Olivia M. Kim, State Bar No. 228382
WILSON SONSINI GOODRICH & ROSATI
Professional Corporation
633 West Fifth Street, Suite 1550
Los Angeles, CA 90071-2027
Telephone: (323) 210-2900
Facsimile: (866) 974-7329
Email: okim@wsgr.com

Attorneys for Amici Curiae American Hospital Association, Association of American Medical Colleges, and California Hospital Association

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 [Assigned for all purposes to the Hon. James Chalfant, Dept. 85] **APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF BY THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND CALIFORNIA HOSPITAL ASSOCIATION AND [PROPOSED] BRIEF IN SUPPORT OF PETITIONERS** Action Filed: March 30, 2021

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

Amici curiae the American Hospital Association, Association of American Medical Colleges, and California Hospital Association respectfully apply to this Court for permission to file the attached 10-page brief in support of Petitioners Pasadena Hospital Association Ltd., operating Huntington Memorial Hospital, and Cedars-Sinai Health System and their petition for writ of mandate. *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 briefs with the Court's permission. *See, e.g.*, In re Veterans' Industries, Inc. (1970) 8 Cal. App. 3d 902, 924-25.

STATEMENT OF INTEREST

The American Hospital Association ("AHA") is a national organization that represents nearly 5,000 hospitals, healthcare systems, networks, and other providers of care, including 314 members in California, as well as 43,000 individual members. AHA members are committed to improving the health of the communities that they serve and to helping ensure that care is available to and affordable for all Americans. The AHA provides extensive education for health care leaders and is a source of valuable information and data on health care issues and trends. It ensures that members' perspectives and needs are heard and addressed in national health-policy development, legislative and regulatory debates, and judicial matters.

The Association of American Medical Colleges ("AAMC") is a national, not-for-profit association that represents and serves all 155 accredited U.S. medical schools (including the 13 schools in California), more than 400 major teaching hospitals and health systems (including 30 members in California), and more than 70 academic societies. Through these institutions and organizations, the AAMC represents 179,000 faculty members, 92,000 medical students, and 140,000 resident physicians. The AAMC leads and serves the academic medicine community to improve the health of people everywhere. The AAMC is dedicated to transforming health through medical education, health care, medical research, and community collaborations. In addition, one of the AAMC's core missions is to advocate on behalf of its members and patients in connection

with national health-policy matters.

The California Hospital Association ("CHA") is a nonprofit organization dedicated to representing the interests of California hospitals and the patients they serve. CHA represents more than 400 acute care hospital and health system members and 94 percent of the patient beds in California, including general acute care hospitals, rural hospitals, psychiatric hospitals, academic medical centers, county hospitals, investor-owned hospitals, and multi-hospital health systems. These hospitals furnish vital health care services to millions of our state's citizens. CHA provides its members with state and federal representation in the legislative, judicial, and regulatory arenas, in an effort to improve health care quality, access, and coverage; promote health care reform and integration; achieve adequate health care funding and contain costs; improve and update laws and regulations; and maintain public trust in health care. CHA often participates as an *amicus curiae* in cases that have a substantial impact on hospitals and health systems.

Within the rapidly changing healthcare sector, hospital mergers and affiliations often provide significant benefits to patients and communities by allowing hospitals to lower their costs, improve quality, and deliver more integrated and innovative care to communities. Many of the AHA, AAMC, and CHA's members are or will be parties to such mergers and affiliations, including transactions in California; the *amici* therefore have a strong interest in ensuring that the standards used to evaluate hospital transactions and affiliations comport with well-accepted methods of economic analysis and market realities, rather than novel, speculative theories that lack a sound legal, economic, or factual basis. Relatedly, the *amici* have an interest in ensuring that the Office of the California Attorney General applies standards that are objective and predictable so that their members can make informed judgments about pursuing transactions.

HOW THIS BRIEF WILL ASSIST THE COURT

Amici respectfully contend that the proposed brief will assist the Court by addressing two issues: (1) how hospital transactions that involve community hospitals benefit patients and communities in California and elsewhere; and (2) the analytical flaws and arbitrariness in the approach that the Office of the California Attorney General and its retained economist use to analyze the petitioners' affiliation's likely competitive effects and justify the onerous conditions

placed on the transaction. *Amici*'s members have significant experience and expertise with hospital mergers and affiliations, and the resulting cost savings and innovative care that such transactions can produce.

