No. S274927

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA,
Petitioner,

v.

THE SUPERIOR COURT OF SANTA CLARA,
Respondent,

DOCTORS MEDICAL CENTER OF MODESTO, et al.,
Real Parties in Interest.

On Appeal of a Decision by the Court of Appeal,
Sixth Appellate District, Case No. H048486

APPLICATION OF NATIONAL HEALTH ECONOMICS AND POLICY SCHOLARS FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF RESPONDENT; [PROPOSED] AMICUS CURIAE BRIEF

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

Pursuant to the California Rules of Court, rule 8.520(f), the undersigned national health economics and policy scholars respectfully request leave to file the attached brief amicus curiae in support of Respondent the County of Santa Clara in the above-captioned case.

INTEREST OF THE AMICI

Amici are faculty scholars and experts in health care and economics. Martin Gaynor is the E.J. Barone University Professor of Economics and Public Policy at Carnegie Mellon University.[1] Sherry Glied, Ph.D., is the Dean of the Robert F.

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[1] Martin Gaynor was Director of the Bureau of Economics at the U.S. Federal Trade Commission in 2013-2014. He is one of the founders of the Health Care Cost Institute, an independent non-partisan nonprofit dedicated to advancing knowledge about U.S. health care spending and served as the first Chair of its governing board. He is also an elected member of the National Academy of Medicine and of the National Academy of Social Insurance, and a Research Associate at the National Bureau of Economic Research.

His research focuses on competition and antitrust policy, both in health care markets, and more generally. He has written extensively on this topic, testified before Congress, the Federal Trade Commission, and advised the governments of the Netherlands, the United Kingdom, and South Africa on competition issues.

Professor Gaynor received his B.A. from the University of California, San Diego and his Ph.D. from Northwestern University. He has previously taught at Johns Hopkins University and a number of other universities. Professor Gaynor is the recipient of the NIHCM Foundation Health Care Research Award in 2018 and 2005, the Kenneth J. Arrow Award in 2017 and 1996, the Best Paper Award from the American Economic Journal: Economic Policy in 2016, was a finalist for the Jerry S. Cohen Award for Antitrust Scholarship in 2014, received the 2007 Victor R. Fuchs Award, and is a recipient of a

Wagner Graduate School of Public Service at New York University.[2] Amici join this brief as individuals and do not write on behalf of their universities in this case. Institutional affiliations are for identification purposes only.

As scholars of health care and economics, amici have extensive knowledge of and experience in pricing and costs in the health care marketplace, and how hospitals respond to reductions

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Robert Wood Johnson Foundation Investigator Award in Health Policy Research.

[2] From 1989 to 2013, Sherry Glied was professor of Health Policy and Management at Columbia University's Mailman School of Public Health. She was Chair of the Department of Health Policy and Management from 1998-2009; Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services from July 2010 through August 2012; Senior Economist for health care and labor market policy on the President's Council of Economic Advisers in 1992-1993, and participated in the Clinton Health Care Task Force. She is a Nonresident Senior Fellow of the Brookings Institution, and has been elected to the National Academy of Medicine, the National Academy of Social Insurance, and the American Academy of Arts and Sciences. In 2021, she was awarded the AUPHA's William B. Graham Prize for Health Services Research.

Dr. Glied's principal areas of research are in health policy reform and mental health care policy. She is the author of *Chronic Condition* (Harvard University Press, 1998), coauthor (with Richard Frank) of *Better but Not Well: Mental Health Policy in the U.S. Since 1950* (Johns Hopkins University Press, 2006), and coeditor (with Peter C. Smith) of *The Oxford Handbook of Health Economics* (Oxford University Press, 2011).

Dr. Glied holds a B.A. in economics from Yale University, an M.A. in economics from the University of Toronto, and a Ph.D. in economics from Harvard University.

in payments from public insurers like Medicare. Amici are deeply concerned with ensuring that accurate information is available to inform decisions that will impact health care systems and the patients who rely upon those systems. They submit this brief to provide data and analysis to contextualize the public policy arguments introduced by the Appellants in this case.

