ALLISON A. DAVIS (State Bar No. 139203)
DAVIS WRIGHT TREMAINE LLP
505 Montgomery Street, Suite 800
San Francisco, California 94111
Telephone: (415) 276-6500
Facsimile: (415) 276-6599
Email: allisondavis@dwt.com

DOUGLAS C. ROSS (*Pro Hac Vice* Admission Pending)
DAVIS WRIGHT TREMAINE LLP
1201 Third Avenue, Suite 2200
Seattle, WA 98101
Telephone: (206) 622-3150
Facsimile: (206) 757-7700
Email: douglasross@dwt.com

Attorneys for *Amicus Curiae*
AMERICAN HOSPITAL ASSOCIATION

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE CITY AND COUNTY OF SAN FRANCISCO

PEOPLE OF THE STATE OF CALIFORNIA EX REL. XAVIER BECERRA, Plaintiff, vs. SUTTER HEALTH, Defendant.	NO. CGC-18-565398 Assigned for All Purposes To Hon. Curtis E.A. Karnow Dept. 304 **BRIEF OF AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION IN OPPOSITION TO CONSOLIDATION** Action Filed: March 29, 2018

TABLE OF CONTENTS

TABLE OF CONTENTS

Cases

Statutes

Other Authorities

I. INTRODUCTION AND INTEREST OF AMICUS CURIAE

The American Hospital Association (AHA) is a national organization that represents nearly 5,000 hospitals, health care systems, networks, and other providers of care, as well as 43,000 individual members. Hospitals and health systems operate in a highly regulated health care market that is continually evolving. The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 accelerated structural changes that have produced an unprecedented realignment in the provision of health care. Hospitals and physicians are in the midst of a shift from the traditional fee-for-service payment system to new and innovative reimbursement models that reward providers for improving patient outcomes and controlling the total cost of care provided. To succeed in this new era, health systems and payers alike must experiment and each must be free to use lessons it learns in one place to advance how it restructures care in another.

The federal and state antitrust enforcement agencies have recognized the importance of preserving competition—and promoting innovation—in this changing health care marketplace. The two federal agencies that enforce the antitrust laws, the Federal Trade Commission and the Department of Justice, often joined by their state counterparts, have challenged conduct and proposed acquisitions they believe present a substantial threat to competition. In those actions (whatever their individual merits) the federal enforcement agencies haven't sought behavioral remedies, such as rate regulation, enforced arbitration, or the like. The federal enforcers are justifiably skeptical that those remedies, which call on judges or arbitrators to predict the workings of the market without the resources, staff, and expertise available to a regulatory agency, can succeed. The federal agencies understand that such remedies can cause more harm than good.

The complaint the State has filed against Sutter Health initiating this action advances questionable claims similar to those made in pending private litigation filed against Sutter.[1] But the relief the State seeks—a series of mandatory injunctions that would fundamentally restructure how Sutter serves its communities —is radically different from the straightforward relief sought in

[1] *See UFCW & Employers Benefit Trust v. Sutter Health et al.*, No CGC 14-538451 (Superior Court, City and County of San Francisco) (filed April 7, 2014).

the private case. AHA at this time expresses no views on the merits of the State's dubious claims but strongly urges that the Court not combine this newly-filed case with the existing private litigation. Before the expensive, complex, and untried regulatory remedies the State seeks here are imposed on Sutter, the Court should consider carefully, after full discovery, the alleged need for—and the possible consequences of—that relief. Experts will need to be engaged to analyze what the effect would be on the availability, affordability, and safety of the health care system if it were to be restructured as the State urges. But fact discovery in the long-running private litigation closes August 31 of this year. This schedule doesn't provide Sutter with enough time to conduct the necessary discovery and to search for, and retain, the appropriate experts. If the State's ability to conduct appropriate discovery and retain experts is given short shrift, it isn't just Sutter that will suffer. AHA is concerned that a poorly structured remedy runs a serious risk of damaging the health care delivery system in northern California, inadvertently inflicting on consumers the very things the State professes it wants to avoid—increased health care costs, reduced access to care, and less innovation.

For these reasons AHA respectfully requests the Court not to consolidate the two cases.

