler had identified a small study of those, yes.

Q. And --

A. And those patients existed in the universe of Lyme disease patients.

Q. And if those patients were denied treatment because they did not meet the criteria of a positive ELISA and a Western Blot, you knew that if they still had the Lyme disease anyway that they were going to get sicker because they weren't treated, true, yes or no, sir?

A. We knew that those patients had an

R. Sanchez, M.D.

appellate route to receive treatment if they could make the compelling case that they were sero-negative but had the disease, which is, you know, I think not a formidable but there has to be that clinical history and the progression and the response to this all has to be documented in the clinical chart.

At that point there's a process in which that appeal could have been overturned and we would have approved it and that's how we slept with ourselves, that these patients were not going to get initial treatment, these rare patients were not getting initial treatment at the first part of this, that there was still a route by which the doctor and the patient could appeal the decision.

Q. You knew that the disease is not a static one, that it continues to progress when not treated, didn't you, talking about Lyme disease?

A. Lyme disease is a great masquerader, so it's difficult to distinguish between other diseases and it is progressive and it does seem to go through plateaus, rapid dissemination in

R. Sanchez, M.D.

some cases and some cases it's a more indolent progression.

Q. Okay. Since you knew that Lyme disease can be progressive in nature you were therefore aware, were you not, that denying treatment to some Lyme disease patients thinking well, we will catch the ones that truly have Lyme on the appeal, first of all, there's a fundamental problem with that because you knew that some people wouldn't appeal, right, isn't that true, you've already told me that?

A. That's common sense.

Q. And, second of all, you know that those people are sick and they are waiting for the appeal to be handled and the appeal can take some period of time, true?

A. It takes a finite amount of time, yes.

Q. That finite time varied tremendously, didn't it, couldn't it range anywhere from weeks to months to years in some cases?

A. I believe our appellate process was much quicker than that in that in the cases of catastrophic illness and those that the process took much less in months or years and it was

R. Sanchez, M.D.

within weeks.

Q. Really. Are you aware of anyone who took -- any cases where it took more than weeks to go through the appeal process and reverse the denial if appropriate?

A. No, I'm not. I'm assuming from the -- from the process of the steps that are involved in the appellate process that this was a matter of weeks and not months.

Q. If it took months would you think that that approach was sympathetic to the chronically ill if, in fact, the patient actually had the disease and had to wait that long?

A. No.

Q. Doctor, how much of a bonus did you receive from Empire for the first year that you were there which I guess was the calendar year 1995?

A. I don't recall the number.

Q. Your best estimate.

A. $40,000.

MR. MAURER: I have no further questions. Thank you, Doctor.

MR. DRISCOLL: Off tape for a moment,

R. Sanchez, M.D.

please.

THE VIDEOGRAPHER: The time is 1732. We are going off the record.

(Whereupon, there is a recess in the proceedings.)

THE VIDEOGRAPHER: The time is 1735 and we are back on the record.

BY MR. DRISCOLL:

Q. Dr. Sanchez, Mr. Maurer just spent some time with you on the question of the impact of the appeal process and what period of time that took. Isn't it also -- isn't it true, sir, that there was also something called a pre-approval process for doctors to seek pre-approval for intravenous antibiotic therapy?

A. Yes, yes, there was.

Q. If a doctor made a sufficient showing at that point in time and submitted materials than Empire might authorize the IV therapy at that time?

A. Yes.

MR. DRISCOLL: I have no further questions.

MR. MAURER: I have nothing further.

R. Sanchez, M.D.

MR. DRISCOLL: Thank you for your time,, Doctor.

THE VIDEOGRAPHER: The time is 1736 on February 23, 1999. This completes the videotape deposition of Dr. Richard Sanchez M.D.

MR. MAURER: Off record.

(Time noted: 5:36 p.m.)

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DR. RICHARD SANCHEZ, M.D.

Subscribed and sworn to before me this day of 1999.

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CERTIFICATE

STATE OF NEW YORK)

) ss.:

COUNTY OF NEW YORK)

I, ERICA L. RUGGIERI, a Registered Professional Reporter and Notary Public within and for the State of New York, do hereby certify:

That DR. RICHARD SANCHEZ, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 9th day of March, 1999.

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ERICA L. RUGGIERI, RPR

----------INDEX----------

----------INFORMATION REQUESTS----------

- None -

----------EXHIBITS----------

---------- EXHIBITS (Cont'd) ----------

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