STATEMENT REGARDING PREPARATION OF THIS BRIEF

No party or counsel in the pending case authored the proposed *amicus curiae* brief in whole or in part, or made any monetary contribution intended to fund the preparation or submission of the brief. No person or entity other than the proposed *amici* and their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

Counsel for Petitioners Pasadena Hospital Association Ltd. and Cedars-Sinai Health System consent to the filing of this application and proposed *amicus curiae* brief. Counsel for Respondents California Department of Justice and Rob Bonta, in his official capacity as Attorney General of California, take no position on the filing of this application and proposed *amicus curiae* brief.

For the foregoing reasons, *amici* respectfully request that the Court grant this application to file the attached *amicus curiae* brief in support of Petitioners' petition for writ of mandate.

Dated: May 27, 2021

WILSON SONSINI GOODRICH & ROSATI
Professional Corporation

By: */s/ Olivia M. Kim*
Olivia M. Kim

Attorneys for Amici Curiae American Hospital Association, Association of American Medical Colleges, and California Hospital Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

MISCELLANEOUS

I. Introduction

The onerous conditions that the Office of the California Attorney General ("OCAG") seeks to impose on the affiliation between Cedars-Sinai Health System ("CSHS") and Pasadena Hospital Association ("Huntington") (the "Affiliation") are arbitrary and unwarranted. The expert on which the OCAG exclusively relies for its decision concedes in his affidavit that (1) CSHS and Huntington do *not* materially compete; and (2) he has not determined that the transaction is likely to produce anticompetitive effects. Gregory Vistnes, Competitive Effects Analysis 2-3 (Dec. 20, 2020) (AG Decision, ex. 4) ("Vistnes Report"). Nor could the expert make this determination because he also concedes that he has not tried to analyze whether the transaction will produce benefits for consumers. *Id.* at 1 n.3.

The OCAG and its expert's sole basis for the onerous conditions is a novel "theory" of "cross-market" effects. Moreover, there is no established methodology to apply the theory to a specific merger or accepted principles to cabin its use. And the theory is so malleable that the OCAG could use it to block or modify Huntington's affiliation with many major hospital systems. If approved by this Court, such wide-ranging, arbitrary authority would produce substantial uncertainty in the hospital sector and deter transactions that would benefit patients and communities throughout California.

II. Affiliations Between Community Hospitals and Academic Medical Centers Bring Substantial Benefits to Patients

For decades, hospitals and health professionals have worked to improve patient outcomes and lower the costs of care by reducing fragmentation in the delivery of health care. Affiliations with hospital systems are effective ways for community hospitals to lower costs and improve clinical care while preserving access to care in underserved communities. Huntington is seeking these benefits through the Affiliation with CSHS, but the OCAG's action puts the Affiliation and other beneficial transactions in California at risk. *See* Compl. ¶ 48 (quoting the OCAG's analysis that Huntington would "be at a competitive disadvantage" if it remains a standalone hospital compared to "more integrated health care systems").

In contrast to the theoretical and speculative harms posited by the OCAG's economist,

economic research supports Petitioners' position that the planned Affiliation will expand access and improve patient care for the Los Angeles communities the facilities serve. The research shows that community hospitals partnering with hospital systems provide measurable benefits to patients: lower healthcare costs, improved patient care, and better access to providers. *See* Monica Noether, Sean May & Ben Stearns, Charles River Assocs., Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis – An Update 1 (2019).[1]

A. Operating Expense Reductions

Decreasing inpatient admissions and lower government reimbursement rates challenge community hospitals' financial stability, potentially reducing access to care for their communities. Huntington is similarly positioned, with negative operating income over the past five years according to the OCAG's contracted analysis. Compl. ¶¶ 5, 46. Over the period 2004 to 2014, inpatient admissions at community hospitals fell by 5.8% and the number of inpatient days declined by 8.7%. Monica Noether & Sean May, Charles River Assocs., Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis 3 (2017).[2] At the same time, Medicare and Medicaid reimbursement rates continue to fall below hospitals' actual costs: combined underpayments were $75.8 billion in 2019. Am. Hospital Assoc., Underpayment by Medicare and Medicaid Fact Sheet (Jan. 2021).[3]

