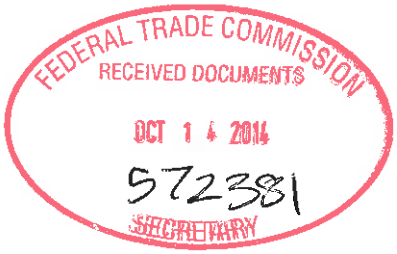
ORIGINAL

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION



In the Matter of	
Phoebe Putney Health System, Inc.,	
Phoebe Putney Memorial Hospital, Inc.,	
Phoebe North, Inc.,	
HCA, Inc.,	Docket No. 9348
Palmyra Park Hospital, Inc., and	
Hospital Authority of Albany-Dougherty County,	
Respondents.	

MOTION TO QUASH SUBPOENA *DUCES TECUM*

Pursuant to 16 C.F.R. § 3.34(c) and Rule 3.34(c) of the Rules of Practice for Adjudicative Proceedings before the United States Federal Trade Commission ("FTC Rules of Practice"), Blue Cross and Blue Shield of Georgia, Inc. ("BCBS"), a non-party to this proceeding, files the following Motion to Quash Subpoena.

I. INTRODUCTION AND STATEMENT OF FACTS

On October 3, 2014, Respondents Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., and Hospital Authority of Albany-Dougherty County (collectively referred to herein as "Respondents") served a subpoena *duces tecum* ("Respondents' Second Subpoena") upon BCBS.[1] A copy of Respondents' Second Subpoena is attached hereto as Exhibit A.

[1] Pursuant to 16 C.F.R. § 3.34(c) and FTC Rule of Practice 3.34(c), any motion to limit or quash a subpoena must be filed within the earlier of ten days after service or the time of compliance.

A. BCBS Previously Produced a Significant Amount of Data to Respondents in Connection with this Investigation.

The investigation at issue here concerns an agreement entered in December 2010 for the acquisition of the Palmyra Medical Center by the Hospital Authority of Albany-Dougherty County (the "Transaction"). The Federal Trade Commission ("FTC") opened a non-public preliminary investigation of the Transaction in December 2010, believing that the Transaction created a "virtual monopoly for inpatient general acute care services sold to commercial health plans and their customers in Albany, Georgia and its surrounding area." The FTC subsequently converted that investigation to a formal investigation in February 2011. (Compl. at 2.)

On February 22, 2011, the FTC issued a Civil Investigative Demand ("CID") to WellPoint, Inc. ("WellPoint"), the ultimate parent company of BCBS, and requested certain documents from WellPoint, including among other things contracts with hospitals in the relevant geographic area, documents reflecting negotiations of those contracts, data regarding inpatient admissions, information regarding products offered, documents relating to price increases, and documents relating to comparisons of hospitals. (Affidavit of Michelle M. Rothenberg-Williams ("Rothenberg-Williams Aff."), attached hereto as Exhibit B, ¶ 3.)

In May of 2011, after WellPoint and the FTC negotiated certain modifications to the CID, WellPoint produced to the FTC several CDs of data and documents. (Rothenberg-Williams Aff. ¶ 5.) BCBS has been informed by counsel for the FTC that the documents and data produced by WellPoint in May 2011 were provided to Respondents. (Rothenberg-Williams Aff. ¶ 6.)

In April of 2013, the FTC served a subpoena *duces tecum* on BCBS, essentially requesting that BCBS update the documents it produced in May of 2011. (Rothenberg-Williams

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Respondents' Subpoena was served on BCBS by registered mail on October 3, 2014. Pursuant to its terms BCBS must comply on or before October 24, 2014. Thus, BCBS's motion to quash or limit must be filed on or before October 13, 2014. This motion is therefore timely.

Aff. ¶ 7.) The FTC agreed to apply to the subpoena the same modifications negotiated by the parties in connection with the CID. (Rothenberg-Williams Aff. ¶ 8.) Using the agreed-upon modifications, BCBS conducted a reasonable and diligent search and produced all relevant, non-privileged documents to the FTC in a timely manner. (Affidavit of Diane L. Weinstein ("Weinstein Aff."), attached hereto as Exhibit C, ¶ 3.) It is BCBS' understanding that all documents produced by BCBS in response to the subpoena were provided to Respondents. (Weinstein Aff. ¶ 3.)

B. In 2013 BCBS Produced Data to Respondents Pursuant to an Agreement That Respondents Would Not Seek Any Further Data or Information from BCBS in this Matter.

In April of 2013, Respondents also served a subpoena *duces tecum* ("Respondents' First Subpoena") upon BCBS. (A copy of Respondents' First Subpoena is attached hereto as Exhibit D.) Respondents' First Subpoena was expansive and broad-ranging, and BCBS determined that it would be impossible to search for, locate, review, and produce the requested documents in the timeframe requested by Respondents. BCBS also determined that such a search would be unduly burdensome and expensive. Counsel for BCBS sought to reach agreement with counsel for Respondents to reasonably limit the subpoena; however, those efforts initially proved unsuccessful and, on May 9, 2013, BCBS timely moved to quash Respondents' First Subpoena. Thereafter, counsel for the parties again conferred regarding the scope of the subpoena, and the parties were able to resolve their dispute.[2] BCBS agreed that it would provide information in response to Request No. 11 of Respondents' First Subpoena in exchange for Respondents' agreement (1) that the response operated to fully satisfy Respondents' First Subpoena in its entirety; (2) that no further response from BCBS to any other requests in Respondents' First

[2] As a result of the parties' agreement, BCBS withdrew its motion to quash on May 23, 2013.

Subpoena would be required or provided; and (3) that Respondents "***agree[] to make no additional requests for information upon BCBS[] in the above-captioned matter***." (June 14, 2013 Letter from Mark Cohen to John Fedele and May 29, 2013 Letter from Mark Cohen to Brian Burke, both attached hereto as Exhibit D (emphasis added).) BCBS also agreed that, in the event Respondents' experts had questions concerning the ability to interpret the provided information, BCBS would facilitate responses to those questions. (*Id.*)

Pursuant to the terms of the parties' agreement, on May 29, 2013, and on June 14, 2013, BCBS produced data in response to Request No. 11 of Respondents' First Subpoena. (Weinstein Aff. ¶ 4.) In addition, BCBS received questions from Respondents regarding the data produced and facilitated responses to those questions. (Weinstein Aff. ¶ 4.) Accordingly, BCBS has upheld its end of the agreement. Conversely, Respondents' Second Subpoena violates Respondents' express agreement not to request additional documents and information from BCBS in this matter.[3]

II. ARGUMENT AND CITATION OF AUTHORITY

The FTC's Rules of Practice and relevant federal regulations provide that "[p]arties may obtain discovery to the extent that it may be reasonably expected to yield information relevant to the allegations of the complaint, to the proposed relief, or to the defenses of any respondent." FTC Rule of Practice 3.31(c)(1); 16 C.F.R. § 3.31(c)(1). Further, the Administrative Law Judge may limit the use of discovery if he determines that:

[3] Counsel for BCBS contacted counsel for Respondents and requested that Respondents withdraw Respondents' Second Subpoena in light of the parties' agreement that, in exchange for BCBS' production of data in response to Respondents' First Subpoena, Respondents would not seek any additional information from BCBS. However, Respondents declined to withdraw their subpoena.

(i) The discovery sought from a party or third party is unreasonably cumulative or duplicative, or is obtainable from some other source that is more convenient, less burdensome, or less expensive;

(ii) The party seeking discovery has had ample opportunity by discovery in the action to obtain the information sought; or

(iii) The burden and expense of the proposed discovery on a party or third party outweigh its likely benefit.

FTC Rule of Practice 3.31(c)(2); 16 C.F.R. § 3.31(c)(2).

Given Respondents' agreement that they would make no additional requests for information from BCBS in the above-captioned matter, Respondents' Second Subpoena should be quashed in its entirety. Moreover, each of the three requests contained in Respondents' Second Subpoena is objectionable for reasons independent of the parties' agreement.

Respondents' first request seeks documents or communications relied upon by Amy Cheslock in connection with statements made in her declaration dated March 29, 2011. On May 15, 2013, Respondents took Ms. Cheslock's deposition and inquired at length regarding the statements made in her March 2011 declaration and the documents and information she relied upon when making that declaration. (Deposition of Amy Cheslock, attached hereto as Exhibit E.) Because Respondents had ample opportunity during that deposition to obtain the information they now seek, Respondents should not be permitted a second opportunity to request this information, particularly in light of the parties' agreement (which post-dated Ms. Cheslock's deposition) that Respondents' would not seek any additional information from BCBS in this matter. Accordingly, Respondents' first request should be quashed on the ground that Respondents have had ample opportunity to obtain this information. *See* FTC Rule of Practice 3.31(c)(2)(ii); 16 C.F.R. § 3.31(c)(2)(ii).

Respondents' second request seeks documents sent to or received from the FTC regarding the investigation at issue here. All documents that were submitted to the FTC in connection with the FTC's CID and the FTC's April 2013 subpoena have been transmitted to Respondents. (Rothenberg-Williams Aff. ¶ 6; Weinstein Aff. ¶ 3.) In addition, on October 2, 2014, the FTC served a second subpoena on BCBS, and it is the understanding of BCBS that all documents submitted to the FTC in connection with that subpoena will also be transmitted to Respondents. (Weinstein Aff. ¶ 5.) Because Respondents currently have all information submitted to the FTC by BCBS, and because they will be provided information submitted in connection with the subpoena dated October 2, 2014, Respondents' second request is unreasonably cumulative and duplicative and should therefore be squashed. *See* FTC Rule of Practice 3.31(c)(2)(i); 16 C.F.R. § 3.31(c)(2)(i).

Respondents' third request seeks detailed information and data for each inpatient or outpatient discharge at all hospitals and health care facilities in the State of Georgia. Identifying and collecting the data responsive to this request would be a difficult and time-consuming undertaking for BCBS, after which BCBS would have to redact all sensitive health information and comply with the elaborate instructions contained in the subpoena regarding production of this data. These efforts would require significant resources from BCBS and would disrupt its normal business operations. Furthermore, in 2013, BCBS agreed to undertake these efforts and provide data responsive to this request on the condition that no additional data would be sought from BCBS.[4] Because the burden and expense required to comply with Respondents' third

[4] Anticipating that Respondents may assert that BCBS has a duty to supplement its responses to Respondents' First Subpoena, BCBS asserts that it has no such duty. First, the parties' May 2013 agreement does not contemplate that BCBS will supplement its responses. Second, the FTC's Rules of Practice do not require BCBS to supplement. BCBS is required to supplement a previous response only if ordered by the Administrative Law Judge to do so or if BCBS "learns

request outweighs any benefit that Respondents could hope to obtain, and because BCBS previously agreed to undertake these efforts on the condition that it would not again be required to do so, Respondents' third requests should be quashed. *See* FTC Rule of Practice 3.31(c)(2)(iii); 16 C.F.R. § 3.31(c)(2)(iii).

For these reasons, BCBS respectfully requests that Respondents' Subpoena be quashed in its entirety.

III. RESPONSES AND OBJECTIONS TO DOCUMENT REQUESTS

BCBS incorporates by reference the arguments made in its Motion to Quash Subpoena *Duces Tecum*. In addition, BCBS hereby adopts and incorporates by reference the following General Objections into each of its specific objections to Respondents' Second Subpoena.

GENERAL OBJECTIONS

1. BCBS objects to Respondents' Second Subpoena to the extent that it seeks to impose obligations on BCBS that exceed or modify the requirements of the FTC's Rules of Practice, the FTC's governing regulations, and other applicable rules of procedure.

2. BCBS objects to Respondents' Second Subpoena on the grounds that is overbroad and seeks the production of documents that are neither relevant to the subject matter of the pending investigation, nor reasonably calculated to yield information relevant to the allegations of the complaint, to the proposed relief, or to the defenses of any respondent.

3. BCBS objects to Respondents' Second Subpoena on the grounds that it is duplicative and harassing because the subpoena seeks information and documents that are publicly available and already are or should be in Respondents' possession, custody, or control.

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that the response is in some material respect incomplete or incorrect." FTC Rule of Practice 3.31(e); 16 C.F.R. § 3.31(e). To date, BCBS has not been so ordered, nor are BCBS's previous responses incomplete or incorrect in any material respect.

4. BCBS objects to Respondents' Second Subpoena to the extent it seeks documents that are protected by the attorney-client privilege, work product doctrine, the common interest privilege, and other applicable privileges, immunities, and duties of confidentiality belonging to BCBS.

5. BCBS objects to Respondents' Second Subpoena on the grounds that it seeks information or documents that constitute, contain, or refer to trade secrets or other confidential business and commercial information of BCBS. BCBS further objects to Respondents' Second Subpoena to the extent that it seeks information or documents that are subject to confidentiality provisions or obligations between BCBS and others that may not be disclosed without notice to and/or consent of the parties to such contracts or otherwise.

6. BCBS objects to Respondents' Second Subpoena to the extent that it seeks documents or information that contain or comprise personal health information that is privileged and confidential under federal or state law that prohibits unauthorized disclosure.

7. BCBS objects to Instruction B on the grounds that it is overbroad, seeks information that is not relevant nor reasonably calculated to yield relevant information, unduly burdensome, harassing, and oppressive.

8. BCBS's objections as set forth herein are based upon information presently known to BCBS. BCBS reserves the right to rely on any facts, documents, or other evidence which may develop or subsequently come to its attention; to assert additional objections should BCBS discover additional information or grounds for objections; and to supplement or amend these objections at any time.

SPECIFIC OBJECTIONS AND RESPONSES TO DOCUMENT REQUESTS

Subject to and without waiving the foregoing General Objections, BCBS objects and responds to the Document Requests as follows.

Request No. 1:

All documents or communications relied upon, consulted, created, or reviewed by Amy Cheslock, Vice President, Provider Engagement and Contracting, in connection with the following statements in her declaration dated March 29, 2011 and provided to the Federal Trade Commission:

- "It is my understanding that BCBSGs' contracted reimbursement rates for Phoebe Putney are among the higher for all hospitals in Georgia on a case-mix-adjusted basis." Cheslock Decl. ¶ 12.

- "Based on a comparison for similar services, we calculated that many of the rates in the Palmyra hospital agreement were between 20% and 70% less than the comparable rates in the Phoebe Putney hospital agreement, thereby resulting in savings to us for Palmyra's services over Phoebe Putney's services." Cheslock Decl. ¶ 13.

RESPONSE:

In addition to its General Objections, BCBS objects to Request No. 1 on the grounds that Respondents had ample opportunity to obtain this information through the deposition of Amy Cheslock dated May 15, 2013.

Request No. 2:

All documents relating to the Transaction, including but not limited to, all documents sent to or received from the Federal Trade Commission and all documents relating to any communications between You and the Federal Trade Commission or any existing or potential customer regarding the Transaction.

RESPONSE:

In addition to its General Objections, BCBS objects to Request No. 2 on the grounds that it is unreasonably cumulative and duplicative.

Subject to and without waiving its General Objections and the foregoing objections, BCBS states that all documents submitted to the FTC in response to the CID and in response to

the FTC's April 2013 subpoena have been provided to Respondents. BCBS further states that all documents submitted to the FTC in response to the FTC's October 2014 subpoena will be provided to Respondents.

Request No. 3:

For each year during the relevant period, provide individual claim level, annual electronic inpatient files in delimited text format that include the following individual data elements for each inpatient or outpatient discharge at all hospitals and health care facilities in the State of Georgia:

(a) a numerical patient identifier that masks the true identity (name) of the patient;

(b) a unique claim number for that inpatient or outpatient episode;

(c) any facility-specific identifier;

(d) all submitted data elements included on the UB-92 or UB-04 for an inpatient claim depending on which form of the claim was submitted to You by the hospital or health care facility, and all data elements contained on an outpatient claim. For both the inpatient and outpatient claims data provided provide a full and complete definition of each data element;

(e) the Diagnosis Related Group ("DRG") version and number assigned;

(f) the allowed amount of the claim as determined by You, the amount You paid the hospital or health care facility for that claim, and whether the hospital or health care facility was paid for an inpatient claim under a per-diem, DRG, capitation, percentage of charges, or some other type of reimbursement methodology, and similarly the type of reimbursement methodology used to calculate payment for each outpatient claim;

(g) the amount of patient copay, deductible, and any other out-of-pocket responsibility;

(h) the commercial name of the health plan product in which the patient was enrolled, including whether that product is an HMO, PPO, or POS product, the number of tiers used to identify in-network facilities to the extent any such product contained tiers, whether that product is a commercial product sold to employers or whether it is a product sold to beneficiaries of Government insurance programs such as Medicare or Medicaid, and if so, which Government program;

(i) whether the hospital or health care facility was paid as an "in-network" or "out-of-network facility," and if paid as an "in-network facility," the "tier" in which the hospital or health care facility was assigned;

(j) for inpatient claims, the identity of the patient's admitting physician and, if different, the identity of the patient's primary treating physician; for outpatient claims, the identity of patient's treating physician;

(k) all crosswalk or lookup files necessary to translate encoded or numeric data fields to their English meaning, as well as an English description of the possible values for any encoded data element;

(l) the name(s) of the employee(s) at the health plan responsible for compiling and maintaining this data file during the relevant period; and

(m) the name(s) of the employee(s) at the managed care plan principally responsible for analyzing the data over the relevant period and who made comparisons of different hospitals' and health care facilities' reimbursement rates or prices.

RESPONSE:

In addition to its General Objections, BCBS objects to Request No. 3 on the grounds that it is overbroad, seeks information that is not relevant nor reasonably calculated to yield relevant information, unduly burdensome, harassing, and oppressive. BCBS further objects to Request No. 11 on the grounds that it is unreasonably cumulative and duplicative.

Subject to and without waiving its General Objections and the foregoing objections, BCBS states that it has previously produced data responsive to Request No. 3.

IV. CONCLUSION

For all of the foregoing reasons, BCBS respectfully requests that the Administrative Law Judge quash Respondent's Subpoena in its entirety.

V. CERTIFICATE OF CONFERENCE

Pursuant to FTC Rule of Practice 3.34(c) and 16 C.F.R. § 3.34(c), counsel for BCBS hereby certify that they have conferred with counsel for Respondents by phone in a good faith attempt to resolve by agreement the issues raised herein. On Thursday, October 9, 2014, Mark Cohen, counsel for BCBS, and John Fedele, counsel for Respondents, conferred by telephone in an attempt to resolve BCBS's objections to Respondents' Second Subpoena. Based on that

telephone conversation, BCBS understands that Respondents recognize that they will be provided the data that is submitted to the FTC in response to the FTC's October 2014 subpoena, which will likely include data responsive to Request No. 3. BCBS further understands that, based upon the production of data provided by the FTC, Respondents may not insist on their requests in Respondents' Second Subpoena. Nonetheless, at present, counsel have been unable to reach agreement on the disputed issues.

Respectfully submitted, this 13th day of October, 2014.

/s/ Lindsey B. Mann
Mark H. Cohen
Georgia Bar No. 174567
Lindsey B. Mann
Georgia Bar No. 431819

TROUTMAN SANDERS LLP
600 Peachtree St., N.E., Suite 5200
Atlanta, Georgia 30308
Phone: 404-885-3000
Fax: 404-885-3900

Counsel for BCBS

EXHIBIT A

To Motion to Quash Subpoena *Duces Tecum*

SUBPOENA DUCES TECUM

Provided by the Secretary of the Federal Trade Commission, and Issued Pursuant to Commission Rule 3.34(b), 16 C.F.R. § 3.34(b) (2010)

1. TO	2. FROM
Blue Cross Blue Shield of Georgia, Inc. C/O Morgan Kendrick, CEO, Or Person Authorized to Receive Service 3350 Peachtree Rd. Ne Atlanta, GA, 30326	UNITED STATES OF AMERICA FEDERAL TRADE COMMISSION

Engagement & Contracting

OCT - 6 2014

Regional Vice President

This subpoena requires you to produce and permit inspection and copying of designated books, documents (as defined in Rule 3.34(b)), or tangible things, at the date and time specified in Item 5, and at the request of Counsel listed in Item 9, in the proceeding described in Item 6.

3. PLACE OF PRODUCTION	4. MATERIAL WILL BE PRODUCED TO
Baker & McKenzie LLP 815 Connecticut Avenue, NW Washington, DC 20006	John J. Fedele, Respondents
	5. DATE AND TIME OF PRODUCTION October 24, 2014 - 9:00 a.m.

Received

OCT 06 2014

BCBSGA Legal

6. SUBJECT OF PROCEEDING

In the Matter of Phoebe Putney Health System, et al., D09348

7. MATERIAL TO BE PRODUCED

Documents and materials responsive to the attached Subpoena Duces Tecum Requests for Production.

8. ADMINISTRATIVE LAW JUDGE	9. COUNSEL AND PARTY ISSUING SUBPOENA
D. Michael Chappell Federal Trade Commission Washington, D.C. 20580	Lee K. Van Voorhis 815 Connecticut Avenue, NW Washington, DC 20006 202-835-6162

DATE SIGNED	SIGNATURE OF COUNSEL ISSUING SUBPOENA
10/3/14	

GENERAL INSTRUCTIONS

APPEARANCE

The delivery of this subpoena to you by any method prescribed by the Commission's Rules of Practice is legal service and may subject you to a penalty imposed by law for failure to comply.

MOTION TO LIMIT OR QUASH

The Commission's Rules of Practice require that any motion to limit or quash this subpoena must comply with Commission Rule 3.34(c), 16 C.F.R. § 3.34(c), and in particular must be filed within the earlier of 10 days after service or the time for compliance. The original and ten copies of the petition must be filed before the Administrative Law Judge and with the Secretary of the Commission, accompanied by an affidavit of service of the document upon counsel listed in Item 9, and upon all other parties prescribed by the Rules of Practice.

TRAVEL EXPENSES

The Commission's Rules of Practice require that fees and mileage be paid by the party that requested your appearance. You should present your claim to counsel listed in Item 9 for payment. If you are permanently or temporarily living somewhere other than the address on this subpoena and it would require excessive travel for you to appear, you must get prior approval from counsel listed in Item 9.

A copy of the Commission's Rules of Practice is available online at http://bit.ly/FTCRulesofPractice. Paper copies are available upon request.

This subpoena does not require approval by OMB under the Paperwork Reduction Act of 1995.

RETURN OF SERVICE

I hereby certify that a duplicate original of the within subpoena was duly served: (check the method used)

( ) *in person.*

(X) *by registered mail.*

( ) *by leaving copy at principal office or place of business, to wit:*

_____

_____

_____

on the person named herein on:

October 3, 2014

(Month, day, and year)

John J. Fedele, Esquire

(Name of person making service)

Attorney

(Official title)

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of Phoebe Putney Health System, Inc. a corporation, and Phoebe Putney Memorial Hospital, Inc. a corporation, and HCA Inc. a corporation, and Palmyra Park Hospital, Inc. a corporation, and Hospital Authority of Albany-Dougherty County	)	**Docket No. 9348**

RESPONDENTS' SUBPOENA *DUCES TECUM* TO BLUE CROSS BLUE SHIELD OF GEORGIA, INC.

Pursuant to the Federal Trade Commission's Rules of Practice, 16 C.F.R. §§ 3.31 and 3.34, and the Scheduling Order entered by Chief Administrative Law Judge Chappell on September 15, 2014, Respondents, Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., and Hospital Authority of Albany-Dougherty County ("Phoebe") hereby request that Blue Cross Blue Shield of Georgia, Inc. produce the documents set forth below in accordance with the Definitions and Instructions set forth below:

DEFINITIONS

A. The term "computer files" includes information stored in, or accessible through, computer or other information retrieval systems. Thus, you should produce documents that exist in machine-readable form, including documents stored in personal computers, portable computers, workstations, minicomputers, mainframes, servers, backup disks and tapes, archive disks and tapes, and other forms of offline storage.

B. The words "and" and "or" shall be construed conjunctively or disjunctively as necessary to make the request inclusive rather than exclusive.

C. The term "communication" means any transfer of information, written, oral, or by any other means.

D. The terms "constitute," "contain," "discuss," "analyze," or "relate to" mean constituting, reflecting, respecting, regarding, concerning, pertaining to, referring to, relating to, stating, describing, recording, noting, embodying, memorializing, containing, mentioning, studying, assessing, analyzing, or discussing.

E. The term "documents" means all computer files and written, recorded, and graphic materials of every kind in your possession, custody, or control. The term documents includes, without limitation: electronic mail messages; electronic correspondence and drafts of documents; metadata and other bibliographic or historical data describing or relating to documents created, revised, or distributed on computer systems; copies of documents that are not identical duplicates of the originals in that person's files; and copies of documents the originals of which are not in your possession, custody, or control.

F. The terms "each," "any," and "all" mean "each and every."

G. The term "hospital" means a health care facility providing care through specialized staff and equipment on either an in-patient or out-patient basis.

H. The term "health care facility" means a hospital, health maintenance organization facility, ambulatory care center, first aid or other clinic, urgent care center, free-standing emergency care center, imaging center, ambulatory surgery center and all other entities that provide health care services.

I. The term "health plan" means any health maintenance organization, preferred provider arrangement or organization, managed health care plan of any kind, self-insured health benefit plan, other employer or union health benefit plan, Medicare, Medicaid, TRICARE, or private or governmental health care plan or insurance of any kind.

J. The term "including" shall mean "including without limitation."

K. The term "Palmyra" means HCA/Palmyra, Palmyra Medical Center, and Palmyra Park Hospital doing business as Palmyra Medical Center and its domestic and foreign parents, predecessors, divisions, subsidiaries, affiliates, partnerships and joint ventures, and all directors, officers, employees, agents, and representatives of the foregoing.

L. The term "person" or "persons" means natural persons, groups of natural persons acting as individuals, groups of natural persons acting in a collegial capacity (*e.g.*, as a committee, board, panel, etc.), associations, representative bodies, government bodies, agencies, or any other commercial entity, incorporated business, social or government entity.

M. The term "Phoebe" means Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., Phoebe Health Partners.

N. The term "reimbursement rate" means the rate paid to a health care provider for performing a certain procedure.

O. The term "relating to" means in whole or in part constituting, containing, concerning, discussing, reflecting, describing, analyzing, identifying, or stating.

P. The term "Transaction" means the Hospital Authority of Albany-Dougherty County's acquisition of Palmyra Park Hospital, which was consummated in December 2011.

Q. The term "You" and "Your" mean Blue Cross Blue Shield of Georgia, Inc. and all of its subsidiaries, affiliates or predecessors.

R. Unless otherwise defined, all words and phrases used in this Subpoena shall be accorded their usual meaning as defined by Webster's New Universal Unabridged Dictionary, Fully Revised and Updated (2003).

INSTRUCTIONS

A. All responsive documents should be produced by October 24, 2014.

B. All references to year refer to calendar year. Unless otherwise specified, each of the specifications calls for documents and/or information for each of the years from January 1, 2008 to the present.

C. Unless modified by agreement with Respondents, this Subpoena requires a complete search of all Your files. You shall produce all responsive documents, wherever located, that are in the actual or constructive possession, custody, or control of Your Company and its representatives, attorneys, and other agents, including, but not limited to, consultants, accountants, lawyers, or any other person retained by, consulted by, or working on behalf or under the direction of You.

D. This subpoena is governed by the terms of the attached Protective Order Governing Discovery Material issued on April 21, 2011.

E. To protect patient privacy, You shall mask any Sensitive Personally Identifiable Information ("PII") or Sensitive Health Information ("SHI"). For purposes of this Subpoena, PII means an individual's Social Security Number alone; or an individual's name or address or phone number in combination with one or more of the following: date of birth, Social Security Number, driver's license number or other state identification number or a foreign country equivalent, passport number, financial account numbers, credit or debit card numbers. For purposes of this Subpoena, SHI includes medical records or other individually identifiable health information. Where required by a particular request, You shall substitute for the masked information a unique patient identifier that is different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient. Otherwise, You shall redact the PII or SHI but are not required to replace it with an alternate identifier.

F. Forms of Production: Your Company shall submit documents as instructed below absent written consent signed by Respondents.

(1) Documents stored in electronic or hard copy format in the ordinary course of business shall be submitted in electronic format provided that such copies are true, correct, and complete copies of the original documents:

(a) Submit Microsoft Access, Excel, and PowerPoint in native format with extracted text and metadata;

(b) Submit all other documents other than those identified in subpart (1)(a) in image format with extracted text and metadata; and

(c) Submit all hard copy documents in image format accompanied by OCR.

(2) For each document submitted in electronic format, include the following metadata fields and information:

(a) For documents stored in electronic format other than email: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, and MD5 or SHA Hash value;

(b) For emails: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, to, from, CC, BCC, subject, date and time sent, Outlook Message ID (if applicable), child records (the beginning Bates or document identification number of attachments delimited by a semicolon);

(c) For email attachments: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, parent record (beginning Bates or document identification number of parent email), and MD5 or SHA Hash value; and

(d) For hard copy documents: beginning Bates or document identification number, ending Bates or document identification number, page count, and custodian.

(3) Submit electronic files and images as follows:

(a) For productions over 10 gigabytes, use SATA, IDE, and EIDE hard disk drives, formatted in Microsoft Windows-compatible, uncompressed data in USB 2.0 external enclosure;

(b) For productions under 10 gigabytes, CD-R CD-ROM and DVD-ROM for Windows-compatible personal computers, USB 2.0 Flash Drives are also acceptable storage formats; and

(c) All documents produced in electronic format shall be scanned for and free of viruses.

(4) All documents responsive to this request, regardless of format or form and regardless of whether submitted in hard copy or electronic format:

(a) Shall be produced in complete form, un-redacted unless privileged, and in the order in which they appear in Your Company's files and shall not be shuffled or otherwise rearranged;

(b) Shall be produced in color where necessary to interpret the document (if the coloring of any document communicates any substantive information, or if black-and-white photocopying or conversion to TIFF format of any document (*e.g.*, a chart or graph), makes any substantive information contained in the document unintelligible, Your Company must submit the original document, a like-colored photocopy, or a JPEG format image);

(c) If written in a language other than English, shall be translated into English, with the English translation attached to the foreign language document;

(d) Shall be marked on each page with corporate identification and consecutive document control numbers; and

(e) Shall be accompanied by an index that identifies: (i) the name of each person from whom responsive documents are submitted; and (ii) the corresponding consecutive document control number(s) used to identify that person's documents, and if submitted in paper form, the box number containing such documents. If the index exists as a computer file(s), provide the index both as a printed hard copy and in machine-readable form.

G. If you object to responding fully to any of the below requests for documents based on a claim of privilege, You shall provide pursuant to 16 C.F.R. § 3.38A, for each such request, a schedule containing the following information: (a) the date of all responsive documents, (b) the sender of the document, (c) the addressee, (d) the number of pages, (e) the subject matter, (f) the basis on which the privilege is claimed, (g) the names of all persons to whom copies of any part of the document were furnished, together with an identification of their employer and their job titles, (h) the present location of the document and all copies thereof, and (i) each person who has ever had possession, custody, or control of the documents.

H. If documents responsive to a particular specification no longer exist for reasons other than the ordinary course of business but Your Company has reason to believe have been in existence, state the circumstances under which they were lost or destroyed, describe the documents to the fullest extent possible, state the specification(s) to which they are responsive, and identify persons having knowledge of the content of such documents.

I. Any questions you have relating to the scope or meaning of anything in this request or suggestions for possible modifications thereto should be directed to John Fedele at (202) 835-6144. The response to the request shall be addressed to the attention of John Fedele, Baker & McKenzie LLP, 815 Connecticut Ave. NW, Washington, D.C. 20006, and delivered between 8:30 a.m. and 5:00 p.m. on any business day to Baker & McKenzie.

DOCUMENTS TO BE PRODUCED

1. All documents or communications relied upon, consulted, created, or reviewed by Amy Cheslock, Vice President, Provider Engagement and Contracting, in connection with the following statements in her declaration dated March 29, 2011 and provided to the Federal Trade Commission:

   - "It is my understanding that BCBSGs' contracted reimbursement rates for Phoebe Putney are among the higher for all hospitals in Georgia on a case-mix-adjusted basis." Cheslock Decl. ¶12.

   - "Based on a comparison for similar services, we calculated that many of the rates in the Palmyra hospital agreement were between 20% and 70% less than the comparable rates in the Phoebe Putney hospital agreement, thereby resulting in savings to us for Palmyra's services over Phoebe Putney's services." Cheslock Decl. ¶13.

2. All documents relating to the Transaction, including but not limited to, all documents sent to or received from the Federal Trade Commission and all documents relating to any communications between You and the Federal Trade Commission or any existing or potential customer regarding the Transaction.

3. For each year during the relevant period, provide individual claim level, annual electronic inpatient files in delimited text format that include the following individual data elements for each inpatient or outpatient discharge at all hospitals and health care facilities in the State of Georgia:

   (a) a numerical patient identifier that masks the true identity (name) of the patient;

   (b) a unique claim number for that inpatient or outpatient episode;

   (c) any facility-specific identifier;

   (d) all submitted data elements included on the UB-92 or UB-04 for an inpatient claim depending on which form of the claim was submitted to You by the hospital or health care facility, and all data elements contained on an outpatient claim. For both the inpatient and outpatient claims data provided provide a full and complete definition of each data element;

   (e) the Diagnosis Related Group ("DRG") version and number assigned;

(f) the allowed amount of the claim as determined by You, the amount You paid the hospital or health care facility for that claim, and whether the hospital or health care facility was paid for an inpatient claim under a per-diem, DRG, capitation, percentage of charges, or some other type of reimbursement methodology, and similarly the type of reimbursement methodology used to calculate payment for each outpatient claim;

(g) the amount of patient copay, deductible, and any other out-of-pocket responsibility;

(h) the commercial name of the health plan product in which the patient was enrolled, including whether that product is an HMO, PPO, or POS product, the number of tiers used to identify in-network facilities to the extent any such product contained tiers, whether that product is a commercial product sold to employers or whether it is a product sold to beneficiaries of Government insurance programs such as Medicare or Medicaid, and if so, which Government program;

(i) whether the hospital or health care facility was paid as an "in-network" or "out-of-network facility," and if paid as an "in-network facility," the "tier" in which the hospital or health care facility was assigned;

(j) for inpatient claims, the identity of the patient's admitting physician and, if different, the identity of the patient's primary treating physician; for outpatient claims, the identity of the patient's treating physician;

(k) all crosswalk or lookup files necessary to translate encoded or numeric data fields to their English meaning, as well as an English description of the possible values for any encoded data element;

(l) the name(s) of the employee(s) at the health plan responsible for compiling and maintaining this data file during the relevant period; and

(m) the name(s) of the employee(s) at the managed care plan principally responsible for analyzing the data over the relevant period and who made comparisons of different hospitals' and health care facilities' reimbursement rates or prices.

Subpoena *Duces Tecum* Issued to Blue Cross Blue Shield of Georgia, Inc.
(FTC Docket 9348)
CERTIFICATION

Pursuant to 28 U.S.C. § 1746, I hereby certify under penalty of perjury that this response to the Subpoena *Duces Tecum* has been prepared by me or under my personal supervision from the records of Blue Cross Blue Shield of Georgia, Inc. and is complete and correct to the best of my knowledge and belief.

Where copies rather than original documents have been submitted, the copies are true, correct, and complete copies of the original documents. If Respondents use such copies in any court or administrative proceeding, Blue Cross Blue Shield of Georgia, Inc. will not object based upon Respondents not offering the original document.

_____ _____

(Signature of Official) (Title/Company)

_____ _____

(Typed Name of Above Official) (Office Telephone)

Dated: October 3, 2014

Respectfully submitted,

By /s/ Lee K. Van Voorhis_
Lee K. Van Voorhis, Esq.
Brian F. Burke, Esq.
Jennifer A. Semko, Esq.
John J. Fedele, Esq.
Teisha C. Johnson, Esq.
Jeremy W. Cline, Esq.
Baker & McKenzie LLP
815 Connecticut Avenue, NW
Washington, DC 20006
Counsel For Phoebe Putney Memorial Hospital, Inc. and Phoebe Putney Health System, Inc.