REASON WHY THE APPLICATION SHOULD BE GRANTED

This case presents the question of whether the Government Claims Act prevents lawsuits seeking to force counties to pay hospitals more for certain emergency medical services. In urging this Court to answer that question in the negative, Appellants warn that serious and widespread public policy consequences might flow from affirming that the counties do have immunity from such lawsuits. The brief that follows will provide the Court with data, analysis, and context for the public policy issues that Appellants have raised. Specifically, it explains why those public policy consequences cannot reasonably be expected to follow an affirmance of the decision below.

No party or counsel for a party has authored any part of this brief, nor has any person or entity made a monetary contribution intended to fund the preparation or submission of the brief. No person has made a monetary contribution intended to fund the preparation or submission of the brief, other than the amici or their counsel.

Dated: March 3, 2023

Respectfully submitted,

OLSON REMCHO, LLP

By: _____

Margaret R. Prinzing
Attorneys for [Proposed] Amicus Curiae National Health Economics and Policy Scholars

[PROPOSED] BRIEF AMICUS CURIAE

INTRODUCTION

The Appellants in this case – Doctors Medical Center of Modesto, Inc. and Doctors Hospital of Manteca, Inc. (the "Appellant Hospitals" or "Hospitals") – ask this Court to find that the Government Claims Act does not prevent lawsuits seeking to force counties to pay hospitals more for certain emergency medical services. In doing so, the Appellant Hospitals devote Section IV of their Opening Brief on the Merits ("Op. Br.") to warnings about the dire public policy consequences that would allegedly flow from a ruling against the Hospitals, including everything from the systematic underpayment of California's emergency care providers to hospitals offsetting lost revenues by increasing charges for patients seeking non-emergency services.

The Appellant Hospitals allege that they invoiced the County of Santa Clara (the "County") for emergency services provided to patients enrolled in the County's health plan, but the County only paid the Hospitals "roughly 20 percent" of that amount. (Op. Br. at p. 15.) The Hospitals do *not* allege that the payments materially differ from the average payments other insurers pay to the Hospitals, or that the County's payments failed to cover the Hospitals' costs. Nevertheless, the Hospitals premise their public policy arguments on speculation that the County's payment amounts – left unchecked by the courts – would lead to shortfalls that threaten the very financial viability of California's emergency health care delivery system. (*Id.* at

p. 39.) The implication appears to be that this Court should assume that the Legislature could not have intended such outcomes and so would not have intended to extend immunity to the facts of this case.

Amici are economists with expertise in health care policy and competition in health care markets who submit this brief to explain why this Court need not be concerned that affirming the decision below will lead to the grave public policy outcomes described by the Hospitals. Simply put, the amounts that the Hospitals seek to recover from the County are list prices, known as "billed charges," which are so inflated and arbitrary in nature that almost no insurer or patient pays them. Accordingly, the fact that the County has not paid those charges cannot reasonably be expected to have a negative impact on the Hospitals, let alone the kind of sweeping consequences the Hospitals describe for California's emergency health care delivery system as a whole.

The Hospitals also speculate that hospitals may be forced to consider increasing prices on non-emergency services to restore revenues lost to the County's reimbursement decisions. Yet the research evidence demonstrates that hospitals do not engage in the kind of cost-shifting behavior the Hospitals fear.

In short, the Appellant Hospitals' public policy arguments do not withstand scrutiny and so do not provide any basis upon which to reverse the Court of Appeal decision below.

ARGUMENT

I.