II. DISCUSSION

A. The State's Case Seeks Unprecedented Relief that Warrants Close Scrutiny Separate from the Competing Concerns of a Longstanding Class Action

The State's case against Sutter seeks extraordinary equitable relief. Yet the State asks to move its case into the slipstream of a private class action that has been pending for over four years and that seeks very different, and much simpler, relief: a prohibitory injunction and money. The State acknowledges that the "Court (or Sutter) may be concerned about disruption in [the State's] case as it speeds to trial." Opening Br. at 4. AHA's concern isn't disruption but the serious risk, if the cases are combined, that the requested relief won't receive the careful consideration that is needed if the Court is properly to assess the consequences of that relief, including the impact it will have on the delivery of health care in northern California.

The relief sought by the State raises critical questions that command close, independent scrutiny on a separate schedule from the class action. ***First***, the State's requested relief would interfere with Sutter's ability to innovate that is critical to the success of value-based care models. ***Second***, the State requests relief that would create an expensive, complex regulatory regime that antitrust courts have long acknowledged they are ill equipped to administer. ***Third***, the State's requested relief is unprecedented for an antitrust enforcement action and contrary to prevailing views of appropriate antitrust enforcement.

1. The Requested Relief Would Undermine Innovation and the Movement to Value-Based Care

The Affordable Care Act strongly encourages providers and payers to innovate and to move to value-based payments to hospitals.[2] The Act was passed in order to address "[s]erious problems" that Congress saw in the provision of health care.[3] Those problems include payment systems that "encourage volume-driven care, rather than value-driven care [and] often penalize providers financially for keeping people healthy, reducing errors and complications, and avoiding unnecessary care." By enacting the ACA, Congress encouraged value-based reimbursement and encouraged providers to find new and innovative solutions to old problems.

AHA is strongly supportive of the efforts of its members and others in health care who are responding to the ACA's mandate and the demands of the public to experiment and find new ways to deliver care more efficiently and effectively. Health care executives and scholars are working to develop new ways to pay for care and to spread knowledge of new practices throughout the industry.[4] Value-based models create incentives for providers to hire care coordinators to manage the health needs of patients and to hire nurses who will visit patients after

---

[2] *See* Bruce Fried & David Sherer, *Value Based Reimbursement: The Rock Thrown into the Health Care Pond*, Health Aff. Blog (July 8, 2016), *available at* http://healthaffairs.org/blog/2016/07/08/value-based-reimbursement-the-rock-thrown-into-the-health-care-pond/.

[3] Harold D. Miller, *From Volume To Value: Better Ways To Pay For Health Care*, 28 Health Aff. 5, 1418, 1418 (Sept./Oct. 2009) (footnote omitted), *available at* http://content.healthaffairs.org/content/28/5/1418.full.pdf+html..

[4] *See, e.g.*, Rob Houston, *Maintaining the Momentum: Using Value-Based Payments to Sustain Provider Innovations*, Ctr. for Health Care Strategies (Mar. 14, 2016), *available at* http://www.chcs.org/maintaining-the-momentum-using-value-based-payments-to-sustain-provider-innovations/.

discharge from the hospital to ensure they are taking their medications and have appropriate home care.[5] These simple steps can promote patient wellbeing while simultaneously lessening the chance of expensive readmissions to the hospital.[6] This movement has been ushered in through a mix of innovation and collaboration on both sides of payer-provider contracting process.

The relief the State seeks may seriously jeopardize efforts by Sutter to implement value-based care models. For example, the State asks the Court to force Sutter to hire separate negotiating teams to handle negotiations with each of the payers with which Sutter deals. Most health care systems deal with many payers. Sutter is no exception. So, if Sutter works with ten payers then, if the State gets its way, Sutter must hire ten negotiating teams, instead of letting one do the job. The State also seeks an order forbidding the different negotiating teams "from communicating with each other directly or indirectly."[7] This relief, if granted, would cause havoc to Sutter's efforts to move from fee-for-service reimbursement to value-based care through greater collaboration and innovation in payer contracting. Within a health system such as Sutter, those charged with payer negotiations work with payers to develop innovative, value-based reimbursement systems. A negotiator may learn from one payer of new ways to deliver better care more efficiently that it would like to suggest to another payer. As the courts noted when reviewing the recent proposed merger of Anthem and Cigna, not all payers are alike or equally interested in value-based arrangements.[8] In that case, the district and appellate courts both recognized that Cigna was renowned for its innovative approaches to providers to work collaboratively with them on value-based payment methods.[9] Anthem had no such reputation

---

[5] *See, e.g.*, Richard B. Salmon, et al., *A Collaborative Accountable Care Model In Three Practices Showed Promising Early Results On Costs And Quality of Care*, 31 Health Aff. 11, 2379, 2380 (Nov. 2012), *available at* http://content.healthaffairs.org/content/31/11/2379.full.pdf+html.