Frank M. Lowrey, Esq.
Bondurant, Mixson & Elmore LLP
1201 W. Peachtree Street, Suite 3900
Atlanta, Georgia 30309

Michael A. Caplan, Esq.
Caplan Cobb
1447 Peachtree Street, N.E., Suite 880
Atlanta, Georgia 30309

Counsel for Respondent Hospital Authority of Albany-Dougherty County

Subpoena *Duces Tecum* Issued to Blue Cross Blue Shield of Georgia, Inc.
(FTC Docket 9348)
CERTIFICATE OF SERVICE

I hereby certify that this 3rd day of October, 2014 I delivered via FedEx this Subpoena *Duces Tecum* to:

Blue Cross Blue Shield of Georgia, Inc.
C/O Morgan Kendrick, CEO, Or Person Authorized to Receive Service
3350 Peachtree Rd. Ne
Atlanta, GA, 30326

I also certify that I delivered via electronic mail a copy of the foregoing document to:

Alexis Gilman, Esq.
Federal Trade Commission
Bureau of Competition
600 Pennsylvania Avenue, NW
Washington, DC 20580
agilman@ftc.gov

Maria M. DiMoscato, Esq.
Federal Trade Commission
Bureau of Competition
600 Pennsylvania Avenue, NW
Washington, DC 20580
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Mark Seidman
Federal Trade Commission
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jmeyer@stblaw.com
Abram J. Ellis, Esq.
aellis@stblaw.com
Simpson Thacher and Bartlett, LLP
425 Lexington Avenue
New York, New York 10017

This 3rd day of October, 2014.

By:

/s/ John Fedele
John J. Fedele, Esq.
Counsel for Phoebe Putney Memorial Hospital, Inc. and Phoebe Putney Health System, Inc.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

ORIGINAL

In the Matter of	
PHOEBE PUTNEY HEALTH SYSTEM, INC., and	
PHOEBE PUTNEY MEMORIAL HOSPITAL, INC., and	DOCKET NO. 9348
PHOEBE NORTH, INC., and	
HCA INC., and	
PALMYRA PARK HOSPITAL, INC., and	
HOSPITAL AUTHORITY OF, ALBANY-DOUGHERTY COUNTY, Respondents.	

PROTECTIVE ORDER GOVERNING DISCOVERY MATERIAL

Commission Rule 3.31(d) states: "In order to protect the parties and third parties against improper use and disclosure of confidential information, the Administrative Law Judge shall issue a protective order as set forth in the appendix to this section." 16 C.F.R. § 3.31(d). Pursuant to Commission Rule 3.31(d), the protective order set forth in the appendix to that section is attached verbatim as Attachment A and is hereby issued.

ORDERED:

Dm Chappell
D. Michael Chappell
Chief Administrative Law Judge

Date: April 21, 2011

ATTACHMENT A

For the purpose of protecting the interests of the parties and third parties in the above-captioned matter against improper use and disclosure of confidential information submitted or produced in connection with this matter:

IT IS HEREBY ORDERED THAT this Protective Order Governing Confidential Material ("Protective Order") shall govern the handling of all Discovery Material, as hereafter defined.

1. As used in this Order, "confidential material" shall refer to any document or portion thereof that contains privileged, competitively sensitive information, or sensitive personal information. "Sensitive personal information" shall refer to, but shall not be limited to, an individual's Social Security number, taxpayer identification number, financial account number, credit card or debit card number, driver's license number, state-issued identification number, passport number, date of birth (other than year), and any sensitive health information identifiable by individual, such as an individual's medical records. "Document" shall refer to any discoverable writing, recording, transcript of oral testimony, or electronically stored information in the possession of a party or a third party. "Commission" shall refer to the Federal Trade Commission ("FTC"), or any of its employees, agents, attorneys, and all other persons acting on its behalf, excluding persons retained as consultants or experts for purposes of this proceeding.

2. Any document or portion thereof submitted by a respondent or a third party during a Federal Trade Commission investigation or during the course of this proceeding that is entitled to confidentiality under the Federal Trade Commission Act, or any regulation, interpretation, or precedent concerning documents in the possession of the Commission, as well as any information taken from any portion of such document, shall be treated as confidential material for purposes of this Order. The identity of a third party submitting such confidential material shall also be treated as confidential material for the purposes of this Order where the submitter has requested such confidential treatment.

3. The parties and any third parties, in complying with informal discovery requests, disclosure requirements, or discovery demands in this proceeding may designate any responsive document or portion thereof as confidential material, including documents obtained by them from third parties pursuant to discovery or as otherwise obtained.

4. The parties, in conducting discovery from third parties, shall provide to each third party a copy of this Order so as to inform each such third party of his, her, or its rights herein.

5. A designation of confidentiality shall constitute a representation in good faith and after careful determination that the material is not reasonably believed to be already in the public domain and that counsel believes the material so designated constitutes confidential material as defined in Paragraph 1 of this Order.

6. Material may be designated as confidential by placing on or affixing to the document containing such material (in such manner as will not interfere with the legibility thereof), or if an entire folder or box of documents is confidential by placing or affixing to that folder or box, the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, together with an indication of the portion or portions of the document considered to be confidential material. Confidential information contained in electronic documents may also be designated as confidential by placing the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, on the face of the CD or DVD or other medium on which the document is produced. Masked or otherwise redacted copies of documents may be produced where the portions deleted contain privileged matter, provided that the copy produced shall indicate at the appropriate point that portions have been deleted and the reasons therefor.

7. Confidential material shall be disclosed only to: (a) the Administrative Law Judge presiding over this proceeding, personnel assisting the Administrative Law Judge, the Commission and its employees, and personnel retained by the Commission as experts or consultants for this proceeding; (b) judges and other court personnel of any court having jurisdiction over any appellate proceedings involving this matter; (c) outside counsel of record for any respondent, their associated attorneys and other employees of their law firm(s), provided they are not employees of a respondent; (d) anyone retained to assist outside counsel in the preparation or hearing of this proceeding including consultants, provided they are not affiliated in any way with a respondent and have signed an agreement to abide by the terms of the protective order; and (e) any witness or deponent who may have authored or received the information in question.

8. Disclosure of confidential material to any person described in Paragraph 7 of this Order shall be only for the purposes of the preparation and hearing of this proceeding, or any appeal therefrom, and for no other purpose whatsoever, provided, however, that the Commission may, subject to taking appropriate steps to preserve the confidentiality of such material, use or disclose confidential material as provided by its Rules of Practice; sections 6(f) and 21 of the Federal Trade Commission Act; or any other legal obligation imposed upon the Commission.

9. In the event that any confidential material is contained in any pleading, motion, exhibit or other paper filed or to be filed with the Secretary of the Commission, the Secretary shall be so informed by the Party filing such papers, and such papers shall be filed *in camera*. To the extent that such material was originally submitted by a third party, the party including the materials in its papers shall immediately notify the submitter of such inclusion. Confidential material contained in the papers shall continue to have *in camera* treatment until further order of the Administrative Law Judge, provided, however, that such papers may be furnished to persons or entities who may receive confidential material pursuant to Paragraphs 7 or 8. Upon or after filing any paper containing confidential material, the filing party shall file on the public record a duplicate copy of the paper that does not reveal confidential material. Further, if the protection for any such material expires, a party may file on the public record a duplicate copy which also contains the formerly protected material.

10. If counsel plans to introduce into evidence at the hearing any document or transcript containing confidential material produced by another party or by a third party, they shall provide advance notice to the other party or third party for purposes of allowing that party to seek an order that the document or transcript be granted *in camera* treatment. If that party wishes *in camera* treatment for the document or transcript, the party shall file an appropriate motion with the Administrative Law Judge within 5 days after it receives such notice. Except where such an order is granted, all documents and transcripts shall be part of the public record. Where *in camera* treatment is granted, a duplicate copy of such document or transcript with the confidential material deleted therefrom may be placed on the public record.

11. If any party receives a discovery request in any investigation or in any other proceeding or matter that may require the disclosure of confidential material submitted by another party or third party, the recipient of the discovery request shall promptly notify the submitter of receipt of such request. Unless a shorter time is mandated by an order of a court, such notification shall be in writing and be received by the submitter at least 10 business days before production, and shall include a copy of this Protective Order and a cover letter that will apprise the submitter of its rights hereunder. Nothing herein shall be construed as requiring the recipient of the discovery request or anyone else covered by this Order to challenge or appeal any order requiring production of confidential material, to subject itself to any penalties for non-compliance with any such order, or to seek any relief from the Administrative Law Judge or the Commission. The recipient shall not oppose the submitter's efforts to challenge the disclosure of confidential material. In addition, nothing herein shall limit the applicability of Rule 4.11(e) of the Commission's Rules of Practice, 16 CFR 4.11(e), to discovery requests in another proceeding that are directed to the Commission.

12. At the time that any consultant or other person retained to assist counsel in the preparation of this action concludes participation in the action, such person shall return to counsel all copies of documents or portions thereof designated confidential that are in the possession of such person, together with all notes, memoranda or other papers containing confidential information. At the conclusion of this proceeding, including the exhaustion of judicial review, the parties shall return documents obtained in this action to their submitters, provided, however, that the Commission's obligation to return documents shall be governed by the provisions of Rule 4.12 of the Rules of Practice, 16 CFR 4.12.

13. The provisions of this Protective Order, insofar as they restrict the communication and use of confidential discovery material, shall, without written permission of the submitter or further order of the Commission, continue to be binding after the conclusion of this proceeding.

EXHIBIT B

To Motion to Quash Subpoena *Duces Tecum*

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., Phoebe North, Inc., HCA, Inc., Palmyra Park Hospital, Inc., and Hospital Authority of Albany-Dougherty County, Respondents.	)	Docket No. 9348

AFFIDAVIT OF MICHELLE M. ROTHENBERG-WILLIAMS

PERSONALLY APPEARED before the undersigned attesting officer, duly authorized to administer oaths in the State of Georgia, MICHELLE M. ROTHENBERG-WILLIAMS, who having been first duly sworn, deposes and states as follows:

1.

I am over the age of 21 years and competent to testify as a witness. I have personal knowledge of the facts set forth in this Affidavit or, for purposes hereof, have made due inquiries of other persons with such personal knowledge, and make this Affidavit for use in the above-captioned proceeding.

2.

I am employed by the WellPoint Companies, Inc. as Managing Associate General Counsel. The WellPoint Companies, Inc. is an affiliate of WellPoint, Inc. ("WellPoint"), the

ultimate parent company of Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA") and Blue Cross Blue Shield Health Plan of Georgia, Inc. ("BCBSHP") (collectively, "BCBS").

3.

On February 22, 2011, the Federal Trade Commission ("FTC") issued a Civil Investigative Demand ("CID") to WellPoint and requested certain documents from WellPoint, including among other things contracts with hospitals in the relevant geographic area, documents reflecting negotiations of those contracts, data regarding inpatient admissions, information regarding products offered, documents relating to price increases, and documents relating to comparisons of hospitals. A copy of the Civil Investigative Demand is attached hereto as Exhibit A.

4.

In response to the CID, WellPoint and the FTC negotiated certain modifications to reduce the burden placed on WellPoint in responding to the CID. Among other things, the parties agreed to limit the geographic area that was implicated by the CID to Dougherty County and the contiguous counties. They also agreed to limit the relevant time period to January 1, 2008 through March 22, 2011. A copy of WellPoint's submission in response to CID, including correspondence memorializing the parties' modifications, is attached hereto as Exhibit B.

5.

In May of 2011, WellPoint produced several CDs of data and documents, and below is a brief description of the documents produced:

- Participating Hospital Agreements/Preferred Provider Agreements between BCBSGA and BCBSHP and the following hospitals:
    - Calhoun Memorial Hospital
    - Archbold Medical Center
    - South Georgia Surgical Associates
    - Palmyra Medical Center

    - Phoebe Health System
    - Phoebe Putney Memorial Hospital
    - Baptist Hospital Worth County;
- Correspondence regarding contracting between BCBSGA and BCBSHP, on the one hand, and HCA, Inc. and Palmyra Medical Center, on the other;
- Documents, including nearly 1800 emails and attachments, related to contracting and contract negotiations conducted by BCBSGA and BCBSHP;
- Inpatient admissions data;
- Fee schedule information for BCBSGA and BCBSHP; and
- Lists of network hospitals for particular products offered by BCBSGA and BCBSHP.

6.

BCBS has been informed by counsel for the FTC that the documents and data produced by WellPoint in May 2011 were provided to Respondents.

7.

In April of 2013, the FTC served a subpoena *duces tecum* ("FTC's Subpoena") on BCBS, essentially requesting that BCBS update the documents it produced in May of 2011. A copy of FTC's Subpoena to BCBS is attached hereto as Exhibit C.

8.

Consistent with the agreement reached in connection with the CID, FTC's Subpoena limits the relevant geographic area to the counties of Baker, Dougherty, Lee, Mitchell, Terrell, and Worth. Further, the FTC has agreed to apply to FTC's Subpoena the same modifications negotiated by the parties in connection with the CID. Accordingly, using the agreed-upon modifications, BCBS intends to conduct a reasonable and diligent search and to produce all relevant, non-privileged documents to the FTC in a timely manner. A copy of a letter memorializing the parties' modifications is attached hereto as Exhibit D. BCBS understands that all documents produced by BCBS in response to FTC's Subpoena will be provided to Respondents.

9.

On April 29, 2013, BCBS received a subpoena *duces tecum* propounded by Respondents Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., and Hospital Authority of Albany-Dougherty County ("Respondents' Subpoena"). I have reviewed Respondents' Subpoena. Compliance with Respondents' Subpoena will require BCBS to search for, review, and produce documents and data and will result in a large economic and administrative burden on BCBS. Moreover, if BCBS is compelled to comply with the requests contained in Respondents' Subpoena as stated, it would require a period of time far in excess of the deadline of May 21, 2013 contained in Respondents' Subpoena.

FURTHER AFFIANT SAYETH NOT.

MICHELLE M. ROTHENBERG-WILLIAMS

Sworn to and subscribed before me
this 9 day of May, 2013.

NOTARY PUBLIC
My Commission expires: 1/24/2016

NORA L MATHIS
NOTARY PUBLIC
CHEROKEE COUNTY, GEORGIA
MY COMMISSION EXPIRES JANUARY 24, 2016

EXHIBIT A

To Affidavit of Michelle M. Rothenberg-Williams

CIVIL INVESTIGATIVE DEMAND
ISSUED TO WELLPOINT, INC.
FTC File 111-0067

Unless modified by agreement with the staff of the Federal Trade Commission, each Specification of this Civil Investigative Demand ("CID") requires a complete search of "the Company" as defined in the Definitions and Instructions which appear after the following Specifications. If the Company believes that the required search or any other part of the CID can be narrowed in any way that is consistent with the Commission's need for information, you are encouraged to discuss such questions and possible modifications with the Commission representative identified in this CID. All modifications to this CID must be agreed to in writing.

SPECIFICATIONS

1. Submit, for each year from 2004 to the present, all contracts now in effect or that were in effect at any time since January 1, 2004, with hospitals in the relevant area, and each physician organization under contract with the Company whose contract was negotiated by or in conjunction with any such hospital (such as, but not limited to, a hospital-owned medical group practice, or hospital-affiliated physician-hospital organization), including any amendments or modifications thereto.

2. Submit, for each hospital contract provided or identified in response to Specification 1, a description of any services associated with covered treatments or diagnoses for which payments are made to another provider, and include the identity of each such provider by each service identified.

3. Submit, for each year from 2004 to the present, all documents relating to the development or negotiation of the contracts provided or identified in response to Specification 1, including, but not limited to, communications with hospitals, internal Company decisions regarding negotiating positions and proposed and final reimbursement rates, computer spreadsheets and programs the Company uses in connection with pricing decisions, training manuals or other internal documents that describe the Company's methods and procedures for determining proposed and final reimbursement rates, planned contracts (including contracts not entered into, not yet finalized or in force, or no longer in force), and amendments or modifications to existing contracts. Also provide a description of the ways in which these documents and information sources are used in the rate-setting process; and identify the Company's specific financial and operational benchmarks and requirements that impact the determination of the Company's proposed and final reimbursement rates.

4. Submit, for each year from 2006 to the present, for each inpatient admission, or outpatient treatment episode, for any patient residing in the relevant area, and in any county in Georgia, except for those counties in the Metro Atalanta area:

a. the identity of the hospital, healthcare facility, or physician practice at which the patient was treated, including the owner of the hospital, healthcare facility, or physician practice, the address of the hospital, healthcare facility, or physician practice including ZIP code, and any hospital, healthcare facility, or physician practice identification number used for reimbursement purposes;

b. a unique patient identifier, different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, by substituting a unique patient identifier);

c. the patient's residence 5-digit ZIP code;

d. the patient's age (in years), gender, and race;

e. the patient's newborn status;

f. whether the treatment episode was inpatient or outpatient, if inpatient, the date of admission and date of discharge, and if outpatient, the date of treatment;

g. the primary associated DRG and ICD9 diagnosis and procedure codes, and any secondary DRG and ICD9 diagnosis and procedure codes;

h. whether the treatment provided was for an emergency;

i. the source of the patient (such as by referral from another hospital, or by a physician who does not admit the patient);

j. the specific name of the entity and type of health plan offered by the Company (such as HMO, POS, PPO, ASO, etc.) that was the principal source of payment;

k. for each product listed in Specification 4(j), identify whether this product is offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;

l. whether the hospital, healthcare facility, or physician practice identified in response to Specification 4(a) was a participating provider under the patient's health plan and, if the patient's health plan had different tiers of participating providers, which tier the hospital, healthcare facility, or physician practice was in;

m. whether there was a capitation arrangement with a health plan, if any, covering the patient (identify the arrangement);

n. the billed charges of the hospital, healthcare facility, or physician practice, allowed charges under the patient's health plan, the amount of charges actually paid by the health plan, whether the amount of charges actually paid by the health plan includes any adjustments under any stop-loss provisions, and any additional amounts paid by the patient;

o. any breakdown of the hospital's, healthcare facility's, or physician practice's charges by any categories of hospital services rendered to the patient (such as medical/surgical, obstetrics, pediatrics, or ICU) for which the Company provides reimbursement to the hospital, healthcare facility, or physician practice at different per diem or other rates;

p. the identity of the patient's admitting physician and, if different, the identity of the treating physician;

q. the amount of any reimbursement by the Company to any physicians, separately from any reimbursement to the hospital, healthcare facility, or physician practice for any physician services associated with the admission or treatment, or for any services associated with covered treatments or diagnoses identified in Specification 4(n); and

r. the patient's status (*e.g.*, normal discharge, deceased, transferred to another hospital, etc.) upon discharge.

5. Identify, for each hospital under contract with the Company in the relevant area since January 1, 2004, and for each such hospital each physician organization under contract with the Company whose contract was negotiated by or in conjunction with the hospital, each person who is or was responsible for the Company's negotiation of contracts with the hospital or physician organization, the health plans or products for which each such person negotiates, and the time periods of that person's responsibilities.

6. Describe, for each health insurance product (such as HMO, POS, PPO, ASO, etc.) offered by the Company in the relevant area since January 1, 2006:

a. the name of the plan as it is referred to in the Company's claims data provided in response to Specification 4;

b. the number of covered lives in the plan, stated by county, if possible;

c. the counties in which the plan is offered;

d. the hospitals and physicians that are included in the plan or are preferred providers in the plan (if the plan is tiered, describe the hospitals and physicians in each tier); and, for each physician, the physician's specialty, employer, and affiliated hospital; and

e. the services or procedures covered by the plan and, for each service or procedure:

(i) all deductibles, co-pays, or co-insurance that apply and how these differ across tiers or between preferred and non-preferred providers; and

(ii) any other inducements offered to plan patients to use certain providers.

7. Submit all documents relating to the impact of hospital and other provider price increases, or the actual or contemplated changes in the composition of a provider network, in the relevant area during the relevant time period, on the price or quality of the health plan products offered by the Company, or other persons, to employers, employees, or other customers.

8. Submit all documents relating to (a) the quality of any hospital in the relevant area, and (b) any comparisons of quality, cost, price, variety or breadth of services, or consumer preference between or among any hospitals in the relevant area.

9. Submit all documents analyzing or discussing the effect of any merger, joint venture, acquisition, consolidation, or divestiture of hospitals in the relevant area, including both the relevant transaction and other transactions, on the hospitals' prices, costs, services, quality, or any other aspect of competitive performance, including, but not limited to, documents comparing the actual cost savings or other benefits of such transactions to those previously projected, and documents discussing how such benefits were or might be achieved.

10. Submit all information described in Instruction U below relating to, and other instructions necessary for the Commission to use or interpret, the databases or other data compilations submitted in response to this CID, to the extent such documentation is not contained in documents submitted in response to this CID.

11. Submit the name(s) and title(s) of the person(s) responsible for preparing the response to this CID and a copy of all instructions prepared by the Company relating to the steps taken to respond to this CID. Where oral instructions were given, identify the person who gave the instructions and describe the content of the instructions and the person(s) to whom the instructions were given. For each Specification, identify the individual(s) who assisted in the preparation of the response, with a listing of the persons (identified by name and corporate title or job description) whose files were searched by each.

DEFINITIONS AND INSTRUCTIONS

For the purposes of this CID, the following definitions and instructions apply:

A. The term "the Company" means WellPoint, Inc., its domestic and foreign parents, predecessors, divisions, subsidiaries, affiliates, partnerships and joint ventures, and all directors, officers, employees, agents, and representatives of the foregoing.

B. The terms "subsidiary," "affiliate," and "joint venture" refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.

C. The term "documents" means all computer files and written, recorded, and graphic materials of every kind in the possession, custody or control of the Company. The term "documents" includes, without limitation: electronic mail messages; electronic correspondence and drafts of documents; metadata and other bibliographic or historical data describing or relating to documents created, revised, or distributed on computer systems; copies of documents that are not identical duplicates of the originals in that person's files; and copies of documents the originals of which are not in the possession, custody, or control of the Company.

(1) Unless otherwise specified, the term "documents" excludes (a) bills of lading, invoices, purchase orders, customs declarations, and other similar documents of a purely transactional nature; (b) architectural plans and engineering blueprints; and (c) documents solely relating to enviroumental, tax, human resources, OSHA, or ERISA issues.

(2) The term "computer files" includes information stored in, or accessible through, computer or other information retrieval systems. Thus, the Company should produce documents that exist in machine-readable form, including documents stored in personal computers, portable computers, workstations, minicomputers, mainframes, servers, backup disks and tapes, archive disks and tapes, and other forms of offline storage, whether on or off company premises. If the Company believes that the required search of backup disks and tapes and archive disks and tapes can be narrowed in any way that is consistent with the Commission's need for documents and information, you are encouraged to discuss a possible modification to this instruction with the Commission representatives identified on the last page of this CID. The Commission representative will consider modifying this instruction to:

(a) exclude the search and production of files from backup disks and tapes and archive disks and tapes unless it appears that files are missing from files that exist in personal computers, portable computers, workstations, minicomputers, mainframes, and servers searched by the Company;

(b) limit the portion of backup disks and tapes and archive disks and tapes that needs to be searched and produced to certain key individuals, or certain time periods or certain specifications identified by Commission representatives; or

(c) include other proposals consistent with Commission policy and the facts of the case.

(3) If the Company intends to utilize any De-duplication or Near-de-duplication software or services when collecting or reviewing information that is stored in the Company's computer systems or electronic storage media in response to this CID, or if the Company's computer systems contain or utilize such software, the Company must contact Commission representatives to determine, with the assistance of the appropriate government technical officials, whether and in what manner the Company may use such software or services when producing materials in response to this CID.

D. The term "person" includes the Company and means any natural person, corporate entity, partnership, association, joint venture, government entity, or trust.

E. The term "relating to" means in whole or in part constituting, containing, concerning, discussing, describing, analyzing, identifying, or stating, but not merely referring to.

F. The terms "and" and "or" have both conjunctive and disjunctive meanings.

G. The terms "each," "any," and "all" mean "each and every."

H. The term "entity" means any natural person, corporation, company, partnership, joint venture, association, joint-stock company, trust, estate of a deceased natural person, foundation, fund, institution, society, union, or club, whether incorporated or not, wherever located and of whatever citizenship, or any receiver, trustee in bankruptcy or similar official or any liquidating agent for any of the foregoing, in his or her capacity as such.

I. The term "plans" means tentative and preliminary proposals, recommendations, or considerations, whether or not finalized or authorized, as well as those that have been adopted.

J. The term "relevant service" means the provision of general acute care hospital services including (1) inpatient services; (2) outpatient services; (3) emergency room services; (4) gastroenterological services; and (5) diagnostic imaging and scanning services including magnetic resonance imaging ("MRI"). The relevant service encompasses the provision of hospital care for medical diagnosis, treatment, and care of physically injured or sick persons with short-term or episodic health problems or infirmities but excludes treatments of mental illness or substance abuse, long-term services such as skilled nursing care, and services provided by a non-employee physician or non-owned physician organizations.

K. The term "relevant area" means the area encompassing the following counties in the State of Georgia: Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady,

Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Quitman, Pulaski, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Wilcox, and Worth.

L. The term "Metro Atlanta" area means the area encompassing the following counties in the State of Georgia: Fulton, DeKalb, Gwinnett, Cobb, Clayton, Cherokee, Douglas, Fayette, Rockdale, Hall, Coweta, Paulding, Forsyth, and Bartow.

M. The term "health plan" means any health maintenance organization, preferred provider arrangement or organization, managed health care plan of any kind, self-insured health benefit plan, other employer or union health benefit plan, Medicare, Medicaid, TRICARE, or private or governmental health care plan or insurance of any kind.

N. The term "hospital" means a facility that provides the relevant service as defined herein.

O. The term "provider" means a facility that provides any of the relevant services as defined herein, including, but not limited to, hospitals, physician group practices, or other healthcare facilities.

P. The term "physician group" means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, or employees, or in which only one physician practices medicine

Q. The term "operate" with reference to a hospital facility means to directly or indirectly own or lease the facility or unit, manage its operations on behalf of another person under a management contract, have the power to appoint the majority of the facility's governing board or body, or otherwise directly or indirectly control the facility or unit.

R. The term "relevant transaction" means and includes the proposed joinder or acquisition by the Hospital Authority of Albany - Dougherty County (the "Hospital Authority") of Palmyra Park Hospital, Inc. d/b/a Palmyra Medical Center ("Palmyra"), from HCA Inc., and all related transactions or agreements.

S. All references to year refer to calendar year. Unless otherwise specified, each of the specifications calls for documents and/or information for each of the years from January 1, 2006, to the present. Where information is requested, provide it separately for each year. Where yearly data is not yet available, provide data for the calendar year to date. If calendar year information is not available, supply the Company's fiscal year data indicating the twelve month period covered, and provide the Company's best estimate of calendar year data.

T. This CID shall be deemed continuing in nature so as to require production of all documents responsive to any specification included in this CID produced or obtained by the Company up to forty-five (45) calendar days prior to the date of the Company's full compliance with this CID.

U. To protect patient privacy, the Company shall mask any Sensitive Personally Identifiable Information ("PII") or Sensitive Health Information ("SHI"). For purposes of this CID, PII means an individual's Social Security Number alone; or an individual's name or address or phone number in combination with one or more of the following: date of birth, Social Security Number, driver's license number or other state identification number or a foreign country equivalent, passport number, financial account numbers, credit or debit card numbers. For purposes of this CID, SHI includes medical records or other individually identifiable health information. Where required by a particular specification, the Company shall substitute for the masked information a unique patient identifier that is different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient. Otherwise, the Company shall redact the PII or SHI but is not required to replace it with an alternate identifier.

V. Forms of Production: The Company shall submit documents as instructed below absent written consent signed by an Assistant Director of the Commission's Bureau of Competition.

(1) Documents stored in electronic or hard copy format in the ordinary course of business shall be submitted in electronic format provided that such copies are true, correct, and complete copies of the original documents:

(a) Submit Microsoft Access, Excel, and PowerPoint in native format with extracted text and metadata;

(b) Submit all other documents other than those identified in subpart (1)(a) in image format with extracted text[1] and metadata; and

(c) Submit all hard copy documents in image format accompanied by OCR.

(2) For each document submitted in electronic format, include the following metadata fields and information:

(a) For loose documents stored in electronic format other than email: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, and MD5 or SHA Hash value;

(b) For emails: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, to, from, CC, BCC, subject, date and time sent, Outlook Message ID (if applicable),

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[1] "Extracted text" is a term of art that refers to the underlying text of a native file that allows the native file to be converted into another searchable format.

child records (the beginning Bates or document identification number of attachments delimited by a semicolon);

(c) For email attachments: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, parent record (beginning Bates or document identification number of parent email), and MD5 or SHA Hash value; and

(d) For hard copy documents: beginning Bates or document identification number, ending Bates or document identification number, page count, and custodian.

(3) If the Company intends to utilize any de-duplication or email threading software or services when collecting or reviewing information that is stored in the Company's computer systems or electronic storage media in response to this CID, or if the Company's computer systems contain or utilize such software, the Company must contact a Commission representative to determine, with the assistance of the appropriate government technical officials, whether and in what manner the Company may use such software or services when producing materials in response to this CID.

(4) Submit data compilations in Excel spreadsheet or in delimited text formats, with all underlying data un-redacted and all underlying formulas and algorithms intact.

(5) Submit electronic files and images as follows:

(a) For productions over 10 gigabytes, use IDE and EIDE hard disk drives, formatted in Microsoft Windows-compatible, uncompressed data in USB 2.0 external enclosure;

(b) For productions under 10 gigabytes, CD-R CD-ROM and DVD-ROM for Windows-compatible personal computers, and USB 2.0 Flash Drives are also acceptable storage formats; and

(c) **All documents produced in electronic format shall be scanned for and free of viruses. The Commission will return any infected media for replacement, which may affect the timing of the Company's compliance with this CID.**

W. All documents responsive to this CID, regardless of format or form and regardless of whether submitted in hard copy or electronic format:

(1) Shall be produced in complete form, un-redacted unless privileged, and in the order in which they appear in the Company's files and shall not be shuffled or otherwise rearranged. For example:

(a) If in their original condition hard copy documents were stapled, clipped or otherwise fastened together or maintained in file folders, binders, covers or containers, they shall be produced in such form, and any documents that must be removed from their original folders, binders, covers or containers in order to be produced shall be identified in a manner so as to clearly specify the folder, binder, cover or container from which such documents came; and

(b) If in their original condition electronic documents were maintained in folders or otherwise organized, they shall be produced in such form and information shall be produced so as to clearly specify the folder or organization format;

(2) If written in a language other than English, shall be translated into English, with the English translation attached to the foreign language document;

(3) Shall be produced in color where necessary to interpret the document (if the coloring of any document communicates any substantive information, or if black-and-white photocopying or conversion to TIFF format of any document (*e.g.*, a chart or graph), makes any substantive information contained in the document unintelligible, the Company must submit the original document, a like-colored photocopy, or a JPEG format image);

(4) Shall be marked on each page with corporate identification and consecutive document control numbers;

(5) Shall be accompanied by an affidavit of an officer of the Company stating that the copies are true, correct and complete copies of the original documents; and

(6) Shall be accompanied by an index that identifies: (a) the name of each person from whom responsive documents are submitted; and (b) the corresponding consecutive document control number(s) used to identify that person's documents, and if submitted in paper form, the box number containing such documents. If the index exists as a computer file(s), provide the index both as a printed hard copy and in machine-readable form (provided that Commission representatives determine prior to submission that the machine-readable form would be in a format that allows the agency to use the computer files). The Commission representative will provide a sample index upon request.

X. If any documents are withheld from production based upon a claim of privilege, provide a statement of the claim of privilege and all facts relied upon in support thereof, in the form

of a log (hereinafter "Complete Log") that includes each document's authors, addressees, date, a description of each document, and all recipients of the original and any copies. Attachments to a document should be identified as such and entered separately on the log. For each author, addressee, and recipient, state the person's full name, title, and employer or firm. Denote all attorneys with an asterisk and state the representation. The description of the subject matter shall describe the nature of each document in a manner that, though not revealing information itself privileged, provides sufficiently detailed information to enable Commission staff, the Commission, or a court to assess the applicability of the privilege claimed. For each document withheld under a claim that it constitutes or contains attorney work product, also state whether the Company asserts that the document was prepared in anticipation of litigation or for trial and, if so, identify the anticipated litigation or trial upon which the assertion is based. Submit all nonprivileged portions of any responsive document (including nonprivileged or redactable attachments) for which a claim of privilege is asserted (except where the only nonprivileged information has already been produced in response to this instruction), noting where redactions in the document have been made. Documents authored by outside lawyers representing the Company that were not directly or indirectly furnished to the Company or any third-party, such as internal law firm memoranda, may be omitted from the log.

In place of a Complete Log of all documents withheld from production based on a claim of privilege, the Company may elect to submit a Partial Privilege Log ("Partial Log") for each person searched by the Company whose documents are withheld based on such claim and a Complete Log for a subset of those persons, as specified below:

(1) The Partial Log will contain the following information: (a) the name of each person from whom responsive documents are withheld on the basis of a claim of privilege; and (b) the total number of documents that are withheld under a claim of privilege (stating the number of attachments separately) contained in each such person's files. Submit all nonprivileged portions of any responsive document (including nonprivileged or redactable attachments) for which a claim of privilege is asserted (except where the only nonprivileged information has already been produced in response to this instruction), noting where redactions in the document have been made.

(2) Within five (5) business days after receipt of the Partial Log, Commission staff may identify in writing five individuals or ten percent of the total number of persons searched, whichever is greater, for which the Company will be required to produce a Complete Log in order to certify compliance with this CID.

(3) For the Company to exercise the option to produce a Partial Log, the Company must provide a signed statement in which the Company acknowledges and agrees that, in consideration for being permitted to submit a Partial Log:

(a) the Commission retains the right to serve a discovery request or requests regarding documents withheld on grounds of privilege in the event the Commission seeks relief through judicial or administrative proceedings;

(b) the Company will produce a Complete Log of all documents withheld from production based on a claim of privilege no later than fifteen (15) calendar days after such a discovery request is served, which will occur promptly after the filing of the Commission's complaint; and

(c) the Company waives all objections to such discovery, including the production of a Complete Log of all documents withheld from production based on a claim of privilege, except for any objections based strictly on privilege.

(4) The Company shall retain all privileged documents that are responsive to this CID until the completion of any investigation of the relevant transaction.

(5) The Commission will retain the right to require the Company to produce a Complete Log for all persons searched in appropriate circumstances.

Y. If the Company is unable to answer any question fully, supply such information as is available. Explain why such answer is incomplete, the efforts made by the Company to obtain the information, and the source from which the complete answer may be obtained. If books and records that provide accurate answers are not available, enter best estimates and describe how the estimates were derived, including the sources or bases of such estimates. Estimated data should be followed by the notation "est." If there is no reasonable way for the Company to make an estimate, provide an explanation.

Z. If documents responsive to a particular specification no longer exist for reasons other than the ordinary course of business or the implementation of the Company's document retention policy, but the Company has reason to believe have been in existence, state the circumstances under which they were lost or destroyed, describe the documents to the fullest extent possible, state the specification(s) to which they are responsive, and identify persons having knowledge of the content of such documents.

AA. In order for the Company's response to this CID to be complete, the attached certification form must be executed by the official supervising compliance with this CID, notarized, and submitted along with the responsive materials.

Any questions you have relating to the scope or meaning of anything in this CID or suggestions for possible modifications thereto should be directed to Stephen Sockwell at (202) 326-2950. The response to the CID shall be addressed to the attention of Stephen Sockwell, and delivered between 8:30 a.m. and 5:00 p.m. on any business day to the Federal Trade Commission's offices at 601 New Jersey Ave N.W., Washington, DC 20580. Please notify the staff listed above in advance of each such delivery.

