Alexandra Montague
State Bar No. 337740
200 McAllister St.
San Francisco, CA 94123
Tel: (203) 524-9237
Email: montaguealexandra@uchastings.edu
Attorney for *Amici Curiae* The Source on Healthcare Price and Competition and Affiliated Scholars

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

PASADENA HOSPITAL ASSOCIATION LTD. d/b/a HUNTINGTON HOSPITAL, and CEDARS-SINAI HEALTH SYSTEM, Petitioners/Plaintiffs, v. CALIFORNIA DEPARTMENT OF JUSTICE, and ROB BONTA, in his official capacity as Attorney General of California, Respondents/Defendants.	Case No.: 21STCP00978 APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF BY THE SOURCE ON HEALTHCARE PRICE AND COMPETITION AND AFFILIATED SCHOLARS AND [PROPOSED] BRIEF IN SUPPORT OF RESPONDENTS Dept: 85 Judge: The Honorable James C. Chalfant Trial Date: July 29, 2021 Action Filed: March 30, 2021

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

Amici curiae health policy and law scholars respectfully apply to this Court for permission to file the attached brief in support of Defendants California Department of Justice and Rob Bonta, in his official capacity as Attorney General of California. Amici respectfully contend that this brief would assist the Court in deciding this matter. (*See* Calif. R. Court 8.200(c)(2); Calif. R. Court 8.882(d).) Although the rules governing trial court proceedings are silent regarding the criteria for filing amicus briefs, individuals and entities may file such brief with the Court's permission. (*See, e.g.*, *In re Veterans' Industries, Inc*. (1970) 8 Cal. App. 3d 902, 924–25.)

STATEMENT OF INTEREST

Amici are professors of law and economics and health policy researchers. Members have testified before Congress as well as the California legislature regarding the harms of consolidation within healthcare markets in the United States. They have also conducted extensive research and have published widely on topics of healthcare consolidation, the role of states in addressing that consolidation, antitrust law in health care, and specifically cross-market mergers. Their interest in this case is to illustrate the harms of consolidation of healthcare markets, specifically the potential negative impacts of cross-market mergers on healthcare markets.

HOW THIS BRIEF WILL ASSIST THE COURT

Amici respectfully contend that the proposed brief will assist the Court by addressing three issues: 1) the harms of consolidation in healthcare markets; 2) the scope of empirical research, economic and legal literature, and legal precedent supporting the facts and analyses put forward by the California Attorney General; and 3) the Petitioners misleading assumptions regarding hospital mergers and the remedies imposed by the Attorney General.

STATEMENT REGARDING PREPARATION OF THIS BRIEF

No party or counsel for any party authored any portion of the proposed amicus brief and no party or counsel for any party contributed financially to the preparation of the brief in any way. (Cal. Rules of Court, rule 8.200(c)(3).)

For the foregoing reasons, *amici* respectfully request that the Court grant this application to file the attached amicus curiae brief.

Dated: July 9, 2021

Respectfully submitted,
The Source on Healthcare Price and Competition and affiliated scholars

By: /s/ Alexandra Montague
Alexandra Montague

Attorney for *Amici Curiae*

[PROPOSED] ORDER

The application to file an amicus brief by The Source on Healthcare Price and Competition and affiliated scholars is granted.

IT IS SO ORDERED.

Date: _____

_____
Honorable James C. Chalfant
Judge of the Superior Court

Table of Contents

Table of Authorities

Page(s)

CASES

STATUTES

MISCELLANEOUS

I. Introduction and Summary

This important case continues a long series of challenges to health care mergers that impair competition, raise costs, and may reduce quality of care for patients. This brief seeks to assist the court by providing context on three points. First, it documents the harmful effects of health care mergers, including those between providers not competing in the same product or geographic market. Second, it demonstrates that the facts and analyses put forward by the Attorney General are well supported by both economic studies and legal precedent and satisfy both the substantial evidence standard under traditional mandamus review and the arbitrary, capricious standard under administrative review. Finally, it corrects some of the misleading assumptions contained in Petitioners' complaint and brief concerning hospital mergers and the remedies imposed by the Attorney General. Overall, we find that the Attorney General's competitive impact conditions align with California legislation and regulation, historical antitrust law, and modern empirical evidence on the functioning of healthcare markets.

