Q. Okay. Now, let's assume that the HMO negotiates what you consider to be an unreasonably low reimbursement rate.
A. Okay.
Q. Let's not define what that is first. But let's assume the HMO gets the doctor to agree to an unreasonably low reimbursement rate. Does that benefit the HMO?
A. It does, it benefits the HMO significantly.
Q, Okay. And can you break down how that benefits the HMO?
A. In several different ways, and one kind of builds upon the other, starting with the fact that if an HMO can reduce the amount of money that it pays or has to pay for doctors for procedures, then that reduces the largest cost or one of the largest costs of businesses – business for the HMO.
MR. KEMP: Can I have that point, Brendan.
BY MR. KEMP:
Q. Okay. So, one, if the HMO pays a low reimbursement rate to the doctor, it reduces its cost of doing business, right?
A. That's correct.
Q. And what's the second way an unreasonably low reimbursement rate can benefit an HMO?
A. Well, if its cost of business is lower because it is paying doctors less money, then the HMO has –
Q. By the way, Wendell, you have notes on the slide up there so –
A. Right, yeah. So I can follow along with what's on the screen. – then the HMO has the ability to charge lower premiums if the HMO decides that it has to do that to sell its health insurance to new purchasers.
MR. ROBERTS: Your Honor, may we approach?
THE COURT: Yes.
MR. ROBERTS: Thank you.
(Discussion was had at bench, not reported)
THE COURT: All right. As far as the objection is concerned, I will overrule at this time.
MR. KEMP: Thank you, your Honor.
BY MR. KEMP:
Q. Okay Mr. Potter, did we finish two or, I can't remember, were you cut off in two?
A. Well, I just reiterated that if – if the cost of business at an HMO is lower because it was paying doctors less, then the HMO can, and does often, have the ability to change – to charge lower premiums to its prospective new customers if it decides it must do that to – to get new business.
Q. Okay. Is there another benefit to the HMO?
A. Right. By doing this, it can increase market share. In other words, it can get more members, more enrollees by obtaining additional business with lower premiums, by underbidding or what's referred to in the business as buying the market share or buying business.
Q. Okay. By buying the business, they give – they give new members a lower rate for a while and try to get them in the door, right?
A. That's right. That's why it's called buying market share, and with increased market share, the HMO has even more bargaining power at the negotiating table with doctors and hospitals to – to get even lower reimbursement rates.
Q; And it has more bargaining power because it has more patients to deliver to the doctor, right?
A. That's exactly right. It's a matter of volume at that point.
Q. And backup. Can you give me the fourth benefit?

A. The fourth benefit is the – the HMO gaining bargaining power because of its increase in market share. It makes a big difference to have a sizeable membership if you're an HMO. It gives you much more ability to do that negotiating in ways that are more favorable to the HMO.
Q And when you have more bargaining power, how does that impact your ability to negotiate reimbursement rates with doctors?
A. Significantly. If you have greater market share, you are able to negotiate from a position that is stronger, typically, and almost always, than your competitors in the market.
Ql Okay. So if you're an HMO with two patients as opposed to a HMO with 200,000 patients, you're able to negotiate lower rates for the doctors because you're bringing a big book of business.
A. Exactly right. And doctors and the hospitals, because of that, because of the big volume, are certainly more willing to – to negotiate and be agreeing to pay lower rates
Q. Okay. Okay. And fifth, assuming that the HMO does get significant market power or increased market share what benefit, if any, does that allow the HMO to do?
A. Well, at this point, it can begin raising health insurance premiums and making more money because if you've been able to attain that market dominance of the big market share, then you can begin raising premiums, and that increases – enhances your profitability.