EXHIBIT B

To Affidavit of Michelle M. Rothenberg-Williams

DONAHUE, DURHAM & NOONAN, P.C.

Michael G. Durham
Extension 111
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Concept Park
741 Boston Post Road
Suite 306
Guilford, CT 06437
Tel (203) 458-9168
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June 9, 2011

Attorney Goldie V. Walker
Federal Trade Commission
601 New Jersey Avenue, N.W.
Washington, DC 20001

RE: FTC File No. 111-0067 (Proposed acquisition by Hospital Authority Of Albany-Dougherty County of Palmyra Park Hospital, Inc. d/b/a Palmyra Medical Center from HCA, Inc.)
Civil Investigation Demand Issued To WellPoint, Inc.

Dear Attorney Walker:

As you know, our firm is outside counsel to WellPoint, Inc. ("WellPoint") in connection with the above Civil Investigation Demand ("CID") and I have been working with Attorney Katherine D. Mayberry from WellPoint to prepare its rolling compliance with the CID.

Enclosed please find WellPoint's compliance with the CID, as modified by Attorney Sockwell's April 6, 2011 letter, including WellPoint's CD marked WLPPPCID#3_002 (Document Bates Nos. 001013-001377).

WellPoint's compliance, including its production of CDs of data and documents on May 3, 2011 and May 20, 2011, is being provided in accordance with Section 57 of Title 15 of the United States Code and is subject to all of the Court's Orders, including the Protective Order Governing Discovery Materials issued by Chief Administrative Law Judge D. Michael Chappell on April 21, 2011 in In The Matter Of Phoebe Putney Health System, Inc., et al, Docket No. 9348. WellPoint requests that its disclosures and documents be afforded all of the protections of confidentiality available under the Court's Orders, including the cited April 21, 2011 Protective Order, and under Section 57b-2 of Title 15 and Title 16. WellPoint also requests that all of its materials produced in response to the CID be returned to my office at the termination of the Federal Trade Commission's statutory investigation. WellPoint reserves all of its rights to challenge in Court the authority for and the scope of the CID.

6/13/11
KS

Very truly yours,

Michael G. Durham

MGD/csr
enc

cc: Attorney Katherine D. Mayberry
Attorney Stephen W. Sockwell, Jr.

JUNE 9, 2011 COMPLIANCE WITH CIVIL INVESTIGATIVE DEMAND ISSUED TO WELLPOINT, INC. FTC File No. 111-0067

CIVIL INVESTIGATIVE DEMAND
ISSUED TO WELLPOINT, INC.
FTC File No. 101-0167

Unless modified by agreement with the staff of the Federal Trade Commission, each Specification of this Civil Investigative Demand ("CID") requires a complete search of "the Company" as defined in the Definitions and Instructions which appear after the following Specifications. If the Company believes that the required search or any other part of the CID can be narrowed in any way that is consistent with the Commission's need for information, you are encouraged to discuss such questions and possible modifications with the Commission representative identified in this CID. All modifications to this CID must be agreed to in writing.

GENERAL COMPLIANCE STATEMENT. WellPoint, Inc. ("WellPoint") hereby provides its compliance with the February 22, 2011 Civil Investigative Demand, as modified by Attorney W. Stephen Sockwell's April 6, 2011 letter (Attachment 1 hereto). WellPoint's compliance, including the Company's production of CDs of data and documents on May 3, 2011 and May 20, 2011, as identified herein, is subject to all of the court's orders, including the Protective Order Governing Discovery Material issued by Chief Administrative Law Judge D. Michael Chappell on April 21, 2011 in In The Matter Of Phoebe Putney Health System, Inc., et al, Docket No. 9348 (Attachment 2 hereto), and should otherwise be afforded all of the protections of confidentiality available under Section 57b-2 of Title 15 and under Title 16.

SPECIFICATIONS

1. Submit, for each year from 2004 to the present, all contracts now in effect or that were in effect at any time since January 1, 2004, with hospitals in the relevant area, and each physician organization under contract with the Company whose contract was negotiated by or in conjunction with any such hospital (such as, but not limited to, a hospital-owned medical group practice, or hospital-affiliated physician-hospital organization), including any amendments or modifications thereto.

RESPONSE:

See Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGa") and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. ("BCBSHPGa") hospital contracts contained on CD marked as WLPPPCID#1 (Document Bates Nos. 000001 - 000012) produced by the Company on May 20, 2011. Please also see the General Compliance Statement hereinabove.

2. Submit, for each hospital contract provided or identified in response to Specification 1, a description of any services associated with covered treatments or diagnoses for which payments are made to another provider, and include the identity of each such provider by each service identified.

RESPONSE:

None.

3. Submit, for each year from 2004 to the present, all documents relating to the development or negotiation of the contracts provided or identified in response to Specification 1, including, but not limited to, communications with hospitals, internal Company decisions regarding negotiating positions and proposed and final reimbursement rates, computer spreadsheets and programs the Company uses in connection with pricing decisions, training manuals or other internal documents that describe the Company's methods and procedures for determining proposed and final reimbursement rates, planned contracts (including contracts not entered into, not yet finalized or in force, or no longer in force), and amendments or modifications to existing contracts. Also provide a description of the ways in which these documents and information sources are used in the rate-setting process; and identify the Company's specific financial and operational benchmarks and requirements that impact the termination of the Company's proposed and final reimbursement rates.

RESPONSE:

See BCBSGa and BCBSHPGa documents contained on CD marked as WLPPPCID#3 (Document Bates Nos. 000001-001012) produced by the Company on May 20, 2011; and documents on CD marked as WLPPPCID#3_002 (Document Bates Nos. 001013-001377) produced with this supplemental compliance. Please also see the General Compliance Statement hereinabove.

4. Submit, for each year from 2006 to the present, for each inpatient admission, or outpatient treatment episode, for any patient residing in the relevant area, and in any county in Georgia, except for those counties in the Metro Atlanta area:

   a. the identity of the hospital, healthcare facility, or physician practice at which the patient was treated, including the owner of the hospital, healthcare facility, or physician practice, the address of the hospital, healthcare facility, or physician practice including ZIP code, and any hospital, healthcare facility, or physician practice identification number used for reimbursement purposes;

   b. a unique patient identifier, different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient (to protect patient privacy, the Company shall mask personal identifying

information, such as the patient's name or Social Security number, by substituting a unique patient identifier);

c. the patient's residence 5-digit ZIP code;

d. the patient's age (in years), gender, and race;

e. the patient's newborn status;

f. whether the treatment episode was inpatient or outpatient, if inpatient, the date of admission and date of discharge, and if outpatient, the date of treatment;

g. the primary associated DRG and ICD9 diagnosis and procedure codes, and any secondary DRG and ICD9 diagnosis and procedure codes;

h. whether the treatment provided was for an emergency;

i. the source of the patient (such as by referral from another hospital, or by a physician who does not admit the patient);

j. the specific name of the entity and type of health plan offered by the Company (such as HMO, POS, PPO, ASO, etc.) that was the principal source of payment;

k. for each product listed in Specification 4(j), identify whether this product is offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;

l. whether the hospital, healthcare facility, or physician practice identified in response to Specification 4(a) was a participating provider under the patient's health plan and, if the patient's health plan had different tiers of participating providers, which tier the hospital, healthcare facility, or physician practice was in;

m. whether there was a capitation arrangement with a health plan, if any, covering the patient (identify the arrangement);

n. the billed charges of the hospital, healthcare facility, or physician practice allowed charges under the patient's health plan, the amount of charges actually paid by the health plan, whether the amount of charges actually paid by the health plan includes any adjustments under any stop-loss provisions, and any additional amounts paid by the patient;

o. any breakdown of the hospital's, healthcare facility's, or physician practice's charges by any categories of hospital services rendered to the patient (such as medical/surgical, obstetrics, pediatrics, or ICU) for which the Company provides reimbursement to the hospital, healthcare facility, or physician practice at different per diem or other rates;

p. the identity of the patient's admitting physician and, if different, the identity of the treating physician;

q. the amount of any reimbursement by the Company to any physicians, separately from any reimbursement to the hospital, healthcare facility, or physician practice for any physician services associated with the admission or treatment, or for any services associated with covered treatments or diagnoses identified in Specification 4(n); and

r. the patient's status (*e.g.*, normal discharge, deceased, transferred to another hospital, etc.) upon discharge.

RESPONSE:

See BCBSGa and BCBSHPGa confidential and sensitive personal data contained on the CD produced by the Company on May 3, 2011. Please also see the General Compliance Statement hereinabove.

5. Identify, for each hospital under contract with the Company in the relevant area since January 1, 2004, and for each such hospital each physician organization under contract with the Company whose contract was negotiated by or in conjunction with the hospital, each person who is or was responsible for the Company's negotiation of contracts with the hospital or physician organization, the health plans or products for which each such person negotiates, and the time periods of that person's responsibilities.

RESPONSE:

To be provided.

6. Describe, for each health insurance product (such as HMO, POS, PPO, ASO, etc.) offered by the Company in the relevant area since January 1, 2006:

a. the name of the plan as it is referred to in the Company's claims data provided in response to Specification 4;

b. the number of covered lives in the plan, stated by county, if possible;

c. the counties in which the plan is offered;

d. the hospitals and physicians that are included in the plan or are preferred providers in the plan (if the plan is tiered, describe the hospitals and physicians in each tier); and, for each physician, the physician's specialty, employer, and affiliated hospital; and

e. the services or procedures covered by the plan and, for each service or procedure:

i. all deductibles, co-pays, or co-insurance that apply and how these differ across tiers or between preferred and non-preferred providers; and

ii. any other inducements offered to plan patients to use certain providers.

RESPONSE:

See BCBSGa and BCBSHPGa documents contained on CD marked as WLPPPCID#6 (Document Bates Nos. 0001-00169) produced by the Company on May 20, 2011. Please also see the General Compliance Statement hereinabove.

7. Submit all documents relating to the impact of hospital and other provider price increases, or the actual or contemplated changes in the composition of a provider network, in the relevant area during the relevant time period, on the price or quality of the health plan products offered by the Company, or other persons, to employers, employees, or other customers.

RESPONSE:

None.

8. Submit all documents relating to (a) the quality of any hospital in the relevant area, and (b) any comparisons of quality, cost, price, variety or breadth of services, or consumer preference between or among any hospitals in the relevant area.

RESPONSE:

See BCBSGa documents contained on CD marked as WLPPPCID#8 (Bates Nos. 00001-00006) produced by the Company on May 20, 2011. Please also see the General Compliance Statement hereinabove.

9. Submit all documents analyzing or discussing the effect of any merger, joint venture, acquisition, consolidation, or divestiture of hospitals in the relevant area, including both the relevant transaction and other transactions, on the hospitals' prices, costs, services, quality, or any other aspect of competitive performance, including, but not limited to, documents comparing the actual cost savings or other benefits of such transactions to those previously projected, and documents discussing how such benefits were or might be achieved.

RESPONSE:

None.

10. Submit all information described in Instruction U below relating to, and other instructions necessary for the Commission to use or to interpret, the databases or other data compilations submitted in response to this CID, to the extent such documentation is not contained in documents submitted in response to this CID.

RESPONSE:

None.

11. Submit the name(s) and title(s) of the person(s) responsible for preparing the response to this CID and a copy of all instructions prepared by the Company relating to the steps taken to respond to this CID. Where oral instructions were given, identify the person who gave the instructions and describe the content of the instructions and the person(s) to whom the instructions were given. For each Specification, identify the individual(s) who assisted in the preparation of the response, with a listing of the persons (identified by name and corporate title or job description) whose files were searched by each.

RESPONSE:

The information sought by this Request is privileged as the Company's attorneys have coordinated and prepared the Company's compliance with this CID.

DEFINITIONS AND INSTRUCTIONS

For the purpose of this CID, the following definitions and instructions apply:

A. The term "the Company" means WellPoint, Inc., its domestic and foreign parents, predecessors, divisions, subsidiaries, affiliates, partnerships and joint ventures, and all directors, officers, employees, agents, and representatives of the foregoing.

B. The terms "subsidiary", "affiliate", and "joint venture" refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.

C. The term "documents" means all computer files and written, recorded, and graphic materials of every kind in the possession, custody or control of the Company. The term "documents" includes, without limitation: electronic mail messages; electronic correspondence and drafts of documents; metadata and other bibliographic or historical data describing or relating to documents created, revised, or distributed on computer systems; copies of documents that are not identical duplicates of the originals in that person's files; and copies of documents the originals of which are not in the possession, custody, or control of the Company.

(1) Unless otherwise specified, the term "documents" excludes (a) bills of lading, invoices, purchase orders, customs declarations, and other similar documents of a purely transactional nature; (b) architectural plans and engineering blueprints; and (c) documents solely relating to environmental, tax, human resources, OSHA, or ERISA issues.

(2) The term "computer files" includes information stored in, or accessible through, computer or other information retrieval systems. Thus, the Company should produce documents that exist in machine-readable form, including documents stored in personal computers, portable computers, workstations, minicomputers, mainframes, servers, backup disks and tapes, archive disks and tapes, and other forms of offline storage, whether on or off company premises. If the Company believes that the required search of backup disks and tapes and archive disks and tapes can be narrowed in any way that is consistent with the Commission's need for documents and information, you are encouraged to discuss a possible modification to this instruction with the Commission representatives identified on the last page of this CID. The Commission representative will consider modifying this instruction to:

(a) exclude the search and production of files from backup disks and tapes and archive disks and tapes unless it appears that files are missing from files that exist in personal computers, portable computers, workstations, minicomputers, mainframes, and servers searched by the Company;

(b) limit the portion of backup disks and tapes and archive disks and tapes that needs to be searched and produced to certain key individuals, or certain time periods or certain specifications identified by Commission representatives; or

(c) include other proposals consistent with Commission policy and the facts of the case.

(3) If the Company intends to utilize any De-duplication or Near-de-duplication software or services when collecting or reviewing information that is stored in the Company's computer systems or electronic storage media in response to this CID, or if the Company's computer systems contain or utilize such software, the Company must contact Commission representatives to determine, with the assistance of the appropriate governmental technical officials, whether and in what manner the Company may use such software or services when producing materials in response to this CID.

D. The term "person" includes the Company and means any natural person, corporate entity, partnership, association, joint venture, government entity, or trust.

E. The term "relating to" means in whole or in part constituting, containing, concerning, discussing, describing, analyzing, identifying, or stating, but not merely referring to.

F. The terms "and" and "or" have both conjunctive and disjunctive meanings.

G. The terms "each", "any", and "all" mean "each and every".

H. The term "entity" means any natural person, corporation, company, partnership, joint venture, association, joint-stock company, trust, estate of a deceased natural person, foundation, fund, institution, society, union, or club, whether incorporated or not, wherever located and of whatever citizenship, or any receiver, trustee in bankruptcy or similar official or any liquidating agent for any of the foregoing, in his or her capacity as such.

I. The term "plans" means tentative and preliminary proposals, recommendations, or considerations, whether or not finalized or authorized, as well as those that have been adopted.

J. The term "relevant service" means the provision of general acute care hospital services, including (1) inpatient services; (2) outpatient services; (3) emergency room services; (4) gastroenterological services; and (5) diagnostic imaging and scanning services including magnetic resonance imaging ("MRI"). The relevant service encompasses the provision of hospital care for medical diagnosis, treatment, and care of physically injured or sick persons with short-term or episodic health problems or infirmities, but excludes treatments of mental illness or substances abuse, long-term services such as skilled

nursing care, and services provided by a non-employee physician or non-owned physician organizations.

K. The term "relevant area" means the area encompassing the following counties in the State of Georgia: Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Quitman, Pulaski, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Wilcox and Worth.

L. The term "Metro Atlanta" area means the area encompassing the following counties in the State of Georgia: Fulton, DeKalb, Gwinnett, Cobb, Clayton, Cherokee, Douglas, Fayette, Rockdale, Hall, Coweta, Paulding, Forsyth and Bartow.

M. The term "health plan" means any health maintenance organization, preferred provider arrangement or organization, managed health care plan of any kind, self-insured health benefit plan, other employer or union health benefit plan, Medicare, Medicaid, TRICARE, or private or governmental health care plan or insurance of any kind.

N. The term "hospital" means a facility that provides relevant service as defined herein.

O. The term "provider" means a facility that provides any of the relevant services as defined herein, including, but not limited to, hospitals, physician group practices, or other healthcare facilities.

P. The term "physician group" means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, or employees, or in which only one physician practices medicine.

Q. The term "operate" with reference to a hospital facility means to directly or indirectly own or lease the facility or unit, manage its operations on behalf of another person under a management contract, have the power to appoint the majority of the facility's governing board or body, or otherwise directly or indirectly control the facility or unit.

R. The term "relevant transaction" means and includes the proposed joinder or acquisition by the Hospital Authority of Albany – Dougherty County (the "Hospital Authority") of Palmyra Park Hospital, Inc. d/b/a Palmyra Medical Center ("Palmyra"), from HCA, Inc., and all related transactions or agreements.

S. All references to year refer to calendar year. Unless otherwise specified, each of the specifications calls for documents and/or information for each of the years from January 1, 2006, to the present. Where information is requested, provide it separately for each year. Where yearly data is not yet available, provide data for the calendar year to date. If calendar year information is not available, supply the Company's fiscal year data indicating the twelve month period covered, and provide the Company's best estimate of calendar year data.

T. This CID shall be deemed continuing in nature so as to require production of all documents responsive to any specification included in this CID produced or obtained by the Company up to forty-five (45) calendar days prior to the date of the Company's full compliance with this CID.

U. To protect patient privacy, the Company shall mask any Sensitive Personally Identifiable Information ("Sensitive PII") or Sensitive Health Information ("SHI"). For purposes of this CID, PII means an individual's Social Security Number alone; or an individual's name or address or phone number in combination with one or more of the following: date of birth, Social Security Number, driver's license number or other state identification number or a foreign country equivalent, passport number, financial account numbers, credit or debit card numbers. For purposes of this CID, SHI includes medical records or other individually identifiable health information. Where required by a particular specification, the Company shall substitute for the masked information a unique patient identifier that is different from that for other patients and the same as that for different admissions, discharges or other treatment episodes for the same patient. Otherwise, the Company shall redact the PII or SHI but is not required to replace it with an alternate identifier.

V. Forms of Production: The Company shall submit documents as instructed below absent written consent signed by the Assistant Director of the Commission's Bureau of Competition.

(1) Documents stored in electronic or hard copy formats in the ordinary course of business shall be submitted in electronic format provided that such copies are true, correct, and complete copies of the original documents:

(a) Submit Microsoft Access, Excel, and PowerPoint in native format with extracted text and metadata;

(b) Submit all other documents other than those identified in subpart(1)(a) in image format with extracted text[1] and metadata; and

(c) Submit all hard copy documents in image format accompanied by OCR.

(2) For each document submitted in electronic format, include the following metadata fields and information:

(a) For loose documents stored in electronic format other than email: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, and MD5 or SHA Hash value;

[1] "Extracted text" is a term of art that refers to the underlying text of a native file that allows the native file to be converted into another searchable format.

(b) For emails: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, to, from, CC, BCC, subject, date and time sent, Outlook Message ID (if applicable), child records (the beginning Bates or document identification number of attachments delimited by a semicolon);

(c) For email attachments: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, parent record (beginning Bates or document identification number of parent email), and MD5 or SHA Hash value; and

(d) For hard copy documents: beginning Bates or document identification number, ending Bates or document identification number, page count, and custodian.

(3) If the Company intends to utilize any de-duplication or email threading software or services when collecting or reviewing information that is stored in the Company's computer systems or electronic storage media in response to this CID, or if the Company's computer systems contain or utilize such software, the Company must contact a Commission representative to determine, with the assistance of the appropriate government technical officials, whether and in what manner the Company may use of such software or services when producing materials in response to this CID.

(4) Submit data compilations in Excel spreadsheets or in delimited text formats, with all underlying data un-redacted and all underlying formulas and algorithms intact.

(5) Submit electronic files and images as follows:

(a) For productions over 10 gigabytes, use IDE and EIDE hard disk drives, formatted in Microsoft Windows-compatible, uncompressed data in USB 2.0 external enclosure;

(b) For productions under 10 gigabytes, CD-R, CD-ROM and DVD-ROM for Windows-compatible personal computers, and USB 2.0 Flash Drives are also acceptable storage formats; and

(c) **All documents produced in electronic format shall be scanned for and free of viruses. The Commission will return any infected media for replacement, which may affect the timing of the Company's compliance with this CID.**

W. All documents responsive to this CID, regardless of format or form and regardless of whether submitted in hard copy or electronic format:

(1) Shall be produced in complete form, un-redacted, unless privileged, and in the order in which they appear in the Company's files, and shall not be shuffled or otherwise rearranged. For example:

(a) If in their original condition hard copy documents were stapled, clipped, or otherwise fastened together or maintained in file folders, binders, covers, or containers, they shall be produced in such form, and any documents that must be removed from their original folders, binders, covers, or containers in order to be produced shall be identified in a manner so as to clearly specify the folder, binder, cover, or container from which such documents came; and

(b) If in their original condition electronic documents were maintained in folders or otherwise organized, they shall be produced in such form and information shall be produced so as to clearly specify the folder or organization format;

(2) If written in a language other than English, shall be translated into English, with the English translation attached to the foreign language document;

(3) Shall be produced in color where necessary to interpret the document (if the coloring of any document communicates any substantive information, or if black-and-white photocopying or conversion to TIFF format of any document (*e.g.*, a chart or graph), makes any substantive information contained in the document unintelligible, the Company must submit the original document, a like-colored photocopy, or a JPEG format image);

(4) Shall be marked on each page with corporate identification and consecutive document control numbers;

(5) Shall be accompanied by an affidavit of an officer of the Company stating that the copies are true, correct, and complete copies of the original documents; and

(6) Shall be accompanied by an index that identifies: (a) the name of each person from whom responsive documents are submitted; and (b) the corresponding consecutive document control number(s) used to identify that person's documents, and if submitted in paper form, the box number containing such documents. If the index exists as a computer file(s), provide the index both as a printed hard copy and in machine-readable form (provided that Commission representatives determine prior to submission that the machine-readable form would be in a format that allows the agency to use the computer files). The Commission representative will provide a sample index upon request.

X. If any documents are withheld from production based on a claim of privilege, provide a statement of the claim of privilege and all facts relied upon in support thereof, in the form of a log (hereinafter "Complete Log") that includes each document's authors, addressees, date, a description of each document, and all recipients of the original and any copies. Attachments to a document should be identified as such and entered separately on the log. For each author, addressee, and recipient, state the person's full name, title, and employer or firm. Denote all attorneys with an asterisk and state the representation. The description of the subject matter shall describe the nature of each document in a manner that, though not revealing information itself privileged, provides sufficiently detailed information to enable Commission staff, the Commission, or a court to assess the applicability of the privilege claimed. For each document withheld under a claim that it constitutes or contains attorney work product, also state whether the Company asserts that the document was prepared in anticipation of litigation or for trial and, if so, identify the anticipated litigation or trial upon which the assertion is based. Submit all nonprivileged portions of any responsive document (including nonprivileged or redactable attachments) for which a claim of privilege is asserted (except where the only nonprivileged information has already been produced in response to this instruction), noting where redactions in the document have been made. Documents authored by outside lawyers representing the Company that were not directly or indirectly furnished to the Company or any third-party, such as internal law firm memoranda, may be omitted from the log.

In place of a Complete Log of all documents withheld from production based on a claim of privilege, the Company may elect to submit a Partial Privilege Log ("Partial Log") for each person searched by the Company whose documents are withheld based on such claim and a Complete Log for a subset of those persons, as specified below:

(1) The Partial Log will contain the following information: (a) the name of each person from whom responsive documents are withheld on the basis of a claim of privilege; and (b) the total number of documents that are withheld under a claim of privilege (stating the number of attachments separately) contained in each such person's files. Submit all nonprivileged portions of any responsive document (including nonprivileged or redactable attachments) for which a claim of privilege is asserted (except where the only nonprivileged information has already been produced in response to this instruction), noting where redactions in the document have been made.

(2) Within five (5) business days after receipt of the Partial Log, Commission staff may identify in writing five individuals or ten percent of the total number of persons searched, whichever is greater, for which the Company will be required to produce a Complete Log in order to certify compliance with this CID.

(3) For the Company to exercise the option to produce a Partial Log, the Company must provide a signed statement in which the Company acknowledges and agrees that, in consideration for being permitted to submit a Partial Log:

(a) the Commission retains the right to serve a discovery request or requests regarding documents withheld on grounds of privilege in the event the Commission seeks relief through judicial or administrative proceedings;

(b) the Company will produce a Complete Log of all documents withheld from production based on a claim of privilege no later than fifteen (15) calendar days after such a discovery request is served, which will occur promptly after the filing of the Commission's complaint; and

(c) the Company waives all objections to such discovery, including the production of a Complete Log of all documents withheld from production based on a claim of privilege, except for any objections based strictly on privilege.

(4) The Company shall retain all privileged documents that are responsive to this CID until the completion of any investigation of the relevant transaction.

(5) The Commission will retain the right to require the Company to produce a Complete Log for all persons searched in appropriate circumstances.

Y. If the Company is unable to answer any question fully, supply such information as is available. Explain why such answer is incomplete, the efforts made by the Company to obtain the information, and the source from which the complete answer may be obtained. If books and records that provide accurate answers are not available, enter best estimates and describe how the estimates were derived, including the sources or bases of such estimates. Estimated data should be followed by the notation "est." If there is no reasonable way for the Company to make an estimate, provide an explanation.

Z. If documents responsive to a particular specification no longer exist for reasons other than the ordinary course of business or the implementation of the Company's document retention policy, but the Company has reason to believe have been in existence, state the circumstances under which they were lost or destroyed, describe the documents to the fullest extent possible, state the specification(s) to which they are responsive, and identify persons having knowledge or the content of such documents.

AA. In order for the Company's response to this CID to be complete, the attached certification form must be executed by the official supervising compliance with this CID, notarized, and submitted along with the responsive materials.

ATTACHMENT 1

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
W. Stephen Sockwell
Direct Dial
(202) 326-2950

April 6, 2011

VIA E-MAIL

Katherine D. Mayberry, Esquire
Senior Legal Counsel
WellPoint, Inc.
120 Monument Circle
Indianapolis, Indiana

RE: Phoebe Putney Hospital System/Palmyra Medical Center, FTC File No. 111-0067

Dear Kathy:

This letter responds to your e-mail dated March 17, 2011, concerning the Civil Investigative Demand ("CID") issued to WellPoint Inc. ("WellPoint") in the Federal Trade Commission's (the "Commission's") investigation of the above-captioned matter. Your e-mail requested certain modifications to the CID. This letter also reflects subsequent discussions. We agree to the following modifications:

Response time: We agree to accept a rolling submission of data and documents.

Scope of production: WellPoint's production need be only for the state of Georgia. WellPoint does not need to produce corporate level documents that do not deal with the relevant area, as set forth in the CID.

Instruction C (documents): We agree to limit the scope of custodians who are to be searched to people in the provider contracting, actuarial, and marketing functions.

Instruction K (relevant area): Except for Specifications 4 and 6 of the CID, the county scope is modified to Dougherty County and the contiguous counties.

Instruction V (format of production): WellPoint may produce documents in their native format.

Instruction S (time period): Except for Specifications 1 and 3, WellPoint can produce documents from January 1, 2008, to March 22, 2011. We make this modification as an accommodation to reduce WellPoint's search burden. However, we may have need of additional

data, or documents, beyond this time to complete our analysis. Therefore, we are willing to defer the requirement that WellPoint currently produce documents or data from 2006 forward, unless we notify you of this requirement.

Specification 4: WellPoint may use search terms consistent with those that WellPoint used in responding to the Commission's CID issued in its *ProMedica Health System/St. Luke's Hospital*, File No. 101-0167, investigation.

Specifications 7-9: WellPoint may produce only management-level correspondence, reports, and other documents responsive to these specifications.

If you have questions, or need to discuss any other aspects of WellPoint's submission, please give me a call and we can discuss any issues.

Kind regards,

W. Stephen Sockwell
Attorney

Approved by:

Matthew J. Reilly
Assistant Director
Mergers IV

ATTACHMENT 2

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

ORIGINAL

In the Matter of	
PHOEBE PUTNEY HEALTH SYSTEM, INC., and	
PHOEBE PUTNEY MEMORIAL HOSPITAL, INC., and	DOCKET NO. 9348
PHOEBE NORTH, INC., and	
HCA INC., and	
PALMYRA PARK HOSPITAL, INC., and	
HOSPITAL AUTHORITY OF, ALBANY-DOUGHERTY COUNTY, Respondents.	

PROTECTIVE ORDER GOVERNING DISCOVERY MATERIAL

Commission Rule 3.31(d) states: "In order to protect the parties and third parties against improper use and disclosure of confidential information, the Administrative Law Judge shall issue a protective order as set forth in the appendix to this section." 16 C.F.R. § 3.31(d). Pursuant to Commission Rule 3.31(d), the protective order set forth in the appendix to that section is attached verbatim as Attachment A and is hereby issued.

ORDERED:

D. Michael Chappell
Chief Administrative Law Judge

Date: April 21, 2011

ATTACHMENT A

For the purpose of protecting the interests of the parties and third parties in the above-captioned matter against improper use and disclosure of confidential information submitted or produced in connection with this matter:

IT IS HEREBY ORDERED THAT this Protective Order Governing Confidential Material ("Protective Order") shall govern the handling of all Discovery Material, as hereafter defined.

1. As used in this Order, "confidential material" shall refer to any document or portion thereof that contains privileged, competitively sensitive information, or sensitive personal information. "Sensitive personal information" shall refer to, but shall not be limited to, an individual's Social Security number, taxpayer identification number, financial account number, credit card or debit card number, driver's license number, state-issued identification number, passport number, date of birth (other than year), and any sensitive health information identifiable by individual, such as an individual's medical records. "Document" shall refer to any discoverable writing, recording, transcript of oral testimony, or electronically stored information in the possession of a party or a third party. "Commission" shall refer to the Federal Trade Commission ("FTC"), or any of its employees, agents, attorneys, and all other persons acting on its behalf, excluding persons retained as consultants or experts for purposes of this proceeding.

2. Any document or portion thereof submitted by a respondent or a third party during a Federal Trade Commission investigation or during the course of this proceeding that is entitled to confidentiality under the Federal Trade Commission Act, or any regulation, interpretation, or precedent concerning documents in the possession of the Commission, as well as any information taken from any portion of such document, shall be treated as confidential material for purposes of this Order. The identity of a third party submitting such confidential material shall also be treated as confidential material for the purposes of this Order where the submitter has requested such confidential treatment.

3. The parties and any third parties, in complying with informal discovery requests, disclosure requirements, or discovery demands in this proceeding may designate any responsive document or portion thereof as confidential material, including documents obtained by them from third parties pursuant to discovery or as otherwise obtained.

4. The parties, in conducting discovery from third parties, shall provide to each third party a copy of this Order so as to inform each such third party of his, her, or its rights herein.

5. A designation of confidentiality shall constitute a representation in good faith and after careful determination that the material is not reasonably believed to be already in the public domain and that counsel believes the material so designated constitutes confidential material as defined in Paragraph 1 of this Order.

6. Material may be designated as confidential by placing on or affixing to the document containing such material (in such manner as will not interfere with the legibility thereof), or if an entire folder or box of documents is confidential by placing or affixing to that folder or box, the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, together with an indication of the portion or portions of the document considered to be confidential material. Confidential information contained in electronic documents may also be designated as confidential by placing the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, on the face of the CD or DVD or other medium on which the document is produced. Masked or otherwise redacted copies of documents may be produced where the portions deleted contain privileged matter, provided that the copy produced shall indicate at the appropriate point that portions have been deleted and the reasons therefor.

7. Confidential material shall be disclosed only to: (a) the Administrative Law Judge presiding over this proceeding, personnel assisting the Administrative Law Judge, the Commission and its employees, and personnel retained by the Commission as experts or consultants for this proceeding; (b) judges and other court personnel of any court having jurisdiction over any appellate proceedings involving this matter; (c) outside counsel of record for any respondent, their associated attorneys and other employees of their law firm(s), provided they are not employees of a respondent; (d) anyone retained to assist outside counsel in the preparation or hearing of this proceeding including consultants, provided they are not affiliated in any way with a respondent and have signed an agreement to abide by the terms of the protective order; and (e) any witness or deponent who may have authored or received the information in question.

8. Disclosure of confidential material to any person described in Paragraph 7 of this Order shall be only for the purposes of the preparation and hearing of this proceeding, or any appeal therefrom, and for no other purpose whatsoever, provided, however, that the Commission may, subject to taking appropriate steps to preserve the confidentiality of such material, use or disclose confidential material as provided by its Rules of Practice; sections 6(f) and 21 of the Federal Trade Commission Act; or any other legal obligation imposed upon the Commission.

9. In the event that any confidential material is contained in any pleading, motion, exhibit or other paper filed or to be filed with the Secretary of the Commission, the Secretary shall be so informed by the Party filing such papers, and such papers shall be filed *in camera*. To the extent that such material was originally submitted by a third party, the party including the materials in its papers shall immediately notify the submitter of such inclusion. Confidential material contained in the papers shall continue to have *in camera* treatment until further order of the Administrative Law Judge, provided, however, that such papers may be furnished to persons or entities who may receive confidential material pursuant to Paragraphs 7 or 8. Upon or after filing any paper containing confidential material, the filing party shall file on the public record a duplicate copy of the paper that does not reveal confidential material. Further, if the protection for any such material expires, a party may file on the public record a duplicate copy which also contains the formerly protected material.

10. If counsel plans to introduce into evidence at the hearing any document or transcript containing confidential material produced by another party or by a third party, they shall provide advance notice to the other party or third party for purposes of allowing that party to seek an order that the document or transcript be granted *in camera* treatment. If that party wishes *in camera* treatment for the document or transcript, the party shall file an appropriate motion with the Administrative Law Judge within 5 days after it receives such notice. Except where such an order is granted, all documents and transcripts shall be part of the public record. Where *in camera* treatment is granted, a duplicate copy of such document or transcript with the confidential material deleted therefrom may be placed on the public record.

11. If any party receives a discovery request in any investigation or in any other proceeding or matter that may require the disclosure of confidential material submitted by another party or third party, the recipient of the discovery request shall promptly notify the submitter of receipt of such request. Unless a shorter time is mandated by an order of a court, such notification shall be in writing and be received by the submitter at least 10 business days before production, and shall include a copy of this Protective Order and a cover letter that will apprise the submitter of its rights hereunder. Nothing herein shall be construed as requiring the recipient of the discovery request or anyone else covered by this Order to challenge or appeal any order requiring production of confidential material, to subject itself to any penalties for non-compliance with any such order, or to seek any relief from the Administrative Law Judge or the Commission. The recipient shall not oppose the submitter's efforts to challenge the disclosure of confidential material. In addition, nothing herein shall limit the applicability of Rule 4.11(e) of the Commission's Rules of Practice, 16 CFR 4.11(e), to discovery requests in another proceeding that are directed to the Commission.

12. At the time that any consultant or other person retained to assist counsel in the preparation of this action concludes participation in the action, such person shall return to counsel all copies of documents or portions thereof designated confidential that are in the possession of such person, together with all notes, memoranda or other papers containing confidential information. At the conclusion of this proceeding, including the exhaustion of judicial review, the parties shall return documents obtained in this action to their submitters, provided, however, that the Commission's obligation to return documents shall be governed by the provisions of Rule 4.12 of the Rules of Practice, 16 CFR 4.12.

13. The provisions of this Protective Order, insofar as they restrict the communication and use of confidential discovery material, shall, without written permission of the submitter or further order of the Commission, continue to be binding after the conclusion of this proceeding.