II. The Importance of Preserving Competition Among Health Care Providers

While it is well known that America spends more on health care than other developed nations without commensurate increases in quality, access, or outcomes, the significant role that provider consolidation and market power play in health care spending is less well-known. Many experts agree that health care markets are not functioning well. In May 2021, Professor Martin Gaynor testified before the U.S. Senate Judiciary Committee that "[p]rices are high and rising … they vary in seemingly incoherent ways, there are egregious pricing practices . . . there are serious concerns about the quality of care, and the system is sluggish and unresponsive, lacking the innovation and dynamism that characterize much of the rest of our economy."[1] (Hearings before the Sen. Com. on the Judiciary, Subcom. on Competition Policy, Antitrust, and Consumer Rights on Antitrust Applied: Hospital Consolidation Concerns and Solutions, 117th Congress, 1st Sess. (2021) testimony of Professor Martin Gaynor, E.J. Barone University Professor of Economics and Public Policy Carnegie Mellon University (hereafter Testimony of

[1] See text for internal citations: https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf.

Professor Martin Gaynor).) Voluminous economic research "shows that hospitals and doctors who face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality" and a "tremendous amount of consolidation" by dominant providers has resulted in lagging competition nationwide. (Gaynor, *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work* (2020) The Hamilton Project < https://www.hamiltonproject.org/assets/files/Gaynor_PP_FINAL.pdf>.)

The harmful effects of healthcare consolidation are well-documented. Most of the research literature on consolidation has examined the effects of horizontal consolidation – that is mergers of hospitals in the same geographic markets. While the magnitude of the price increase associated with consolidation varies, nearly all studies have found that prices increased following a hospital merger. (Gaynor & Town, *The Impact of Hospital Consolidation—Update* (2012) The Synthesis Project: Robert Wood Johnson Foundation.)[2] For example, an FTC retrospective analyzing the Sutter-Summit merger in Northern California revealed that Alta Bates, the Sutter hospital, increased its prices between 10.2 percent and 20.7 percent and Summit increased its prices between 29 percent and 72 percent during the two years following the merger. (Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction* (2011) 18 Int'l J. Econ Bus. 65, 75.) Capps and Dranove found that following a merger, three-quarters of the hospitals studied increased prices by more than the median price increase and no merging hospital had price increases below the median price increase. (Capps & Dranove, *Hospital Consolidation and Negotiated PPO Prices* (2004) 23 Health Affs. 175.) Not only does the merger enable the merging entities to raise price, but it can also lead to price increases by rival hospitals. Capps and Dranove found that in most markets, consolidation enabled all hospitals in that market to significantly increase prices. (*Id*. at p. 179.) Dafny also found significant post-merger price increases beyond the merged entity, including increases of approximately 40 percent at bystander hospitals following the merger of nearby rivals. (Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers* (2009) 52

[2] In fact, the only recent study to dispute price increases is a report sponsored by the AMA. (Noether et al., *Views from Hospital Leaders and Econometric Analysis – An Update* (2019) Am. Hosp. Ass'n 1 <https://www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-f.pdf>.)

J. L. Econ. 523, 544.) Likewise, mergers between competing physician groups have been associated with significantly elevated prices. (Koch & Ulrick, *Price Effects of a Merger: Evidence from a Physicians' Market* (2021) 59 Econ. Inquiry 790; Baker et al., *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits* (2014), 312 JAMA 1653.)

Furthermore, price increases resulting from mergers are not confined to horizontal combinations. Multiple research studies also demonstrate that when health systems acquire physician practices, prices and spending increase. (*See, e.g.*, Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending* (2014) 33 Health Affs. 756.) For example, Capps et al. found that hospital acquisitions of physician practices led to physician prices increasing by an average of 14 percent, with cardiologists increasing prices by 33 percent. (Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* (2018) 59 J. Health Econ. 139.) Capps et al. also found that the price increases were larger when the acquiring hospital had a larger market share. (*Ibid*.) Similarly, Neprash et al. found that markets with greater increases in physician-hospital consolidation exhibited greater increases in prices without a significant increase in utilization. (Neprash et al., *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices* (2015) 175 JAMA Internal Medicine 1932.) The researchers report that "these findings are consistent… with hospitals conferring their existing market power to newly employed physicians or acquired practices… [and that] physician-hospital integration was not associated with lower utilization, suggesting that this form of provider consolidation has not led to gains in health care efficiency." (*Id*. at p. 1937.) Not only do these mergers raise physician prices for payers and employers, but they can foreclose competition or raise the costs of rival hospitals, thus enhancing the market power of the acquiring hospital. (Greaney, *The New Health Care Merger Wave: Does the "Vertical Good" Maxim Apply?* (2019) 46 J. of L. Medicine & Ethics 918.) Further, health economists at Stanford University recently found that combinations between physicians in different specialties that do not compete with one another, both primary-specialist integrations and cross-specialty

integrations, (i.e., cross-product mergers) are associated with higher prices for both merging entities. (Baker et al., *Does Multispecialty Enhance Physician Market Power?* (2020) Am. J. of Health Econ. 324.)