Q. Have you looked at the membership of Health Plan of Nevada between 1999 and 2008?
A. I have.
Q. And in general what did you find?
A. Very significant very rapid growth. Very, very fast growth.
Q;. Okay.
MR. KEMP: And can I have my next slide please.
BY MR. KEMP:
Q. And by significant growth are you referring to – first of all let's break it down.
A. All right.
Q. The 199,000 and 2000 what does that mean?
A. The means in that year the total enrollment or the total number of members was just, just a little bit under 200,000. 199,771 was the total enrollment of that health plan and you can see there how much the membership increased over the – over the subsequent years.
Q. And so in 1999, 2000 when they went back to Dr. Desai they had 200,000 members, patients, customers, whatever you want to call them?
A. Correct.
Q. Right?
A. Right.
Q. And then what happened?
A. Well, it went up significantly every year. By 2007 it had more than doubled in membership.
Q. And 402,000 is what you're referring to?
A. That's right. In 2007 the total enrollment of the health plan was 402,191.
Q. So seven years after they contracted with re-contracted with Dr. Desai they had doubled the number of patients?
A. That's right. That's right.
Q. Doubled their customers?

A. Right.
Q. Okay. Is that unusual for a HMO to double its membership in seven years?
A. It is. It is unusual. Especially in an – in a large market like Las Vegas.
Q. Have you ever seen that happen before?
A. I have not.
Q. What is the fourth benefit to the HMO?
MR. KEMP: Put that slide back up.
THE WITNESS: – pertains to the increased market share that a HMO can get from what we've been talking about. And it gives the HMO even more clout, if you will, even more bargaining power to negotiate even lower reimbursement rates with doctors because as you – as the health plan gains members, as we've seen here, it can pretty much assure the providers that they'll have more patients so their volume of patients, the number of people in their what they call patient panels likely increase.
BY MR. KEMP:
Q. Okay. And by increased market share you're talking about them going from 200,000 to 400,000 members?
A. Right. That's a big, big, big significant growth.
Q. And this bargaining power, that – that applies not just to Dr. Desai but that's any contract they negotiate?
A. That's correct.
Q. So their bargaining power increases for every doctor, every hospital?
A. That's right.

Q. Okay. So since HPN doubled, they grew hundred percent, and Las Vegas only grew 35, 40 percent –
A. Forty.
Q. – something else was going on besides just population growth, correct?
A. Right. We see here gaining in market share.
Q. And the definite gain in market share?
A. Right. Exactly, very significant.
Q. Okay. Does being the biggest HMO in a county or a state benefit the HMO?
A. It does. It makes a big difference, and that's why in many cases you don't have competitors coming into the market because when, when one or two large HMOs get such a market presence, the barriers to enter a new market are very high.
Q. So if you have one big dog in the yard, there's not going to be another big dog come in?
A. That's right.
Q. Scare it away?
A. Exactly, right.
Q. Okay. And is that common for a HMO? I think we heard yesterday that Health Plan of Nevada had 79 80 percent of the HMO market here. Is that common?
A. You know, it's becoming increasingly common. But that's even – that's higher than many, many markets. There is market concentration around the country, but that's high.

Q. Okay. Just to make sure we all understand, so if someone goes in to Dr. Desai's office and has this colonoscopy diagnostic, Dr. Desai gets paid 294.77?
A. That's right.
Q. Okay. And there may be other charges from the facility to HPN, but this is for that procedure code, right?