EXHIBIT C

To Affidavit of Michelle M. Rothenberg-Williams

SUBPOENA DUCES TECUM

Provided by the Secretary of the Federal Trade Commission, and Issued Pursuant to Commission Rule 3.34(b), 16 C.F.R. § 3.34(b)(2010)

1. TO

Blue Cross & Blue Shield of Georgia, Inc. &
Blue Cross & Blue Shield Health Plans of Georgia, Inc.
c/o Michelle Rothenberg-Williams, Esq.
350 Peachtree Road
Atlanta, GA 30326

2. FROM

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

This subpoena requires you to produce and permit inspection and copying of designated books, documents (as defined in Rule 3.34(b)), or tangible things, at the date and time specified in Item 5, and at the request of Counsel listed in Item 9, in the proceeding described in Item 6.

3. PLACE OF PRODUCTION

Federal Trade Commission
601 New Jersey Avenue NW
Washington, DC 20001

4. MATERIAL WILL BE PRODUCED TO

Stephen Sockwell, Complaint Counsel

5. DATE AND TIME OF PRODUCTION

May 16, 2013

6. SUBJECT OF PROCEEDING

In the Matter of Phoebe Putney Health System, Inc., et al., Docket No. 9348

7. MATERIAL TO BE PRODUCED

Documents & materials responsive to the attached Subpoena Duces Tecum Requests for Production

8. ADMINISTRATIVE LAW JUDGE

The Honorable D. Michael Chappell

Federal Trade Commission
Washington, D.C. 20580

9. COUNSEL AND PARTY ISSUING SUBPOENA

Jeffrey Perry or designee
Federal Trade Commission
601 New Jersey Avenue NW
Washington, DC 20001
(202) 326-2331

DATE SIGNED

4/25/13

SIGNATURE OF COUNSEL ISSUING SUBPOENA

GENERAL INSTRUCTIONS

APPEARANCE

The delivery of this subpoena to you by any method prescribed by the Commission's Rules of Practice is legal service and may subject you to a penalty imposed by law for failure to comply.

MOTION TO LIMIT OR QUASH

The Commission's Rules of Practice require that any motion to limit or quash this subpoena must comply with Commission Rule 3.34(c), 16 C.F.R. § 3.34(c), and in particular must be filed within the earlier of 10 days after service or the time for compliance. The original and ten copies of the petition must be filed before the Administrative Law Judge and with the Secretary of the Commission, accompanied by an affidavit of service of the document upon counsel listed in Item 9, and upon all other parties prescribed by the Rules of Practice.

TRAVEL EXPENSES

The Commission's Rules of Practice require that fees and mileage be paid by the party that requested your appearance. You should present your claim to counsel listed in Item 9 for payment. If you are permanently or temporarily living somewhere other than the address on this subpoena and it would require excessive travel for you to appear, you must get prior approval from counsel listed in Item 9.

A copy of the Commission's Rules of Practice is available online at http://bit.ly/FTCRulesofPractice. Paper copies are available upon request.

This subpoena does not require approval by OMB under the Paperwork Reduction Act of 1980.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

ORIGINAL

In the Matter of	
PHOEBE PUTNEY HEALTH SYSTEM, INC., and	
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PHOEBE NORTH, INC., and	
HCA INC., and	
PALMYRA PARK HOSPITAL, INC., and	
HOSPITAL AUTHORITY OF, ALBANY-DOUGHERTY COUNTY, Respondents.	

PROTECTIVE ORDER GOVERNING DISCOVERY MATERIAL

Commission Rule 3.31(d) states: "In order to protect the parties and third parties against improper use and disclosure of confidential information, the Administrative Law Judge shall issue a protective order as set forth in the appendix to this section." 16 C.F.R. § 3.31(d). Pursuant to Commission Rule 3.31(d), the protective order set forth in the appendix to that section is attached verbatim as Attachment A and is hereby issued.

ORDERED:

D. Michael Chappell
Chief Administrative Law Judge

Date: April 21, 2011

ATTACHMENT A

For the purpose of protecting the interests of the parties and third parties in the above-captioned matter against improper use and disclosure of confidential information submitted or produced in connection with this matter:

IT IS HEREBY ORDERED THAT this Protective Order Governing Confidential Material ("Protective Order") shall govern the handling of all Discovery Material, as hereafter defined.

1. As used in this Order, "confidential material" shall refer to any document or portion thereof that contains privileged, competitively sensitive information, or sensitive personal information. "Sensitive personal information" shall refer to, but shall not be limited to, an individual's Social Security number, taxpayer identification number, financial account number, credit card or debit card number, driver's license number, state-issued identification number, passport number, date of birth (other than year), and any sensitive health information identifiable by individual, such as an individual's medical records. "Document" shall refer to any discoverable writing, recording, transcript of oral testimony, or electronically stored information in the possession of a party or a third party. "Commission" shall refer to the Federal Trade Commission ("FTC"), or any of its employees, agents, attorneys, and all other persons acting on its behalf, excluding persons retained as consultants or experts for purposes of this proceeding.

2. Any document or portion thereof submitted by a respondent or a third party during a Federal Trade Commission investigation or during the course of this proceeding that is entitled to confidentiality under the Federal Trade Commission Act, or any regulation, interpretation, or precedent concerning documents in the possession of the Commission, as well as any information taken from any portion of such document, shall be treated as confidential material for purposes of this Order. The identity of a third party submitting such confidential material shall also be treated as confidential material for the purposes of this Order where the submitter has requested such confidential treatment.

3. The parties and any third parties, in complying with informal discovery requests, disclosure requirements, or discovery demands in this proceeding may designate any responsive document or portion thereof as confidential material, including documents obtained by them from third parties pursuant to discovery or as otherwise obtained.

4. The parties, in conducting discovery from third parties, shall provide to each third party a copy of this Order so as to inform each such third party of his, her, or its rights herein.

5. A designation of confidentiality shall constitute a representation in good faith and after careful determination that the material is not reasonably believed to be already in the public domain and that counsel believes the material so designated constitutes confidential material as defined in Paragraph 1 of this Order.

6. Material may be designated as confidential by placing on or affixing to the document containing such material (in such manner as will not interfere with the legibility thereof), or if an entire folder or box of documents is confidential by placing or affixing to that folder or box, the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, together with an indication of the portion or portions of the document considered to be confidential material. Confidential information contained in electronic documents may also be designated as confidential by placing the designation "CONFIDENTIAL–FTC Docket No. 9348" or any other appropriate notice that identifies this proceeding, on the face of the CD or DVD or other medium on which the document is produced. Masked or otherwise redacted copies of documents may be produced where the portions deleted contain privileged matter, provided that the copy produced shall indicate at the appropriate point that portions have been deleted and the reasons therefor.

7. Confidential material shall be disclosed only to: (a) the Administrative Law Judge presiding over this proceeding, personnel assisting the Administrative Law Judge, the Commission and its employees, and personnel retained by the Commission as experts or consultants for this proceeding; (b) judges and other court personnel of any court having jurisdiction over any appellate proceedings involving this matter; (c) outside counsel of record for any respondent, their associated attorneys and other employees of their law firm(s), provided they are not employees of a respondent; (d) anyone retained to assist outside counsel in the preparation or hearing of this proceeding including consultants, provided they are not affiliated in any way with a respondent and have signed an agreement to abide by the terms of the protective order; and (e) any witness or deponent who may have authored or received the information in question.

8. Disclosure of confidential material to any person described in Paragraph 7 of this Order shall be only for the purposes of the preparation and hearing of this proceeding, or any appeal therefrom, and for no other purpose whatsoever, provided, however, that the Commission may, subject to taking appropriate steps to preserve the confidentiality of such material, use or disclose confidential material as provided by its Rules of Practice; sections 6(f) and 21 of the Federal Trade Commission Act; or any other legal obligation imposed upon the Commission.

9. In the event that any confidential material is contained in any pleading, motion, exhibit or other paper filed or to be filed with the Secretary of the Commission, the Secretary shall be so informed by the Party filing such papers, and such papers shall be filed *in camera*. To the extent that such material was originally submitted by a third party, the party including the materials in its papers shall immediately notify the submitter of such inclusion. Confidential material contained in the papers shall continue to have *in camera* treatment until further order of the Administrative Law Judge, provided, however, that such papers may be furnished to persons or entities who may receive confidential material pursuant to Paragraphs 7 or 8. Upon or after filing any paper containing confidential material, the filing party shall file on the public record a duplicate copy of the paper that does not reveal confidential material. Further, if the protection for any such material expires, a party may file on the public record a duplicate copy which also contains the formerly protected material.

10. If counsel plans to introduce into evidence at the hearing any document or transcript containing confidential material produced by another party or by a third party, they shall provide advance notice to the other party or third party for purposes of allowing that party to seek an order that the document or transcript be granted *in camera* treatment. If that party wishes *in camera* treatment for the document or transcript, the party shall file an appropriate motion with the Administrative Law Judge within 5 days after it receives such notice. Except where such an order is granted, all documents and transcripts shall be part of the public record. Where *in camera* treatment is granted, a duplicate copy of such document or transcript with the confidential material deleted therefrom may be placed on the public record.

11. If any party receives a discovery request in any investigation or in any other proceeding or matter that may require the disclosure of confidential material submitted by another party or third party, the recipient of the discovery request shall promptly notify the submitter of receipt of such request. Unless a shorter time is mandated by an order of a court, such notification shall be in writing and be received by the submitter at least 10 business days before production, and shall include a copy of this Protective Order and a cover letter that will apprise the submitter of its rights hereunder. Nothing herein shall be construed as requiring the recipient of the discovery request or anyone else covered by this Order to challenge or appeal any order requiring production of confidential material, to subject itself to any penalties for non-compliance with any such order, or to seek any relief from the Administrative Law Judge or the Commission. The recipient shall not oppose the submitter's efforts to challenge the disclosure of confidential material. In addition, nothing herein shall limit the applicability of Rule 4.11(e) of the Commission's Rules of Practice, 16 CFR 4.11(e), to discovery requests in another proceeding that are directed to the Commission.

12. At the time that any consultant or other person retained to assist counsel in the preparation of this action concludes participation in the action, such person shall return to counsel all copies of documents or portions thereof designated confidential that are in the possession of such person, together with all notes, memoranda or other papers containing confidential information. At the conclusion of this proceeding, including the exhaustion of judicial review, the parties shall return documents obtained in this action to their submitters, provided, however, that the Commission's obligation to return documents shall be governed by the provisions of Rule 4.12 of the Rules of Practice, 16 CFR 4.12.

13. The provisions of this Protective Order, insofar as they restrict the communication and use of confidential discovery material, shall, without written permission of the submitter or further order of the Commission, continue to be binding after the conclusion of this proceeding.

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of	)	
	)	
Phoebe Putney Health System, Inc.	)	
a corporation, and	)	
	)	
Phoebe Putney Memorial Hospital, Inc.	)	
a corporation, and	)	DOCKET NO. 9348
	)	
Phoebe North, Inc.	)	
a corporation, and	)	
	)	
HCA Inc.	)	
a corporation, and	)	
	)	
Palmyra Park Hospital, Inc.	)	
a corporation, and	)	
	)	
Hospital Authority of Albany-Dougherty County.	)	
	)	

COMPLAINT COUNSEL'S SUBPOENA *DUCES TECUM* TO
BLUE CROSS & BLUE SHIELD OF GEORGIA, INC. AND
BLUE CROSS & BLUE SHIELD HEALTH PLANS OF GEORGIA, INC.

Pursuant to the Federal Trade Commission's Rules of Practice, 16 C.F.R. §§ 3.31 and 3.34, and the Scheduling Order entered by Chief Administrative Law Judge Chappell on April 4, 2013, Complaint Counsel hereby requests that Blue Cross & Blue Shield of Georgia, Inc. and Blue Cross & Blue Shield Health Plan of Georgia, Inc. produce the following in accordance with the Definitions and Instructions set forth below:

1. Submit all contracts currently in effect or having been in effect at any time since January 1, 2011, with hospitals in the relevant area, and with each physician organization whose contract with the Company was negotiated by or in conjunction with any such hospital (such as, but not limited to, a hospital-owned medical group practice, or hospital-affiliated physician-hospital organization), including any amendments or modifications thereto.

2. Submit, for each hospital contract provided or identified in response to Specification 1, a listing of which physician services (if any) are included in the hospital's payment for an inpatient admission, and which physician services are billed separately.

3. Submit, for each year from 2011 to the present, all documents relating to the development or negotiation of the contracts provided or identified in response to Specification 1, including, but not limited to, communications with hospitals, internal Company documents or analyses relating to negotiating positions and proposed and final reimbursement rates, computer spreadsheets and programs the Company uses in connection with pricing decisions, training manuals or other internal documents that describe the Company's methods and procedures for determining proposed and final reimbursement rates, planned contracts (including contracts not entered into, not yet finalized or in force, or no longer in force), and amendments or modifications to existing contracts.

4. Submit all documents relating to the efforts or plans of any hospital in the relevant area to induce, impose, or otherwise secure, its exclusive participation in the Company's preferred provider network or the exclusion of another hospital or provider from the Company's network.

5. Submit all documents that relate to changes in hospital charges or reimbursement rates for provision of relevant services in the relevant area at any time after Phoebe Putney acquired Palmyra Park Hospital.

6. Submit all documents relating to (a) enhancements or changes in hospital quality or quality of relevant services offered by hospitals in the relevant area, (b) the transfer, relocation, limitation, diminution, or elimination of any relevant service offered at either the former Palmyra Park Hospital, currently known as Phoebe North, or Phoebe Putney Memorial Hospital, or (c) changes or shifts in the provision of, or consolidation of, relevant services provided by the former Palmyra Hospital and Phoebe Putney Memorial Hospital.

7. All documents that relate to reimbursement programs or initiatives of the Company to encourage or incentivize hospitals in the relevant area to meet standards of quality set forth by the Company.

DEFINITIONS

1. The term "the Company" means Blue Cross & Blue Shield of Georgia, Inc. and Blue Cross & Blue Shield Health Plan of Georgia, Inc., its domestic and foreign parents, predecessors, divisions, subsidiaries, affiliates, partnerships and joint ventures, and all directors, officers, employees, agents, and representatives of the foregoing.

2. The terms "subsidiary," "affiliate," and "joint venture" refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.

3. The term "documents" means all computer files and written, recorded, and graphic materials of every kind in the possession, custody or control of the Company. The term "documents" includes, without limitation: electronic mail messages; electronic correspondence and drafts of documents; metadata and other bibliographic or historical data describing or relating to documents created, revised, or distributed on computer systems; copies of documents that are not identical duplicates of the originals in that person's files; and copies of documents the originals of which are not in the possession, custody, or control of the Company.

4. The term "relating to" means in whole or in part constituting, containing, concerning, discussing, describing, analyzing, identifying, or stating, but not merely referring to.

5. The term "person" includes the Company and means any natural person, corporate entity, partnership, association, joint venture, government entity, or trust

6. The terms "and" and "or" have both conjunctive and disjunctive meanings.

7. The terms "each," "any," and "all" mean "each and every."

8. The term "relevant service" means inpatient general acute care hospital services (*e.g.*, the provision of hospital care for medical diagnosis, treatment, and care of physically injured or sick persons with short-term or episodic health problems or infirmities, excluding the treatment of mental illness or substance abuse, or long-term services such as skilled nursing care), collectively and individually.

9. The term "relevant area" means the area encompassing the counties of Baker, Dougherty, Lee, Mitchell, Terrell, and Worth in the state of Georgia

INSTRUCTIONS

I.1. All documents should be produced within 21 days of the issuance of this Subpoena.

I.2. Unless modified by agreement with Complaint Counsel, this Subpoena requires a complete search of all the files of the Company. The Company shall produce all

responsive documents, wherever located, that are in the actual or constructive possession, custody, or control of the Company and its representatives, attorneys, and other agents, including, but not limited to, consultants, accountants, lawyers, or any other person retained by, consulted by, or working on behalf or under the direction of the Company.

I.3. This Subpoena is continuing in nature and shall be supplemented in the event that additional documents responsive to this request are created, prepared, or received between the time of the Company's initial response and trial.

I.4. To protect patient privacy, the Company shall mask any Sensitive Personally Identifiable Information ("PII") or Sensitive Health Information ("SHI"). For purposes of this Subpoena, PII means an individual's Social Security Number alone; or an individual's name or address or phone number in combination with one or more of the following: date of birth, Social Security Number, driver's license number or other state identification number or a foreign country equivalent, passport number, financial account numbers, credit or debit card numbers. For purposes of this Subpoena, SHI includes medical records or other individually identifiable health information. Where required by a particular request, the Company shall substitute for the masked information a unique patient identifier that is different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient. Otherwise, the Company shall redact the PII or SHI but is not required to replace it with an alternate identifier.

I.5. Forms of Production: The Company shall submit documents as instructed below absent written consent of Complaint Counsel.

1. The Company shall encrypt any data and information before producing to Complaint Counsel. Using NIST FIPS-Compliant[1] cryptographic hardware or software modules is strongly encouraged.

   (a) For any production over 10 gigabytes, use IDE and EIDE hard disk drives, formatted in Microsoft Windows-compatible, uncompressed data; data can be provided on a FIPS-Compliant encrypted hard drive;

   (b) For productions under 10 gigabytes, CD-R CD-ROMs and DVD-ROM for Windows-compatible personal computers, and USB 2.0 Flash Drives are also acceptable storage formats; and

[1] The National Institute of Standards and Technology (NIST) issued the Federal Information Processing Standard (FIPS) Publications 140-1 and 140-2 that details certified cryptographic modules for use by the U.S. Federal government and other regulated industries that collect, store, transfer, share and disseminate sensitive but unclassified information. More information about FIPS 140-1 and 140-2 can be found at http://csrc.nist.gov/groups/STM/index.html.

(c) **All information produced in electronic format shall be scanned for and free of viruses. Complaint Counsel will return any infected media for replacement, which may affect the timing of the Company's compliance with the Subpoena.**

2. Each submission responsive to the Subpoena shall be accompanied with a letter that includes all of the following:

   (a) Volume name;
   (b) A description of encryption software/hardware used;

   (c) The total number of files; and

   (d) A list of data fields in the order in which they appear in the data files.

3. The password for any encrypted data and information shall be provided **separately**, via email, to the representative(s) identified in the final Instruction of this Subpoena.

4. For Request 1 and to the extent any other responsive data exists electronically, provide (a) such data in delimited text or Microsoft Excel format with all underlying data un-redacted and all underlying formulas and algorithms intact; and (b) the entire file or record, including but not limited to, the data or data fields requested.

5. Documents stored in electronic or hard copy format in the ordinary course of business shall be submitted in electronic format provided that such copies are true, correct, and complete copies of the original documents:

   (a) Submit Microsoft Access, Excel, and PowerPoint documents in native format with extracted text and metadata;

   (b) Submit all other documents other than those identified in subpart (1)(a) in image format with extracted text and metadata; and

   (c) Submit all hard copy documents in image format accompanied by OCR.

6. For each document submitted in electronic format, include the following metadata fields and information:

   (a) For documents stored in electronic format other than email: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time,

modification date and time, last accessed date and time, size, location or path file name, and MD5 or SHA Hash value;

(b) For emails: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, to, from, CC, BCC, subject, date and time sent, Outlook Message ID (if applicable), child records (the beginning Bates or document identification number of attachments delimited by a semicolon);

(c) For email attachments: beginning Bates or document identification number, ending Bates or document identification number, page count, custodian, creation date and time, modification date and time, last accessed date and time, size, location or path file name, parent record (beginning Bates or document identification number of parent email), and MD5 or SHA Hash value; and

(d) For hard copy documents: beginning Bates or document identification number, ending Bates or document identification number, page count, and custodian.

7. All documents responsive to this Subpoena, regardless of format or form and regardless of whether submitted in hard copy or electronic format:

(a) Shall be produced in complete form, un-redacted unless privileged, and in the order in which they appear in the Company's files and shall not be shuffled or otherwise rearranged. For example:

i. If in their original condition hard copy documents were stapled, clipped or otherwise fastened together or maintained in file folders, binders, covers, or containers, they shall be produced in such form, and any documents that must be removed from their original folders, binders, covers, or containers in order to be produced shall be identified in a manner so as to clearly specify the folder, binder, cover, or container from which such documents came; and

ii. If in their original condition electronic documents were maintained in folders or otherwise organized, they shall be produced in such form and information shall be produced so as to clearly specify the folder or organization format;

(b) If written in a language other than English, shall be translated into English, with the English translation attached to the foreign language document;

(c) Shall be produced in color where necessary to interpret the document (if the coloring of any document communicates any substantive information, or if black-and-white photocopying or conversion to TIFF format of any document (*e.g.*, a chart or graph), makes any substantive information contained in the document unintelligible, the Company must submit the original document, a like-colored photocopy, or a JPEG format image);

(d) Shall be marked on each page with corporate identification and consecutive document control numbers;

(e) Shall be accompanied by an affidavit of an officer of the Company stating that the copies are true, correct and complete copies of the original documents; and

(f) Shall be accompanied by an index that identifies: (i) the name of each person from whom responsive documents are submitted; and (ii) the corresponding consecutive document control number(s) used to identify that person's documents, and if submitted in paper form, the box number containing such documents. If the index exists as a computer file(s), provide the index both as a printed hard copy and in machine-readable form (provided that Complaint Counsel representatives determine prior to submission that the machine-readable form would be in a format that allows the agency to use the computer files). The Complaint Counsel representative will provide a sample index upon request.

1.6. If any documents are withheld from production based on a claim of privilege, provide a statement of the claim of privilege and all facts relied upon in support thereof, in the form of a log that includes each document's authors, addressees, date, a description of each document, and all recipients of the original and any copies. Attachments to a document should be identified as such and entered separately on the log. For each author, addressee, and recipient, state the person's full name, title, and employer or firm, and denote all attorneys with an asterisk. The description of the subject matter shall describe the nature of each document in a manner that, though not revealing information itself privileged, provides sufficiently detailed information to enable Complaint Counsel or a court to assess the applicability of the privilege claimed. For each document withheld under a claim that it constitutes or contains attorney work product, also state whether the Company asserts that the document was prepared in anticipation of litigation or for trial and, if so, identify the anticipated litigation or trial upon which the assertion is based. Submit all non-privileged portions of any responsive document (including non-privileged or redactable attachments) for which a claim of privilege is asserted (except where the only non-privileged information has already been produced in response to this instruction), noting where redactions in the document have been made. Documents authored by outside lawyers representing the Company that were not directly or indirectly

furnished to the Company or any third-party, such as internal law firm memoranda, may be omitted from the log.

I.7. If documents responsive to a particular specification no longer exist for reasons other than the ordinary course of business or the implementation of the Company's document retention policy, but the Company has reason to believe such documents have been in existence, state the circumstances under which they were lost or destroyed, describe the documents to the fullest extent possible, state the request(s) to which they are responsive, and identify persons having knowledge of the content of such documents.

I.8. In order for the Company's response to this Subpoena to be complete, the attached certification form must be executed by the official supervising compliance with this Subpoena, notarized, and submitted along with the responsive materials.

I.9. Any questions relating to the scope or meaning of anything in this Subpoena or suggestions for possible modifications thereto should be directed to Stephen Sockwell at (202) 326-2950. The response to the Subpoena shall be addressed to the attention of Stephen Sockwell, Federal Trade Commission, Suite 5249, 601 New Jersey Avenue, NW, Washington, DC 20580,

CERTIFICATION

Pursuant to 28 U.S.C. § 1746, I hereby certify under penalty of perjury that this response to the Subpoena *Duces Tecum* has been prepared by me or under my personal supervision from the records of Blue Cross & Blue Shield of Georgia, Inc. and Blue Cross & Blue Shield Health Plan of Georgia, Inc. and is complete and correct to the best of my knowledge and belief.

Where copies rather than original documents have been submitted, the copies are true, correct, and complete copies of the original documents. If Complaint Counsel uses such copies in any court or administrative proceeding, Blue Cross & Blue Shield of Georgia, Inc. and Blue Cross & Blue Shield Health Plan of Georgia, Inc. will not object based upon Complaint Counsel not offering the original document.

_____ _____

(Signature of Official) (Title/Company)

_____ _____

(Typed Name of Above Official) (Office Telephone)

CERTIFICATE OF SERVICE

This is to certify that on April 25, 2013, I delivered via electronic mail and Federal Express Complaint Counsel's *Subpoena Duces Tecum* to:

Blue Cross & Blue Shield of Georgia, Inc. and Blue Cross & Blue Shield Health Plan of Georgia, Inc.
c/o Michelle Rothenberg-Williams
3350 Peachtree Rd.
Atlanta, Georgia 30326
(404) 842-8798
michelle.rothenberg-williams@wellpoint.com

This is to certify that on April 25, 2013, I delivered via electronic mail a copy of Complaint Counsel's *Subpoena Duces* Tecum to:

Lee K. Van Voorhis, Esq.
Katherine I. Funk, Esq.
Teisha C. Johnson, Esq.
Brian Rafkin, Esq.
Jeremy Cline, Esq.
Brian Burke, Esq.
Jennifer Semko, Esq.
John Fedele, Esq.
Baker & McKenzie, LLP
815 Connecticut Avenue, NW
Washington, DC 20006
(202) 835-6162
lee.vanvoorhis@bakermckenzie.com
katherine.funk@bakermckenzie.com
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jeremy.cline@bakermckenzie.com
brian.burke@bakermckenzie.com
jennifer.semko@bakermckenzie.com
john.fedele@bakermckenzie.com

Counsel for Respondent
Phoebe Putney Memorial Hospital, Inc., Phoebe Putney Health System, Inc., and Phoebe North, Inc.

Emmet J. Bondurant, Esq.
Frank M. Lowrey, Esq.
Ronan P. Doherty, Esq.
Michael A. Caplan, Esq.

Bondurant, Mixson & Elmore LLP
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Counsel for Respondent
Hospital Authority of Albany-Dougherty County

Kevin J. Arquit, Esq.
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(212) 455-7680
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agoldstein@stblaw.com
jrie@stblaw.com

Counsel for Respondent
HCA Inc. and Palmyra Park Hospital, Inc.

By: s/ Maria DiMoscato
Maria DiMoscato
Attorney

RETURN OF SERVICE

I hereby certify that a duplicate original of the within subpoena was duly served: (check the method used)

○ *in person.*

◉ *by registered mail.*

○ *by leaving copy at principal office or place of business, to wit:*

_____

_____

_____

on the person named herein on:

April 25, 2013

(Month, day, and year)

Devon Kelly

(Name of person making service)

Litigation Support Specialist

(Official title)

EXHIBIT D

To Affidavit of Michelle M. Rothenberg-Williams

United States of America
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Mergers IV

May 3, 2013

VIA E-MAIL

Michelle M. Rothenberg-Williams, Esq.
Managing Associate General Counsel
Blue Cross and Blue Shield of Georgia
3350 Peachtree Road, N.E.
Atlanta, Georgia 30326

Re: In the Matter of Phoebe Putney Health System, Inc., FTC Docket No. 9348

Dear Michelle,

This letter confirms our conversation today relating to your request for certain modifications to the Part III Subpoena *Duces Tecum* ("SDT") issued to Blue Cross and Blue Shield of Georgia ("BCBS of GA") on April 25, 2013 in the above-captioned matter. Complaint Counsel agrees to modify the SDT as follows:

Applicability of Previous Civil Investigative Demand Modifications: To the extent they are applicable, Complaint Counsel agrees to extend the modifications set forth in the April 6, 2011 letter to Katherine D. Mayberry from W. Stephen Sockwell to the SDT.

Time Period: BCBS of GA shall produce documents from January 1, 2011 to present.

Scope of Custodians: Complaint Counsel agrees to limit the scope of custodians who are to be searched to those employees in the provider contracting, actuarial, and marketing functions in the relevant area set forth in Definition 9 of the SDT.

Scope of Search: Complaint Counsel agrees to limit the scope of search to self-selection by the relevant custodians of responsive documents, including e-mails and central or shared files. We make this modification as an accommodation to reduce BCBS of GA's search burden. We are willing to defer the requirement that BCBS of GA make a complete search of all files as set forth in Instruction I.2 of the SDT.

Specification 3: BCBS of GA shall produce responsive documents relating to Phoebe Putney Memorial Hospital and Palmyra Park Hospital, currently known as Phoebe North. Complaint Counsel agrees to defer the requirement that BCBS of GA produce responsive documents relating to any other hospitals and physician organizations in the relevant area set forth in Definition 9 of the SDT.

Please call me at (202) 326-2335 with any questions. Thank you for your continued assistance in this matter.

Sincerely,

Jennifer K. Schwab
Complaint Counsel

cc: Diane L. Weinstein, Esq.
Michael G. Durham, Esq.
Mark H. Cohen, Esq.

EXHIBIT C

To Motion to Quash Subpoena *Duces Tecum*

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., Phoebe North, Inc., HCA, Inc., Palmyra Park Hospital, Inc., and Hospital Authority of Albany-Dougherty County, Respondents.	)	Docket No. 9348

AFFIDAVIT OF DIANE L. WEINSTEIN

PERSONALLY APPEARED before the undersigned attesting officer, duly authorized to administer oaths in the State of New York, DIANE L. WEINSTEIN, who having been first duly sworn, deposes and states as follows:

1.

I am over the age of 21 years and competent to testify as a witness. I have personal knowledge of the facts set forth in this Affidavit or, for purposes hereof, have made due inquiries of other persons with such personal knowledge, and make this Affidavit for use in the above-captioned proceeding.

2.

I am employed by the WellPoint Companies, Inc. as Senior Associate General Counsel. The WellPoint Companies, Inc. is an affiliate of WellPoint, Inc. ("WellPoint"), the ultimate

parent company of Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA") and Blue Cross Blue Shield Health Plan of Georgia, Inc. ("BCBSHP") (collectively, "BCBS").

3.

In April of 2013, the FTC served a subpoena *duces tecum* ("FTC's Subpoena") on BCBS. After reaching agreement with the FTC regarding modifications to the subpoena, BCBS conducted a reasonable and diligent search and produced relevant, non-privileged documents to the FTC in a timely manner. It is BCBS' understanding that all documents produced by BCBS in response to the subpoena were provided to Respondents.

4.

In April of 2013, BCBS also received a subpoena *duces tecum* propounded by Respondents Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., and Hospital Authority of Albany-Dougherty County ("Respondents' First Subpoena"). Counsel for the parties reached agreement regarding limitations to be applied to the subpoena, and pursuant to the terms of the parties' agreement, on May 29, 2013, and on June 14, 2013, BCBS produced data in response to Request No. 11 of Respondents' First Subpoena. In addition, BCBS received questions from Respondents regarding the data produced and facilitated responses to those questions.

5.

On October 2, 2014, the FTC served a second subpoena on BCBS, and it is the understanding of BCBS that all documents submitted to the FTC in connection with that subpoena will also be transmitted to Respondents.

FURTHER AFFIANT SAYETH NOT.

DIANE L. WEINSTEIN

Sworn to and subscribed before me
this 13th day of October, 2014.

NOTARY PUBLIC
My Commission expires:

FELICIA M. VARLESE
Notary Public, State of New York
No. 02VA4864638
Qualified in Queens County
Commission Expires June 16, 2018

EXHIBIT D

To Motion to Quash Subpoena *Duces Tecum*

MARK H. COHEN
404.885.3597 telephone
404.962.6753 facsimile
mark.cohen@troutmansanders.com

TROUTMAN SANDERS

TROUTMAN SANDERS LLP
Attorneys at Law
Bank of America Plaza
600 Peachtree Street, NE, Suite 5200
Atlanta, GA 30308-2216
404.885.3000 telephone
troutmansanders.com

May 29, 2013

BY FEDEX

Brian F. Burke, Esq.
Baker & McKenzie LLP
815 Connecticut Avenue, N.W.
Washington, D.C. 20006

Re: *In the Matter of Phoebe Putney Health System, Inc., et al.*, Before the Federal Trade Commission, FTC Docket No. 9348

Dear Brian:

In accordance with our agreement as referenced by our email communications between May 21-22, 2013, please find enclosed a DVD containing information in response to Request No. 11 of Respondents' subpoena *duces tecum* served upon Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA") on April 26, 2013. You will be contacted with any password requirements in a separate communication.

Pursuant to our agreement, this response will operate to fully satisfy Respondents' subpoena *duces tecum* in its entirety, and Respondents have agreed that no further responses from BCBSGA to any other requests in the subpoena *duces tecum* will be required or provided; moreover, Respondents have agreed to make no additional requests for information upon BCBSGA in the above-captioned matter. As we have also agreed, in the event Respondents' experts have further questions concerning the ability to interpret the data provided in the DVD, BCBSGA will facilitate responses to those questions.

This is also to confirm that the DVD and all information contained therein is deemed confidential and subject to the "Protective Order Governing Discovery Material" ("the Protective Order") issued in the above-captioned matter on April 21, 2011, which limits its disclosure only to the individuals identified in Section 7 and only for the purposes described in Section 8 of that Protective Order. In addition, if any of this confidential material is contained in any papers filed by Respondents in the above-captioned proceeding, that information must be filed *in camera* with notice to BCBSGA in accordance with the provisions of Section 9 of the Protective Order. Finally, if Respondents intend on introducing the DVD or any portion contained therein into evidence at the hearing in the above-captioned matter, Respondents shall provide advance notice

to BCBSGA so that an order granting *in camera* treatment of any such material may be sought, in accordance with Section 10 of the Protective Order.

Thank you for your cooperation in reaching our agreement to resolve Respondents' subpoena *duces tecum*.

Sincerely,

Mark H. Cohen / MBM

Mark H. Cohen

Enclosure

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June 14, 2013

BY FEDEX

John Fedele, Esq.
Baker & McKenzie LLP
815 Connecticut Avenue, N.W.
Washington, D.C. 20006

Re: *In the Matter of Phoebe Putney Health System, Inc., et al.*, Before the Federal Trade Commission, FTC Docket No. 9348

Dear John:

In accordance with our agreement as referenced by my email communications with Brian Burke between May 21-22, 2013, and our subsequent discussions by email and telephone, please find enclosed a DVD containing information in response to Request No. 11 of Respondents' subpoena *duces tecum* served upon Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA") on April 26, 2013, which includes all hospitals in the State of Georgia as opposed to being limited to hospitals contained in the definition of "Geographic Area" as contained in the subpoena.

As with our prior response on May 29, this response will operate to fully satisfy Respondents' subpoena *duces tecum* in its entirety, and Respondents have agreed that no further responses from BCBSGA to any other requests in the subpoena *duces tecum* will be required or provided; moreover, Respondents have agreed to make no additional requests for information upon BCBSGA in the above-captioned matter. As we have also agreed, in the event Respondents' experts have further questions concerning the ability to interpret the data provided in the DVD, I will facilitate responses to those questions.

This is also to confirm that the enclosed DVD and all information contained therein is deemed confidential and subject to the "Protective Order Governing Discovery Material" ("the Protective Order") issued in the above-captioned matter on April 21, 2011, which limits its disclosure only to the individuals identified in Section 7 and only for the purposes described in Section 8 of that Protective Order. In addition, if any of this confidential material is contained in any papers filed by Respondents in the above-captioned proceeding, that information must be filed *in camera* with notice to BCBSGA in accordance with the provisions of Section 9 of the Protective Order. Finally, if Respondents intend on introducing the DVD or any portion contained therein into evidence at the hearing in the above-captioned matter, Respondents shall

provide advance notice to BCBSGA so that an order granting *in camera* treatment of any such material may be sought, in accordance with Section 10 of the Protective Order.

Sincerely,

Mark H. Cohen

Enclosure

EXHIBIT E

To Motion to Quash Subpoena *Duces Tecum*

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

IN THE MATTER OF	)
PHOEBE PUTNEY HEALTH SYSTEM, INC., a corporation, and	)
	)
PHOEBE PUTNEY MEMORIAL HOSPITAL, INC., a corporation, and	)
	)
HCA, INC., a corporation, and	)
	)
PALMYRA PARK HOSPITAL, INC., a corporation, and	)
	)
HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY	)
	)

DEPOSITION OF AMY CHESLOCK
DESIGNATED CONFIDENTIAL
MAY 15, 2013
9:00 A.M.