For the last two decades, economists and health services researchers have produced a compelling body of evidence demonstrating the anticompetitive effects of healthcare consolidation. Initially, that research focused on horizontal hospital mergers, but over time it expanded to include vertical mergers between health systems and physicians and multi-specialty practices. The conclusions drawn from these studies are remarkably uniform – healthcare consolidation in a wide variety of forms is associated with price increases without corresponding increases in quality. (*See, e.g.,* Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions* (2020) 382 NEJM 51.) In recent years, leading health economists have analyzed the market impact of cross-market healthcare mergers, finding similar price effects arising from the creation of "system power."

III. "System Power": The Harmful Effects of Cross-Market Consolidation

System power is the ability of multi-hospital health systems to demand supra-competitive reimbursement for services provided by some or all of their hospitals by exploiting the market power associated with having one or more "must have" hospitals, that is, hospitals that payers must include in their networks in order to compete effectively. The "must have" hospitals may also be a collection of hospitals with mid-level market power such that the group as a whole creates market power. As discussed infra, the Cedars Sinai/Huntington affiliation is a textbook example of the kind of union that economic studies have shown can increase the market power of health systems and hence enable anticompetitive pricing.

Concerns about cross-market mergers are not new. In 1950, Congress amended the Clayton Act specifically to guard against the potential anticompetitive effects of non-horizontal mergers. (Halverson, *Report to the House Delegates on Proposed Amendments to Section 7 of the Clayton Act* (1986) 55 Antitrust L. J. 673, 676.) As amended, the Clayton Act clearly grants antitrust enforcers the ability to restrict mergers between entities in different geographic and product markets that can harm competition or consumer welfare. The Act currently states "[n]o

person engaged in commerce or in any activity affecting interstate commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital. . . *where in any line of commerce or in any activity affecting commerce in any section of the country*, the effect of such acquisition may be to substantially lessen competition or tend to create a monopoly." (15 U.S.C. §18.) (Italics added.) Based on these amendments, the Supreme Court identified antitrust problems associated with mergers combining firms that manufacture distinct, but related or linked products as far back as the 1960s. (*See, e.g.*, *F.T.C. v. Procter & Gamble, Co.* (1967) 386 U.S. 568, 580–581; *U.S. v. Falstaff Brewing Co.* (1973) 410 U.S. 526, 531–32.)

These concerns have more recently been applied to healthcare markets. In 2010, Robert Berenson noted the potential for health systems to use cross-market bargaining leverage to increase prices. He stated, "[n]egotiating as a system across a broad geographic area avoids antitrust scrutiny, which focuses on local market concentration. At the same time, this strategy permits hospital systems with strong bargaining positions in some markets to negotiate high rates elsewhere as well." (Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform* (2010) 29 Health Affs. 1, 4.)

The scope of health care systems — and system power — have been increasing in recent years. The authors of this brief have been conducting research on trends in cross-market hospital mergers throughout the United States, analyzing all hospital mergers between 2010 and 2020 to identify those that are cross-market and clarify how the markets are consolidating. Our findings thus far reveal that over half of the hospital mergers in the U.S. between 2010 and 2020 occurred across geographic markets. Further, health systems have consolidated over time to form more state-wide, multi-state, and national systems. This kind of consolidation is especially prevalent in the markets under review in this case. As Petitioners noted in their Complaint, "[h]ealthcare providers in the Los Angeles area are increasingly consolidated and represented by larger and more integrated healthcare systems including Kaiser Permanente, Providence, Adventist Health, Dignity, PIH Health, and UCLA Health." (Compl. ¶ 48.) JD Healthcare noted that system growth readily translates into system power, explaining that "these health systems have competitive advantages including size, geographic coverage, expanded

ambulatory services, ability to access capital, and more developed physician alignment models." (R. 232.)