SPENDING ON HOSPITALS IS ALREADY HIGH

A central animating principal behind the Appellant Hospitals' public policy arguments is that hospital payments should be higher. It is therefore worth noting that spending on hospital services is already very high. It comprises the largest share of national health expenditures, at 31 percent or $1.3 trillion. (Martin et al., *National Health Care Spending in 2021: Decline in Federal Spending Outweighs Greater Use of Health Care* (Jan. 2023) 42 Health Affairs 1, 11, 15 (hereafter 2023 Martin et al.).) It also exceeds spending for all physician services and retail prescription drug costs *combined*.[3] Indeed, hospital spending alone constitutes 5.7 percent of U.S. gross domestic product. (*Id.* at pp. 7, 11 [calculations based on data from Exhibits 1 and 5 in 2023 Martin et al.].) This makes hospital services one of the largest sectors of the U.S. economy, surpassing computer hardware or software, commercial banking, and pharmaceuticals.

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[3] See Telesford et al., *How has U.S. spending on healthcare changed over time* (February 7, 2023) Peterson-KFF Health System Tracker <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Local%20and%20federal%20expenditures%20on%20public%20health,%20US%20$Billions,%201970-2021> [as of March 1, 2023].

Moreover, increased health care prices play a large role in driving increases in health care spending.[4] Thus, increasing health care prices leads to increased expenditures on health care.

II.

HOSPITALS' BILLED CHARGES ARE ARBITRARY AMOUNTS THAT DO NOT RELFECT PRICES OR COSTS

At the heart of the Appellant Hospital's policy arguments is the notion that the gap between the amount the Hospitals charged the County and the reduced amount the County paid the Hospitals will force the Appellant Hospitals to grapple with a revenue "shortfall." (Op. Br. at pp. 15, 40, 41, 42.) It is this purported "shortfall" that would lead to the cascade of public policy consequences that the Hospitals describe.

The problem with the Hospitals' argument, however, is that it is premised on an unalleged assumption that the amounts that the Hospitals charged the County (frequently referred to as "billed charges") reflect the Hospitals' costs or some other economically meaningful construct, so that the County's decision to pay a lower amount can reasonably be expected to lead to consequential revenue shortfalls. In other words, it

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[4] Health Care Cost Institute, 2020 Health Care Cost and Utilization Report (May 2022) <https://healthcostinstitute.org/images//pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf> [as of March 2, 2023]; Martin et al., *National Health Care Spending in 2019: Steady Growth For The Fourth Consecutive Year* (Jan. 2021) 40 Health Affairs 1, 14:24 (hereafter 2021 Martin et al.).)

assumes that hospitals' billed charges are amounts that hospitals need to some extent in order to maintain "the financial viability of California's emergency health care delivery system." (See Op. Br. at p. 39.)

This assumption, however, is false. As discussed below, the research demonstrates that hospitals' billed charges neither reflect the prices that insurers pay to hospitals for a given service, or the cost of the service. Nor do they even have a significant impact on hospital revenues. As such, hospitals cannot reasonably expect to receive the full amount of their billed charges in exchange for their services, and cannot reasonably be expected to struggle when they are paid lesser amounts.

A. Billed Charges Do Not Reflect The Prices Insurers Pay Hospitals

By way of background, every hospital has its own list of charges for different services, which are called "billed charges." These charges are not subject to government regulation or oversight, but are instead established by the hospitals themselves according to criteria chosen by each hospital, such as the hospital's own assumptions about its costs, the quality of the care it provides, and revenue targets. (See, e.g., Anderson, *From 'Soak the Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing* (May/June 2007) 26 Health Affairs 3, 784 (hereafter Anderson) [noting that hospitals have "sole discretion" in determining billed charges and appear "to lack a rigorous methodology to set charges"].) Accordingly, a hospital's billed