APPEARANCES OF COUNSEL

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* * *

MR. BURKE: Good morning, Amy. Thank you for coming in today, making yourself available. Who is your current employer?

MR. COHEN: Before we get started I just wanted to put on the record that this deposition is my understanding is subject and the transcript and any exhibits that may be offered are subject to the protective order governing discovery material dated April 21st 2011 in this matter and we understand obviously that if any party designates any portion of this deposition or any of the exhibits in the record that we have the right obviously under this order if the exhibits are not already designated as confidential and I think Ms. Cheslock's declaration has already been so designated that it will be subject to the

confidentiality provisions of this protective order.

MS. SCHWAB: And I'd also like to note on the record my agreement with Mr. Burke that any of witness' counsel's Mr. Cohen's objections today shall be joined in by complaint counsel.

MR. COHEN: And vice versa when your questions --

MS. SCHWAB: That's correct.

MR. COHEN: That's fine.

AMY M. CHESLOCK,

having been first duly sworn, was deposed and testified as follows:

EXAMINATION

BY MR. BURKE:

Q Okay. Start again. Who is your current employer?

A My employer is Wellpoint.

Q Wellpoint is a publicly traded company?

A Correct.

Q On New York Stock Exchange?

A Correct.

Q And what does Wellpoint do?

A Wellpoint is the parent company of -- well, what do they do. It's a health insurance

company, you know, predominantly and they own and operate 14 Blue Cross and Blue Shield plans across the country, among other things but predominantly that would be the business as I would describe it.

Q Okay. I'm going to offer into -- as an Exhibit a copy of Wellpoint's most recent 10-K -- I promise we won't go through every page of it.

(Whereupon, marked by the court reporter for identification purposes, Exhibit No. 1.)

BY MR. BURKE:

Q And I have clipped pages that I think that we might be referencing for your ease.

A Okay.

Q Just in case rather than flipping through the whole thing. On Page 3 of the 10-K there's a discussion there at the third paragraph about the broad spectrum of network based managed care plans -- managed care services for self funded customers and specialty insurance federal employee program and then contact lenses and other ocular products. Is the company organized -- are those separate business units or are those --

MR. COHEN: Go ahead.

BY MR. BURKE:

Q Are those separate business units within

Wellpoint?

MR. COHEN: I would just object for the record that that question lacks any foundation with respect to this witness.

BY MR. BURKE:

Q Okay. What are your responsibilities in your current position? Let me back up. What is your current position?

A Currently I am vice-president of cost of care and planning and provider engagement and contracting.

Q And how long have you been in that position?

A I assumed that role in May of 2011.

Q Is that part of a distinct business unit within Wellpoint?

A Yes, I guess little -- the word -- assuming I understand what you mean by the word business unit, the business unit I report in through is called our commercial business unit.

Q Commercial business unit, okay. And does the commercial business unit within Wellpoint include all of the products that we just talked about I just referenced?

A Can you be more specific about products?

of teams that provide the -- that do work on behalf of Wellpoint -- we consider at an enterprise level which means for all of our markets, all 14 states where we have Blue Cross and Blue Shield plans. And so one of those team's responsibilities is for managing a plan of cost of care initiatives that we implement to manage medical costs. I oversee a team that does contracting and network management for ancillary providers for all 14 states, ancillary providers defined here as non hospital non physician provider types, an enterprise team that oversees the maintenance and administration of our standard provider contracts and I oversee a team that negotiates contracts with vendors on behalf of Wellpoint.

Q And the vendor group, what sort of solutions -- I presume that means Wellpoint is on the purchasing side?

A Yes, for -- in this instance vendors for -- this team, the vendor management organization manages relationships with companies that provide a delegated service on behalf of Wellpoint. So vendors are not things Wellpoint uses to procure services for itself like negotiate a contract for a company to maintain software computer systems. It's

Q Well, the network based managed care plans, the managed care services for self funded customers. In particular, the first sentence in paragraph -- the third paragraph on Page 3?

A First sentence and the third paragraph.

Q On Page 3.

A Okay.

MR. COHEN: You know, for the record, I would again object. I don't believe you've laid a foundation that this witness has knowledge of information in this particular Exhibit.

BY MR. BURKE:

Q Do you want me to repeat the question?

A Sure. That would be helpful.

Q In the first sentence of paragraph three on the third page of the annual report, there's a listing of the broad spectrum of products or solutions offered by Wellpoint. Which ones of those fall into your area of responsibility?

A Can you clarify what you mean by my area of responsibility?

Q What do you do on a day-to-day basis in your current position?

A In my current position I oversee a number

vendors that provide a service, a delegated service on behalf of us to consumers. So a vendor in this example could be a company that provides chiropractic network services for us or manages musculoskeletal condition costs.

Q And your oversight of those -- is it just the four teams that you identified or are there others?

A Presently.

Q The geographic scope of those teams is the 14 states?

A Correct.

Q And among those 14 states are Georgia, or include Georgia?

A Correct.

Q And within Georgia or within the jurisdictions there, who underneath and on your team is responsible for Georgia or the allocation not geographic specific?

A The person who is responsible for managing the network relationships in Georgia does not report to me.

Q And who is that?

A Alexandra Leopold.

Q How long has she been in that position?

A She assumed that position I believe it was July of 2011.
Q Who held that position before her?
A I did.
Q Who does she report to currently, Alexandrea Leopold?
A Colin Drowdozski.
Q Can you spell that?
A C-O-L-I-N, D-R-O-W-S-K-I -- sorry, D-R-O-W -- it's hard to do, D-R-O-W-D-O-Z-S-K-I.
Q And what is Mr. Drowdozski's title?
A Something like vice-president provider engagement in contracting. I'm not specifically sure the exact wording of his title.
Q Okay. And was he in that position when you held the current position held by the Ms. Leopold? I mean, was he your boss at the time?
A No, he was not.
Q Who do you report to today?
A Doug Wenners.
Q And who did you report to in your prior position?
A I believe -- I have to check. I believe at the time I was reporting to Robert McEntyre.
Q Is Mr. McEntyre still with Wellpoint?

A No, he's retired.
Q In your prior position, the one that's held currently by Ms. Leopold are her responsibilities today similar to what yours were when you held that position?
A Yes, similar.
Q What is the -- I'm sorry, to repeat this. What is the position again that Ms. Leopold holds?
A She is a regional vice-president provider engagement and contracting.
Q For Georgia?
A For Georgia.
Q Could you explain to me your understanding of the difference between what I've seen referred to as fully insured products and self-insured products that Wellpoint offers?
A Sure. A fully insured products would be products where we assumed the risk for the cost of the claims incurred and self-insured products would be products where we're providing administrative services on behalf of the customer but the customer is actually underwriting the claims cost risk themselves or assuming that risk themselves.
Q Is the revenue generated by Wellpoint from the sale of those products those two categories of

products tracked separately?
A I don't know that I can say for sure.
Q Do both of those products fall into Ms. Leopold's area of responsibility with respect to Georgia?
A Yes.
Q In terms of annual revenue that is generated by Wellpoint from the sale of its fully insured products, is that category referred to as premiums? Is the revenue generated by fully insured products referred to as premiums?
A Where?
Q Well, what is -- in fully insured products the revenue that Wellpoint has generated from, are those fees or premiums?
MS. SCHWAB: Objection.
THE WITNESS: I'm not sure that I understand the question.
BY MR. BURKE:
Q Can we go to page 43 of the annual report please. Actually, I'm sorry, 44, first paragraph. It says premium revenue comes from fully insured contracts where we indemnify our policyholders against cost for covered health and life benefits. Administrative fees come from contracts where our

customers are self-insured or where the fee is based on either processing of transactions or a percent of network discount savings realized. Is that statement consistent with your understanding?
MR. COHEN: I object again for lack of a foundation with respect to this witness' knowledge. You can answer if you can.
THE WITNESS: I don't -- I don't -- I'm not responsible for crafting this document and so this -- these statements appear to confirm the way this document has been crafted. I just don't think I can answer that question.
BY MR. BURKE:
Q Who pays Wellpoint for -- who are the customers of the fully insured products? What are some of the customer types of the fully insured products?
A If I understand the question correctly, customers are generally employer groups and it's more common that fully insured products are with smaller employer groups, although that's not always the case.
Q And how do they pay you -- how do they pay Wellpoint for fully insured products?
A Like how in terms of like the transaction

of money how it exchanges hands?
Q Is there a monthly bill? Is it an annual bill? Is it a fixed fee? Is it --
A I'm not -- I don't know that I'm a subject matter expert in the billing of customers. So, I mean, I'm not sure how to answer your question specifically. I may not understand where you're coming from with it.
Q What are the products -- let me back up. You referenced Blue Cross-Blue Shield earlier as a brand of products offered by Wellpoint for sale; is that right?
A I don't recall us talking about brands up to this point.
Q Is Blue Cross and Blue Shield a brand that Wellpoint sells products under a license for?
A Wellpoint is a licensee of the Blue Cross and Blue Shield Association.
Q And they sell products branded as Blue Cross and Blue Shield under that license?
A They do. The brands vary by state.
Q In Georgia there's a Blue Cross and Blue Shield --
A Yes.
Q -- managed care plan sold by Wellpoint?

A Right. Blue Cross and Blue Shield of Georgia is a company owned by Wellpoint.
Q And they sell managed care plans under that brand?
A Correct.
Q What are the different products -- are there different products offered under that plan by Blue Cross and Blue Shield of Georgia?
MR. COHEN: Beforehand I guess I would object to the form of the question. You keep calling it a brand. It's a company.
BY MR. BURKE:
Q She just -- the witness just said that they sell products under that brand, managed care plans under that managed brand.
A So your question is much more complicated than what I think that what you're asking. So I'm struggling to actually answer your question. We have multiple insurance licenses in the State of Georgia. And products are generally offered under licenses.
Q What are the licenses other than the one you just described from the Blue Cross-Blue Shield Association?
A That was -- I was not describing a license

in Georgia.
(Whereupon, a discussion ensued off the record.)
BY MR. BURKE:
Q The license that you have from the Blue Cross-Blue Shield Association, are there -- is there more than one?
A I don't know.
MR. COHEN: Just object to the form of the question. When you say you, I'm not sure if you mean her or --
BY MR. BURKE:
Q I have been referring to you as Wellpoint and intending it to cover Blue Cross-Blue Shield but if that's an area of confusion you can please ask me to clarify my question. Why don't you explain to me your understanding of the licensing relationship that Wellpoint has with the Blue Cross-Blue Shield association?
A I can't. It's not an area that I have subject matter expertise and I wouldn't want to go on record describing it. It's not something I manage.
Q Would Ms. Leopold have expertise?
A I can't say.
Q Does Wellpoint sell a Blue Cross-Blue

Shield branded product I've seen referred to as a preferred provider organization and managed care plan in Georgia?
A I think your question is -- is -- a Blue -- is a Blue Cross and Blue Shield of Georgia PPO plan sold by Wellpoint. I would answer that yes.
Q Okay. Is that sold under a license?
A Can you clarify what license you're referring to?
Q I believe you testified earlier that Wellpoint is a licensee from Blue Cross-Blue Shield association?
A That is correct.
Q Is that how sell it -- are they authorized under that license to sell a Blue Cross-Blue Shield of Georgia -- I mean Blue Cross-Blue Shield branded PPO plan in Georgia?
A By the Blue Cross-Blue Shield Association?
Q Under that license agreement?
A I don't know.
Q Okay. Does Blue Cross-Blue Shield or just -- sorry, let me back up. Does Wellpoint sell a health management organization, managed care plan under Blue Cross and Blue Shield brand in Georgia?

MR. COHEN: Object to the form.
THE REPORTER: Can you restate the question?
BY MR. BURKE:
Q You testified a moment ago that Wellpoint sells Blue Cross and Blue Shield branded preferred provider organization managed care plan in Georgia; correct?
A Correct.
Q Do they also sell a health management organization plan branded under the Blue Cross and Blue Shield name in the State of Georgia?
A Yes.
Q What other managed care plan types under the Blue Cross and Blue Shield name does Wellpoint sell in Georgia other than PPO and HMO?
A The other sort of bucket I think what you'd be referring to would be point of service plans.
Q Okay. Are there any others?
A Any others? Can you clarify your question?
Q Are there any other products sold by Wellpoint under the Blue Cross and Blue Shield brand in Georgia different from the PPO, HMO and POS that

we just described?
A Well, what do you mean by product?
Q What is your understanding of the term?
A I mean the word product can refer to lots of things. It could refer to other specialty type benefit plans, dental, vision, life. It could refer to a lot of things.
Q Managed care plans?
MR. COHEN: Object to the form. That's not a question.
MS. SCHWAB: Object.
BY MR. BURKE:
Q The product term that I was using which I thought you were -- had understood from prior questions was managed care plans.
A Can you clarify what you mean by managed care?
Q What is -- you've said that they've sold a PPO, that Wellpoint sells a PPO product in the State of Georgia under the Blue Cross-Blue Shield brand; correct?
A Did I state that previously? Is that your question?
Q Yes.
A I believe I did, yes.

Q And what is that product? What is the term you would refer to as that product -- that describes that product?
MR. COHEN: Again, I object as to the form.
BY MR. BURKE:
Q When you said yes, what are the products that are sold by Wellpoint under that brand and PPO?
A When I said yes to your question what other products -- I don't know that I understand your question, I'm sorry.
Q What is the PPO product that Wellpoint sells under Blue Cross-Blue Shield brand in Georgia, PPO, HMO, POS, what are those products? And I've been using the term managed care plan. That's not something you understand; is that correct?
MR. COHEN: I object. You've got three questions out there. Let's do them one at a time if we can.
THE REPORTER: Can we start -- I need some.
BY MR. BURKE:
Q What is your understanding of the term managed care plan? Do you have an understanding?
A I mean -- yes, I have an understanding.

Q What is that understanding?
A You know, it would generally refer to plans and products that, you know, Blue Cross-Blue Shield or other insurance companies manage on behalf of customers for care that's provided.
Q What kind of care?
A Well, you could have a -- lots of kinds of managed care. You could have managed dental, you could have managed health insurance, you could have managed government plans, you could have managed Medicare, managed Medicaid. There's lots of ways that that term managed care is used.
Q Okay. Let's deal with the health insurance variety.
A Okay.
Q Other than PPO, HMO and POS, are there other health insurance products sold by Wellpoint under the Blue Cross-Blue Shield brand in Georgia?
A There may be indemnity products. I'm not 100 percent certain of that.
Q Under those plans -- well, under the PPO plan, what health plan -- what are the benefits that are provided to the covered -- the individuals covered by that plan?
A Can you clarify what you mean by the word

benefits?
Q Why do people purchase that plan from Wellpoint?
A Is your question specifically why do they purchase the PPO plan?
Q Yes. What benefits, what do they derive from the purchase of that plan?
A I'm not sure I completely understand your question so I'm struggling to answer it.
Q Try and answer with the understanding that you have.
A The word -- are you asking in the word benefits, we use that to describe like do they have a co-pay, a co-insurance that's a benefit? Is that your question?
Q Well, what benefits do -- does Wellpoint provide to purchasers of your -- the PPO health plan under the Blue Cross-Blue Shield name?
A Can you clarify what you mean by the word benefits?
Q Let's look at page 44 in the annual report. The first sentence of the second paragraph.
A Okay.
Q It says our benefit expense primarily includes costs of care for health care -- for health

services consumed by our members such as outpatient care, in-patient hospital care, professional services, primarily physician care and pharmacy benefit costs. Is that consistent with your understanding of what the benefits are under the plans, the health insurance plans offered under the Blue Cross-Blue Shield name in Georgia?
MR. COHEN: Again, I've got an objection to the question with respect to this Exhibit because there's been no foundation laid. You can answer.
THE REPORTER: Okay. So I think the word benefit here is being used in a different connotation than the one you have expressed in your question. So for that reason, I can't say that I think your question and this sentence here are the same.
BY MR. BURKE:
Q Okay. I don't -- forget the earlier question. Does this sentence accurately describe the benefits provided to purchasers of Blue Cross-Blue Shield branded PPO, HMO and POS plans sold by Wellpoint under the Blue Cross brand in Georgia?
A No.

Q Why not?
A This sentence is referring to what is comprised of benefit expense in this annual report as I read it. I've not read the whole report but that's what I would infer the sentence to state.
Q Right. So I understand that sentence to mean that that's the cost to Wellpoint of delivering benefits to the purchasers of the plans that I just described; is that a fair understanding?
MR. COHEN: I object to the form.
THE REPORTER: Can you restate that?
BY MR. BURKE:
Q I read that sentence to mean that this benefit expense is the cost to Wellpoint of delivering benefits to the purchasers of their health insurance plans, the plans we've been talking about. Do you agree with that understanding?
MR. COHEN: Same objection.
THE REPORTER: I can't say that I agree with what you said, no.
BY MR. BURKE:
Q Well, just tell me why I'm wrong.
A As I understood what you stated, you're saying this sentence is describing the cost to Wellpoint of delivering benefits and I would

understand delivering being the costs that we would incur in administering something.
Q Is outpatient care covered under PPO, HMO and POS health care plans offered?
A Yes, generally, yes.
Q Is in patient hospital care covered under those products?
A Yes, generally, yes.
Q Are professional services covered under those products?
A Generally, yes.
Q Are pharmacy benefit costs covered under those products?
A It can be, yes.
Q Do you have an understanding of what -- amongst those four categories, what the break down of those categories is from a standpoint of benefit delivery?
MR. COHEN: Object as to the form.
THE REPORTER: I don't understand the question.
BY MR. BURKE:
Q Are there any other categories of -- are there any other categories covered by these health care plans that you can think of different from

these four generally?
A I mean, I think generally that's a fairly conclusive list of categories.
Q Okay. And in terms of -- do you have any understanding of what the break down would be of the usage of each of those categories under the plans? Is it 25 percent each? Is it skewed toward one category or another?
MS. SCHWAB: Object to the form.
MR. COHEN: Object as to -- same objection.
THE WITNESS: Can you restate the question?
BY MR. BURKE:
Q Let's move on. Are the provider costs -- well, let me back up. What is a provider with respect to the health care plans that we've been discussing?
A In this report or in general?
Q General, your understanding?
A So we would generally when we say we refer to a provider in these plans, we're often referring to a hospital, physician or other kind of ancillary provider that's been contracted to provide services.
Q And when you say contracted to provide

services, that's to the purchasers of the plans?
A Contracted to provide services to the individuals covered by the plans.
Q Okay. Can we call those people members?
A Sure.
Q Okay. And does the category of in patient hospital care broadly capture the provider benefit --
MR. COHEN: Object.
Q -- that you just described?
MR. COHEN: I object to the form of the question.
THE WITNESS: I don't understand the question.
BY MR. BURKE:
Q You said when we say we refer to a provider in these plans, we're often referring to a hospital, physician or other kind of ancillary provider that's been contracted to provide services. Does that description fall into the in patient hospital care category that we were just discussing?
MR. COHEN: Again --
THE REPORTER: Exclusively?
MR. BURKE: No, generally.
BY MR. BURKE:

Q Does it fall into that in patient hospital, hospital care element?
MR. COHEN: Object as to the form.
BY MR. BURKE:
Q Which one does it out of the four? You said they broadly capture the benefits offered by the plans, that you couldn't think of another category. Which one includes the providers?
A We would -- providers could -- there's providers contracted to provide services under all of those categories.
Q Okay. How are the products sold by Wellpoint, PPO products, HMO products?
A I don't know that I understand the question.
Q Are they sold by Wellpoint employees? Are they sold through brokers? How are they sold?
A It depends.
Q On?
A Who's buying the product.
Q Okay. What are the different categories of your customers?
A There can be customers that are individuals purchasing care for themselves, purchasing insurance for themselves and there are

groups of people, generally an employer group though not always, that purchase insurance to cover a group of people.
Q And how are the products sold to the employer groups?
MR. COHEN: Object as to the form.
THE REPORTER: Can you just explain to me what you mean by how.
BY MR. BURKE:
Q Are they sold by Wellpoint employees, marketed by Wellpoint employees or are they sold through brokers?
A There's a sales organization within Wellpoint that is Wellpoint employees who work with customers who are employers who are often represented by brokers.
Q The employers are represented by brokers?
A Oftentimes.
Q Does Wellpoint compensate those brokers that represent those --
A Yes.
Q How do they compensate them?
A I'm not a subject matter expert in that. I can't say.
Q Does it depend -- are you familiar with

any of the factors that would be relevant to the form of compensation that such brokers would receive from Wellpoint?

A Any other factors? I'm very generally probably familiar with certain factors I suppose, depending what you mean by the word factor.

Q What would your general familiarity be?

A With what? I'm so sorry I truly am not understanding your line of questions. I'm not trying to be difficult.

Q You said you're generally -- you're generally familiar with what would be relevant to the factors considered in compensating the brokers. What is your general familiarity?

A I believe they're generally paid based upon, you know, the insurance -- you know, the products that they sell, and there's -- there's probably I think some compensation relative to the size of the group. I'm not an expert in broker compensation by any means.

Q Is it relevant what the premiums that the employees -- employer groups agree to like the larger premium the more compensation?

A I can't say.

Q Are there any other brands other than Blue

Cross-Blue Shield that health insurance plans are sold -- under which Wellpoint sells health insurance plans in Georgia?

A I'm not certain.

Q Are you familiar with Amerigroup?

A Yes.

Q And Caremore?

A Yes.

Q And Unicare?

A Yes.

Q Are those different brands from Blue Cross-Blue Shield?

A In Georgia?

Q Yes.

A In Georgia I'm certain that Amerigroup is -- provides benefits for Medicaid beneficiaries in Georgia.

Q Caremore, how about Caremore?

A Are you asking?

Q Health insurance plans sold under the Caremore brand in Georgia.

A I don't believe so no.

Q Are health insurance plans sold under the Unicare brand in Georgia?

A I'm not sure.

Q Can you explain to me what a PPO product is?

A I would generally describe a PPO product as a health insurance product sold by Blue Cross and Blue Shield of Georgia which provides coverage for health care services received on both an in-network basis and an out-of-network basis generally speaking. And it's generally a product, although not always, that does not require the member to select a primary care physician.

Q And are PPO products, are those PPO products sold? Are they fully insured products or are they self-insured products?

A They're both.

Q Both. How are providers approached by Wellpoint to participate in the PPO product?

A Presently today?

Q Yes.

A I mean by and large the providers are already participating and the majority of providers joining the PPO product today are coming to Blue Cross and requesting contracts.

Q Okay. So what I understand you to just have said is that the networks of providers have already been established largely for PPO product?

A Correct.

Q And how long has that been?

A I can't say.

Q Hospitals are a provider -- a category of provider?

A Yes.

Q And does Wellpoint or Blue Cross-Blue Shield of Georgia pay hospitals the same reimbursement rate under the PPO plan across the State of Georgia for every hospital that's part of the network?

A Does every hospital get paid the same amount?

Q Yes.

A No.

Q What's the reason for the differences?

A The contract -- the PPO contract is a negotiated contract with the hospital between Blue Cross and the hospital.

Q And what are some of the different reimbursement methodologies used with hospitals in the PPO plan?

A Very broadly?

Q Yes.

A Very broadly. I mean generally we would

say there's percentage of charge payments and there's fixed type of payments.

Q And what would be the reason for using one method versus another? What might be some of the reasons?

A For who?

Q For Blue Cross or the provider. Answer from either perspective.

A I mean from Blue Cross' perspective we generally desire a fixed payment rate contract.

Q Why is that?

A We believe it provides predictability in costs for our members and we believe that they provide affordability.

Q Why would you agree to a different method? Why might Wellpoint and Blue Cross agree to a different method percent of charges for example?

A Generally speaking the contracts have been in place for a very very long time and there was a time in which it was the prevailing practice to contract at a percent of charges. And over the course of the last many many years we've been working to move those contracts to fixed rates so by -- generally speaking if a contract is still on a percentage charge, it's a vestige of a past

relationship that hasn't been successfully moved to fixed rate.

Q How is the PPO product priced by Blue Cross-Blue Shield?

A I don't understand the question.

Q When it's sold to its employer groups and with the membership that we talked about earlier, how is the solution of that product, PPO product sold -- I'm sorry priced? Is it a cost plus or is there a different method approach?

MR. COHEN: Object as to the form.

THE REPORTER: I don't know that I can answer. I don't understand the question specifically.

BY MR. BURKE:

Q How does Blue Cross Blue Shield of Georgia make money or get revenue from the Blue Cross-Blue Shield PPO product sale?

A I mean generally speaking we get revenue either in the form of administrative cost paid to us by self funded customers or in the form of the full medical premiums paid to us less the medical costs paid out for fully insured customers.

Q Okay. And so taking that one at a time. So the full medical insurance premiums paid to you less the costs. So how does that full medical care premium number reached is what I'm getting at for the fully insured products?

A I don't know that I can answer that question as you've asked it. I'm sorry. Im not sure exactly what you're asking. There's an entire actuarial and financial division that works on that so there's a lot of parts to this question. I just don't know that I can answer that.

Q What are some of the parts that would be relevant to the setting of that premium?

A Can you help me understand what you're asking. I honestly don't understand what you're asking.

Q The medical premium that you just referred to -- medical care premium you just referred to is the money that comes in the door to Blue Cross, right, for the PPO product?

A It's money.

Q Revenue?

A We are paid premiums by employers. Is that your question?

Q Yes.

A Yes.

Q And how are those premiums set?

A There's so many -- I don't know that I can answer the question.

Q Do you know anything that's relevant at all to setting the premiums, any factors that are relevant?

A Certainly. I mean so there's actuarial associates and underwriting associates who have responsibility for that and they assess what they believe the costs are going to be associated with that product in order to derive an appropriate premium.

Q And is there a target margin that's part of that actuarial process?

A I can't say.

Q Would you think that there is?

MR. COHEN: I object as to the form.

THE REPORTER: I can't say.

BY MR. BURKE:

Q Well, if there wasn't a margin then Blue Cross wouldn't make any money; right?

MR. COHEN: That's been asked and answered.

THE WITNESS: I don't know that I understand what your question is.

BY MR. BURKE:

Q The difference between your costs for -- in the PPO plan, you're being Blue Cross-Blue Shield, and the premium is the margin, profit margin?
A No.
Q What is it?
A The difference between the costs and the premium?
Q Uh-huh.
A Would be all the money that's left over to pay everything else, administrative expenses, overhead, taxes, all kinds of things.
Q Okay. With respect to the self funded product and the administrative costs, how are those -- I would refer to those as fees as opposed to premiums. Is that fair?
A We can use that.
Q How is the amount of those fees set?
A I can't say.
Q Is it the similar actuarial process?
A I can't say.
Q Can we take five minutes please?
MR. COHEN: Sure.
(Whereupon, a brief recess was taken.)
BY MR. BURKE:

Q So you testified earlier that you've been in your current position since May 2011?
A Correct.
Q And before that you held the position that's currently held by Alexandra Leopold?
A Correct.
Q And how long were you in that position held by Alexandrea position?
A Oh, I was in that position about three-and-a-half, four years.
Q So 2007 thereabouts?
A Yes, I started in that position November 1st 2007.
Q And during your tenure in that position did you track the number of members of Blue Cross-Blue Shield in Georgia?
A I did not -- it wasn't my responsibility to track the number of members, no.
Q Were you familiar with how many there were?
A Yes. Generally speaking yes.
Q Do you remember how many there were around the time that you left your former position?
A I don't recall.
Q Do you know what it is today?

A I don't.
Q You testified earlier that you don't understand how premiums are set for the HMO, PPO, POS Blue Cross-Blue Shield products; correct?
A I mean I don't know that was your specific question at the time. I did not -- was not able to answer the question you were posing.
Q Well, can you answer it now? How are the premiums set for those products?
A That is not my responsibility so I'm not responsible for setting premiums.
Q I understand. Do you understand how they're set?
A Generally but not specifically.
Q Okay. What is your general understanding?
A The premiums reflect the cost of the care we assume the claims are -- premiums set based upon projection -- I don't remember where I was going.
Q You said the premiums are reflect the cost of care we assume the claims are -- I think it was the premiums set by the costs and then?
A The process is that the premiums we project the cost of what we think the cost of claims are going to come in and that is, you know, one of the major principles by which the premiums are set.

Q Are there any requirements under Georgia law that go into the factoring of the setting the premiums?
A I don't know.
Q Are you familiar with the term called community rating?
A Yes.
Q And what is your understanding of that term?
A Generally that you have -- you know, take into consideration in setting a rate band it's based upon a geographic, defined geographic area as opposed to a single individual customer.
Q And what is a rate band?
A Specifically -- I mean my understanding I believe is, you know, it's the basis from which you would set the premium for a customer. So I think it establishes some limits around that.
Q And who sets that rate band?
A I don't know.
Q Who defines the geographic area that you just referred to?
A I don't know.
Q Is it your understanding that the community rating would mean that a healthier

community population within that defined geographic area would correlate to a lower rate band for the premiums for your products?
A I believe so. I believe that's one of the factors.
Q And how frequently to your understanding are those rate bands revisited?
A I don't know.
Q With respect to the geographic area including Albany, Georgia, how large is the community rating area do? You have any idea?
A I don't know.
Q What medical care services are covered by your Blue Cross-Blue Shield PPO, HMO and POS plans?
A Generally?
Q Uh-huh.
A Generally it would cover, you know -- everything varies based upon benefits, exclusions, those kinds of things but generally it would cover medical care. So hospital, physician and ancillary type services.
Q Are you familiar with the term primary care?
A I am.
Q And what's your understanding of that

term?
A Primary care is generally considered associated with care delivered by a primary care physician. So an internal medicine physician a, family doc.
Q And secondary care, are you familiar with that term?
A It's not a term I use, no.
Q How about tertiary care?
A Yes.
Q Are you familiar -- you're familiar with the term?
A I am familiar with the term.
Q What's your understanding of the term?
A Generally when we talk about it we would refer to tertiary care as the very specialized services provided by hospitals, highly specialized hospital services.
Q And does Blue Cross-Blue Shield PPO, HMO and POS products cover those sorts of care primary, secondary and tertiary?
MR. COHEN: Object to the form with respect to secondary.
THE WITNESS: Yes, secondary is a not a term I've used. But our products generally

cover primary and tertiary services, yes.
BY MR. BURKE:
Q Is that something that your members desire, to have access to those services?
A By and large, yes.
Q Okay. I'm going to get the declaration you submitted.
A Okay.
(Whereupon, marked by the court reporter for identification purposes, Exhibit No. 2.)
BY MR. BURKE:
Q The declaration is attached to the -- yes, starting there.
Do you recall making this declaration?
A I do.
Q In the first paragraph, it refers to it being made in response to a subpoena ad testificandum issued by the FTC to you.
Do you recall that?
A Do I recall --
Q Receiving a subpoena?
A Somewhat, yes.
Q Do you recall the name of the person at the FTC who issued the subpoena?
A I do not.

Q Do you recall the name of the person or persons at the FTC whom you spoke with about the content of this declaration?
A I do not.
Q Did you speak with anyone on the telephone?
A Did I speak with the FTC on the telephone?
Q Yes.
A Yes.
Q Did you speak with them in person?
A No.
Q And you don't recall anyone -- the names of anybody you spoke with?
A I don't recall, no.
Q Do you recall how many times you spoke with them?
A I don't.
Q More than once?
A You know, I sense it was once, maybe twice.
Q Who prepared this statement initially, the initial draft?
A I don't know.
Q Was it you?
A Who prepared the initial draft? No, it

was not me.
Q Was it someone from the FTC?
A I don't know.
Q Who would it have been otherwise, if it wasn't you or someone from the FTC?
MS. SCHWAB: Object to the form.
THE WITNESS: I -- in working on the declaration, I worked primarily with in-house counsel for WellPoint Blue Cross-Blue Shield.
BY MR. BURKE:
Q Who -- which in-house counsel?
A I worked with Kathy Mayberry and Michelle Rothenberg-Williams.
Q So you received their approval for finalizing the statement?
A I'm not sure I understand the question.
Q Did you receive approval from anyone at WellPoint before signing this statement?
A What do you mean by "approval"?
Q Did anyone else review it from WellPoint?
A Yes.
Q Before you signed it, did you ask permission to sign it? Did you say is this okay if I sign it to anyone?
A I don't recall.

Q When did you last speak with someone from the FTC about this matter?
A It would have been before the declaration. I don't recall.
Q So you've not spoken recently with the FTC?
A No.
Q Is it your understanding that anyone from WellPoint -- anyone else from WellPoint has been contacted by the FTC recently?
A Has been contacted -- I don't know.
Q In Paragraph 2 -- well, this declaration was executed in March of 2011 -- I'm sorry, no -- yes, March 2011.
So this was when you were in your prior position, is that right?
A Correct.
Q So in Paragraph 2, the second sentence, it says: In my position, I have responsibility for contracting activities with health care providers across Georgia for BCBSWGa and BCBS" -- is that health plan -- "HP"?
A Yes.
Q "Provider networks." And the provider networks would include hospitals?

A Yes.
Q In your contracts with providers -- well, let me back up.
Do you know what a most favored nation cost is?
A Generally, yes.
Q What is your understanding of the term?
A It's generally a term that says something about the contract, is a lot of times used in regards to the price, the rate, that it's the lowest rate offered or agreed to by the plan.
They're not providing lower rates is generally the context in which we talked about that.
Q So let me state it one way and if you agree with it, okay?
A Okay.
Q A most favored nation provision would insure that the terms -- pricing terms by provider hospitals would -- to Blue Cross would be the best that they offer any other competitor of Blue Cross.
Is that fair?
A Yes, that's a fair way to describe the most favored nations term.
Q Okay. And in your contracting with providers, did you request most favored nation

provisions to be included in them?
A Not routinely.
Q Sometimes?
A Sometimes, yes.
Q And when would you?
A Sometimes -- well, sometimes it would be something that was already in the contract. We'd carry on. A very common instance of it.
Q When it wasn't in the contract being carried on, why might you ask for it sometimes?
A We may have asked for it in an instance where we were making concessions in the negotiation that we felt were significant and we wanted to insure that we aren't ultimately being disadvantaged by those concessions.
Q Do you think that one potential effect of having a most favored nation provision in a contract with a provider is that the provider would have a disincentive to offer your competitors lower terms or better terms?
A I don't know.
Q Do you think that's a possible effect?
A I don't know.
Q In your discussions with providers, that never came up?

A Specifically what never came up?
Q Well, that a provider saying -- you know, I'm just making up this hypothetical scenario.
A provider saying to you could you remove the MFN provision because I'm being asked by United Health Care, Cigna, to provide a better term and we think it's justified for XYZ reasons, and I can't agree to it without breaching your contract?
MS. SCHWAB: Objection to form.
MR. COHEN: Same objection.
BY MR. BURKE:
Q I mean, is that something that you might have ever heard?
A I don't recall. No, I never heard that.
Q But you do understand that the effect of having an MFN provision is that the provider would be precluded from offering better terms without offering you the same better terms?
A It would depend on the MFN provision.
Q In what way?
A It's a negotiated contract. They may have had various applications.
Q But in some of those applications, that would be -- I mean, that's the effect, right? Didn't you say that that's the benefit to Blue Cross

of having a MFN?
A Say again the first part of the question.
Q To insure that Blue Cross, in whatever applications the contract provides for, gets the best terms?
A By and large, our application of it was to insure we weren't disadvantaged.
Q Right. Which would mean that the providers couldn't offer better terms to your competitors without offering you the same terms?
A Depending upon the -- specificities of that contract and MFN. It would vary.
Q But yes, that is -- in certain specificities, that would be the effect?
A It could be.
Q Have you been willing to pay better rates or higher rates to hospitals in return for an MFN?
A Can you qualify that, like specifically in some time period or --
Q Well, during your tenure in that position that's referenced in Paragraph 2, did you ever offer a hospital an MFN -- I'm sorry.
Did you ever offer to pay better rates to the hospital, more higher reimbursement rate in return for them giving you an MFN?