These findings are not anecdotal — several empirical and theoretical studies have identified the potential harms associated with cross-market mergers in health care. (Vistnes & Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach* (2013) 79 Antitrust L.J. 253; Lewis & Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions* (2017) RAND J. Econ. 579; King & Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care* (2017) 11 St. Louis U. J. Health L. & Pol'y 43; Varanini, *Addressing the Red Queen Problem: A Proposal for Pursuing Antitrust Challenges to Cross-Market Mergers in Health Care Systems* (2020) 83 Antitrust L.J. 509; Schmitt, *Multimarket Contact in the Hospital Industry* (2018) 10 Am. Econ. J.: Econ. Pol'y 361; Dafny et al., *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry* (2019) 50 RAND J. Econ. 286.) Of particular importance are the empirical studies that document price increases following transactions that expand health systems into new geographic territories. These studies examined "the effect of mergers between firms whose products are not viewed as direct substitutes for the same good or service, but are bundled by a common intermediary." (Dafny et al., *supra*, 50 RAND J. Econ. at p. 286.) Dafny, Ho, and Lee found that prices at acquired hospitals increased 7 to 9 percent initially, and within four years, prices at the acquired hospital were 19 percent higher than control hospitals. (*Id.* at p. 311.) Likewise, Lewis and Pflum found that prices at hospitals acquired by out-of-market systems increased 17 percent more than unacquired, stand-alone hospitals. They also found that prices increased about 8 percent at competing hospitals within seven miles of the acquired hospital. (Lewis & Pflum, *supra*, 48 RAND J. Econ. at p. 579.) Another study focusing on mergers that increased multimarket contact between two hospitals systems found price increases of 6 percent. (Schmitt, *supra*, 10 Am. Econ. J.: Econ. Pol'y at p. 377.) These studies not only empirically demonstrate the potential for cross-market healthcare mergers to have anticompetitive results, but they also provide guidance on the types of transactions likely to give

rise to consumer harms — those in which the merging entities sell related or complementary products to a common insurer or customer.

The basic logic behind system power and cross-market merger effects is founded on the fact that the market for healthcare goods and services operates at two levels: that of the insurer constructing a provider network and that of an individual patient. Because most insurance plans limit coverage to a certain network of providers, health systems typically compete for inclusion in a health insurance network as opposed to for individual patients. (*F.T.C. v. Advocate Health Care Network* (7th Cir. 2016) 841 F.3d 460, 465.) In 2013, Vistnes and Sarafidis reported that "many health plans have been expressing serious concerns that large provider systems encompassing multiple (but generally adjoining or nearby) geographic markets are reducing the ability of health plans to negotiate favorable rates." (Vistnes & Sarafidis, *supra*, 79 Antitrust L. J. at p. 255.) They explained that health systems that owned hospitals in multiple areas had increased bargaining strength because those systems could exclude multiple hospitals/providers from the insurer's network if the systems' rate requests were not met. This theory is known as the "network holes" theory because systems derive market power from their ability to put multiple holes in a common insurance carrier's network. (*Id.* at pp. 255–56.) Dafny, Ho, and Lee similarly argued that the presence of a common customer and common insurer for healthcare providers in multiple healthcare markets, whether an insurer building a network that spans more than one geographic market or an employer with employees in multiple markets, would increase the bargaining leverage of a health system that had providers in both markets. (Dafny et al., *supra*, 50 RAND J. Econ. at pp. 287–288, 291.) In this scenario, what generates the leverage is the size and value of the overall package of providers offered by a health system to a common customer (insurer or employer), not the substitutability of any individual provider for a particular patient. This type of leverage is "system power."

As insurers seek to construct comprehensive provider networks in an area, region, state, or even nationally, health systems and other large provider organizations can use their system power to create leverage vis-a-vis those insurers, especially if those systems include "must have" or highly desirable hospitals. Health systems with a single "must have" provider or

several providers with market power in a region, such that an insurer could not build a competitive provider network without their inclusion, can leverage that power to demand higher reimbursement rates for some or all providers in the system.

California has experienced the well-documented effects of system power. In the State's recent case against Sutter Health, the Attorney General's complaint detailed Sutter's ability to leverage its market power in different geographic markets in Northern California to demand anticompetitive contract terms with insurance carriers and supra-competitive prices for providers within the Sutter system. (*People of the State of California ex rel Xavier Becerra v. Sutter Health* (Cal. Super. Ct. S.F. City and Cnty. 2019) CGC 18-565398.) The state argued that because Sutter had "must have" hospitals in certain markets, insurers building a network in Northern California had no choice but to contract with Sutter and acquiesce to their price and contractual demands. While the case ultimately settled, the extent of the settlement terms – including: 1) a historic $575 million settlement payment; 2) prohibitions on Sutter's ability to condition the pricing of certain hospitals on network inclusion of others, use gag clauses, and impose anti-steering clauses; and 3) the imposition of out-of-network rate caps — suggests the magnitude of the harm caused by Sutter's market power. (Order Granting Plaintiffs' Renewed Motion for Preliminary Approval of Settlement (2021) *UFCW & Employers Benefit Trust v. Sutter Health* (Cal.App.1st 2015) No. CGC 14-538451, consolidated with People of the State of California, ex rel. Xavier Becerra v. Sutter Health (Cal. Super. Ct. S.F. City and Cnty. 2019) No. CGC-18-565398.) The Sutter experience is instructive. Sutter became the dominant market power in Northern California largely through cross-market mergers and acquisitions that went unchallenged and unregulated by antitrust enforcers. The Attorney General's competitive impact conditions in this case are a reasoned effort to prevent Cedars-Sinai from having the capacity to engage in similar anticompetitive behavior in Southern California where prices have been historically lower than in Northern California. (Scheffler et al., *Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visits* (2018) Health Affs. 1409.)