Affiliations with larger hospital systems can provide community hospitals like Huntington the scale and resources to decrease costs. Increased administrative and operating efficiencies and reduction of redundant services contribute to merger-specific reductions in the cost of care. *See* Margaret E. Guerin-Calvert & Jen A. Maki, FTI Consulting, Hospital Realignment: Mergers Offer Significant Patient and Community Benefits 2 (2014).[4] Hospital mergers between 2009 and 2014 "were associated with a 2.5 percent reduction in operating expense per admission at the acquired hospitals." Noether & May at 14. Extending the analysis through 2017 found a 2.3% reduction

[1] https://media.crai.com/wp-content/uploads/2020/09/16164319/CRA-report-merger-benefits-2019-FINAL.pdf
[2] https://media.crai.com/wp-content/uploads/2020/09/16164320/Hospital-Merger-Full-Report-FINAL-1.pdf
[3] https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf
[4] https://www.ftc.gov/system/files/documents/public_comments/2014/05/00202-90180.pdf

in operating expenses per admission at acquired hospitals, with hospital systems reporting total expense savings of about 1.5% to 3.5% through consolidation of administrative and supply chain operations. Noether, May & Stearns at 1, 3; *see also* Matt Schmitt, Do Hospital Mergers Reduce Costs?, 52 J. Health Econ. 74 (2017) (finding statistically significant cost reductions at acquired hospitals averaging between 4% and 7%).[5]

Additional substantial savings come from improved IT systems and advanced data analytics. Consolidated hospital systems can better invest in IT infrastructure for both clinical and financial data that they utilize to identify best practices for quality care that is more cost-effective and streamlined. Noether, May & Stearns at 4. These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals. Noether & May at 5. Hospital systems can spread the costs over a larger patient population while also performing more sophisticated analyses, given the larger patient database, to identify patterns and improve care. Noether, May & Stearns at 3-4. That is the case for the planned Affiliation: Petitioners project anticipated cost savings from combined administrative and backend infrastructure, shared electronic medical records system, joint purchasing, and research collaborations. *See* Compl. ¶ 4.

Moreover, hospitals realize the cost benefits of mergers quickly, with hospitals largely reporting reduced operating expenses one year after the merger. Clark Knapp et al., Deloitte Ctr. for Health Solutions, Hospital M&A: When Done Well, M&A Can Achieve Valuable Outcomes 5 (2017).[6] And the benefits last, with one study finding cost savings still evident four years after consummation of the merger, and another finding lower cost growth rates and lower price growth rates at merging hospitals compared to non-merging hospitals over an extended period. Guerin-Calvert & Maki at 18.

B. Capital Investments and Resource Allocation Efficiencies

Financially distressed community hospitals often cannot recruit clinical staff, upgrade technology, or offer specialty services. Noether, May & Stearns at 5. Nearly half of hospitals report putting capital projects on hold. Guerin-Calvert & Maki at 11. Like CSHS, acquiring

[5] http://www.anderson.ucla.edu/Documents/areas/fac/strategy/Schmitt_HospitalMergersCosts.pdf
[6] https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf

hospitals often provide capital infusions to community hospitals to address funding issues, as evidenced by the almost 80% of respondents in one survey who reported significant capital investments in the acquired hospital. Knapp et al. at 3. These capital infusions allow the acquired hospital to restart planned projects or undertake new investments in staff, technology, or facilities, not only preventing closure of the hospital or certain service lines but possibly improving quality of service and patient welfare. Guerin-Calvert & Maki at 16, 19.

The Affiliation will provide beneficial capital to Huntington. The Petitioners' filings state that CSHS will provide up to $300 million of non-operating cash funding for overdue capital projects to improve patient care, safety, and access, including retrofitting buildings, expanding ambulatory services capabilities, implementing a new electronic health records system, and recruiting physicians to maintain and improve service levels. Compl. ¶¶ 5, 43; *see id.* ¶ 113 (improved bond rating for Huntington conditional on the Affiliation).

Hospital transactions can also help improve resource allocation and address resource constraints, including physical space, capital, and personnel. Guerin-Calvert & Maki at 15. With reduced patient volumes, community hospitals often have excess capacity, which can impair their financial performance and access to capital. Noether & May at 6. Academic medical centers, in contrast, often have capacity constraints because communities look to them not only for tertiary and quaternary services—including neurosurgery, severe burn treatment, cancer care, advanced neonatology, and transplantation—but also for less specialized services. *Id*.