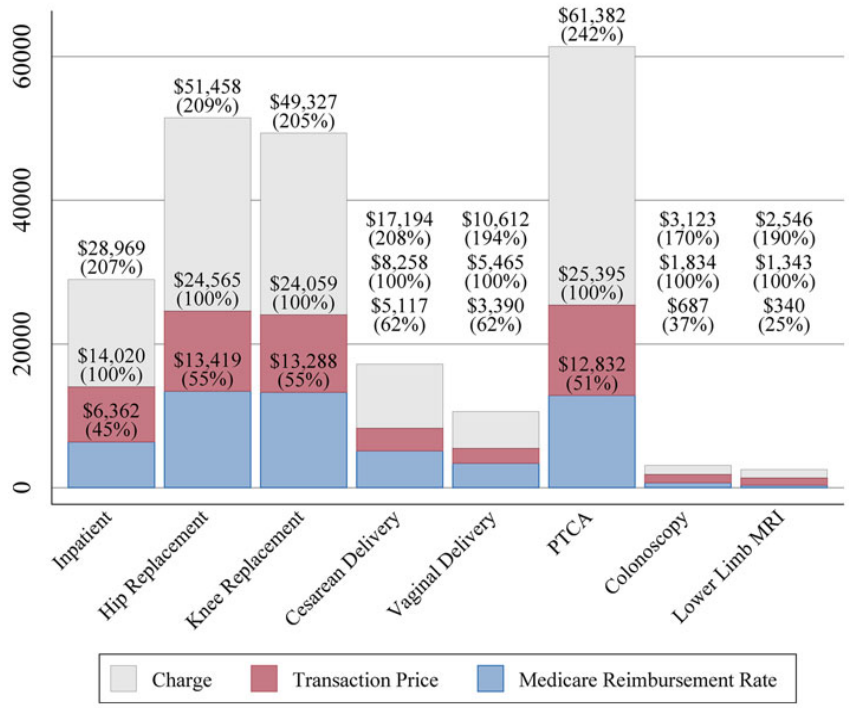
charges may reflect any number of underlying factors that can vary from one hospital to the next.

What is clear, however, is that billed charges do not reflect the prices paid by the vast majority of public and private payors. In fact, ***almost no one pays the hospitals' billed charges***. Rather, public and private insurers almost always pay substantially less than the hospitals' billed charges, as the County did here.

This is true for Medicare, a payor with tremendous power in the marketplace. The federal Centers for Medicare and Medicaid Services set the payments for various procedures based on direct patient costs (*e.g.*, emergency department) and indirect general service costs (*e.g.*, administration). Hospitals must then accept the resulting payments, regardless of the fact that those payments are far less than the typical hospital's billed charges. One study based on 2012 data found that on average, hospitals' billed charges were 340 percent of the Medicare-allowable cost, which means that a hospital that incurs $100 of Medicare-allowable costs on average lists a billed charge of $340 for that service. (Bai & Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios* (June 2015), 34 Health Affairs 6 923 (hereafter Bai & Anderson).)

Private insurers do not pay billed charges either. Hospital prices for the privately insured are instead set through negotiations between hospitals and insurers. (Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* (Feb. 2019) 134 Q. J. of Economics 1, 52

(hereafter Cooper et al.).) The resulting prices are higher than Medicare rates but substantially lower than the average hospital's billed charges. For example, the average hospital's billed charge for a hip replacement in 2011 was $51,458, but the average private insurer paid $24,565, or less than half of the hospital's billed charges, while Medicare paid only $13,419. (*Id.*, pp. 65-66.) In other words, on average, hospitals' billed charges are over 209 percent of the payments they actually receive from private insurers. Additional departures from hospitals' billed charges are shown in the chart below:[5]



[5] Cooper et al. at p. 66. The top of the grey bars show average hospital charges; the top of the red bars show private insurer prices ("transaction price"), and the top of the blue bars show Medicare reimbursement amounts. Prices are shown in 2011 dollar amounts and as a percentage of the private insurer "transaction price."

Once patients with Medicare and private insurance are removed from the equation, there remains a relatively small patient population from whom hospitals can seek to extract their billed charges. Unfortunately, this includes "self-pay" patients who have no health insurance or whose health insurance providers refuse to pay for a hospital's services because the hospital is outside its network of providers. Additionally, hospitals usually charge casualty and workers' compensation insurers, whose patients often have a legal right to go to any hospital, either the full billed charge or a high percentage of that amount.[6] (Bai & Anderson at pp. 922, 924-925; Anderson at p. 781.) In these ways, billed charges are typically reserved for those who have the least bargaining power and the least ability to pay the inflated amounts.