[6] *Id.*; *see also* Aparna Higgins, et al., *Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers*, 30 Health Aff. 9, 1718, 1727 (Sept. 2011), *available at* http://content.healthaffairs.org/content/30/9/1718.full.pdf+html.

[7] Complaint, Prayer for Relief, at E. 2.

[8] *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 230-31 (D.D.C. 2017); *United States v. Anthem, Inc.*, 855 F.3d 345, 350 (D.C. Cir. 2017).)

[9] *United States v. Anthem, Inc.*, 236 F. Supp. 3d at 230 (discussing how Cigna differentiated itself using innovative, value-based models "because its provider discounts were not as strong as other carriers' discounts, particularly those offered by Anthem and the Blues"); *United States v. Anthem, Inc.*, 855 F.3d 345, 350 (D.C. Cir. 2017) ("Cigna's provider discounts have generally not been as good, so Cigna has developed a different and innovative value

(quite the opposite in fact).[10] If the State gets the relief it seeks here, should a Sutter negotiator in the future learn of an innovative, cost-saving way to better pay for care from Cigna, that negotiator must keep the news to herself. Sharing the information with Sutter's Anthem negotiator would be a clear violation of the terms of the order the State urges be imposed on Sutter.

AHA is concerned that the relief the State seeks will slow the movement towards value-based care in one significant health care system. This could increase the cost of health care in northern California, reduce access, delay overdue innovation, and possibly encourage other plaintiffs to seek similarly harmful remedies in cases filed elsewhere. AHA respectfully suggests that if the Court is to consider the relief the State wants to impose here, it should allow the parties to develop a full record, first in discovery and then at trial, of what effects the proposed remedies are likely to have, and whether there might be better, more narrowly-tailored remedies available. That can only be done on a schedule designed for this case, not by grafting this case onto the four-year-old private class action.

2. The Requested Relief Would Impose an Inefficient, Complex, Regulatory Regime

The State seeks to impose relief that would add layers of cost and administrative burden to the already complex regulatory framework in which hospitals and health systems operate. In addition to requiring that Sutter hire multiple negotiating teams, the State would require that all these teams work at different times and conclude contracts with payers on a staggered basis. All this would be subject to oversight of a third party trustee. No hospital system negotiates this way. And for good reason: it would be unnecessarily expensive and inefficient. Payer contracting departments rely on more than just negotiators. There are actuarial staff, financial analysts, and other personnel involved. The State's proposal would likely require Sutter to multiply its payer contracting staffs by orders of magnitude to provide staff to support separate negotiators, all at

---

proposition in order to compete for customers. Under its more collaborative arrangements with providers, and through the integrated, customized wellness programs it offers its customers' employees, Cigna's focus is on reducing employees' utilization of expensive medical procedures and promoting wellness through behavioral supports and lifestyle changes. This offers customers a different means of lowering health care costs than the traditional model relying heavily on provider discounts.").

[10] *Id.*

massive increase in the cost of doing business. In a time when health care costs continue to escalate, requiring additional administrative staff would only hurt, not help this trend.[11]

The complex, regulatory regime the State seeks to impose on Sutter resembles regulation more commonly seen administered by an expert state agency (and imposed on all market participants, not just one). In fact, the California legislature currently is considering a bill that would create a California Health Care Cost, Quality, and Equity Commission to address many of the same issues the State seeks to address here under the guise of antitrust enforcement.[12] Not surprisingly, given the complex dynamics of the health care industry, the drafters of the bill propose that the commission be comprised of a cohort of experts with diverse backgrounds, including the following:

> (A) One individual with demonstrated expertise in health care policy.
> (B) One individual with demonstrated expertise in health care delivery.
> (C) One health economist.
> (D) One consumer advocate.
> (E) One individual with demonstrated expertise in health care financing, including alternative payment methodologies.
> (F) One representative of a labor union organization who serves as a trustee of a trust fund organized under state or federal law.
> (G) One representative of an organization of employers with demonstrated expertise in health care purchasing.
> (H) One physician.
> (I) One individual with experience in hospital administration.[13]

The State effectively requests that the Court appoint a regulatory czar whose remit runs to Sutter alone, but who will not have the staff, resources, or discretion needed for regulation to do more

---

[11] *See, e.g.*, National Health Care Spending, Centers for Medicare & Medicaid Services, Office of the Actuary, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE-Presentation-Slides.pdf. (discussing ongoing increase in the cost of health care as a percent of gross domestic product)

[12] *See* California Bill 3087, California Health Care Cost, Quality, and Equity Commission ("An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage."), *available at* http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB3087. AHA takes no position in this brief on the wisdom of that bill.

[13] *Id.* The initial draft of AB 3087 included nine members on the commission. A subsequent amendment increased the number to eleven. *Id.* at 100601(a)

good than harm. The Court should proceed cautiously before accepting this deeply flawed invitation.

3. The Requested Relief is Unprecedented and At Odds with Current Antitrust Enforcement Policy

The State seeks behavioral relief far beyond the bounds traditionally sought by antitrust enforcers. The federal antitrust enforcement agencies (DOJ and FTC) have long been skeptical of such relief. More than a decade ago, for example, DOJ's Antitrust Division said that in merger cases, anticompetitive mergers should be blocked (unless the parties are willing to divest the businesses that cause the anticompetitive problem) and conduct remedies should be resisted: "A conduct remedy … typically is more difficult to craft, more cumbersome and costly to administer, and easier than a structural remedy to circumvent."[14]

While DOJ has occasionally approved conduct remedies, the current head of the Antitrust Division recently emphasized that antitrust enforcers should avoid them and explained why:

> When competition policy works well, it maintains economic liberty and leaves decision-making to the markets. As Bork explained: "Antitrust was originally conceived as a limited intervention in free and private processes for the purpose of keeping those processes free." Our goal in remedying unlawful transactions should be to let the competitive process play out.
>
> Unfortunately, behavioral remedies often fail to do that. Instead of protecting the competition that might be lost in an unlawful merger, a behavioral remedy supplants competition with regulation; it replaces disaggregated decision making with central planning. That concern was one of the core insights of the 2004 Remedies Guidelines, which were issued while I was last at the Antitrust Division. As the report notes, "conduct remedies generally are not favored in merger cases because they tend to entangle the Division and the courts in the operation of a market on an ongoing basis and impose direct, frequently substantial, costs upon the government and public that structural remedies can avoid."[15]

[14] *See* Dep't of Justice, Antitrust Division Policy Guide to Merger Remedies 4 (2004), available at http://www.justice.gov/atr/public/guidelines/205108.pdf.

[15] *See* Assistant Attorney General Makan Delrahim Keynote Address at the American Bar Association's Antitrust Fall Forum, Nov. 16, 2017, *available at* https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-keynote-address-american-bar.

Assistant Attorney General Delrahim used arbitration on price as a prime example of behavioral relief contrary to the goals of antitrust enforcement:

> Like any regulatory scheme, behavioral remedies require centralized decisions instead of a free market process. They also set static rules devoid of the dynamic realities of the market. With limited information, how can antitrust lawyers hope to write rules that distort competitive incentives just enough to undo the damage done by a merger, for years to come? I don't think I'm smart enough to do that.
>
> Behavioral remedies often require companies to make daily decisions contrary to their profit-maximizing incentives, and they demand ongoing monitoring and enforcement to do that effectively. It is the wolf of regulation dressed in the sheep's clothing of a behavioral decree. And like most regulation, it can be overly intrusive and unduly burdensome for both businesses and government.
>
> Take so-called arbitration remedies as an example. Rather than permitting price to act as a carrier of information in the market as Hayek described, this type of remedy puts the arbitration backdrop in charge. The arbitrator will certainly have limited information—he or she has no more capability than any central planner—yet the expected arbitration outcome will overshadow every negotiation and distort the competitive process.