Other jurisdictions have expressed concerns about cross-market hospital mergers as well. In response to the rising trend of healthcare consolidation in North Carolina, Attorney General Josh Stein released a statement criticizing the proposed merger of nonprofit systems Sentara Healthcare of Virginia and Cone Health of North Carolina due to concerns of anticompetitive cross-market effects. (Attorney General Josh Stein, *AG Stein Statement on Hospital Consolidation and Pricing* (June 2, 2021) < https://ncdoj.gov/ag-stein-statement-on-hospital-consolidation-and-pricing/> [as of July 8, 2021].) The AG's office collected public comments that revealed opposition from both North Carolina and Virginia stakeholders regarding the proposed merger's cross-market aspect and potential to stifle competition and drive-up patient costs.[3] The parties abandoned the merger in light of the antitrust scrutiny.

Of course, not every cross-market merger will give rise to the ability to increase bargaining leverage. What is required is a careful identification of conditions that enable the exercise of market power — throughout the economic literature a similar set of conditions have repeatedly appeared. First, the merging entities must sell products to a common customer. In the case of the Procter & Gamble acquisition of Clorox, the FTC specifically noted that the "products of both parties to the merger are sold to the same customers, at the same stores, and by the same merchandising methods." (*F.T.C. v. Procter & Gamble Co.*, *supra*, 386 U.S. at p. 574.) Second, the merging entities must have the potential to bundle some or all of the products of the merging companies for sale to the common customer in ways that would create a competitive advantage. (Dafny et al., *supra*, 50 RAND J. Econ. at p. 287.) Third, one or more of the merging entities must have market power. (King & Fuse Brown, *supra*, 11 St. Louis U. J. Health L. & Pol'y at p. 62.) These three factors were also critical to the models developed by Lewis and Pflum and Vistnes and Sarafidis. Together these sources document the adverse competitive effects that multi-hospital systems have had when market conditions enable them to exercise system power. They strongly support the theory of cross-market harm and the advisability of the Attorney General's measures to prevent Cedars-Sinai from emulating the Sutter Health model in the Los Angeles area.

[3] *See* Public Comments submitted to Attorney General Joshua Stein from Nancy Crutchfield McCleary (March 24, 2021), Su Wooi Teoh (March 28, 2021), Robert Cherniak (April 22, 2021), Rebecca Sullivan (April 26, 2021).

As is true in all cases in which fact finders must attempt to predict market behavior, such inquiries are highly fact specific. As discussed below, Dr. Vistnes has closely examined pricing and bargaining practices in the Los Angeles region, and has reasonably identified the market conditions necessary to create the risk of anticompetitive price increases following the Cedars-Sinai/Huntington transaction. Huntington and Cedars-Sinai, both entities with likely substantial market power, will sell hospital services to common insurers and employers, will have the opportunity to bundle all or some of those services, and owing to the significant difference in their current reimbursement levels, will have strong incentives to raise the prices at Huntington Hospital. (R. 309). While no attorney general can predict with perfect accuracy the future behavior of a merged entity, as the Supreme Court has reminded, where these determinations rest on sound economic analyses, the fact finder must necessarily make judgments based on "probabilities, not certainties." (*Brown Shoe Co. v. United States* (1962) 370 U.S. 294, 323.) Antitrust law is not static. It was designed to evolve alongside economic analysis and market dynamics. (*Kimble v. Marvel Entertainment, LLC* (2015) 576 U.S. 446, 461; Capps et al., *The Continuing Saga of Hospital Merger Enforcement* (2019) 82 Antitrust L.J. 441.)