Yet not even this population is fully subject to a hospital's billed charges. This is true in part because the law provides some patients with some relief. The federal Affordable Care Act requires nonprofit hospitals to provide financial assistance to certain patients, though this mandate does not extend to for-profit hospitals like the Appellant Hospitals. (26 U.S.C.S. § 501(r); 26 C.F.R. § 1.501(r)-4 (2023).) Some state laws also provide relief. California law, for example, requires

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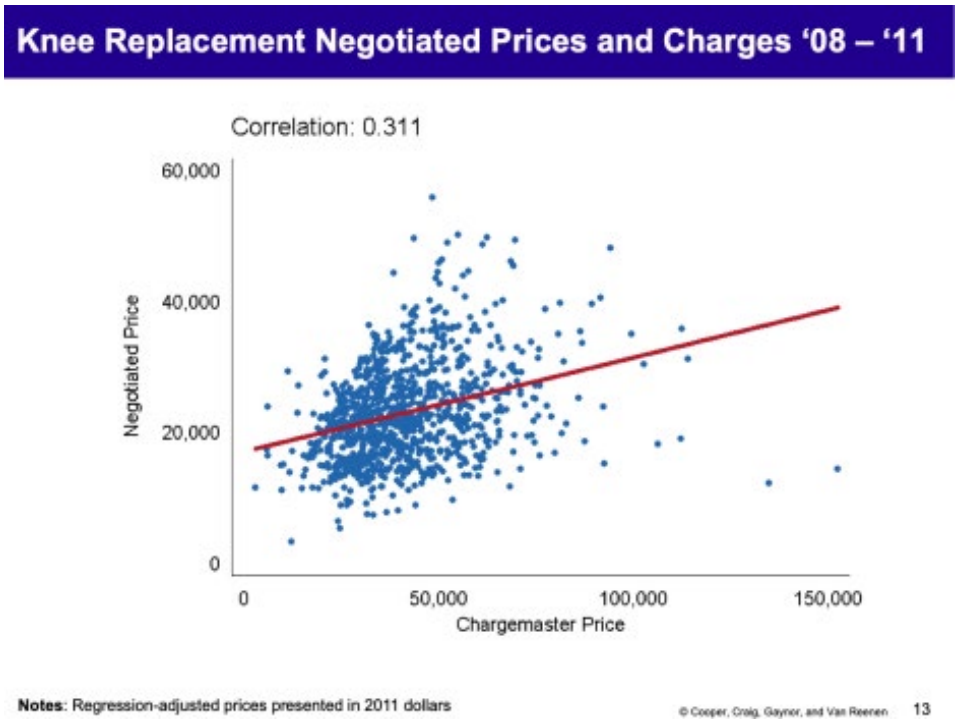
[6] Casualty and workers' compensation insurers constitute a very small percentage of the payments for health care. Workers' compensation constitutes 1.1% of hospital expenditures and amici estimate that casualty insurance may constitute approximately 2.2% of hospital expenditures based on available data. (See 2021 Martin et al. and 2023 Martin et al.)

hospitals to maintain a discounted payment policy for uninsured patients and patients with high medical costs who are at or below 400 percent of the federal poverty level. (Health & Saf. Code, § 127405, subd. (a)(1)(A).) Nevertheless, even with these mandated discounts, many patients cannot pay their hospital bills and the collection rate from uninsured patients is only 10 percent on average. (Anderson at p. 784.)