Here, the State asks the Court to impose a long list of complex behavioral remedies, including arbitrations on rates. As the head of the Antitrust Division stated, arbitrators work with limited information. The information deficit an arbitrator charged with supervising Sutter would face would be massive. Payer contracting is a highly complex process that requires depth and breadth of expertise that likely no individual arbitrator could possibly have. It is unclear how the Court could set up and supervise a system that would give arbitrators access to the information (let alone the expertise) necessary to make informed and impartial decisions. The Court shouldn't be rushed to a decision on whether to impose this behavioral remedy simply because there is a preexisting class action.

* * *

There are many other troublesome aspects of the relief the State requests in its complaint that require careful thought before they are imposed on Sutter. For example, the State asks that Sutter be prevented from raising rates at any newly acquired or affiliated facilities for a substantial

period of time.[16] This "remedy" flies in the face of fundamental principles of economics and antitrust. When a health system acquires a hospital or other facility it often requires an investment of resources to raise the standard of care at the acquired facility. Spending this money is a good thing, not a bad thing. But an increase in quality may require a concomitant increase in price. The enforcers and courts recognize that prices should be looked at on a quality-adjusted basis.[17] It's also possible that a less sophisticated facility may not have good information on market prices or may be negotiating poorly—leaving "money on the table." If a more sophisticated health care system buys the small facility and raises prices there, that is not anticompetitive—as the federal antitrust agencies recognize.[18] But the blunderbuss approach advocated by the State would force Sutter to forego all price increases for a period of time after an acquisition, even when those are not anticompetitive and even when they're necessary to raise the quality of the acquired facility. The Court should proceed with great caution before adopting the State's proposals and this again militates in favor of keeping the State's lawsuit separate from the private class action litigation.

III. CONCLUSION

The extraordinary relief the State seeks in this case raises unique, important questions that will have an effect on not just on Sutter, but on patients across northern California, and potentially beyond, because other enforcers will look to this case to see what relief the Court approves here. The relief threatens to increase health care costs and so ultimately to force patients to pay more in return for less. The relief threatens to forestall as well the introduction of innovative payment systems that can improve value. Before the Court imposes such relief it will want clearly to

---

[16] Compl. Prayer for Relief E(8).

[17] *See, e.g.*, Remarks of Deborah Feinstein, Sept. 18, 2015, *available at* https://www.ftc.gov/system/files/documents/public_statements/802381/150918gcrspeech.pdf. In the DOJ's case against the Anthem/Cigna merger, the district court found that it "takes a higher level of compensation to encourage and enable physicians and hospitals to participate in the arrangements that are aimed at lowering utilization and are central to the value based approach and medical cost trend guarantees." *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 242 (D.D.C. 2017), *aff'd* , 855 F.3d 345 (D.D.C. 2017).

[18] *See, e.g.*, In re ProMedica Health Sys., Opinion of the Commission, Docket. No. 9346,at 31 *available at* https://www.ftc.gov/sites/default/files/documents/cases/2012/03/120328promedicabrillopinion.pdf (finding that smaller hospital acquired by ProMedica could have obtained better rates on its own), *aff'd ProMedica Health Sys., Inc. v. F.T.C.*, 749 F.3d 559 (6th Cir. 2014).

understand the cost this relief would impose on Sutter, how the requested relief is an answer to an antitrust problem, and whether there is evidence that the relief actually will lower cost and improve quality. Only then can the Court decide that benefit of the relief sought isn't wildly speculative and likely would outweigh the certain, additional expense the requested relief would impose. Discovery tailored to this case is needed, as are experts who can analyze and testify on the unprecedented relief sought here. It will take significant time to develop the necessary facts and expert testimony. To ensure careful consideration of these important issues, AHA respectfully requests that the Court deny the State's request to consolidate its case with the private litigation.

Dated: May 1, 2018

Respectfully submitted,

/s/ Allison A. Davis

Allison A. Davis
Douglas C. Ross (*pro hac vice* admission pending)
Davis Wright Tremaine LLP
505 Montgomery Street, Suite 800
San Francisco, CA 94111
allisondavis@dwt.com
douglasross@dwt.com

-and-

Melinda Reid Hatton
American Hospital Association
800 Tenth Street, N.W.
Two City Center, Suite 400
Washington, D.C. 20001

Counsel for Amicus Curiae American Hospital Association