IV. The Analysis Here Supports the Competitive Impact Conditions

As set forth in Section III supra, there is considerable economic evidence that under certain conditions cross-market mergers pose a risk of harm to consumers. Dr. Vistnes' analysis, which is fully consistent with those studies, carefully examined the conditions of the markets in which Cedars Sinai and Huntington Hospital compete and applied the learning derived from the empirical studies. His findings that the Cedars-Sinai/Huntington affiliation creates a risk of harmful price effects are based on a detailed examination of the empirical and theoretical literature, the market power of the affiliated hospitals, their relative prices, the demand conditions of common customers, concerns expressed by health plans through interviews, discussions with lawyers and economists at the FTC, and other factors. (R. 285.) Plaintiffs attempt to distinguish the findings in Dafny, Ho, and Lee and Lewis and Pflum from the Huntington Cedars-Sinai affiliation on the grounds that it does not fit their definitions of

cross-market mergers. Yet, those definitions, which were based on drive time (> 30 minutes, Dafny, Ho, and Lee) and driving distance (>45 mi, Lewis and Pflum), were attempts to approximate on a national scale the detailed diversion and market analysis that were conducted for Huntington Cedars-Sinai. That analysis demonstrated that Huntington and Cedar-Sinai were not substitutes for one another, did not share patients, and had very low diversion ratios. (Compl. ¶ 81.) Huntington and Cedars-Sinai are either competitors in the same product and geographic market or the affiliation is a cross-market merger. Petitioners cannot have it both ways. Given the unequivocal findings on both sides that the entities are not competitors or substitutes for one another, the merger is by definition, a cross-market merger.

V. Mistaken/Misleading Assumptions Embedded in Petitioner's Claims

Petitioners' complaint contains several mistaken and misleading assumptions regarding their nonprofit status, quality improvements, the competitive impact conditions, and all-or-nothing contracting. Studies and case law contradict Petitioners' arguments.

A. Non-profit Status Does Not Negate Incentives to Engage in Anticompetitive Conduct

Petitioners claim that their non-profit status signifies that the "payments they receive are invested into the provision of patient care." (Compl. ¶ 10.) As courts and enforcement agencies have recognized, both non- and for-profit hospitals face similar market pressures and would therefore likely exploit market power in the same way. (Fed. Trade Comm'n & U.S. Dep't of Justice, *Improving Health Care: A Dose of Competition* (2004) Ch. 4 pp. 29–33 (hereafter *A Dose of Competition*).)[4] In fact, seven of the ten most profitable hospitals in the country are non-profit. (Bai & Anderson, *A More Detailed Understanding of Hospital Profitability* (2016) 35 Health Aff. 889, 893.) With respect to post-merger behavior, two case studies found similar price increases following non-profit and for-profit hospital transactions. (*See* Rabbani, *Non-profit Hospital Mergers: The Effect on Healthcare Costs and Utilization* (2021) Int'l J. of Health Econ. and Mgmt.; Vita & Sacher, *Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study* (2001) J. of Indus. Econ. 63.) And case law and the federal antitrust

[4] https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

enforcement agencies have also strongly rejected claims that non-profit status outweighs potential anticompetitive effects. (*See, e.g., F.T.C. v. University Health* (11th Cir. 1991) 938 F.2d 1206, 1224; *U.S. v. Rockford Memorial Corp.* (N.D. Ill. 1989) 717 F. Supp. 1251, 1284; *In the Matter of Evanston Northwestern Healthcare Corp.* 2007-2 Trade Cas. (CCH) ¶ 75,814; *A Dose of Competition*, *supra*, at Ch. 4 pp. 29–33.) As a leading health care antitrust treatise has stated, "while several hospital-merger decisions in the late 1980s and 1990s noted that the hospitals' nonprofit status deserved at least some consideration in the competitive-effects analysis, this argument is a nonstarter today." (Miles, Healthcare and Antitrust Law (2021) Other factors—Nonprofit status § 12:28.) Ultimately, the non-profit status of a hospital provides no assurances that it will not engage in post-merger price increases or that it will reinvest significant savings into patient care. Surplus revenues could just as easily be held in reserve or used to acquire additional healthcare provider organizations.

B. There is No Assurance that the Affiliation Will Improve Quality

Petitioners also mistakenly assume throughout their complaint that consolidation is necessary to "strengthen the quality" of care and to achieve greater efficiencies (Compl. ¶¶ 4, 5, 11, 39.) The efficiencies promised by merging entities are rarely born out in practice. Generally, most studies have found that quality suffers where there is less competition. (Testimony of Professor Martin Gaynor, *supra*, 117th Congress, 1st Sess. (2021).) Although one study funded by the American Hospital Association (AHA) that examined all consummated mergers between 2009 and 2014 found "small improvements in quality for some quality measures" following the merger, the majority of studies have not found similar results. (Noether & May, *Hospital Merger Benefits, a Review and Extension* (2018) Am. Hosp. Ass'n.) For instance, a study published in 2020 found that acquired hospitals' outcome measures did not improve post-merger. (Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions* (2020) 382 NEJM 51.) That study also found that patient experience measures worsened after a merger. (*Id*.) In California specifically, a study found that hospital mergers led to substantially increased mortality rates for patients with heart disease. (Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes* (2012) 47 Health