A A quid pro quo kind of thing.
Q Yes.
A No.
Q Has Phoebe Putney specifically ever offered to give you better rates in return for removal of your MFN provision from its contract?
A Can you clarify what you mean by "better rates"?
Q Lower rates to Blue Cross?
A So the question is?
Q Phoebe Putney would charge Blue Cross less in return for your removing of the MFN provision from the contract?
A I don't recall.
Q You don't recall that. Do you know if the current contract with Phoebe Putney has an MFN provision?
A I don't know.
Q And during the tenure in the position in Paragraph 2, did your contract with Phoebe Putney include an MFN provision?
A I don't recall.
Q Did Phoebe Putney ever ask you for an MFN provision in return to run to Phoebe's benefit?
A Can you clarify what that would mean?

Q If you agreed to provide a higher reimbursement rate to a hospital that's defined in the specificities -- is your term you used -- in the contract, then that higher reimbursement rate would apply to Phoebe as well?
A And your question is?
Q Did Phoebe ever ask for that?
A I don't recall.
Q In your discussions with your providers -- hospital providers in your prior position and negotiating of contracts, did you become familiar with the reimbursement rates those providers received under Medicaid?
A I'm -- not specifically, no.
Q Are you familiar with the federal Medicaid program?
A Yes.
Q Do you have an understanding of the reimbursement rates that Medicaid provides to providers in return for services covered by Medicaid?
A Can you clarify what you mean by "understanding"? Like specifically what the price was for every service?
Q No. Generally what reimbursements -- what

the reimbursement rate was or is for Medicaid to providers?

A I mean, at the time I was in the job, I had probably some familiarity with it, but not deep specificity. I didn't contract for Medicaid.

Q Did providers ever make clear to you in the contract negotiations that reimbursements that they received for Medicaid in the aggregate do not -- are insufficient to cover the costs of their cost services?

A Yes.

Q How about for Medicare, did the same point come up in the contract negotiations?

A It did come up.

Q So the reimbursements received by providers from Medicare were insufficient to cover the costs of services delivered by those providers?

A That point came up. I wouldn't say that it was universally true, but ...

Q Do your reimbursement rates to providers generally exceed the reimbursements that are provided by Medicare and Medicaid?

A Yes, they do.

Q Why is that?

A Well, we -- we -- our contracts with

hospitals are negotiated contracts and, you know, in the course of that negotiation, the price that's ultimately agreed upon by both parties is one that covers the costs of the hospital and most generally provide the margin.

Q And your understanding is that the reimbursements from Medicare and Medicaid don't do that?

A Don't do what?

Q What you've just described that your reimbursement rates do?

A So Medicare Medicaid, they're not negotiated. Is that --

Q Well, they're not negotiated and they don't cover the costs of the hospital and most generally don't provide a margin?

A Not -- and your question on that is?

Q That your understanding is that neither Medicaid nor Medicare reimbursements do that?

MS. SCHWAB: Objection. Foundation.

THE WITNESS: So my understanding is certainly in the case of Medicaid, not always in the case of Medicare.

BY MR. BURKE:

Q Is --

A There are instances where Medicare covers costs and maybe even provides a margin. Depends on the cost efficiency of the provider rendering the service.

Q And in the aggregate?

A In the aggregate?

Q What about in the aggregate?

MR. COHEN: Object as to form.

THE WITNESS: I don't understand the question.

BY MR. BURKE:

Q Well, Medicare covers a variety of medical care services, correct?

A Yes.

Q So I think what I just heard you say is that, in delivering some of those services, depending upon the efficiency of the provider, the Medicare reimbursement may cover the costs of delivering some of those services and in some cases maybe even exceed the cost; is that right?

A Yes, uh-huh.

Q What about in the aggregate, the Medicare -- the aggregated reimbursement for Medicare?

MR. COHEN: Object as to form.

BY MR. BURKE:

Q Is it your understanding that provider's costs are not covered?

MR. COHEN: Object as to the form.

I'm sorry.

THE WITNESS: Depends on the provider.

BY MR. BURKE:

Q You testified that your reimbursement rates to hospitals provide a margin to the provider?

A Generally speaking, we think they do.

Q Why do you do that?

A I think -- why do we do that?

Q Yes.

A In the case of a hospital contract?

Q Yes.

A It's a negotiated contract between two parties. You know, it's a negotiation and it results in a mutually agreed upon price point.

And there's not many instances, in my experience, of hospitals willing to negotiate a rate that doesn't cover their costs. It could happen.

Q And include a margin?

A Generally -- hospitals generally are always seeking a margin, correct.

Q Did you, in the course of your negotiating

with providers, ever use the understood Medicare Medicaid reimbursement rates as a metric from which to base the reimbursement rates to providers?

A Medicare mostly, yes.

Q And how did you use it?

A Generally, Medicare provides a common comparison point.

Q What does that mean, "common comparison point"?

A You can benchmark the price you're paying to the price Medicare would pay and compare across providers.

Q And would your reimbursement rate represent some multiple of that?

A Generally speaking, what we observed was that our rates were higher than Medicare's, generally speaking.

We need to be careful, as we're speaking in general.

Q Right. It's across the various services?

A There are lots of provider, all kinds of provider types, specialties, et cetera.

I mean, it's a big universe, so I'm speaking in general.

Q And would you use as a general metric, a

multiple of Medicare, for it to calculate an acceptable reimbursement rate?

A No.

Q Back to your declaration in Paragraph 3. It says that it's your "understanding that BCBSGa is the largest health care insurance company servicing employers and members in the State of Georgia, including in the Albany" region, "based on membership."

You don't recall what that understanding would be based on? I asked you earlier about the number of members that Blue Cross-Blue Shield had at the time?

A At the time, I remember a range.

Q What was the range?

A I believe it was somewhere between three million, three-and-a-half million members, I believe.

Q And do you have an understanding or recollection of what the universe of all members, including your competitor members, would be?

A All potential people?

Q That are covered, yes, by commercial insurance?

A I don't recall that.

Q Is it your understanding that it's still the largest in Georgia?

A I think so, but I'm not certain.

Q Do you recall the number of members living in the area including Albany, Georgia?

A In the area including what others?

Q Blue Cross-Blue Shield members in the area of Albany, Georgia?

MS. SCHWAB: Objection to form.

THE WITNESS: Can you ask the question again?

BY MR. BURKE:

Q Do you recall the number of members of Blue Cross-Blue Shield insureds that resided in area of Albany, Georgia at the time?

A I don't recall.

Q Your Paragraph 3, the third-from-the-last sentence says -- beginning "over 65 percent", that sentence?

A Uh-huh.

Q Of your commercial membership is with self-insured customers. How does provider charges affect self-insured customers, if at all?

A How does -- like how does the rate the hospital charges affect a self-insured customer,

like the price they charge?

Q How does it affect the fees Blue Cross-Blue Shield charges those customers? Does it?

A Does the billed charges of a provider affect the fees? I don't think I understand your question.

Q That's exactly my question, does the billed charges of the provider affect the fees Blue Cross-Blue Shield charges self-insured -- its self-insured customers?

A Our administrative fees or the underlying claims expense of the ASO provider?

Q What is does ASO stand for?

A Administrative Services Only.

Q I'm talking -- when I use the term "provider", I mean the hospital?

A I understand. I'm seeking clarity as to the word "fees".

Q Well, at the beginning or earlier in the deposition we talked about fully-insured product and self-insured.

A Uh-huh.

Q And I thought we had agreed that premiums are what was paid to Blue Cross in return for the fully-insured product and that fees, administrative

fees, are the form of compensation that Blue Cross-Blue Shield for the self-insured product?
A Uh-huh.
Q So what I'm asking is what -- how might the provider -- hospital providers, you know, charges to Blue Cross -- I mean charges, how might they affect the fees that Blue Cross-Blue Shield charges to its self-insured members?
A I don't know.
Q Is it irrelevant?
A I don't know.
Q Paragraph 5 of your declaration, you describe the geographic area in Georgia?
A Uh-huh.
Q And you refer to it, in a parenthetical, as it generally comprising Blue Cross-Blue Shield of Georgia's administrative area for southwest Georgia.
What is the significance of that area within your organization?
A You know, I'm not certain as to the significance of it. The description here was generally when we thought about our networks and territories for people to manage, you know, that that was how we thought about the southwest area.
And we generally tried to balance

responsibilities geographically across people.
Q Does this correspond to the community rating area?
A I don't know.
Q Does this vary by product?
A From a network management perspective, we did not vary the way we thought about the geographies by product.
Q Does Blue Cross-Blue Shield's products, PPO, POS, HMO products, do they contain geographic limitations?
A Can you clarify what you mean by "geographic limitations"?
Q Is the insurance benefit limited by the geographic area where the services are rendered?
A Does the benefit -- I mean, I think I understand your question. If I do, generally speaking, the products offered coverage state wide.
And through Blue Cross and Blue Shield blue card system, many products offered nationwide coverage.
Q So a member that resides in any of the counties listed in Paragraph 5 that make up the area southwest Georgia could obtain coverage under their plan at any facility in Georgia that's within Blue

Cross-Blue Shield network?
A They could, yes, by taking coverage. I just want to clarify. I think you're saying they could receive services on an in-network level benefits.
Q Right.
A Correct.
Q Your last sentence in Paragraph 5 says the majority of the members in the southwest Georgia area are covered by the Blue Cross-Blue Shield PPO plan, right?
A That's what my sentence says, yes.
Q Does that mean it's the most popular product at the time?
A I'm not sure I understand what you mean by "most popular".
Q Okay. Most subscribed?
A I mean, it was the product that the most people were covered by.
Q Do you have an understanding of why that was?
A Yes. I mean, my understanding, you know, had a lot to do with the fact that that was where the majority of our network was contracted under PPO products.

We had worked over time to contract providers to provide in-network benefits under other products, as well.
Historically the PPO was the plan that providers contracted with Blue Cross for and, therefore, we sold the most members under that.
Q I mean, is it unique to the southwest Georgia area or is that something that's true across state wide?
A It was fairly unique to the southwest Georgia area. I don't know if it's exclusively unique to that, but, you know, the fact that we didn't have providers contracted for other products was somewhat unique to southwest Georgia.
Q I'm sorry. Do you have an understanding as to why that was?
A Historically, in my understanding, is that providers in southwest Georgia were not always willing to contract for products other than PPO products.
Q Is that still the case? Do you know?
A I can speak up through the time that I was there in that role. So, you know, we were working very hard to contract providers for products other than PPO, predominantly our Point of Service

offering.
And we were successfully contracting many providers over a period of time through my tenure there as Point of Service and network providers.
Q In the southwest Georgia area, at the time that you were in this position, did the reimbursement rates received by providers in your network in that area vary by product?
A It depended on the provider.
Q So some providers might charge you the same amount whether the insured member is under the PPO plan or the POS plan?
A Can you clarify what you mean by "charge" us?
Q Well, the reimbursement rate -- the agreement between the provider and the Blue Cross-Blue Shield entity, there's a reimbursement rate --
A Yes.
Q -- for the services?
A Uh-huh.
Q So the -- might that reimbursement rate be the same from a provider -- I thought that's what you just said, from a provider to you -- the charge would be the same irrespective of whether the member

was covered by the PPO or the POS?
A Yes.
Q Paragraph 6. I'm sorry. Before we go to that, just following up on the last question.
Do the premiums Blue Cross-Blue Shield charges its members vary by product?
A Yes.
Q Are they generally higher for PPO product?
A I believe so.
Q And again, generally, would it be POS would be the next highest and then the HMO plan?
A There's a lot of factors, you know, that affect the premium, but I think you could say generally.
Q Okay. So you might be getting the same charges -- Blue Cross-Blue Shield might be receiving the same charges by the providers, but the premiums being received by Blue Cross vary depending upon the products they covered -- the members have?
A So --
MR. COHEN: Object as to the form.
THE WITNESS: The premiums need -- the premiums -- we need to talk about this. The premiums reflect the projected assessment of what the costs are going to be and the claims

that we're going to pay out.
So to the extent we projected those claims costs would be less, the price of the product could reflect the lower price.
BY MR. BURKE:
Q Okay. I understand. What I was just confirming, just to make sure I understood what you said, was that for providers -- the reimbursement rate for some providers, the reimbursement rate they charged Blue Cross-Blue Shield may be the same irrespective of whether the member -- Blue Cross-Blue Shield member is covered by the PPO, POS or HMO plan?
A Yeah. What you're saying is specific to a specific single provider. We may pay the same price for both products, yes.
Q Right. And understood. And generally, the premiums charged by Blue Cross for the plans vary, some are higher and some are lower?
A Generally, they vary.
Q Okay. Paragraph 6. Your second sentence of the paragraph refers to "comprehensive health care provider networks".
What does that mean?
A Comprehensive, in this sentence, means

complete or networks that provide in-network providers for all kinds of care that may need to be received.
Q To include the primary and tertiary that we talked about earlier?
A It would include that. Yes.
Q So cardiology, oncology, et cetera, pathology, all that?
A Yes.
Q The next sentence says: "This can be accomplished in a variety of ways."
What are some of those ways?
A What are some of the ways?
Q You could construct a comprehensive network?
A You may have multiple providers providing the same service or a single provider providing the service to many people.
We may have a national contract with someone, a local contract. Just depends.
Q Are there any benefits to Blue Cross to having -- members having a single provider providing access to this comprehensive network?
A Can you state that again?
Q You said that you could have a single

provider one way to do -- to have a comprehensive network would be to have a single provider provide access to all these services?

A I said that. What's the question? I'm sorry.

Q Okay. Well, so that's what you said. So then my question was: Are there benefits to Blue Cross members to doing it that way? Could there be?

A It depends.

Q What would it depend on?

A I mean, the benefit would be in the eye of the beholder, the consumer purchasing the care.

Q The member?

A Yes, the member purchasing the care.

Q What benefits might they behold?

MS. SCHWAB: Object to form.

THE WITNESS: Which -- who's purchasing this? Who's the "they" in this sentence?

Q You said --

A I said it's in the eye of the beholder. It depends. Who's buying it and what's their value.

BY MR. BURKE:

Q Each one. So with you're familiarity, what might an employer purchaser perceive as a benefit? What might an individual --

A So employer purchasers generally value access. So lots of alternatives for services. And they value paying an affordable price, and there's oftentimes tradeoffs between those, but ...

Q Would you expect a single provider offering access to comprehensive services to have higher costs than the alternative specialty facilities that you referred to?

A Can you explain what you mean by "higher costs"?

Q The costs to provide access to all of those different categories of care?

A Again, can you explain what you mean by the word "cost"?

Q Well, everything from the equipment on hand, employees, space?

A Okay. So now that I understand what you mean by the word "cost", which is helpful, can you restate the question?

Q Would you expect that if a single large facility offering access to the comprehensive panoply of services to have higher costs than specialty facilities that each focus on the one?

A Not necessarily.

Q In the aggregate, to have access -- to

provide access to ten services as opposed to a facility having one sort of -- space for offering one service, you don't think that the one offering the access to ten would have higher cost?

MR. COHEN: Object as to form.

THE REPORTER:: Not necessarily.

BY MR. BURKE:

Q Why not?

A Well, I mean there's a matter of scale. Being able to provide services at a scale drives your cost down.

Q When you say "scale", just tell me what you mean.

A Scale, size, volume.

Q Volume of patients?

A Maybe not patients. Maybe volume of services.

Q So the more services you offer, the less cost you have?

A Potentially, yes.

Q How would that work?

A So, you know, we can just use one example. I mean, if you have to staff an MRI machine 24/7 and you're providing one MRI per day, the cost of that MRI is higher than if you're paying them 100 a day.

Q But that's involving patients, right, delivering --

A I mean, it just depends on your unit of what you're measuring the cost against. In your scenario, I think that they're measuring the cost against the cost of the service.

Q What about -- I mean, the cost of providing access to care is simply -- irrespective of whether it's used or not, you have physicians on-call, you have equipment at the ready, you have staff there and other space, et cetera, whether it's used or not?

A Is there a question?

Q Right. I mean; is that correct, in a single facility?

A I did not understand the question. Is there a question?

Q Isn't there costs associated with having -- simply providing access, having the space to deliver all those services, the equipment to deliver all those services, physicians on-call, staff ready to deliver services?

A Is there costs associated with that? Yes.

Q And if you're offering access to a multitude of services at the same time versus a

narrower list of services, would those costs, all else being equal, be higher at the one that offers more services?

A Not necessarily.

Q How so?

A I've already answered the question. It's a matter of scale, how they -- you know, there's a lot of things that would go into -- it's like any business, in terms of efficiency and how you manage your business and the costs associated.

Q Okay. Let's go to Paragraph 7. In the first sentence of Paragraph 7 you refer to "general acute care".

What do you mean by that term?

A So in that instance, as I state that, general acute care is usually referring to hospitals providing a range of acute services but not necessarily tertiary services.

Q What would be included in acute services?

A General acute services?

Q Yes.

A You know, a range of inpatient services for medical members needing medical care and sort of a range of common outpatient services.

Q Are any of the products that we've been

discussing -- the Blue Cross-Blue Shield products limited in coverage to just general acute care services that you just described?

A Not that I'm aware of, but --

Q The contract with Phoebe Putney isn't limited to that, correct?

A The contract with Phoebe Putney is not limited to general acute care services, correct. Wasn't at the time.

I need to be careful because I'm not currently in charge.

Q In Paragraph 8, in the first sentence you refer to -- you use the term "viable health plan".

What does that mean?

A Viable health plan product would be a desirable product.

Q Desirable in the sense of providing access to all the services we just discussed?

A Yes.

Q Later in that paragraph you list a number of services provided by Phoebe that were not available at the former Palmyra.

Those would be part of a viable health plan?

A Yes.

MR. COHEN: Off the record for a second. We've been going about another hour. I'm just checking to make sure.

MR. BURKE: Sure.

(Whereupon, a discussion ensued off the record.)

(Whereupon, a brief recess was taken.)

BY MR. BURKE:

Q So I think we left off at Paragraph 9, so moving to Paragraph 10.

A Okay.

Q This paragraph describes the exclusive nature of your contract with Phoebe over or during a 11 year period.

Is that right, approximately 11 years?

A Is your question how long did -- was it exclusive or what does this paragraph state?

Q Well, it states that from May 2000 to March 2011 you had an exclusive contract with Phoebe; is that right?

A Yes.

Q And why did Blue Cross agree to grant Phoebe exclusivity?

A I don't know originally why that decision was made.

Q It refers in the middle of the paragraph

to a 2004 agreement.

That preceded your tenure?

A It did.

Q So you weren't a party to any negotiations with Phoebe during your time in this position, your 2007 --

A No, I was a party to negotiation with Phoebe during the time in my position.

Q Well, I'm sorry. Negotiations that resulted in the agreement prior to March 2011? I'm sorry.

MS. SCHWAB: Prior to March 2000 what?

MR. BURKE: Eleven.

THE REPORTER:: I was not a party to negotiations for the 2000 or 2004 agreements.

BY MR. BURKE:

Q But it was, at the time, in the interest of Blue Cross-Blue Shield to agree to provide Phoebe exclusivity?

MS. SCHWAB: Objection. Foundation.

THE REPORTER:: I don't know.

BY MR. BURKE:

Q Under the 2000 and 2004 agreements, was Phoebe a participant in different products or just a single product?

A I know it applied to the PPO product. I'm not sure about Indemnity products.

Q In Paragraph 11, you use the term again "viable hospital".

Are you familiar with the patient mix in the Albany area? Were you familiar at the time?

A I'm not sure. Can you clarify that question? I don't know the connection between viable hospital statement and then --

Q Fair enough. Let me back up from there. Were you familiar with the patient mix in the area of Albany, Georgia at this time?

A Can you clarify what you mean by "patient mix"?

Q The percentage that's covered by a plan such as the Blue Cross-Blue Shield PPO versus Medicare versus Medicaid versus not covered at all?

A I believe I had some familiarity at the time, yes.

Q Was it your understanding that the majority of the patient population in that area were covered by Medicare or Medicaid?

A I don't recall.

Q If that was the case, could a full service hospital be viable providing services only to

Medicare and Medicaid patients?

MS. SCHWAB: Objection. Foundation.

THE REPORTER:: Can you -- I'm -- can you restate the question?

BY MR. BURKE:

Q You referred -- we discussed earlier the viability question in Paragraphs 7 through 9.

A I believe that was referring to a health plan.

Q Viable health plan, fair enough. So you said that for a viable health plan to be or for a health plan to be viable, it needed to offer comprehensive services, access to comprehensive services, and that Phoebe provided that, correct?

A Paragraph 7, just let me go back and read the statement.

Q Eight.

A Eight. The statement of viability here was about the health plan. It was about desirability, as we clarified earlier.

And so we felt, in order to have the statement -- stating in order to have a desirable health plan product, it was important to include either or both.

Q Well, you testified earlier that providing

access to comprehensive services, which included services that Palmyra did not offer and Phoebe did, was important to your membership and desired by your membership?

A When we spoke earlier, the questions were around what was meant by comprehensive.

Q Right.

A And did the services described -- were they inclusive and comprehensive.

Q Right. And you said that your members wanted access to comprehensive health plan and that those services would be included in what you were referring to as the comprehensive health plan?

A Yes.

Q Okay. And a hospital providing such comprehensive services, could it be viable, going back to Paragraph 11, if it's only patients for Medicare or Medicaid?

MS. SCHWAB: Again, same objection. Foundation.

THE REPORTER:: Could the hospital be viable? I think it would depend on the hospital. I don't know. Possibly yes.

BY MR. BURKE:

Q Earlier you testified that you understood

that, in the aggregate, Medicare Medicaid reimbursement rates do not cover providers -- hospital provider costs?

A Medicaid I did. I didn't say that for Medicare.

Q Is it your position that a comprehensive -- a hospital providing comprehensive services does not need commercially insured patients to be viable?

A I mean, that is a very subjective question. It's going to depend upon, I think, the hospital, the locality and the country, the mix.

Q In southwest Georgia?

A I don't know.

Q What did you mean by "viable hospital" down in Paragraph 11, the last sentence?

A A hospital actively open and providing services.

Q And one that would be able to do that would need to cover its costs?

A I have to read the statement. Can you restate the question?

Q Does that mean it would need to cover its costs?

A Correct. I mean, I can't say. I don't

know.
Q So you don't remember what you mean by -- what you meant by "viable hospital"?
A No, I do recall that.
Q Does it include covering costs of operation?
A That was not the point of the statement.
Q So the costs of the hospital operation was irrelevant to the statement?
A Correct.
Q Okay. Paragraph 12, you begin with it's my understanding that the reimbursement rates for Phoebe are among the higher for all hospitals in Georgia on a case-mix-adjusted basis.
What was that understanding based on?
A Our analysis.
Q Whose analysis?
A Blue Cross-Blue Shield of Georgia's.
Q And how do you perform a case-mixed-adjusted analysis?
A Using claims data.
Q And how do you use claims data?
A How do we -- in Access or Excel.
Q Well, how is it used to make it case-mix-adjusted? What does that term mean?

A Case-mix-adjusted refers to a process of adjusting for the effects of the acuity of a population so you can provide an apples to apples comparison on the payment rates.
Q Do you perform that analysis?
A I don't personally perform that analysis, no.
Q Do you have an understanding of whether that's still the case today?
A What is still the case?
Q The accuracy of the first sentence?
A I don't know.
Q Paragraph 12 continues to say that in 2009 you decided to move away from the exclusive arrangement.
Why did you make that decision?
A There -- we had an ongoing significant interest from employer groups in the area having alternative access to Palmyra.
So it was a frequent request. We had concerns about the cost of care we were paying, the cost of the relative case mix adjusted cost of what we paid Phoebe.
And Palmyra offered more cost effective pricing. And Palmyra had significant interest in

participating in our networks.
Q What were the employer groups that you refer to? Can you name some of them?
A I can't. I don't recall their names.
Q None of them?
A No, I can't recall right now.
Q When was the exclusivity ultimately, if it has been, removed from your contract with Phoebe?
A I believe it was removed in the amendment March of 2011.
Q How would adding Palmyra deliver cost savings to your customers in Dougherty County?
A The rates -- the negotiated price with Palmyra was -- for services was significantly lower than the prices we were paying Phoebe.
Q That would reveal Blue Cross-Blue Shield having a cost savings, not necessarily that the patients getting service at Palmyra would be -- not the patients getting service at Palmyra realizing cost savings?
A Okay. So the patients realized cost savings for a number of ways. The premiums, as we talked about, the projected cost of the services that we're going to pay, the medical costs are a component in setting the premiums.

So the premiums would be lower. Benefit design often has a member paying a percentage of the price that we have negotiated for the service, either through deductible, co-insurance.
And all of those things are less if the price you pay for the service is less.
Q So the existing PPO product that Phoebe was a member or participant in, you're saying that when Palmyra joined the premiums were reduced or would have been reduced?
A I don't know what the premiums ultimately were. You know, I changed roles just shortly after this amendment was completed.
Q So you don't know if the premiums were reduced once the Palmyra was -- became a participant?
A I don't know.
Q In Paragraph 13, you refer to a plan for Palmyra to begin participating as an in-network provider for Blue Cross Blue Shield's POS plan, right?
A Uh-huh.
Q Effective May 2010?
A Uh-huh.
Q And Phoebe was not a participant in that

plan at the time, right?
A Correct.
Q It refers further to a plan of joining -- Palmyra joining the PPO plan in March 2011.
Did that require removal of the exclusivity provision in the Phoebe contract?
A The amendment that removed the exclusivity in the Phoebe contract was effective the same date that Palmyra participated.
Q In the PPO?
A Uh-huh.
Q How many POS subscribers were there in the southwest Georgia area at the time that Palmyra became a participant in the network?
A I don't know.
Q Do you know if the premium for the POS plan was higher or lower than the PPO plan?
A I don't know.
Q Paragraph 14, you refer to offering a "standard hospital contract".
What does that mean?
A When we refer to standard hospital contract, we have a template contract that is a starting -- you know, would have been the contract we provided, sort of our standard template.

Q And what is the purpose of the standard contract? Is it to begin from the lowest reimbursement rate?
A No. The standard part is really the language of the contract. So all the provisions that govern the relationship as -- you know, outside of pricing.
Q Is it ordinary for a standard hospital contract to be offered in a situation where you have long standing existing contracts in place?
A Yes.
Q Does your standard contract include an MFN?
A I don't recall.
Q In Paragraph 15, you describe Phoebe's response to your proposal and what was ultimately set out, two offers: A non-exclusive proposal and an exclusive proposal; is that correct?
A I just had to read the sentence. Can you restate the question?
Q The result of your negotiations with Phoebe, as described in Paragraph 15, resulted in two proposals, right?
A Phoebe made two proposals to us.
Q One proposed an exclusive rate with a

higher discount, 20 percent?
A Uh-huh.
Q And a non-exclusive rate for the lower discount of 15 percent?
A Correct.
Q Did the exclusive offer include your maintaining an MFN provision?
A I don't remember.
MS. SCHWAB: Objection. I don't think she testified that there was an MFN provision -- I don't believe that Ms. Cheslock testified that there was an MFN provision previously.
BY MR. BURKE:
Q The question was: Did it include an MFN provision, not whether the prior contract did or didn't.
And you said you don't recall; is that correct?
A I don't recall.
Q And did the 15 percent non-exclusive rate include an MFN provision to run to your benefit?
A I don't recall.
Q What did Blue Cross ultimately agree to? Which proposal did they accept?
A I don't recall the rate. But the

proposal -- the contract we ultimately agreed to was a non-exclusive contract. I don't recall the exact price.
Q So you're not sure if it was the 85 percent discount all charges method that's the non-exclusive proposal you described in Paragraph 15?
A I don't recall the exact price in the final amendment.
Q Paragraph 16 provides that you agreed to something that you don't recall on the same day that the Authority's acquisition of Palmyra was announced; is that right?
A Yes. Was it the same day? I don't know if it was the same day or the day before. It was in advance of the announcement.
Q Okay. And what -- you say in the last sentence you were surprised by the public announcement of the Authority's planned acquisition of Palmyra.
What did you say to Phoebe in response to learning about that? Do you recall?
A I don't recall specifically, but I recall saying that we were not willing to move forward with the agreement that had been made, you know, hours

before.
Q Why was that?
A We had been negotiating the removal of exclusivity with some kinds of concessions. I believe they were price concessions.
I don't recall the exact price. And that had taken a very long time. It was a lot of negotiating over many months.
And Phoebe had said, sort of on the 20th, we're ready to go, sign this but we have to have it done by 9:00 in the morning.
And at that point we were close to a contract. We agreed that we were preparing the final documents and we prepared the final documents.
And an hour-and-a-half later, they announced they were buying the hospital which was the subject of the exclusivity discussions we were having.
Q So then it sounds to me that your recollection is that you agreed to the non-exclusive proposal before the announcement?
A Correct. We agreed to a non-exclusive.
Q Okay. And so when you said you alerted Phoebe you wouldn't go forward with that agreement, what then happened?

A I don't recall specifically what happened next. The person I was working with took that message back and some time passed, as I recall, before -- you know, ultimately we signed the amendment in March.
So some time passed between December and March.
Q Do you remember what was agreed to in terms of the amendment, in terms of whether it was exclusive or non-exclusive and what the reimbursement rate was?
A The final amendment we signed in March was non-exclusive.
Q This is March 2011?
A Yes. But I believe the pricing terms were favorable to those that we were discussing in advance of the announcement.
Q Favorable. And what do you mean, favorable --
A Favorable to Blue Cross-Blue Shield, our members or customers.
Q Okay. So it wasn't -- it was something less than 85 percent of the percent of charges?
A I don't recall the specific percent that was agreed -- that we were moving forward in

agreement on on December 20th or 19th.
But I recall that the amendment we ultimately agreed upon in March of 2011, which was non-exclusive, was more favorable than the one we were potentially agreeing upon in December.
Q Okay. Paragraph 17. Did you, at the time, have knowledge about the share of Blue Cross in the health plan within a given geographic area?
I mean, did you track your market share?
MS. SCHWAB: Objection to form.
THE WITNESS: I was not responsible for tracking market share personally, no.
BY MR. BURKE:
Q Were you familiar with it?
A I had some familiarity -- some familiarity. I'm sorry.
Q Earlier I think you said that you were -- you believe it was the largest in Georgia?
A Yes.
Q Okay. I think you said you thought it was also the largest in southwest Georgia?
A Yes.
Q And do you think that having the largest market share in a given geography provides Blue Cross more leverage in negotiations with providers?

A It's possible.
Q And, I mean, that's just a fact of competition, right? I mean, it is or it isn't?
A Not necessarily.
Q Why? What would it be dependent on?
A If you have a large market share but you don't have alternatives -- that there's no alternative to provide coverage, your leverage, despite your market share, is greatly diminished.
If you have a lot of members but nowhere else for them to go for care, the market share -- effective market share is greatly diminished.
Q You used the term, in paragraph 17, as "must have" -- you characterized Phoebe Putney as a "must have" in a provider network.
Was Phoebe a "must have" in your network?
A Yes, we considered Phoebe a "must have".
Q And that was true before the Hospital Authority's acquisition of Palmyra?
A We felt that it was important to have Phoebe in the network, yes.
Q Did Phoebe Putney and Palmyra ever participate in the same Blue Cross-Blue Shield product network prior to the acquisition by the Authority of Palmyra?

A With Blue Cross, I don't recall. It would have been prior to 2000 if that's the case. I'm not certain.

Q Would the premium -- if they did, would the premiums charged for a POS member vary depending upon whether they got the care at Phoebe or Palmyra?

A Is the question would the premium charged for each member vary depending upon if that member in that year went for care at one versus the other?

Q I asked it a different way. If they both were members or participants in the POS plan, would your POS premium vary depending upon whether the actual patient visited -- got -- received services as Phoebe or Palmyra?

A I'm not sure.

Q Is it normal for members in the same geographic area that subscribe to the same health care plan, Blue Cross-Blue Shield, to have a variety of premiums?

A If it's a large employer that's individually underwritten, their experience -- their actual experience is going to be the basis of the premiums, so ...

Q Okay. So if the two employees are at that same employer, would their premium -- you know,

assuming it's the same plan, the POS plan, would their premium vary based upon where they got the service?

A I can't say. I don't know. It would be how the employer manages that.

Q If it was a fully-insured product.

A I can't -- I don't know.

Q In Paragraph 18, you state that your network would be more attractive with both hospital alternatives, Phoebe and Palmyra.

Why did you believe that?

A At the time, in the years I was in that position, we had a lot of ongoing requests from brokers or employers to have access to Palmyra in addition to Phoebe.

It's a very common thing that we heard.

Q Were you familiar with the fully staffed beds at Palmyra, the number of fully staffed beds that they had?

A I may have been. I don't recall.

Q Are you familiar with the licensed -- the number of licensed beds they have under their Georgia authority?

A I don't recall.

MR. BURKE: Can we go off the record for a

second.

(Whereupon, a discussion ensued off the record.)

BY MR. BURKE:

Q Okay. You're familiar with the fact that there was a limited number of beds that Palmyra was authorized, the maximum capacity under Georgia law?

A I mean, I don't dispute it. I don't dispute that. I just -- I don't recall specifically, you know, what I understood at the time.

Q Right. But -- okay, so you understand there's a limit. They can't just have beds beyond a certain limit?

A Yes.

Q You just don't know what that number is?

A It is a true statement that I don't recall the number of beds.

Q Okay. And relative to the maximum they fully staff up and service, they could go up to that number or some lesser number.

Are you familiar with that concept as well?

A Yes. In concept, yes.

Q Okay. Would it surprise you to learn that Palmyra staffed approximately 50 percent of its

fully -- of its maximum number of beds?

A No.

Q It would not surprise you to learn?

A No.

Q And would it surprise you that, of the beds that it did staff, its utilization rate was approximately 50 percent?

A I don't know -- I don't know that I would say I'm surprised or not surprised. It wasn't a fact, you know, that I recall focusing on, I guess is what I can say.

Q It seems to me, and tell me if you agree -- well, back up.

Do you agree that if those numbers are true, that that's somewhat inconsistent with a significant demand in the area for services from that facility?

MS. SCHWAB: Objection, form.

THE WITNESS: Say that again.

BY MR. BURKE:

Q If the numbers I just told you were true, that they fully staff up and service half of their maximum allotted amount and the utilization rate of those fully staffed beds is approximately 50 percent, if those numbers are true, doesn't that

suggest that there wasn't much demand for service from that hospital?

A From my perspective and from the time I spent in that position and speaking with the hospital, there were challenges associated with them not having a contract with Blue Cross.

And so, you know, from my membership's perspective, the demand was limited by the fact that they couldn't receive services on an in-network base.

Q Well, it's also limited by the fact that they didn't offer the services that your members wanted?

MS. SCHWAB: Objection, form.

THE WITNESS: I wouldn't agree with that statement.

BY MR. BURKE:

Q Well, Phoebe, you testified earlier, provides access to comprehensive services and Palmyra does not?

A Correct. There are services that Phoebe provided that Palmyra did not provide.

Q And your members desire access to comprehensive services?

A In selling a product, yes. But the two

hospitals, where they provided like services, the same service, members from Blue Cross -- from my perspective, our members were not able to access the services offered by Palmyra because we didn't have a contract to provide them on an in-network basis.

So their benefit plan from Blue Cross afforded them access to Phoebe's.

Q And if a member of the PPO plan that Phoebe was a network of obtained service at Palmyra during that time, what would be -- what was the reimbursement rate, if any, that Blue Cross would provide?

A We would provide a reimbursement. I don't recall what the rate was.

Q Was it equivalent to what you provided Phoebe?

A I don't recall.

Q Under your current contract or the contract that was executed in March of 2011, what services -- well, I'm sorry.

Do you recall what products -- Blue Cross-Blue Shield products are covered by that contract?

MS. SCHWAB: Which contract are we talking about?

MR. BURKE: The one in March 2011.

THE WITNESS: With who?

BY MR. BURKE:

Q With Phoebe.

A With Phoebe? That amendment provided coverage for the PPO product and also made them an in-network product for the Point of Service product, I believe.