Mergers and affiliations realign these resources to better meet community needs. Guerin-Calvert & Maki at 14. Integration of lower-cost community hospitals with high-throughput academic medical centers allows the system to optimize service mix to the most appropriate and cost-effective settings of care. Thomas Enders (Manatt Health) & Joanne Conroy (Assoc. Am. Med. Colleges), Advancing the Academic Health System for the Future 26 (2014).[7] Patients who need less complex services would be treated at community hospitals, which eases capacity constraints at the academic medical center, drives down costs, and often provides a more

[7] https://www.manatt.com/uploadedFiles/Content/2_Our_People/Enders,_Thomas/AdvancingtheAcademicHealthSystemfortheFuture_AAMC_Mar2014_Paper.PDF

convenient location for the patients. *See id.* at 6, 26; Noether & May at 6. The academic medical center could then devote existing space for tertiary and quaternary services not available at community hospitals without new capital investments. Noether, May & Stearns at 6.

C. Quality Improvements

Finally, mergers and affiliations provide community hospitals the scale needed to utilize sophisticated data analytics, identify best practices, and implement innovations such as telemedicine that improve access and patient outcomes. *Id*. at 4-5. The Petitioners' anticipated benefits from sharing best practices, new technologies, population health programs, and clinical training are empirically supported by prior hospital transactions. *See* Compl. ¶¶ 4, 50. Researchers found statistically significant improvements in the 30-day readmission rates and mortality rates at acquired hospitals, using CMS data for heart attack, heart failure, and pneumonia patients. Noether, May & Stearns at 12. Other quality improvements following a hospital acquisition include increased HCAHPS scores,[8] reduced readmissions, reduced appointment wait times, and reduced mortality. Knapp et al. at 8. And acquired hospitals improved their Leapfrog Hospital Safety Grade by a median of one grade category. Gay Casey et al., Berkeley Research Grp., Hospital Mergers and Acquisitions — Studying Successful Outcomes 7 (2020).[9]

III. The OCAG Conditions Are Based on an Affidavit from Dr. Vistnes that Fails to Apply Established Economic Methodologies

The OCAG's sole basis for its onerous conditions is an affidavit prepared by Dr. Vistnes of Charles River Associates. Dr. Vistnes hypothesizes a loss of competition from the novel theory of "cross-market" effects. Critical for assessing the arbitrariness of the OCAG's decision is that neither Dr. Vistnes nor any of the theory's proponents have developed an economic methodology to determine if the hypothesized effects are likely to occur for a given transaction. This gap is disqualifying. As Dr. Vistnes has written, there is no evidence that "most (or even many) [cross-market] mergers should raise competitive concerns or a presumption of competitive harm."

---

[8] The Hospital Consumer Assessment of Healthcare Providers and Systems survey ("HCAHPS") is a national, standardized, publicly reported survey of patients' perspectives of hospital care administered by CMS.

[9] https://www.thinkbrg.com/insights/publications/hospital-mergers-acquisitions-juniper/

Gregory Vistnes & Yianis Sarafidis, Cross-Market Hospital Mergers: A Holistic Approach, 79 Antitrust L.J. 253, 259 (2013).[10] Indeed, given the lack of an implementing methodology for the cross-market effects theory, there is doubt that Dr. Vistnes's opinions would be admissible under Evidence Code sections 801 and 802. *See Sargon Enters., Inc. v. Univ. of S. Cal.*, 55 Cal. 4th 747, 769 (2012) ("Expert testimony must not be speculative . . . .").

A. Dr. Vistnes Concedes that He Does Not Know Whether the Transaction Is Likely to Harm Patients or Communities

Dr. Vistnes concedes that "the proposed affiliation is unlikely to significantly reduce direct competition" because the parties generally do not compete with each other. Vistnes Report at 2. This finding ends most objective competition-based investigations of a transaction because the purpose of the antitrust laws is to prevent reductions in competition. *See* 15 U.S.C. §§ 1 & 18. The Federal Trade Commission apparently agreed because it rapidly approved the Affiliation.