Servs. Rsch. 1008.) Provider merger enforcement cases have also uniformly found that alleged efficiencies do not outweigh competitive harms. (*See, e.g., F.T.C. v. Penn State Hershey Medical Center* (3d Cir. 2016) 838 F.3d 327; *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.* (9th Cir. 2015) 778 F.3d 775, 789; *F.T.C. v. OSF Healthcare System*, (N.D. Ill. 2012) 852 F. Supp. 2d 1069, 1089.) Furthermore, "no court yet has upheld a presumptively unlawful hospital merger based on the improvements in quality it would, or did, generate." (Miles, Healthcare and Antitrust Law (2021) Rebutting the prima facie case—Efficiencies § 12:18.)

C. Conditions Imposed by the California Attorney General Are Commonly Adopted in Antitrust Cases

The conditions imposed by the California Attorney General have been imposed before on other healthcare transactions with similar anticompetitive potential. While Petitioners attempt to distinguish those mergers from the Cedars-Sinai/Huntington affiliation, competitive impact conditions have been frequently imposed on a range of healthcare mergers that threaten anticompetitive harm. (*See, e.g.,* Final Order, *Commonwealth of Pa. v. Geisinger Health System Foundation, Bloomsburg Health System and Bloomsburg Hospital* (2012) No. 4:12-cv-01081; Final Order, *Commonwealth of Pa. v. Geisinger Health System Foundation, Lewiston Health Care Foundation* (2013) No. 1:13 CV-02647-YK; Berenson et al., *Addressing Health Care Market Consolidation and High Prices* (2020) Urban Inst. 28–31.) Importantly, as Dr. Vistnes contends, these conditions provide backstops to ensure that prices will not significantly rise, threatening to make the cost of healthcare unaffordable for the patients both hospitals serve. (R. 381.)

D. Petitioners' Claims that an All-or-Nothing Condition Would Have Been Sufficient Is Inaccurate

The Petitioners' repeated contention that their offer to prohibit all-or-nothing contracting would eliminate the potential for anticompetitive behavior post-merger is inaccurate. (Compl. ¶¶ 14, 21, 87.) While it would have prevented the Petitioners from effectively tying *all* their facilities or services together in negotiations with insurers, hospital systems can use their market

power to engage in de facto all-or-nothing contracting or other forms of tying that do not involve requiring an insurer to contract for every facility or service in the health system. (*See, e.g., Cascade Health Sols. v. PeaceHealth* (9th Cir. 2008) 515 F.3d 883, 912–916.) The authors of this brief have recently completed a two-year study of state competition policies including an in-depth analysis of anticompetitive contract clauses in insurer-provider contracts. (*See* Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets* (2020) The Source on Healthcare Price and Competition.) After analyzing healthcare contracting practices and state attempts to prevent anticompetitive behavior by systems with market power, this study concluded that a health system does not need to impose an all-or-nothing provision to leverage its market power across geographic and product markets. Instead, it needs to leverage the knowledge of the insurers' negotiations with other hospitals and providers within the system to create powerful incentives for an insurer to meet its price demands. For example, in the State's case against Sutter Health, it was alleged that if a health plan wanted to exclude a Sutter provider, Sutter would significantly raise the rates for their other contracted providers, making it more economically viable for the health plan to include that provider rather than pay the higher out-of-network rates in a form of de facto all-or-nothing bargaining. (Complaint, *People of the State of California ex rel Xavier Becerra v. Sutter Health* (Cal. Super. Ct. S.F. City and Cnty. 2019) CGC 18-565398.) While Sutter did not explicitly require all-or-nothing contracting, its pricing structure left insurers with few economically feasible alternatives. Furthermore, "the Supreme Court has condemned tying arrangements when the seller has the market power to force a purchaser to do something that he would not do in a competitive market." (*Cascade Health Sols. v. PeaceHealth*, *supra*, 515 F.3d at p. 915.) Under this definition, anticompetitive tying arrangements can include arrangements where a health system with market power leverages that power to force an insurer to contract for just some of the health system's providers or services the insurer did not want or pay higher prices for the ones they do want. A prohibition on all-or-nothing bargaining would not have eliminated the competitive concerns that can arise from arrangements that do not qualify as all-or-nothing bargaining.