It is therefore clear that hospitals' billed charges do not reflect the prices paid by the vast majority of public or private insurers. Yet, while hospitals may use billed charges to enhance their negotiating position with private insurers, further studies reveal that billed charges do not play a direct role in establishing the contractual rates that many private insurers ultimately pay to hospitals. One study of historical data published in 2019 found that only 23 percent of hospitals' inpatient cases had prices contractually set as a share of hospitals' billed charges. (Cooper et al., at pp. 54, 87.) The vast majority of inpatient hospital cases covered by private insurance – 77 percent of such cases – were instead paid through contracts with prices set prospectively, typically set as a fixed percentage of Medicare payment rates. (*Id.* at pp. 86-87.) The minority of share-of-charges contracts tend to exist where hospitals have substantial bargaining power because they are in a monopoly or otherwise concentrated market (*id.* at pp. 90-93), and thus appear to be more indicative of a hospital's negotiating power than local factors relating to the cost or quality of care.

Not only are negotiated prices well below charges on average, it is not even the case that hospitals with higher charges receive higher payments from insurers. As the figure below illustrates for a common treatment (total knee replacement), the negotiated prices that hospitals actually are paid (on the vertical axis) are everywhere well below billed charges (horizontal axis) and the correlation between hospital charges and actual transaction prices is only 0.311, meaning that hospitals with higher charges frequently do not receive higher payments for services, and vice versa. The data for the knee replacement prices and charges are shown below, though similar low correlations were found across six other procedure samples.[7] In other words, these data confirm that the actual prices that hospitals are paid by insurers have little to no relation to the hospital's billed charges.

[7] The other procedure samples studied include hip replacements, cesarean sections, vaginal births, percutaneous transluminal coronary angioplasties, diagnostic colonoscopies, and MRI of lower-limb joints. These procedures were selected because they occur with sufficient frequency to support empirical analysis and are largely homogenous, which facilitates comparisons across facilities and areas. (Cooper et al. at pp. 61-62.)



In short, the research and data demonstrate that hospitals' billed charges do not reflect the prices paid by the vast majority of public or private insurers. This demonstrates that the County's decision to pay the Appellant Hospitals an amount that is substantially less than the Hospital's billed charges is not an anomaly and cannot reasonably be expected to lead to the kind of systemic underpayment described in the Hospitals' brief. (See, e.g., Op. Br. at p. 39.) Moreover, the data above also illustrate that there are already substantial disparities between the prices that public and private insurers pay. This calls into question whether the California Legislature would have shared the Appellant Hospitals' concerns with disparities between public and private insurers. (Op. Br. at pp. 18-19, 22, 40.)

B. Billed Charges Do Not Reflect Hospitals' Costs

In addition to not reflecting prices paid to hospitals, a hospital's billed charges do not reflect the hospital's costs.

A common way to analyze the relationship between a hospital's billed charges and its costs is through the cost-to-charge ratio, which compares that hospital's total billed charges to its total Medicare-allowable cost. One study using 2012 Medicare cost reports for 4,483 Medicare-certified hospitals across the nation found not only that the hospitals' billed charges exceeded costs, but that when compared to historical data, the extent to which billed charges exceed costs has increased over time. (Bai & Anderson at pp. 923-924.) In 1984, the average charge-to-cost ratio was only 1.35. (*Id.* at p. 924.) By 2004, it was 3.07; in 2011, it was 3.3; and in 2012, it had reached 3.4. (*Ibid.*)

These increases in billed charges cannot be explained by rising costs because charges have increased much faster than costs. From 1984 to 2004, hospital charges per admission rose an average of 10.7 percent per year, while Medicare-allowable costs per admission rose only 6.3 percent per year during the same period. (Anderson at p. 783.)

Furthermore, the average cost-to-charge ratios mask large differences in the extent to which charges exceed costs among different hospitals. According to data from 2012, the ratios at the hospitals with the lowest 10 percent of charge-to-cost ratios were below 1.5, while the top 10 percent of hospitals had ratios over 5.7. (Bai & Anderson at p. 924.) The top 1

percent, representing fifty total hospitals, have an average ratio of 10.1 (individually ranging from 9.2 to 12.6), ***meaning that top hospitals "are charging markups of more than 1,000 percent."*** (*Ibid.*, emphasis added.)