Dr. Vistnes nonetheless asserts that the Affiliation "pos[es] a real *risk* of cross-market effects" although he concedes in the same sentence that "the *likelihood*, and likely *magnitude*, of cross-market effects is unclear." Vistnes Report at 3. In other words, Dr. Vistnes admits that he does not know the *probability* that the transaction will harm anyone, the *amount* of any potential harm, or the *amount* of offsetting benefits. *See id.* at 1 n.3. These concessions are fatal as a matter of antitrust law. *See, e.g.*, *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 622-23 (1974) (Clayton Act § 7 "deals in probabilities, not ephemeral possibilities"). And they should be fatal here because they reflect the arbitrariness of the OCAG's decision.

B. Dr. Vistnes's Cross-Market Effects Theory Provides No Reliable Basis for this Court to Reject Petitioners' Challenge to the OCAG's Decision

Dr. Vistnes attempts to leverage the few academic papers that have analyzed the cross-markets theory to bolster his speculative opinions. His efforts are deficient.

1. Dafny, Ho, and Lee – Cross-Market Common Customers

Dr. Vistnes heavily relies on a 2019 paper by Dafny, Ho, and Lee ("Dafny Paper"). The

[10] https://media.crai.com/sites/default/files/publications/Cross-market-hospital-mergers-a-holistic-approach.pdf

authors use a dataset of 144 ostensible cross-market hospital transactions and find that prices were on average 7% to 10% higher for those hospitals than prices for hospitals in a control group. The Dafny Paper[11] proposes that the price effects *might* be caused by the presence of "common customers": employers with employees in multiple antitrust geographic markets who choose one health plan for all their employees and so want a network that includes hospitals in the different geographic markets. Dafny Paper at 294. The authors posit that combining non-competing hospitals from different geographic markets could conceptually allow the merged entities to raise prices to insurers who serve such common customers. *Id.* at 294-95.

The Dafny Paper has significant limitations, as other economists have observed. *First*, the Dafny Paper is "largely agnostic" as to *why* or *how* the cross-market mergers produced the alleged price effects. Vistnes Report at 19; *see* Dafny Paper at 315 (citing the need for research to model the "links between and among insurance choice, insurance competition, and hospital-insurer bargaining"). This gap should make the theory unusable here. *See New York v. Deutsche Telekom AG*, 439 F. Supp. 3d 179, 245 (S.D.N.Y. 2020) ("Anticompetitive . . . effects of a merger do not just 'happen'; they are not self-executing outcomes spontaneously set in motion . . . .").

Second, the theory requires that the merging hospitals operate in distinct geographic markets. But the Dafny Paper uses only rough proxies to identify transactions that might involve facilities in different markets. This is insufficient in antitrust cases and reflects the potential arbitrariness of applying the theory here. *See Flagship Theatres of Palm Desert, LLC v. Century Theatres, Inc.*, 55 Cal. App. 5th 381, 413 (Cal. Ct. App. 2020) (to assess "[d]irect evidence of anticompetitive effects . . . we must first define the relevant market" (quotation omitted)).

Third, the Dafny Paper focuses only on nominal prices charged to insurance companies. Like Dr. Vistnes here, the authors did not attempt to analyze whether the transactions at issue would improve clinical outcomes, provide cost savings, or generate other benefits to *patients*. *See* Dafny Paper at 303-04, 310.

Fourth, and critically, the Dafny Paper provides no *methodology* to analyze a specific

[11] Leemore Dafny, Kate Ho & Robin S. Lee, The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry, 50 RAND J. Econ. 286 (2019).

merger using the cross-market effects theory, a fact that Dr. Vistnes concedes: "the [common customer] . . . cross-market theories are limited with respect to their ability to identify which particular cross-market mergers are likely to cause harm." Vistnes Report at 21 n.82; Vistnes & Sarafidis at 259 n.24 ("We believe that given the premature state of [cross-market] 'theory' . . . we would be overreaching if we used our two models to predict where and when cross-market mergers may be problematic and to identify the determinants of the magnitude of the potential problem."); *see also* Michael J. Perry & Matthew B. Adler, Antitrust Enforcement Policy for Cross-Market Health Care Mergers, 83 Antitrust L.J. 483, 495 (2020) (quoting Dr. Vistnes's presentation on cross-market effects to the American Health Lawyers Association, where he cautioned it "appears to be more difficult to prove the theory than to tell the story").[12]

The lack of a rigorous implementing methodology would make the cross-market theory inadmissible in many proceedings and warrants rejecting the OCAG's reliance on it here. *See, e.g.*, *Sargon Enters.*, 55 Cal. 4th at 781 (affirming exclusion of expert testimony because of "lack of sound methodology in the expert's testimony for determining what the future would have brought"); *Olive v. Gen. Nutrition Ctrs., Inc.*, 30 Cal. App. 5th 804, 820 (Cal. Ct. App. 2018) (affirming exclusion when expert opined on causal connection "without identifying any reliable evidence linking" the events); *Buck v. Ford Motor Co.*, 810 F. Supp. 2d 815, 825-26 (N.D. Ohio 2011) (excluding expert testimony based on an "untested" hypothesis because "even if plausible," it was "not reliably applied").