Q And those members of those products have access to the full services available at Phoebe?

A They should -- right, correct. Access to those -- I mean, those that are covered under their benefit plans.

(Whereupon, a discussion ensued off the record.)

BY MR. BURKE:

Q Paragraph 20. Since the Authority's acquisition of Palmyra, is it your understanding that the contract with Phoebe agreed to in March 2011 has remained in place?

A I don't know.

Q Do you know what has happened to the premiums for the products, the PPO, POS products since the 2011 contract was signed?

A I don't know.

Q In the last paragraph, how much of Blue

Cross-Blue Shield's business in the area that includes Albany, Georgia is self-funded; do you recall?

A No, I don't.

Q Was it a lot? A little?

A I don't recall.

Q But does Blue Cross market and sell or attempt to sell its self-funded products to employers in and around the Albany, Georgia area?

A Yes.

Q Phoebe also markets and sells a health plan to employers in Albany, Georgia, too, right?

A I -- they did at the time. I don't know today.

Q Okay. So at the time, Phoebe and Blue Cross competed in the marketing of those plans to employers in the area?

A Yes. I guess so. It wasn't an area that I highly focused on. So I believe so.

Q In adding the Phoebe North campus, former Palmyra, to that Phoebe health plan list of in-network providers makes the Phoebe managed plan more attractive to potential customers?

A I'm not sure I understand the question.

Q Would the addition of the former Palmyra,

Phoebe North now, campus make the offering by the Phoebe health plan more attractive to employers in the area?
A I don't know.
Q It did -- you thought it did for Blue Cross, though? That it would have been?
A Yes. At the time I was working there, we were -- we thought that having a contract with Palmyra, which was a separate hospital from Phoebe, was -- would make it more attractive to employers and it was something -- the alternative was something the employers were asking of us.
Q Do you recall, again, which employers?
A I really don't recall specifically. There were brokers that would ask for it. It would -- oftentimes these requests would come to me through sales and account managers on behalf of customers and brokers.
MR. BURKE: Okay. Can we take a break for two seconds please.
(Whereupon, a brief recess was taken.)
(Whereupon, marked by the court reporter for identification purposes, Exhibit No. 3.)
BY MR. BURKE:
Q Okay. What I just gave you is a document

that's marked with what looks to be a WellPoint CID number at the top. Seems to have been produced in response to the FTC CID to you back in 2010 time frame? I'm sorry, 2011 time frame?
A Is this -- is that a question?
Q Yes.
A I honestly don't know where this came from. There was a CID and we did provide information.
Q Okay. Flip to Page 3 at the bottom.
A Okay.
Q So this is an E-mail from you dated February 21, 2011?
A Uh-huh, yes.
Q Which would have been after the announcement of the Hospital Authority's acquisition of Palmyra?
A Yes.
Q And this is an E-mail to your team about an Albany market update?
A It was an E-mail to -- primarily focusing the sales organization.
Q Right. That reported to you?
A No.
Q No. Okay. That have responsibility or

interest in the Albany area?
A Right. The E-mail was primarily to people who worked in sales in some capacity, either small group, large group, et cetera.
Q And you report upon the -- Palmyra joining or becoming a participating provider effective March of the year 2011?
A Yes.
Q And the acquisition by the Authority and then Phoebe's also joining the open access HMO, POS networks effective the same day; right?
A Yes. It's an E-mail stating that, yes.
Q And at the bottom there, you say these are great developments for the Blue Cross-Blue Shield network expansion?
A Uh-huh.
Q Flipping forward, Page 2, you get an E-mail from someone named Paula Scott. Who is that?
A I'm sorry.
Q On Page 2?
A Okay. She's a regional sales executive, small group.
Q Okay.
A I didn't know her.
Q You didn't know her?

A I had known her a little bit.
Q So she asks you two questions. One is about whether Palmyra would remain in the network it was already participating in and the other is what the rate was for Phoebe; is that right?
A She asked --
Q Yes, for clarification on the developments that you reported.
A Yes, she's asking about the rates at Phoebe. She's saying the discounts at Phoebe are not good.
Q And then your response to her is to confirm that Palmyra -- it's on Page 1 -- is to confirm that Palmyra remains in the network that they were already a part of, the POS.
And then you cite something called the Hewitt discount study?
A Uh-huh, yes.
Q And you say that, according to that study, the discounts you have are the best overall for both of the plans that Phoebe and Palmyra are participants in and, therefore, you say you don't believe you have a network of great disadvantage; right?
A Correct.

Q What is the Hewitt discount study?
A It's a study that a third party, Hewitt -- Hewitt and Associates performs quarterly, I believe, maybe annually, that basically compares insurance companies, WellPoint and others, aggregate network discounts --
Q From providers?
A -- from providers. They use it as a tool in counseling employers.
Q Hewitt does?
A Uh-huh.
Q And WellPoint relies on it?
A We purchase access to that so we can understand it. It doesn't identify other payers, but it identifies themselves.
Q And you use it in -- WellPoint uses it in the course of its dealings?
A Yes, we use it to understand our relative network discounts and how they compare to our competition.
(Whereupon, a luncheon recess was taken.)
BY MR. BURKE:
Q Can we look back at the document we were talking about just before lunch?
A Yes.

Q We talked before about your recollection, in your declaration, about what the rate was in the contract that was agreed to with Phoebe, ultimately in 2011 time frame?
A Uh-huh, uh-huh.
Q And your E-mail to Paula Scott here and Lynn Zimmerman, Becky Slappey concludes with the statement "Phoebe discounts remain the same".
Does that refresh your memory as to what the agreement was?
A I think it does. The proposal that Phoebe had made, the exclusive and non-exclusive proposal around the end of December, both of those rates offered were worse than the contract we currently had with them.
So the non -- the exclusive rate was worse than the one we currently had and the non-exclusive rate was even worse than that one.
So I didn't recall exactly what we -- what we had agreed upon in principle on the 20th, in terms of the price point.
But this, you know, statement confirms, you know, my recollection that the contract we ultimately signed, the amendment in March of 2011, was superior to the one we had been discussing in

December.
Q The same that it was before?
A It was the same rate but we removed the exclusivity.
Q So is that the rate that was in the bottom -- the last sentence of Paragraph 10 of your declaration, Page 4?
A Yes, I would -- yes, it must be.
Q I'll now introduce another document. This looks like a Power Point presentation that was produced as part of WellPoint's response to the FTC CID, just like the E-mail was.
(Whereupon, marked by the court reporter for identification purposes, Exhibit No. 4.)
BY MR. BURKE:
Q And this was a presentation dated June 25th, 2010 that looks like you prepared or delivered it along with your successor, turns out, Alexandra Leopold.
Do you remember this presentation?
A I don't remember this presentation like very specifically. But the presentation -- this key stakeholder meeting was something we did, you know, regularly with people, other than network management personnel and Blue Cross, in advance of major

negotiations as a planning tool.
Q And do you remember if this was delivered in person at Phoebe Putney or --
A I don't think that this presentation was one that we did with Phoebe Putney. I think it was one we did -- it was an internal meeting, a Blue Cross meeting.
Q You don't think this was delivered to Phoebe Putney?
A No. I'll have to look. There are presentations we would have done, but I don't recall obviously, but ...
Q Okay. Just to go back to your --
A It could have been, I guess.
Q Go back to your declaration again, in Paragraph 12 where you had said that -- it references 2009, at the bottom of Page 4.
And then it says: "BCBSGa decided to move away from our exclusive arrangement with Phoebe Putney and to seek a contract -- to seek to contract with Palmyra."
This date seems -- at least it's between that point and the December 2010.
A Uh-huh, uh-huh.
Q So this may or may not have been delivered

to Phoebe Putney?
A Yes. I mean, we would prepare presentations as part of a planning process to discuss internally and we would oftentimes prepare presentations, as well, you know, to discuss, you know, those plans with the hospitals, as well.
I'm just not sure which -- I would have to look through this, what this --
Q Take your time.
A -- was for. I believe this was an internal presentation used by internal -- well, Blue Cross-Blue Shield of Georgia people.
Q Okay.
A I don't believe we shared this with Phoebe.
Q On Page 3, the third bullet down, it says the point of your contracting goals was "protecting product flexibility and transparency".
I just would like you to explain to me what that means.
A Okay. This page, as I read it, I think -- well, generally, you know -- generally, a principle by which we would contract, and this would have been true in this instance, as well, is that we wanted to insure we had the ability to introduce products.

And product is a term we used -- we used generally and specifically. So we've talk about a PPO product, but there could be things we would refer to as a product as a subset of PPO products, different types of PPOs with different kinds of benefits.
So having -- you know, insuring that we have flexibility to introduce products to meet the demands of the customers was always important to us.
And insuring we had the ability to meet customer expectations around transparency, you know, about the relationship, whether it's putting -- we had a tool called Anthem Care Comparison that provided some comparison on what we paid providers so consumers could be informed in advance of receiving care.
We wanted to insure those kinds of efforts were allowed in our relationships.
Q In the first sub bullet is the single word "Steerage". I'd like you to explain to me what that refers to and is that part of the sort of sub PPO product that you were describing?
A No. I mean, we have, in recent years, been focused a lot on our ability to provide information to consumers so they can make informed

decisions about where to go for care, and we generally call that steerage.
So one example of that kind of steerage is when we get a presearch for a high cost imaging service for a member, we have -- we know the relative cost and quality of alternatives for that imaging service in general. We would contact the member and inform them that they may have a equal quality offering at a lower price. We consider that steerage as an example.
Q At a lower price for the service or with respect to the premiums that they're paying on the product that they have?
A Lower price for the service, because they're generally paying -- their benefits are a percent of what we -- they have to pay a percent of our contracted rate.
If you're paying 10 or 20 percent co-insurance on a service, the price we pay, it would be less expensive for the member.
Q This is a little bit of a tangent. Do your products typically have an out-of-pocket maximum for any given calendar year, for example?
A It varies.
Q Would you attempt to steer -- might you

attempt to steer members, even if they had the out-of-pocket maximum as part of their product?
A I don't know.
Q In the bullet above the product flexibility bullet, there's a main second bullet: "Maintain healthcare affordability more than competitiveness."
What does that mean?
A Oftentimes we would find ourselves in a negotiation where a provider would say well, the rate you're paying is competitive with the rate other payors pay for service.
Therefore, if I'm making you pay a significant increase or if I'm -- you know, in our minds, if we're paying you too much margin on the care we're providing, the argument that simply competitive is not good enough.
Because the truth is people can afford insurance. And so our objective has been to advance affordability. You know, it's not just about paying the highest price possible.
Q Affordability in the sense of driving reimbursement rates down to providers?
A Yes, where reasonable.
Q And just a moment ago you mentioned the

Anthem Care Comparison tool. Could you explain that a little bit more for me?

A It's a web based tool -- it was at the time and it still is -- that provided -- a member could go in and view information about the price, the cost difference of services depending upon where they went for the care, as well as some quality information about the comparisons of quality between -- so if you were going to have a knee arthroscopy, for instance, you could view online providers in a geographic area that would provide that and the relative price for that service.

Q And when you said "geographic area", if somebody was residing in a particular area, then the only providers that would be accessible to that patient or member would be limited by some geographic area?

A No. The member would define the geographic area they wanted to look at.

Q Page 5. Does this map reflect the Albany market from Blue Cross Blue Shield's perspective?

A I believe this map is reflective of the market as we thought about it in network management. So we referred to some counties, I think, earlier, and that was sort of the southwest territory as we

had thought about the geography.

Q You're talking about the southwest Georgia area referenced in Paragraph 5 --

A Yes, I believe those are the same.

Q -- of the declaration, okay. Continuing to the next page. So, again, this presentation would have been delivered in June 2010.

And according to your declaration that we went over, Palmyra Medical was out-of-network for all Blue Cross-Blue Shield products until May 2011; is that right?

A They were not in the PPO product, correct.

Q And they weren't in the POS, either, until May 2011?

A I think it's May 2010 for the POS product.

Q I'm sorry, 2010, sorry. Yes, you're correct. May 2010. So this is, you know, probably a little bit more than a month after their joining the POS network.

And this slide seems to show that -- in the total spend column that Blue Cross-Blue Shield has spent 14,000,000 point -- 14.3 million at Palmyra.

Is that what that column means, the "Total Spend"?

A Correct.

Q So those would be out-of-network benefits?

A Yes. I mean, I'd have to -- you know, I'd have to pull the data. But certainly some of that spend is likely claims paid out-of-network.

Q You testified earlier you did not recall what the out-of-network benefit payment would be to Palmyra?

A Yes, I don't recall specifically what that out-of-network payment rate was.

Q What is the CMI column?

A Case mix index.

Q And the bottom of the slide says: "Data Source: HoPPA and AHD.com."

What is HoPPA?

A It's a tool that -- it's an internal tool. We call it HoPPA. That it claims information is used to provide comparisons across hospitals.

Q And that's the source for the case mix index data that's listed in the table?

A I believe so. I'm not 100 percent certain, but I believe so.

Q And can you translate those numbers for me into what it generally means? What does 1.3 mean versus 1.6 mean?

A It's the general acuity of the patient served. Generally, the higher the case mix the higher the acuity.

Q And acuity means?

A Acuteness. How sick the underlying patients were.

Q And one is the mean or the average?

A Yes, I believe -- yes, I think it is. I don't know exactly the derivation of one, but greater than one is a higher acuity and less than one is a lower acuity.

Q Okay. And what does ALOS mean?

A Average length of stay.

Q And are these days or weeks?

A Days.

Q Days. And the bed column?

A That is probably from -- I'm guessing and I don't recall specifically. But I think that that's from AHD.com is the published number of beds.

Q Right. And if you recall back to our discussion of the beds perviously, the 248 number is the maximum authorized beds at Palmyra.

And then the total spend column is the amount that Blue Cross paid to each of the providers listed here over what period?

A I don't -- it doesn't say. I mean, we would generally look at 12 months, but I'm not certain.

You know, I don't recall specifically. But if I had to guess, I would say it's 12 months.

Q Do you guys operate on a calendar year, generally?

A No, we don't -- we operate on a calendar year as a company. But when we're viewing things like claims paid over a 12 month period, it's not calendar year based.

It's generally 3 to 4 months in arrears and 12 months prior to that.

Q Okay. So this might have been through, for example, April '09 to April 30, 2010? Or maybe March?

A It probably was not that recent. So it, you know, would depend on the period in which the HoPPA tool was updated.

And so it could have been calendar year '09. I don't know. I would have to look at it.

Q A rolling number of months, whenever you requested?

A Based upon when the tool was updated, yes.

Q And the following slides are essentially

the same data for the different Phoebe network hospitals that are identified on Page 4, right?

A The next page --

Q Well, the next several pages are -- essentially the next two are the same data. They're just different -- you know, the first one was for Phoebe Putney Memorial Hospital; is that right?

And the next two are for the --

A Uh-huh. Phoebe southwest, Phoebe -- yes.

Q And Slide 9, it's back to Phoebe Putney Memorial Hospital. It says: "Key statistics", but there's a column that's blank.

Do you know what that might have represented or was it simply incomplete?

A More than -- I mean, I don't think it represented anything that I can think of as important.

I think it was probably -- this was pulled from a spreadsheet somehow and not --

Q Somehow didn't get populated?

A That wasn't populated for this section of the spreadsheet.

Q This is something that you keep track of, the Blue Cross spend as a percentage of the facility's commercial business, overall business

margin, et cetera?

A It would have been -- I'm looking at this and thinking about it more. It would have been something we would try to understand to the extent it was available and we could understand it, yes. I'm guessing it's not populated because we didn't have the information for some reason, when this was produced.

Q Is this something you track or attempt to track, if it's available, for all your providers that are participating in your networks?

A Yes. We would try to look at it for hospitals.

Q Right. Across the state of Georgia?

A Uh-huh. Yes. This would have been standard things we'd want to look at, if we could.

Q Slide 10. Now we're back to the Phoebe Putney Memorial Hospital. And it looks like it's trying to measure expense and revenue trends.

Can you explain the relationship between the two tables and how the conclusion at the bottom is reached?

A I mean, the relationship between the two -- I mean, the first table is revenue information and the second table is expense

information.

Q Whose revenue? The hospital's revenue?

A Yes, this would be the hospital or the hospital system. I don't recall specifically if it was the whole system or just the one hospital.

Q It looks like it's just the hospital, based on the next page. So this would be revenue, irrespective of whether it was from Blue Cross-Blue Shield, that whatever source this is coming from would have attributed to Phoebe Putney Memorial Hospital; is that right?

A Yes. We would generally be trying -- yes, I believe we would have been looking at this -- the hospital as a whole, not just specific to Blue Cross.

Q And the expense, as well?

A Uh-huh.

Q And where would you get this information?

A We would generally pull it from financial statements.

Q Issued by the hospital?

A Yes, issued by the hospital. I don't know the source for this whether that information was on AHD or GuideStar.

We would work with publicly available

sources of information on hospital financial statements.

Q And again, this is something you would track for all hospitals?

A Yes. These were the kinds of things we would look at routinely, correct, for hospitals.

Q For the entire state of Georgia?

A Yes. By "track", I mean, we would -- there was an effort in advance of a renewal of a contract or renegotiation.

While we would look at things regularly, I can't say we would look at all of this every week on every hospital.

In advance of a negotiation, we would spend time looking at lots of information to understand the hospital.

Q And can you -- I'm sorry. The conclusion in the slide, how does the data in the table reflect that?

A I don't recall specifically -- "revenue trends are exceeding expense trends." It's been so long, I don't recall the conclusion specifically here.

I'm sorry. I would have to spend some time thinking about this.

Q Okay. It looks like it -- and just on this slide at least, I know it gets -- it's inconsistency across.

But looks like Phoebe Putney, according to this, Memorial Hospital derived about $28 million less in, I presume, the 12 month period ending July 31, 2008 versus the previous year.

And then the expenses were about 25 million less. So the drop in expenses, in real dollar terms, wasn't the same -- it was less than the revenue.

Is that what that means?

A I mean, I agree with what you've described here as we read it -- as you've read it. I'd have to give some thought to the change on the revenue and expense side.

Q Okay. The next one, it says the same information for a different Phoebe. I think it's Sumter. Is that not what it is, Phoebe Sumter, S-U-M-T-E-R.

Same information, same question we would have about what the trend in information means?

A Uh-huh.

Q And then continuing expense trends are now exceeding revenue trends with respect to this

facility --

A Uh-huh.

Q -- on Page 12. And then 13, another facility?

MS. SCHWAB: Are these questions?

MR. BURKE: If she can answer what the trend statement means in looking at these other slides, then that would be great.

THE WITNESS: I'm not sure I understand. Is it why were we looking at this is your question?

BY MR. BURKE:

Q No. I'm just trying to interpret the information in the table and reconcile it with the statement at the bottom of the slide of each slide.

A What is the question? I just -- it's been some time. I don't recall all of the work that went into this specifically, so ...

Q Well, in the Slides 10, 11, 12, and 13 and 9 -- sorry. 10, just starting 10, has the same information, it revenue and expense comparing two years and then it has a number -- it's either positive or negative -- stated as a percentage.

Then there's a conclusion at the bottom of the slide that says either based upon -- presumably

based upon the information in the tables that a trend is occurring and that one category, either revenue or expense, is exceeding the other.

And it's just difficult for me to understand how that conclusion is reached with respect to each of these slides on a consistent basis.

And if you can provide that, then that would be great.

A I don't know that I can provide clarity beyond that without spending some time looking at it and remembering.

I just don't recall, you know. I know, you know, we wanted to look at these things and understand them.

But specifically how -- I don't think I can provide clarity in looking for them. I'm not sure.

Q Why was the identification of a trend, one way or the other, meaningful to WellPoint? Do you remember that?

A Yes. I mean, generally we'd want to understand how things were trending from a revenue and an expense perspective.

They were all indicators of financial

management, financial health, trends. I mean, no one thing is -- you know, there's not one piece of information that we would look at.

We just -- we were working to understand the relative operations financially of hospitals.

And we would use publicly available information. So trends on revenue expenses were a piece of that.

Q Would that data be something that you would use in contract negotiations?

A I mean, not in a significant manner. I mean, we wouldn't spend a lot of time negotiating that or something.

Q No, no. What I mean is we see your revenues increasing and your expenses dropping, we'd like to lower our reimbursement rate, something like that?

A No, we would just use it to understand, you know. What would be the -- you know, despite what you maybe thought, we generally wanted to understand what's happening with hospitals.

Because that would usually inform the position they would take with us and sometimes it was indicative of -- we may have had a difference of opinion about something involving how they were

performing or we may have concurred based upon what we understood.

It was genuinely used to understand what was happening.

Q Okay. Moving to Slide 14, what does -- at the top table, second column in, it says: "ASO."

What does that stand for?

A Administrative Services Only. Generally it's used interchangeably with self-insureds.

Q Okay. So this would reflect the revenue that Blue Cross-Blue Shield paid to Phoebe Putney Memorial Hospital for self-insured PPO, 55,924,000.

Is that what that means?

A Yes. We wouldn't call it revenue. We would say that our claims expense, what we paid in claims split between fully-insured and self-insured and by product, was laid out here.

Q So claims expense for Blue Cross, revenue for Phoebe Putney Memorial Hospital?

A Right.

Q And what does "IND" stand for in the product column?

A That would be that Indemnity product.

Q Is that the POS?

A No, it's another product altogether. It's

generally quite small.

Q And then the HMO is the health maintenance?

A Uh-huh.

Q Now, based upon your prior testimony, it's my understanding that Phoebe Putney Memorial Hospital was out-of-network for everything but the PPO product?

A And potentially that Indemnity. I just didn't recall.

Q Okay. So at least this HMO information would have been out-of-network; is that correct?

A We did not have a contracted -- a contract with Phoebe Putney for HMO. But in the case -- it's possible that -- I would have to look into this -- that an HMO member without out-of-network benefits had an emergency service while they were in Albany where we may have processed and paid the claim as an in-network level benefits for them, because of the nature of the emergency.

Q Okay. Would that require some sort of negotiation with Phoebe?

A No.

Q So they would be out-of-network for that procedure and you would reimburse them at --

A It's really a matter of what the member's benefit was. Was the benefit level in in-network level benefits and out-of-network level benefits.

And typically HMO products don't have out-of-network benefits at all.

Q What does "FI" stand for in the next column?

A Fully Insured.

Q Okay. The bottom table the first column is denoted as being a percent of state-wide hospital market share?

A Uh-huh.

Q What does that mean relative to the two rows that follow that?

A I believe that this was the percent. So what that 89 million reflected as a percent of all of our hospital spend state-wide.

So what we spend on hospital services.

Q In network? Out-of-network? Not case mixed? Just total spend?

A Yes. Case mix irregardless, I think it was probably -- I don't know, I would have to check. But I would think it was more weighted towards what we spend on in-network level.

But I'm not certain of that.

Q You said it's -- the 89 million would be reflected as a 2.6 percent that's shown in the bottom table?
A Right.
Q And then the bottom table has 2008. Does that mean that this revenue data up top is from 2008?
A I'm sorry. I don't see 2008. Oh, year. I don't know. I don't know.
Q Okay. The next few slides state the same data for the different Phoebe hospitals; right?
A Appears to be, yes.
Q Page 18 lists, apparently, Blue Cross Blue Shield's top ten PPO employer groups; is that right?
A Correct.
Q And these are employers in the Albany market?
A They would be employers with a significant presence there. They may or may not be actually physically headquartered in them or --
Q Which one of these do you recall, if any, approaching you to request the inclusion of Palmyra in your PPO network?
A As I said, I don't recall the customer specific. I do recall clearly that it was an

ongoing request that we had over the time I was there.
Q So you don't have any specific recollection with respect to any of these companies listed on the Slide 18?
A I recall -- no. I recall working a lot with our national accounts area, but I don't recall specifically which employer.
And I recall getting the question, as well, from like people in small group sales and local sales.
So my sense from that is that it was a variety of employers, not just one employer, because it was different people.
Q Which employer groups listed on Slide 18 are national accounts?
A I'm not totally sure. I, you know, certainly would think Proctor and Gamble would be, but I'm not certain of that. I think Kroger is a national account. I can't say for certain.
Q And why would -- is there anything about national accounts that would make them more likely to make the request for Palmyra to be included than non national accounts?
A No, not necessarily. I mean, I recall

having this conversation with people in national accounts and non national accounts.
Q But just not people -- not the names of any persons or the company they were affiliated with?
A I don't recall which employer specifically, no.
Q Slide 19 lists five services that are characterized as unique to Phoebe Putney Memorial Hospital; is that correct?
A Correct.
Q Is this intended to be an exhaustive list?
A I would -- I don't think there was an intention to be exhaustive.
Q Did it mean to be unique to Phoebe Putney relative to the other hospitals in the Albany market?
A You know, this was probably intended to say these are services that are not readily offered by someone very close by, readily available within Albany as an alternative to --
Q And these would be services that your members would want to have access to in their health plans?
A To the extent they were available.

Q Right. And they were available at Phoebe Putney?
A Correct.
Q For the members in the area?
A Correct.
Q Moving to Slide 20, could you describe for me what this table in the slide represents?
A This would have been reflective of rates of increase made. There's blanks here because obviously we didn't have all the information entirely populated or it didn't populate at the time we pulled this together.
Q Meaning that there may or may not have been annual increases for Phoebe Putney Memorial Hospital or the other two at the bottom?
A Right. I mean, the payment rate was at a percent of charges. So the increase would have been as a result whatever changes they made to their charges.
We either didn't have exact clarity on that or we didn't populate it here. I'm not -- I don't recall necessarily.
Q It might mean that there weren't any?
A If there was literally no increase and we knew that, I believe we would have put a zero in

there.
Q Slide 21. What do the numbers on the Y axis indicate?
A I believe they're percentages.
Q Percentages. And looking at the legend on the right side, the first line says: CPI All Items." It's red on the color version.
Consumer Price Index for everything; is that what that means?
A I don't recall specifically. I believe, based upon this, it's referring to the general standard CPI as opposed to something more specific than that.
Q Okay. The green line: "CPI-U Medical." Do you know what the "U" stands for?
A I think it's urban.
Q So that would be the urban medical component of the CPI?
A I believe so, but I am not certain.
Q And the lighter blue line would be the urban hospital component of CPI?
A Yes, I believe so.
Q And what does Line 4 --
A I don't know.
Q Okay. Slide 22, this first bullet says:

PPMH case mix index is in line with their peer hospitals."
Would that bullet point correspond to the table, the CMI numbers, on Page 6?
Is that what that's intended to correspond to?
A Yes, I believe so.
Q And Slide 23, this is a table depicted in bar graph format of dollars up the Y axis and hospitals along the X axis.
Could you tell me what this depicts?
A This is the case mix adjusted inpatient case rate we pay at Phoebe compared to these peers.
Q This is a per case?
A Per case -- it's case-mix-adjusted per case.
Q And this would be the HoPPA data is the source?
A I can't say for sure.
Q Well, the HoPPA data was the data that you indicated was the source for the CMI information on the Slide 6, correct?
A Yes. And I have to clarify: I'm stating that because that's the footnote on the slide, not because I actually recall that.

Q Okay. Fair enough. And then the Slide 24 shows what?
A A case-mix-adjusted outpatient rate comparison.
Q This says, "Allowed per Service" is the header of that table.
What does that mean?
A It would be the closest proximity of our contract allowance as opposed to what's paid after member benefits.
Q So according to this, Archibald Medical Hospital Center, a peer facility of Phoebe Putney and Palmyra, had an allowed per service outpatient limit of about $160?
A Correct.
Q Okay. I don't have any more.
MR. LOWREY: Just go straight through?
MR. BURKE: Uh-huh.
EXAMINATION
BY MR. LOWREY:
Q Ms. Cheslock, I'm Frank Lowrey. I represent the Hospital Authority of Albany-Dougherty County. My colleague has covered most of the information I'm going to obtain, so this will be short.

Do I understand correctly that Blue Cross-Blue Shield of Georgia signed its current price contract with Phoebe, including the final price term, in March 2011 for the PPO?
A We signed an amendment in March of 2011. I'm not sure if it's still the amendment governing the relationship today.
Q The last one you know about is the March 2011 amendment?
A Correct.
Q And that March 2011 amendment sets a price term, correct? A reimbursement rate?
A I believe it did. I believe so.
Q And, in fact, your recollection is that it is a more favorable reimbursement rate to Blue Cross-Blue Shield than the contract that Blue Cross-Blue Shield was willing to sign the morning before the acquisition was announced; correct?
A Yes.
Q So you got a better price from Phoebe Putney Memorial Hospital after the acquisition was announced than the price you were willing to pay before the acquisition was announced?
A The hospital had offered us a rate that was higher than the rate we currently paid for a

non-exclusive deal the day they announced the acquisition.

Q And before they announced that acquisition, you were preparing to sign that contract; correct?

A We were preparing to sign a contract with a rate. I don't recall specifically what the rate was in that December 20th amendment.

I recall that the deal we ultimately signed in March was more favorable than that. I just don't recall specifically what the price was that we were drafting up in that December 20th amendment.

Q Fair enough. I'm not going to hold you to answers. It's really the relationship to the two that I'm curious about. I just want to make sure I'm clear on this.

There was some rate that Blue Cross-Blue Shield was willing to agree to in December 2010?

A Yes. December 2010, yes.

Q And then the acquisition was announced; correct?

A Correct.

Q And then March 2011, Blue Cross-Blue Shield signs a final contract with Phoebe with a

better rate than the contract rate that you would have been willing to agree to in December 2010 before the acquisition was announced?

A To be clear, the amendment we signed in March of 2011, I believe, was the same rate we had in place in the current agreement.

It removed the exclusivity, allowed us to contract with Palmyra and it added Phoebe as a participating in-network provider to the Point of Service product.

Q So it was the same rate in March 2011 that you were paying under the 2000 contract?

A I'm not sure about the 2000 contract.

Q It was the same rate you were paying under the 2004 contract?

A It was certainly the same rate we were paying currently, which I think was from the 2004 contract, if I recall correctly.

Q The rate didn't change before and after the acquisition was announced?

A The rate requested of us during -- you know, right around the acquisition was higher. But ultimately the rate we signed in the amendment in March of 2011 was the same rate as we were currently paying.

That is what I recall.

Q The rate requested of you before the acquisition was announced was higher than the rate that Phoebe agreed to after the acquisition was announced?

A So -- I mean, I need to be clear about the experience I had in negotiating the contract. They were requesting us to sign a contract at a higher rate before 9:00 a.m. the morning --

THE REPORTER: I'm sorry, whoa, whoa, whoa. I need you to slow down.

MR. COHEN: Just go through where you were going through with the dates but slower.

THE WITNESS: So we were attempting to negotiate a contract with Phoebe Putney and there was a request of -- ultimately the parties were working on a deal.

And the request of Phoebe, at the very, very end of that process at that point in time, was -- like December 19th, that we had to draft up and have final documents ready for them and they needed them before 9:00 a.m. December 20th.

And it was on December 20th, following that 9:00 a.m. period, that a merger was then

announced.

BY MR. LOWREY:

Q And I'm not going to cut you off. I am going to let you finish the whole sequence, but I want to take it step-by-step to make sure I understand.

So how far did you get towards drafting a final entire agreement before the merger was announced?

A I believe -- if I recall correctly, I do believe that we had drafted amendment documents that we felt were in a state of preparedness for signature, and we sent them to them like that night, maybe, or early that morning of the 20th.

Q Then the acquisition is announced?

A The acquisition was announced the same morning.

Q And then ultimately, in March 2011, a few months after the acquisition was announced, you enter a contract with Phoebe calling for the same rate as the 2004 contract, as best you recall?

A Yes.

Q Thank you. I'm clear now.

A Okay.

Q And then, after March 2011, at some point

you went on to enter a Point of Service contract with Phoebe; is that correct?
A If I recall correctly, I think that they occurred in the same time frame. So they joined the open access Point of Service in that same March of 2011 amendment.
Q So at the same reimbursement rate?
A I don't recall.
Q Okay.
A I thought we looked at that today, though. I think so.
Q And you're not aware of any subsequent contracts, subsequent rate increases; are you?
A I don't know.
Q One way or the other?
A Correct.
Q We talked a lot about cost of care, talked briefly about quality for a moment. I assume I'm right that Blue Cross-Blue Shield of Georgia cares about the quality of care that its members receive, not just what's paid for the care; is that fair?
A Sure, yes.
Q And for it seems like about a decade, Phoebe was the exclusive in-network hospital for Blue Cross-Blue Shield's PPO program; is that right,

in Albany?
A Correct.
Q So, fair to say that Blue Cross-Blue Shield was satisfied with the quality of care Phoebe was rendering its members during that period?
MS. SCHWAB: Objection. Foundation.
THE WITNESS: I can't say. I don't know.
BY MR. LOWREY:
Q Made no effort to find out?
A It's -- it's difficult to answer. I mean what the whole company felt about that.
Q Well, for a decade the company was steering its Albany members to Phoebe Putney Hospital as the exclusive in-network hospital; correct?
A We had an exclusive agreement with Phoebe, correct.
Q So from your members' standpoint, you were telling your members if you want a hospital, the in-network hospital is Phoebe Putney; correct?
A Correct.
Q I assume that that means you were satisfied with the quality of care they would receive there, otherwise you wouldn't have done that, right?

A So the way I would answer your question is to say -- my feeling from the time I joined the plan is that there was a level of anxiety over the exclusive relationship in Albany.
In a sense, there was many requests from employers to add Palmyra, was something I routinely heard.
We had concerns about the cost. And I think that there were some things that we felt were not as favorable as we wished to seek from a quality perspective.
I don't recall specifically, but I do recall, in preparing that presentation and thinking about the quality, that there were some outliers relative to what you would -- publicly available information, CMS, Care Compare and other things.
So there was a lot of thought that went into the decision to not continue an exclusive relationship and it wasn't instantaneous process, but it was something that was discussed for some time.
Q And Phoebe continues to be in-network today, as far as you know?
A I don't know. I think -- I assume so, but I don't know.

Q When last you left a position of responsibility, which I believe would have been May 2011, Phoebe was in-network?
A They were in-network, correct.
Q Whatever concerns you did or didn't have, they weren't sufficient to take Phoebe out-of-network?
A Right, they were in-network.
Q Is Blue Cross-Blue Shield willing to pay higher reimbursement rates for higher quality of care?
A It's a difficult question to answer, because quality is not -- it's not singularly measurable. So, you know, quality is an important factor.
But if it was simply easy to measure, you know, quality on a scale of one to ten and compare it to everyone else, there would probably be a much more exact one-to-one relationship between those two things.
It's certainly an element that's taken into consideration, but it's a very, very complex thing to measure.
Q So is the answer that they are willing to pay more but quality is difficult to measure? Or is

that they aren't willing to pay more because quality is difficult to measure? Or something in between?
MS. SCHWAB: Objection. Form.
THE WITNESS: I mean, I don't think that my answer fits into any of those buckets.
BY MR. LOWREY:
Q Help me understand that. I understand what you're saying about quality being difficult to measure, so I agree with you.
So the question, then, is -- however you measure quality, is Blue Cross-Blue Shield willing to pay higher reimbursement rates if it believes that it's obtained the higher quality of services for its members?
A I can't answer that question, because quality is not simply measurable by one number. And so therefore the scenario you're suggesting isn't something I actually, you know, worked under.
Q Let's switch topics for a second. And I want to make sure I understand your testimony about scale and its role in lowering health care costs.
Do you remember that?
A Yes.
Q The basic premise, I think -- you tell me if I'm wrong -- is that the larger the scale the

lower the cost?
Do I understand that to be the principle you were describing?
A I believe it was somewhat more nuanced and complex than that. It was a response to a general statement that if you offered more services you had to be higher costs.
And I was saying not necessarily.
Q Because with scale can come cost savings?
A Scale is one thing that might cause cost savings.
Q And one aspect of scale is the number of patients you serve; agree?
A It could be one aspect.
Q So just to take your example of the MRI machine -- I don't remember the exact numbers you gave, but they were hypothetical anyway.
A Correct.
Q It was to the effect that if you ran one MRI machine 24/7 and you take one image a day, obviously your costs per image are going to be much higher than if you take, say, 100 images a day?
A Correct.
Q And so the more patients you have at the hospital, all other things being equal, you would

expect to have more MRI images; yes?
A The more patients you have at the hospital --
Q The more MRI images you would likely have?
A I mean, I don't think that's an unreasonable thing to say, but, you know, the care that's needed is based upon the care that the patients present with, so ...
Q Fair enough. Over time, over a broad range of experience, you would expect, generally, hospitals with greater patient volumes to have more MRIs?
A I mean, I don't think that's an unreasonable thing to say but, you know, the care that's needed is based upon the care that the patients presented with, so ...
Q Fair enough. Over time, over a broad range of experience, you would expect, generally, hospitals with greater patient volumes to have more MRIs?
A I mean, I don't think that's an unreasonable statement, but if you were an MRI specialty facility -- I mean, there's ways you could consider why something is smaller might be a lot --
THE REPORTER: I'm sorry, you're going to

have to slow down. You're just going to have to slow down. You guys are both really fast.
"I mean, I don't think that's an unreasonable statement but if you were an MRI speciality --
THE WITNESS: You can envision -- you know, someone that might specialize in MRIs and therefore be small but do a high volume.
I don't think what you're saying is unreasonable. I just wouldn't say it's universally applicable in every possbile scenario.
BY MR. LOWREY:
Q I think that's a fair answer.
A Okay.
Q And to take it one step further, if you staff a radiology unit 24/7 that reads those MRIs, again, the more images they read the lower the cost per image.
Is that what you're talking about with the effect of scale and cost?
A I think that would depend upon the relationship the hospital had and the way they paid for those imaging reads.
There's multiple ways that might happen.