A. That's right.
Q. All right. Now, this, this monetary amount $294, is that the same as the Medicare rate?
A. No, it's not. No.
Q. Okay. Have you determined what the national average Medicare rate was, say, in the year 2000 2003?
A. Right, I did.
MR. ROBERTS: Objection, foundation.
MR. EGLET: Foundation determined it.
THE COURT: Anything else? You need something from me? Did I say something.
(Discussion was had at bench, not reported.)
THE COURT: Thank you, Counsel. As far as the objection is concerned, I'll overrule.
BY MR. KEMP:
Q. Mr. Potter, did you determine what the national rate was in 2002, 2003 for this procedure code.
A. Right. For that particular CPT code it was $497. I think something like that.
Q. Okay. You want to look at your notes?
A. Yeah. I'm sorry. $459.47 for that particular code at that particular time.
Q. Okay. So this is what the United States government paid for this exact same operation nationally?
A. That's right, nationally.
Q. All right. Now, usually are HMOs lower or higher than the amount of money they pay to doctors and hospitals in the Medicare rate.
A. Higher.
Q. So usually the HMO pays more than Medicare pays?
A. Absolutely correct, yes.
Q. That generally understood in the industry?
A. Very much understood in the industry, absolutely.
Q. Are there actually studies about how much more the HMOs typically pay doctors and hospitals than Medicare pays?
A. Yes. And there was a seminal study done in 2008 that was paid for the Americans Health Insurance Plans, American Hospital Association and Blue Cross Blue Shield of America that hired a big consulting firm that does a lot of business for in healthcare to do an analysis.
Q. So this plan was paid for by one of the trade groups you are a member of?
A. Yes, that's correct.
Q. Okay. And Milliman, can you explain to the jury who Milliman is, or what, I guess, is better?
A. Milliman is a now a very very large consulting business that provides consultative services, analysis of data to health insurers and employers and healthcare providers.
Q. Okay. And they're the recognized people in the industry who do this kind of research?
A. That's correct.
Q. Okay. And what did Milliman find in 2000 – what time period you said?
A. The report was done in 2008.
Q. Okay. And what did Milliman find via-a-vis what the Medicare rate was and whether a typical commercial rate is higher or lower?
A. What Milliman found, and this was based on a lot of data, obviously, that it was able to collect, was that Medicare pays about 78 percent of what commercial health insurers pay on average.
Q. So Medicare typically pays 78 cents, and the commercial carrier pays a dollar?
A. That's right.

Q. And this is all throughout the nation?
A. That's right.
Q. Including Nevada was included in this nation wide study?
A. Yes, that's correct.
Q. All right. So to convert the Medicare rate to what the hypothetical national rate would be, what do we have to do?
A. Well using that, the converse of that is that health insurers are paying about 130 percent of what the Medicare rate is. So to determine what the hypothetical commercial rate would be you can do the math, you can take the national Medicaid rate and apply 130 percent that would get you to $588.
Q. You said Medicaid. You mean Medicare?
A. I meant Medicare. Pardon me.
Q. Okay. And you've done the math, and the result is what?
A. $599 for that specific CPT code.
Q. Okay. So HPN was paying $294, correct?
A. That's correct.
Q. The national Medicare average was $459?
A. That's right.

Q. Do you have an opinion as to why HPN is able to pay 294 when Medicare pays 460, and the hypothetical commercial rate is 588?
A. In my opinion it was because what we were talking about a few minutes ago. It has significant market share and the ability to negotiate low rates in many cases, rates lower than what even Medicare would pay.
Q. Okay. And this is just one operation, correct?
A. That's right.
Q. So why don't we do 10,000 operations and see what the difference is. Okay?
A. Okay.
Q. If you do 10,000 operations you would just multiply the figures, right?
A. That's right.
Q. Okay.
MR. KEMP: Brendan, can I have my next slide?
BY MR. KEMP:
Q. So for 10,000 operations the exact same procedure under the HPN Sierra Fee Schedule it's 2.947, correct?
A. That's right.
Q. Medicare is 4,594,000?
A. That's right.
Q. And the hypothetical commercial rate is the 5.880, right?
A. That's right.
Q. So somehow or another HPN saved $3 million over what Milliman would predict?
A. That's right.
Q. Now, we've talked a lot about the HMO benefit of getting an unreasonably low reimbursement rate. What is the impact of an unreasonably low reimbursement rate on the doctors?
A. Well, it can jeopardize patient care. It would mean that the doctor would need to figure out some way to cut costs or pump up the volume in some way.
Q. Okay. I mean, this is America. Shouldn't – if Dr. Desai's is willing to take a nickel for each one of those operations, shouldn't HPN just go ahead and just pay the nickel?

A. I – HPN could. But if what you are wanting to make sure is that you have a fair reimbursement rate, and you're certainly focused on the well being of your members, you would – you would be concerned about that because you really can't – you can't buy something of high quality for a little bit of money.
Q. And you heard what Mrs. Christiansen said yesterday?
A. Yeah. You can't buy a Cadillac for 50 cents.
Q. And that's understood in the healthcare industry, right?
A. That's correct.
Q. And does this mean that if you give an unreasonably low reimbursement rate that the HMO would know this could potentially compromise patient care?
A. Yes.