Dr. Vistnes tries to overcome the lack of an established implementing methodology for the common customer theory by identifying several self-selected "plus factors" that he claims provide a "rationale for intervening here but not in every cross-market merger or affiliation." Vistnes Report at 21. His first "plus factor" of market power is actually a requirement for the common customer theory to apply in the first place, not an indicator that cross-market effects are likely. *Id.* at 29 n.110 ("market power at both the acquired and acquiring hospital are required"). Regardless, Dr. Vistnes has not done a rigorous market power analysis. He lacks verifiable and quantitative

[12] https://www.americanbar.org/content/dam/aba/publishing/antitrust_law_journal/alj-832/alj-83-2-perry-adler.pdf

direct evidence of market power, *see Forsyth v. Humana, Inc*., 114 F.3d 1467, 1475 (9th Cir. 1997) ("Direct proof of market power may be shown by evidence of restricted output and supracompetitive prices."), and has not properly defined a market. *See Sidibe v. Sutter Health*, 4 F. Supp. 3d 1160, 1180 (N.D. Cal. 2013) ("Plaintiffs' conclusory allegations do not establish direct evidence of market power. Thus, they needed to define the relevant market.").

Underscoring the lack of fairness in the OCAG's process, Dr. Vistnes relies on conclusory snippets of his private discussions with health insurers that are not reliable economic evidence of a relevant market or market power. *See Fed. Trade Comm'n v. Thomas Jefferson Univ.*, No. 2:20-cv-01113, 2020 U.S. Dist. LEXIS 229735, at *5 (E.D. Pa. Dec. 8, 2020) ("[The insurers'] conclusory assertions that they would have to succumb to a price increase for services in the Government's proposed markets instead of looking to healthcare providers outside those markets are not credible."). As Dr. Vistnes has written, asking a health plan representative if purported network holes caused by a merger would disproportionately affect the plan's profitability is "unlikely to yield a meaningful response." Vistnes & Sarafidis at 280.

In addition, Dr. Vistnes tries to assess market power by looking at the parties' shares in various zip codes. But because Dr. Vistnes does not define relevant markets and the parties' competitors in those markets, his "share" analysis is uninformative and inconsistent with standard economic methodology. *See Roth v. Rhodes*, 25 Cal. App. 4th 530, 542 (Cal. Ct. App. 1994) (market power can be inferred from "possession of a substantial percentage of the sales in a market carefully defined in terms of both product and geography" (quotation omitted)).

Dr. Vistnes also attempts to bolster the common customer theory by citing the views of health insurance companies about the presence of common customers, payor concerns, and purportedly high Cedars-Sinai Medical Center prices. None of this is verifiable or even testable because many of his assertions are based on non-public interviews with insurance companies. Courts rarely credit the unverified say-so of an expert about the existence of factual information. *See Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997) (a court need not "admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert"); *Sargon Enters.*, 55 Cal. 4th at 770 (expert opinions may not be based on "assumptions of fact without evidentiary support").

As Dr. Vistnes cautions: payor concerns "should not be taken at face value" and should not replace "a more thorough competitive effects analysis." Vistnes Report at 28-29.

2. Lewis and Pflum – Bargaining Knowledge

Dr. Vistnes also discusses a 2017 article by Lewis and Pflum, which also uses a regression to find price increases allegedly attributable to cross-market hospital transactions.[13] In contrast to the Dafny Paper, Lewis and Pflum attribute the price increases to the possible increased bargaining sophistication of the smaller acquired hospitals. In other words, the authors purport to find price increases that result from massive health insurance companies being less able to use their superior knowledge to take advantage of community hospitals in rate negotiations. *See* Keith Brand & Ted Rosenbaum, A Review of the Economic Literature on Cross-Market Health Care Mergers, 82 Antitrust L.J. 533, 543 (2019) (explaining the possible price effect in terms of the hospital's ability to extract a greater share of the negotiating surplus from the more sophisticated insurer).[14]

Even if true, such price effects are not anticompetitive because increased bargaining knowledge is not a reduction in competition. *See generally Atlantic Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 344 (1990) (antitrust injury must "stem[] from a competition-*reducing* aspect or effect of the defendant's behavior"); Perry & Adler at 499, 502.