VI. Conclusion

The risk of anticompetitive effects from cross-market mergers is real and substantial and the Attorney General has identified paradigmatic market conditions creating a risk of harm. The conditions imposed are based on sound economic analysis and are in keeping with restrictions customarily imposed on mergers that increase the risk of anticompetitive practices.

Addendum

Identities of *Amici Curiae*

Jaime S. King, J.D., Ph.D., is the John and Marylyn Mayo Chair in Health Law and Professor of Law at the University of Auckland, Faculty of Law, Senior Affiliate Scholar to the UCSF/UC Hastings, Consortium on Science, Law and Health Policy, and the Executive Editor of The Source for Health care Price and Competition.

Thomas L. Greaney, J.D., is a visiting professor at the University of California Hastings College of the Law and the Chester A. Myers Professor Emeritus at Saint Louis University School of Law.

Alexandra D. Montague, J.D., is a Health Policy Researcher at The Source for Healthcare Price and Competition at the University of California Hastings College of the Law.

Katherine L. Gudiksen, M.S., Ph.D., is a Senior Health Policy Researcher for The Source on Healthcare Price and Competition.

Amy Gu, J.D., is the Managing Editor of The Source on Healthcare Price and Competition.

Richard M. Scheffler, Ph.D., is a Distinguished Professor of Health Economics and Public Policy and Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

Brent D. Fulton, Ph.D., MBA, is an Associate Adjunct Professor of Health Economics and Policy, School of Public Health and Associate Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

Daniel R. Arnold, Ph.D., is an Assistant Research Economist in the School of Public Health and Research Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

DECLARATION OF SERVICE BY E-MAIL

Case Name: **Pasadena Hospital Association LTD dba Huntington Hospital and Cedars-Sinai Health System v. California Department of Justice, et al.**

Case No.: **21STCP00978**

I declare:
I am 18 years of age or older and not a party to the within action. I am employee of University California, Hastings. My business address is, 200 McAllister St., San Francisco, CA 94102.

On July 9, 2021, I served the attached:
APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF BY THE SOURCE ON HEALTHCARE PRICE AND COMPETITION AND AFFILIATED SCHOLARS AND [PROPOSED] BRIEF IN SUPPORT OF RESPONDENTS by transmitting a true copy via electronic mail as follows:

Andrew Baum
Glaser Weil Fink Howard Avchen & Shapiro LLP
10250 Constellation Blvd., 19th Floor
Los Angeles, CA 90067
Tel: (310) 282-6298
Email: abaum@glaserweil.com
Counsel for Petitioners Cedars-Sinai Health System and Pasadena Hospital Association Ltd. d/b/a Huntington Hospital

David Maas
Davis Wright Tremaine LLP
920 5th Avenue, Suite 3300
Seattle, WA 98104-1610
Tel: (206) 622-3150
Email: davidmaas@dwt.com
Counsel for Petitioners Cedars-Sinai Health System and Pasadena Hospital Association Ltd. d/b/a/ Huntington Hospital

Margaret H. Warner
Paul W. Hughes
McDermott Will & Emery LLP
500 North Capitol Street NW
Washington, DC 20001
Tel: (202)- 756-8000
Email: mwarner@mwe.com
phughes@mwe.com
Counsel for Petitioners Cedars-Sinai Health System and Pasadena Hospital Association Ltd. d/b/a/ Huntington Hospital

Jean Tom
Davis Wright Tremaine LLP
505 Montgomery Street, Suite 800
San Francisco, CA 94111
Tel: (415) 276-6538
Email: jeantom@dwt.com
Counsel for Petitioners Cedars-Sinai Health System and Pasadena Hospital Association Ltd. d/b/a/ Huntington Hospital

Seth E. Goldstein
Office of the Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244
Tel: (916) 210-6063
Email: Seth.Goldstein@doj.ca.gov
Counsel for Respondents California Department of Justice and Rob Bonta, in his official capacity as Attorney General of California

BY E-MAIL OR ELECTRONIC TRANSMISSION: Based on a court order or an agreement of the parties to accept service by e-mail or electronic transmission, by causing the documents to be sent to the persons at the e-mail addresses listed on the service list on the date below, from the court authorized efiling service at OneLegal.com. No electronic message or other indication that the transmission was unsuccessful was received within a reasonable time after the transmission.

I declare under penalty of perjury of laws of the State of California that the foregoing is true and correct. Executed at San Francisco, CA on July 9, 2021.

/s/ Mallory Warner
Mallory Warner