Q Do I understand correctly that you don't know if the premiums for Blue Cross-Blue Shield's PPO product decreased when Palmyra joined your PPO network?
A I don't recall.
Q Leave that question aside and let me ask this one: You were -- you had more direct responsibility for the Albany market from about 2007 to spring 2011; is that right?
A Correct, yes.
Q Over that range of time, were Blue Cross-Blue Shield's premiums for its PPO product trending up, trending down or staying flat?
A I don't recall.
Q You don't recall that they were increasing, for example?
A It would seem to me that they were increasing, but I can't say for certain.
Q You believe they were increasing in 2007?
A I don't recall specifically. I mean, health care costs and our premiums were increasing over that time period across the state, specifically in Albany.
And by what percent, I don't recall.
Q Do you know if Phoebe's charges to Blue

Cross-Blue Shield were increasing or decreasing during that period?
A I don't recall.
Q So as you sit there, you certainly couldn't attribute any increase in your premiums that may or may not have been occurring to any increase in charges by Phoebe that may or may not have been occurring; is that fair?
A I'm not sure I understand the question. I don't recall what was happening specifically to premiums in Albany in that time.
So beyond that, I don't know what else I could say.
Q Fair enough. I'm going to take one more shot at forming a better question, which is simply you wouldn't be able to testify that premiums were going up from 2007 to 2011 due to anything involving Phoebe Putney; is that fair?
A I would have to go back and refresh my memory significantly on what was the state of things at that time.
Q Okay. Can I ask you to take a look at your declaration? I think it was marked as Exhibit 1?
MR. COHEN: Two.

BY MR. LOWREY:
Q I think it was marked as Exhibit 2. In Paragraph 6, the second sentence, you write: It is my sense that our employer groups and members value health plans that provide them access to comprehensive, cost-effective health care provider networks."
Do you see that?
A Yes, I do.
Q So in the period that you were familiar with Albany, 2007 to 2011, an insurer marketing health insurance in the Albany area that had only Palmyra as an in-network hospital wouldn't have been offering a comprehensive cost-effective health care provider network; is that true?
A You know what I can say about that is we felt that we couldn't have only Palmyra in-network and not Phoebe, because there was a number of services provided by Phoebe, such as maternity, which were not provided by Palmyra.
Q That's helpful. That's what I'm asking about. So in your -- it says: Blue Cross-Blue Shield, Phoebe and Palmyra were not substitutes."
They weren't equivalents?
A They were not exact equivalents. They

were the closest things to substitutes for one another, but Palmyra provided a subset of the services provided by Phoebe.
Q And you didn't enter contracts with hospitals for a subset of services they provide. You enter contracts with hospitals for the full range of services they provide; is that true?
A That is most typically true. I can't think of an exception at the moment.
Q We are nearing the end.
A Okay.
Q Page 4, Paragraph 10 of your declaration, last sentence. In so many words, it says your exclusive reimbursement rate with Phoebe Putney was 78.32 percent of charges or list prices.
Are you with me?
A Yes.
Q And that is, to the best of your recollection, the rate that was memorialized in the 2004 contract?
A To the best of my recollection, I think so.
Q And to your best knowledge, that's where you are today?
A I don't have knowledge of the contract

today.
Q You leave the market effectively in March 2011; correct?
A And it was May of 2011, just a few weeks after.
Q So, yes. So let me ask a clean question, then, because I think I got the date wrong.
You're basically -- you leave your responsibility for the Georgia market in May 2011?
A Correct.
Q So when you left Georgia, to the best of your knowledge, the 78.32 percent was the going rate for Phoebe?
A Yes.
Q Okay. Now drop down to Paragraph 12, if you would, for me. You say: "It is my understanding that BCBSGa's contracted reimbursement rates for Phoebe Putney are among the higher for all hospitals in Georgia on a case-mix-adjusted basis."
Do you see that?
A Yes.
Q All right. So are you comparing the 78.32 percent rate for Phoebe with rates for other hospitals in Georgia when you say that?
A No.

Q Tell me what you're doing.
A We're comparing the effect of the 78.32 percent rate on a case-mix-adjusted basis to the rates we're paying other providers.
Q So it sounds like there is some database behind that sentence?
A I don't know if I would say there's a database. There's an analysis performed.
Q There's data, evidently, about what Blue Cross-Blue Shield pays all hospitals in Georgia on a case-mix-adjusted basis; correct?
A Correct, created from our claims experience.
Q And that would be the data that you would have relied on when you wrote the sentence I read to you; correct?
A Correct.
Q Do you think it's fair for me to be able to see that data?
A I don't have an opinion on that.
Q As the Vice-President of Blue Cross-Blue Shield and, as I understand it, cost of care and planning responsibility for 14 states, including Georgia, and someone who gave this declaration to the FTC, do you think it's fair for me to be able to

see the data underlying your statement?
MR. COHEN: I would object to that to the extent that if you're asking her about a specific objection we may have had to a subpoena request.
MR. LOWREY: Nothing that's not in my question is in my question.
BY MR. LOWREY:
Q Do you have my question in mind?
A Yes. I don't have an opinion on "fair". I don't know what that means in this context.
Q So in what form is the data that you relied on when you wrote that sentence? That's a terrible question, wasn't it.
Is there a computer database maintained at Blue Cross-Blue Shield that contains the data that you relied on when you wrote that sentence?
A I don't know today. I mean, the process would have been one where we pulled information from claims experience to perform some analysis to state that.
So as to where that actually sits at the moment, I don't know.
Q Fair enough. You were willing to pull that data and do that analysis to give this

declaration?
A I don't believe we pulled -- I don't recall that we pulled that data and did that analysis for purpose of this declaration.
I recall that that was information we had pulled and understood in the context of the negotiation. That's what I recall most about it.
Q We've talked some about tertiary care services. So that we're talking about the same things, give me some examples of what you consider to be tertiary care services.
A Generally we would refer to tertiary care as highly specialized acute care services performed by only a subset of hospitals in the country.
So in any given state, there's generally a subset or a handful of tertiary based hospitals.
They're generally providing, you know, very advanced kinds of cardiac surgeries or transplants.
Q Cancer surgeries?
A There are a fair number of community cancer hospitals. So I can't say for certain that we would say all cancer surgeries would fall into tertiary.
Q Some would, some wouldn't?

A Yes, I would think so.
Q Same true of neurosurgery?
A I would say that we would generally consider complex neurosurgery, brain, very complex things, as tertiary.
There's neurosurgeries that are -- surgeries performed by neurosurgeons that are less complex and done in general acute care hospitals.
Q Will patients travel farther for tertiary care services than they will for what you've been calling primary care services?
A In what context are you asking that?
Q Well, will a patient travel farther to get a scheduled heart bypass operation than he or she would be willing to travel to, say, get a tonsillectomy?
A I think that the answer to that depends very much on the person. And there's a wide range of willingness to travel for care. Individuals feel differently about that.
Q In Paragraph 9 of your declaration, you talked about the preference of patients to stay close to home.
So you felt comfortable making a general statement based on your knowledge of patients in the

industry in that paragraph; yes?
A Yes.
Q So does your general knowledge base allow you to say whether patients are willing to travel farther for tertiary care services than they are primary care, as a general matter?
A So sometimes patients have to travel farther for tertiary services because they are simply not offered in the community in which they reside.
And so that would be an instance where that is the common practice.
Q And even if they are offered, they will sometimes travel farther because they might prefer to receive them elsewhere?
MS. SCHWAB: Frank, when you say "them", you're talking about tertiary care services?
MR. LOWREY: Them would be the patients receiving tertiary care services.
MS. SCHWAB: When you said "travel for them", I just wanted to make sure I understand what services you're referring to.
MR. LOWREY: Yes, the question was about tertiary care services. But let me see if I can do a better job, then.

BY MR. LOWREY:
Q Even in localities where tertiary care services are offered, patients will sometimes travel farther for those services because they prefer to receive them elsewhere; is that true?
A Yes, I think there's instances of people traveling for care in general. I think it's going -- in my experience, it depends upon if they have the ability to do that, the time to do that, knowledge to do that and the network of physicians they're working with to do that.
Q Blue Cross-Blue Shield has a statewide network? Almost nationwide, but certainly statewide network of physicians; correct?
A Blue Cross-Blue Shield of Georgia contracts a network in Georgia statewide.
Q And so going to my example of scheduled cardiac bypass surgery, for example, you might have a patient travel from Albany to Columbus, Georgia for that procedure?
A Is your question is there a patient that would ever do that?
Q Would that be uncommon?
MS. SCHWAB: Objection, speculation.
THE WITNESS: Yes, I don't know

specifically.
BY MR. LOWREY:
Q I recall a couple of points in the deposition, I think perhaps two, you referred to Phoebe as a "must have" hospital.
Did I hear that correctly?
A Yes.
Q Can you identify other markets or cities, your choice, in Georgia where there are other "must have" hospitals, from Blue Cross-Blue Shield's standpoint?
A There are other "must have" hospitals. I'd have to give some thought to who else would be qualified in that context.
It would certainly be a provider -- the sole and only provider of care in a given geography would often fall into that "must have" bucket.
I'd have to give more thought to that.
Q I don't want to interrupt your thought process. So where a hospital is, you say, the sole provider for a geographic market, you would regard it as a "must have" hospital for your network?
A Yes.
Q And there are other instances of that in Georgia? When I say "other instances", I shouldn't

say that.
There are instances of that in Georgia that have nothing to do with Albany; correct?
A Yes, I would say there's other -- potentially other areas, yes, where we felt like we had to have -- the hospital is important to have.
Q Those are all my questions.
A Okay.
MR. COHEN: Do you want to take a five minute break.
(Whereupon, a brief recess was taken.)
EXAMINATION
BY MS. SCHWAB:
Q Ms. Cheslock, thanks again for joining us today. I'm Jennifer Schwab. I'm an attorney with the Federal Trade Commission representing complaint counsel in this particular litigation.
Hopefully I won't keep you here too long, but I do want to go through and ask some clarifying questions about the testimony that you provided to Mr. Burke and Mr. Lowrey and ask a few other questions, as well.
A Okay.
Q First, Mr. Burke asked you a number of questions about Exhibit 2, which is -- the

attachment, at least, is your sworn declaration which is dated March 29th, 2011.
Do you generally stand behind the contents of that declaration?
A I do.
Q And is everything in there was true, to the best of your knowledge, at the time you signed it on March 29th, 2011?
A Yes, it was.
Q And we talked a little bit today about the term self-funded and fully-funded or fully-insured.
If reimbursement rates go up, how, if at all, does that affect your self-funded members?
A Self-funded members are responsible for the claims expense, for the claims incurred. So if their members receive care at a hospital, they're paying the cost of that hospital care based upon our contract.
So if the rate in our contract were to go up, their claims expense would go up.
Q And for your fully-insured members, if the reimbursement rates that you have with the particular provider go up, how, if at all, does that affect your fully-insured members?
A So our premiums for fully-insured members

reflect the projection of what claims costs are expected to be, inclusive of what increases we expect to pay.
And so that would be factored into the increase that's ultimately analyzed in the premium. The premiums reflect those projected claimant expense increases.
Q And we also talked a little bit today about providers being in-network and out-of-network.
Do you remember that?
A Yes.
Q And if a provider is out-of-network, how, if at all, does that affect your members' out-of-pocket expenses?
A Generally, it would depend upon the benefit plan that they have. If they have an out-of-network benefit -- PPO plans generally have out-of-network benefits, they generally pay a higher portion themselves of the care that's received at an out-of-network provider than for care that's received at an in-network provider.
Q "They" being your members?
A The member themselves.
Q And I believe you were the Vice-President of Provider Engagement and Contracting from about

2007 to 2011; is that correct?
A Yes.
Q So as part of your former job responsibilities in that role, that included negotiating contracts with hospitals and providers in Georgia, correct?
A Yes.
Q And did your negotiations with providers include both nonprofit and for-profit systems?
A Yes.
Q And based on your number of years of experience working at Blue Cross, in your view, are there any differences in the way that Blue Cross negotiates with nonprofit hospitals versus for-profit hospitals?
A No, not generally. We would go through a similar process to try to prepare and understand, and the negotiation themselves would commence along a very similar identical process, regardless of whether they were for-profit or not for-profit.
Q So would it be fair to say --
MR. LOWREY: Object. Leading.
BY MS. SCHWAB:
Q When a provider negotiates with Blue Cross, the provider generally tries to seek the

highest possible reimbursement rate, regardless of whether it's a nonprofit or a for-profit provider?

MR. LOWREY: Object again. Leading.

THE WITNESS: I don't know that -- you know, it's hard for me to say whether or not they would clarify that as seeking the highest possible rate.

But it's been my experience that not-for-profit hospitals and for-profit hospitals negotiate equally vigorously for a rate with their commercial carriers.

BY MS. SCHWAB:

Q When Blue Cross comes to the table to negotiate with a hospital for reimbursement rates, what are the forms of leverage that Blue Cross brings to the table?

A I mean -- I mean, leverage -- obviously what we bring to the relationship is the people that we insure in paying their claims expense timely and accurately.

And that would be -- the services that those members receive at the hospital creates volume that hospitals generally count on in assessing their financial situation.

And so, you know, that sort of helps us

have a discussion, relationship and negotiate a contract.

Q And then, conversely, when Blue Cross again comes to the table to negotiate with a particular provider or hospital, rather, for reimbursement rates, what are the forms of leverage that a hospital generally brings to the table?

A You know, leverage would be, you know, if they were to have unique services, if they were the sole provider and, you know, just the general fact that -- as we sell to employer groups, they generally desire to have broader access than narrower access.

And so for that reason, more often than not we have an interest on behalf of our employer groups to contracting, as well, and that gives them leverage.

Q And then focusing specifically on the Albany area, would you say that Phoebe Putney brings leverage to the table when it negotiates reimbursement rates with Blue Cross?

MR. LOWREY: Object, leading.

THE WITNESS: Yes.

BY MS. SCHWAB:

Q How does Phoebe Putney brings leverage to

the table when it negotiates with Blue Cross?

A They have leverage, for one, because they have a -- provide a unique set of services in that community than another provider -- there isn't another provider of those services specifically in their geography. And so that gives them leverage.

They, you know, are a major tertiary hospital with a lot of relationships with the physicians and that -- that helps to provide leverage.

Because if you were to not contract with them, there are a not a lot of really suitable alternatives for everything that they provide.

Q We've also talked a bit today about different types of reimbursement rates, fixed rates, percent of charges.

Do you recall that discussion?

A Uh-huh.

Q And I don't think we got a definition of what percent of charges -- what types of rates those are.

A That would be where our payment is a straight percentage of whatever is billed to us. So if they bill $100 and the percentage charge is 85 percent, we would pay $85 on that claim and

85 percent of every other claim that's billed.

Q What are the charges based on?

A I can't say.

Q Are those charges that are set by the hospital?

A I mean, generally speaking hospitals govern what they charge. Yes, the hospital would.

Q So if the -- assuming you have a contract with a provider that's on a percent of charges basis, does that mean, then, that the rates that Blue Cross pays may fluctuate depending upon if the hospital changes or revises its chargemaster?

A It could mean that. We generally would try to have something called chargemaster protection in the contract that tries to provide some protection to us for changes in chargemasters.

So we do what we can to, you know, minimize that if possible. Chargemaster protection is not perfect.

Q And I believe you testified earlier to this. I apologize if I'm repeating it. Do you recall whether -- during your tenure in the southwest Georgia market, whether Phoebe Putney had changed its chargemaster at all during the pendency of the duration of the contract?

A I don't recall.
Q And we talked a good bit, as well -- today Mr. Burke asked you a number of questions and I believe Mr. Lowrey did, as well, about what a marketable network and viable network contains.
Do you recall that discussion?
A Uh-huh.
Q Could Blue Cross offer a marketable network to residents of the Albany area today without Phoebe Putney Memorial Hospital?
A I would be most comfortable speaking for the time that I was there.
Q Sure.
A As opposed to today.
Q Let me rephrase my question, then. At the time that you were Vice-President of Provider Engagement and Contracting, in your view, could Blue Cross offer a marketable network to residents of the Albany area without having Phoebe Putney Memorial Hospital in-network?
A We felt that we would be significantly challenged to have a desirable product in a marketable network without Phoebe Putney Memorial Hospital.
We felt that that would be very

challenging and something that would not be attractive generally to employers.
Q We also talked about the services offered by Phoebe Putney Memorial Hospital in Palmyra.
Do you remember that?
A Uh-huh.
Q Do you know approximately what percentage of services are similar or overlapping between facilities?
A I don't recall.
Q Is it fair to say it's the majority of the services?
MR. LOWREY: Object. Leading.
THE WITNESS: I don't recall.
BY MS. SCHWAB:
Q Going back to discussion of self-insured or self-funded customers of Blue Cross, I believe you testified that you do not recall the exact percentage of self-insured and fully-insured customers in the State of Georgia; is that correct?
A As I recall that question, it was specific to the Albany geography. And I don't recall the split -- I didn't -- in that question, I don't recall the split, fully-insured self-insured, for that Albany region or the southwest Georgia region.

Q Do you recall the split for the State of Georgia overall?
A Overall for the state of Georgia, we -- and I believe I have this in my declaration, as well. It was 65 percent self-insured.
Q Do you have any reason to believe that that percentage is different for any reason than the Albany market?
A I don't know.
Q Mr. Burke also asked you about community rating.
Do you recall that?
A Yes.
Q And I believe you testified that a healthier population my correlate to lower premiums.
Do you recall that?
A Yes.
Q Are there any other factors that may affect the community rating of a particular area?
A I think I testified that I'm not an expert in community rating, and so I don't set those rates.
But my general understanding is they would be reflective of the costs in that area. So the health and population, the cost of the care, our contracted rates in that area, that's my general

understanding.
Q And, again, is this something that Blue Cross-Blue Shield sets?
A The community rates?
Q Uh-huh.
A I don't know.
Q Earlier Mr. Burke asked you the membership of Blue Cross-Blue Shield, and I believe you testified it's in the range of three to three-and-a-half million members?
A I think so.
Q For what geographic area is that range?
A That was a statewide number.
Q Do you recall the range of membership for the Albany area?
A I do not recall.
Q Earlier you also testified, and correct me if I'm wrong, that employers value access; is that correct?
A That's correct.
Q Based on your discussions over the -- over the years in your position as Vice-President of Provider Engagement and Contracting, what is your understanding as to why employers value access?
A What is my understanding -- you know, a

couple of things. You know, employers are generally purchasing insurance on behalf of a employee population of people with different needs and desires.

And so, from an employer's perspective, because they're tying to meet the needs of a population of people, having access -- it's desirable to have access to a broad range of services, because that is most satisfying to the diverse needs of their employee population.

You know, that would be, you know, one reason. I mean, it provides a way for them to have an attractive health care offering for their employees. People have different needs and wants.

Q You mentioned that's one reason. Are there any other reasons you can think of?

A On why employers value access?

Q Yes.

A You know, I think employers would desire -- well, they value access for ease of use. So efficiency for people to be able to get the care they need, you know, closer to where they live or work.

And to the extent having access to lots of services provides an opportunity for creating

environment that's more cost effective, that is very much -- cost effectiveness is also very much an interest of employers.

Q And how would Blue Cross go about providing a network focusing on cost effectiveness?

A Can you clarify the question?

Q You had mentioned that having access to lots of services provides an opportunity for creating an environment that's more cost effective.

How does Blue Cross go about making sure that -- strike that. Bad question.

MR. LOWREY: Guilty of that myself.

BY MS. SCHWAB:

Q So you had also previously testified, if I'm stating it correctly, that employers value paying an affordable price for health care services; is that correct?

A Yes.

Q And again, based on your discussions with employers over the years in your former position, what is your understanding as to why employers want to pay an affordable price for health care?

A You know, health insurance is an expensive line item for them in running a business and it is one that has historically grown faster than the rate

of inflation of other things.

So affordability is very much on the top of minds of employers, because they wish to continue to provide access and health insurance for their employee population, but it's increasingly become a more costly benefit.

And so they have a strong interest in insuring that we're providing affordable offerings, because it's better business for them and they're able to provide better benefits for their employees, generally.

Q Now, earlier we talked about your negotiations, "you" being Blue Cross negotiations with Phoebe Putney in and around July 2010.

And you had mentioned the presentation of a standard hospital contract or a template hospital contract?

A Yes.

Q Does the template mention anything about the reimbursement methodology?

A Is the question generally the template or specifically with the template that we presented to Phoebe?

Q Let's take them both in turn. How about generally? Does the template ordinarily mention

anything about reimbursement methodology?

A So we have -- the template contract is comprised of several parts. But importantly, a base contract that is primary language driven that talks about how -- you know, how we will relate to one another, relationship and how we interact.

And then there's something we call, you know, like a rate sheet appendix or a payment appendix. We call it various things.

And that payment appendix is generally the source that governs the actual price for the services we pay.

Our standard template lays out preferred ways in which we would contract under a rate -- under the rate appendix.

Our preference is to pay a fixed payment rate, but the standard rate sheet appendix would lay out the categories at which you would contract, not generally the actual price you're going to pay.

Q And again, your preference is fixed rates because of the predictability of the rates?

A We generally prefer fixed rates because of the predictability and, long term, they have proven to be generally more affordable over time.

Q So going to the template that was provided

to Phoebe Putney in July of 2010, how, if at all, did that template deviate from the normal one that you just -- the standard one that you just described to me?

A I don't recall specifically.

Q Do you recall whether it had a particular reimbursement methodology set forth?

A I don't recall. I seem to recall that I -- that we had proposed some fixed pricing as opposed to percent of charges.

But I'm not 100 percent certain of that.

Q Do you recall why that was?

A We had, in principle, a desire to have fixed rate contracts with providers, because they were -- because they were more predictable in terms of the cost and they proved to be more affordable over time.

Q Mr. Burke also asked you earlier today about the Phoebe Putney health plan that Phoebe Putney markets -- markets some health services. Do you recall that?

A Somewhat yes.

Q Do you know if Phoebe Putney markets and sell its health plan services to anyone besides its employees and the employee dependents?

A I don't know.

Q At the time that you were Vice-President of Provider Engagement and Contracting for Blue Cross in Georgia, did Blue Cross consider a Phoebe Putney health plan a competitor to Blue Cross?

A I don't recall specifically. I don't recall that being a significant area of emphasis, but I don't recall.

Q Do you recall any analysis that you or anyone in your department would have done related to any sort of competition with Phoebe Putney health plan?

A I don't recall that we did analysis on that.

Q If you don't mind, let's take a quick look at Exhibit 4, which is the Network Contracting Key Stakeholder Meeting presentation that Mr. Burke went through with you earlier today.

A Yes.

Q And in particular, I want to show you Slide 23.

A Okay.

Q Again, this slide is titled "Phoebe and Peer Hospitals IP CMI Adjusted Case Rates". I believe you testified earlier today that

CMI means Case Mix Index?

A Correct.

Q And IP is inpatient; is that correct?

A That's correct.

Q Based on Slide 23, looks like Palmyra is about $4,000 less expensive than Phoebe, according to this particular graph; is that correct?

A It does appear to be correct.

Q And then going to the previous slide, Slide 22, the second bullet, "PPMH", which I assume is Phoebe Putney Memorial Hospital; is that correct?

"Inpatient rates rank the highest in their peer grouping." Is this a similar type analysis to what you explained earlier to Mr. Lowrey related to the claims data?

Or let me ask you this question: Do you know how this determination was made?

A I don't recall specifically the basis of this analysis, but I can say that the analysis would have been done based upon claims data.

Exactly which, you know, tool or database that came from, I don't recall specifically. But the basis of this information would be our claims experience, claims that we had paid.

Q Did Blue Cross routinely do these sorts of

analyses to look at the relative rates between providers?

A I mean, I would say we did this routinely. We maintained a tool called the HoPPA tool, which was always available and routinely updated.

I don't recall the exact frequency that it was updated, but it was always available to look at.

And we would pay close attention to these relative comparisons in advance of negotiating a contract.

Q Turning to the 2011 Blue Cross-Blue Shield contract amendment with Phoebe Putney, I believe you testified that you recall that it was the -- the rate was the same as in your declaration at Paragraph 10, which is the 78.32 percent of charges; is that correct?

So it would have been -- to your recollection, that same 78.32 percent would have been set forth in the 2011 contract amendment?

A You know, I don't -- I'm a little fuzzy on the exact price, and this has come up a couple times.

I do believe it was the same rate as we had in place and I think that that was also referenced in a document we looked at today.

So sort of reinforced my belief that it was the same. I don't have an exact recall on the percentage.

Q But again, the 2011 contract amendment with Phoebe Putney did remove the exclusivity requirement in Dougherty County; is that correct?

A That is what I recall.

Q And that removal of the exclusivity requirement, that was a benefit to Blue Cross; is that correct?

A We felt that it was.

Q And why did you feel that it was a benefit?

A You know, I think we had stated earlier that we had a desire to provide broader access in the Albany market and that we, sort of over the years, had routinely had requests from the employer groups through sales for access to Palmyra as an alternative.

And so, for that reason, when we set about beginning that negotiation, we had an objective of bringing Palmyra in-network, which would necessitate removing that exclusivity.

So from our perspective, that was a benefit.

Q Mr. Lowrey asked you earlier about the set of services that Phoebe Putney provides and that Palmyra provides.

Do you recall that?

A Uh-huh.

Q And I believe you testified that Palmyra provides a subset of the services that Phoebe Putney provides?

A That is what I, yes, recall. It provides a subset of them.

Q But Blue Cross-Blue Shield of Georgia entered into a contract for all services that Palmyra provides, correct?

A Yes. What I recall, and it's typically the practice most commonly, is our contract covers all the services provided by the hospital.

Just to be clear, exclusions would be things that might be excluded in the member benefit plan, like experimental or investigational type things that we wouldn't say were a benefit where we wouldn't cover it.

But the contract itself would lay out the totality of the services they provide.

Q We also talked earlier today about -- or you did about a southwest Georgia administrative

area that Blue Cross has.

And I believe that's referenced in your declaration, as well, at Paragraph 5.

A Yes.

Q Besides splitting up the state into administrative areas for the purpose of employee workload and that sort of thing, are there any other reasons that Blue Cross uses the administrative areas?

A What I recall about this administrative area -- I don't recall the relevance of this area as it pertains to products or community rating or those kinds of things.

What I recall most is that this was how we defined geographic territories for purposes of, you know, assigning employees responsibility for managing.

And part of the benefit -- from a network perspective, one of the benefits of having people manage geographic areas is because it would allow them to understand the marketplace in that geography.

Because there are differences, you know, as you travel across a very large state. And so we had interest in assigning people, where possible, to

have responsibility for providers, you know, in a general geography.

It wasn't always possible, but it was in the case of the southwest territory.

Q And is it possible that Blue Cross might have looked at a subset or smaller portion of that administrative area for purposes of putting together a viable -- as we talked about earlier, a viable health plan network for its members?

A Yes. I mean, when we would think about if the product was viable to the members, we would be thinking about that viability in a subset of -- you know, for instance, this geography here.

This was not laid out because we considered this geography, any one place, to be equally viable for all the members living in the whole geography.

Q So I want to make sure I understand you on that point. So if I'm a member that's living in Dougherty County, you, then -- "you" being Blue Cross-Blue Shield -- are trying to put together a viable network of providers that I can reasonably access and that may or may not -- that may not include all of these counties; is that correct?

A Let me be sure I understand. Can you

restate the question?
Q Sure. I didn't ask it very well, so I'm happy to restate that.
For those members that live in Dougherty County, Blue Cross may be looking at a viable health plan network for them that encompasses a smaller subset of the counties that are listed in the administrative area?
A Yes. I mean, the viability for us would be more a function of marketability, desirability for members residing in a geography, which is very much a subset of this territory here.
Q And that, again, depends on the local conditions of each of these areas?
A Uh-huh.
Q The number of providers, the number of members, that sort of thing?
A Yes.
Q Any other factors that you can think of?
A That would what?
Q That would factor into the marketability or viability of a particular health plan network?
A We would look at -- you know, employers would generally desire access to a broad range of services.

So we would understand what was the available services in that market and what subset of those did we contract with and what our competition, people that would be offering health plans in the same geography, the type of access they provided would be something we would also consider in thinking about marketability or desirability.
Q Ms. Cheslock, prior to today and our conversations within this room, have you had any conversations with anyone at Baker & McKenzie, counsel for Phoebe Putney?
A Not that I recall.
Q And have you had any conversations with anyone at Bondurant Mixson & Elmore, counsel for the Hospital Authority?
A Not that I recall.
Q And have you had any conversations with anyone at Simpson Thacher, counsel for HCA Palmyra?
A Not that I recall. Just to be clear for all of those questions, is it like ever in the whole time I was here? Or like --
Q Related to this particular matter.
A Oh, okay. No, not that I recall. Did we ever talk?
MR. LOWREY: I've heard that you don't

remember.
MS. SCHWAB: I have nothing further. Thank you.
FURTHER EXAMINATION
BY MR. LOWREY:
Q The testimony you just gave about negotiating dynamics and Phoebe Putney's leverage, you were drawing on your experience from 2007 to May 2011; is that correct?
A Can you just --
Q Sure. Without trying to rephrase it, in response to the FTC's question, you gave some testimony about what Phoebe's leverage would be and what negotiating with Phoebe was like.
And I just want to confirm that all of your knowledge is that period of 2007 to May 2011, where you are actually responsible for arranging Georgia provider networks; is that right?
A Yes. I mean, I'm sorry I'm blanking on the specific testimony. But I would have been speaking about my experience negotiating with Phoebe.
But depending upon what I was saying, also sort of generally my experience managing and negotiating contracts sort of over the 10 year

period.
Q Fair enough. The chargemaster protection you referenced, there was such provision in the Phoebe Blue Cross-Blue Shield contracts; correct?
A I don't recall.
Q You testified about the difference or lack of difference in negotiating with a not-for-profit and a for-profit hospital.
Do you recall?
A Yes.
Q Does Blue Cross-Blue Shield analyze that quantitively? In other words, do you look at your claims database and see whether the fact that a hospital is for-profit or not-for-profit, whether that makes any difference in the cost of care?
A That is not something I believe was analyzed, no.
Q The claims database that you described earlier, if someone took that database and they knew which hospitals were for-profit and not-for-profit, they could do analysis like that, you presume?
A They could analyze the case mix adjusted cost comparison between the two similar to what we did -- if you knew, yes. Yes.
Q And in that claims database we were

talking about earlier it's the same claims database that would underlie Page 23 of Exhibit 4 that complaint counsel asked you about; correct?

A Yes. I don't recall the specific genesis of that, but it would have come from the underlying claims database system that we have.

Q So if I wanted to understand or test or run comparisons related to this chart on Page 23 of Exhibit 4, I would need your claims database to do that; correct?

A You would need a subset of information from the claims database. It's massive.

Q HoPPA is the name of it?

A We call it HoPPA.

Q And you say it's a massive database because it probably covers all 14 states where you do business?

A The HoPPA database -- I was referring to our claims database, which is a -- would be every claim that we've paid for a long, long time across all states.

The HoPPA mountain called the HoPPA model is not really -- I don't think of it as a database.

It's an analysis of information contained in the database. I believe it's in Excel.

Q Okay. That's a good correction. I don't want to call it the wrong thing. Claims database, I guess, is a better word.

And you can sort that by state, by hospital; is that right?

A The claims database or the HoPPA model?

Q The HoPPA model.

A Okay. So say that again.

Q Yes. I'm not sure I exactly understand the difference between the HoPPA model and the claims database.

Maybe you could help me understand that.

A The claims database, as it exists today in some form there, is a massive relational database. I don't know, it's terabytes and terabytes of information.

And you pull -- you know, programmers would pull information back from that, you know, joining tables together to create an analysis.

And the HoPPA model would be an analysis pulled from information contained in the claims database. That would be in an Excel format, I believe. It may be in Access, but I think it's in Excel.

Q All right. Leaving aside whether it's Excel or Access, because I don't know the difference, you could use the HoPPA tool -- is that --

A HoPPA model, we call it.

Q -- the HoPPA model to extract claims data from this massive database for, for example, all Georgia hospitals?

A The HoPPA model does not extract data. The HoPPA model is the expression of information after it's been extracted.

It's an analysis and it has information about all hospitals in Georgia.

Q Right. But some smart person who knew how to ask for the right information from your claims database could extract the claims information for all hospitals in Georgia?

A Yes.

Q Well, I think from our perspective we can let you go and the FTC is nodding. So I think the war is over for you.

MR. COHEN: She'll be happy to read and sign.

MR. LOWREY: I guess that's FTC procedure. Is that right?

(Deposition Concluded)

_____
AMY M. CHESLOCK
Sworn to and subscribed before me,
this the _____ day of _____, 2013.

_____
Notary Public
My commission expires:

C E R T I F I C A T E

- - - - - - - - - - -

STATE OF GEORGIA:
FULTON COUNTY:

I hereby certify that the foregoing transcript was taken down as stated in the caption, and the questions and answers thereto were reduced to typewriting under my direction; that the foregoing pages 1 through 194 represent a true and correct transcript of the evidence given upon said hearing, and I further certify that I am not a relative or employee or attorney or counsel of any of the parties, nor am I a relative or employee of such attorney or counsel, nor am I financially interested in the action.

This the 27th day of May, 2002.

_____
KELLY A. EMERY, CCR-B-941

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CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of October, 2014, a true and correct copy of the foregoing *Motion to Quash Subpoena Duces Tecum* was filed electronically with the FTC E-Filing System and will be delivered to:

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I further certify that on the 13th day of October, 2014, a true and correct copy of the foregoing *Motion to Quash Subpoena Duces Tecum* was delivered via electronic mail and sent by Federal Express to the following:

The Honorable D. Michael Chappell
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I further certify that on the 13th day of October, 2014, a true and correct copy of the foregoing *Motion to Quash Subpoena Duces Tecum* was delivered via electronic mail to the following:

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Docket No. 9348
Public Document

CERTIFICATE FOR ELECTRONIC FILING

I hereby certify that the electronic copy filed through FTC E-File is a true and correct copy of the paper original of the foregoing Motion to Quash Subpoena *Duces Tecum*.

October 13, 2014.

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