Dr. Vistnes's reliance on the Lewis and Pflum paper also reflects the arbitrariness of his conclusions and uncertainty that would follow from this Court endorsing his approach. As other economists have observed, Lewis and Pflum focus on the nebulous concept of improved bargaining knowledge rather than an "identifiable reduction in competition, thus there are no effective limiting principles on how [their] theory could be applied in practice." Perry & Adler at 499; *see* Brand & Rosenbaum at 548 (discussing the Dafny and Lewis and Pflum papers and finding no "good evidence on which mechanisms are most relevant and, therefore, how to best predict ex ante which mergers are likely to be problematic").[15]

---

[13] Matthew S. Lewis & Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions. 48 RAND J. Econ. 579 (2017).

[14] http://www.tedrosenbaum.org/uploads/1/4/3/6/14360754/brand_rosenbaum_alj_82-2_final.pdf

[15] Dr. Vistnes also mentions a theory of harm based on antitrust "tying" law but presents no academic research studying cross-market effects in this context or economic analysis of the Affiliation using a "traditional tying" framework.

Dated: May 27, 2021

WILSON SONSINI GOODRICH & ROSATI
Professional Corporation

By: */s/ Olivia M. Kim*

Olivia M. Kim, State Bar No. 228382
WILSON SONSINI GOODRICH & ROSATI
Professional Corporation
633 West Fifth Street, Suite 1550
Los Angeles, CA 90071-2027
Telephone: (323) 210-2900
Facsimile: (866) 974-7329
Email: okim@wsgr.com

Attorneys for Amici Curiae American Hospital Association, Association of American Medical Colleges, and California Hospital Association

PROOF OF SERVICE

I, Amanda Navarro, declare:

I am employed in Los Angeles County, State of California. I am over the age of 18 years and not a party to the within action. My business address is Wilson Sonsini Goodrich & Rosati, 633 West Fifth Street, Suite 1550, Los Angeles, CA 90071-2027.

On this date, I served:

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF BY THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND CALIFORNIA HOSPITAL ASSOCIATION AND [PROPOSED] BRIEF IN SUPPORT OF PETITIONERS

on the interested parties to this action by delivering thereof in a sealed envelope addressed to each of said interested parties at the following address(es):

☒ By placing the document(s) in a sealed envelope for collection and mailing with the United States Postal Service on this date to the following person(s):

Seth E. Goldstein – State Bar No. 238228 OFFICE OF THE ATTORNEY GENERAL 1300 I Street, Suite 125 P.O. Box 944255 Sacramento, CA 94244-2550 (916) 210-6063 Seth.Goldstein@doj.ca.gov	*Counsel for Defendants California Department of Justice and Rob Bonta, in his official capacity as Attorney General of California*
MARGARET H. WARNER mwarner@mwe.com PAUL W. HUGHES phughes@mwe.com MCDERMOTT WILL & EMERY LLP 500 North Capitol Street NW Washington, DC 20001 Telephone: (202) 756-8000 ANDREW BAUM - State Bar No. 190397 abaum@glaserweil.com GLASER WEIL FINK HOWARD AVCHEN & SHAPIRO LLP 10250 Constellation Boulevard, 19th Floor Los Angeles, California 90067 Telephone: (310) 553-3000	*Counsel for Plaintiffs Cedars-Sinai Health System and Pasadena Hospital Association Ltd. d/b/a Huntington Hospital*

Jean Tom – State Bar No. 304393
DAVIS WRIGHT TREMAINE LLP
505 Montgomery Street, Suite 800
San Francisco, CA 94111
(415) 276-6538

Counsel for Plaintiff Pasadena Hospital Association Ltd. d/b/a Huntington Hospital

I am readily familiar with Wilson Sonsini Goodrich & Rosati's practice for collection and processing of documents for delivery according to instructions indicated above. In the ordinary course of business, documents would be handled accordingly.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at Los Angeles, California on May 27, 2021.

/s/ Amanda Navarro
Amanda Navarro