Nearly all of the 50 hospitals with the highest charge-to-cost ratios – 49 out of 50 – are for-profit hospitals. (*Id.*; *see also* Anderson at 781 [according to data from 2004, for-profit hospitals have the highest charge-to-cost ratios of 4.1, but even public hospitals' billed charges were two and one-half times the Medicare allowable cost].) This includes the Appellants Hospitals – Doctors Hospital of Manteca, Inc. and Doctors Medical Center of Modesto, Inc. – which appear at numbers 29 and 30 on the list, respectively. (Bai & Anderson, appen. A).[8] In 2012, the billed charges for both hospitals were 9.6 times their Medicare-allowed costs. (*Ibid.*)

The extent to which billed charges in general, and the Appellant Hospitals' billed charges in particular, exceed hospitals' costs further undermines the Hospitals' argument that they will be forced to contend with systemic underpayments.

C. Changes In Billed Charges Do Not Lead To Changes In Hospital Revenues

Finally, the correlation between billed charges and hospital revenues is also weak. Increases in billed charges do not translate into a corresponding increase in overall hospital

[8] See Bai & Anderson, appen. A, https://www.healthaffairs.org/doi/suppl/10.1377/hlthaff.2014.1414/suppl_file/2014-1414_bai_appendix.pdf (as of March 1, 2023).

revenues. From 1984 to 2004, the annual rate of increase in net hospital revenues (6.6 percent) was roughly similar to the annual increase in Medicare-allowable costs (6.3 percent), but significantly below the annual rate of increase in billed charges (10.7 percent). (Anderson at p. 783.) This is true because, again, hardly anyone pays a hospital's billed charges. More specifically, the charges have no impact on public insurers like Medicare, which set payments through the regulatory process based on cost data, and little impact on private insurers, which seek deeper discounts from rising charges during contract negotiations with hospitals. (*Id.* at p. 784.)

Another analysis of data from 1974 through 2012 reached a similar conclusion. While hospital revenue increased by 9 percent annually during this period, billed charges increased substantially faster, by 12.4 percent annually. (Batty & Ippolito, *Financial Incentives, Hospital Care, and Health Outcomes: Evidence From Fair Pricing Laws* (May 2017) 9 American Economic J.: Economic Policy 2, 28-29 (hereafter Batty & Ippolito).) The growing disparity is shown in the chart below:[9]

[9] See page 29 of Batty & Ippolito. Charges represent the billed charges or "list price" of hospital care delivered, while revenue represents actual prices paid to hospitals.

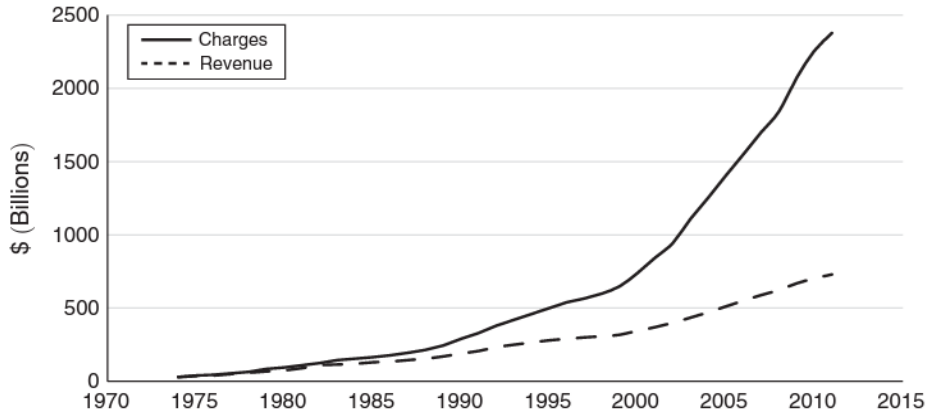


FIGURE 1. CHARGES AND REVENUES FOR US HOSPITALS, 1974–2012

These results further underscore the minimal role, and arbitrary nature, of the billed charges that Appellant Hospitals place at the center of their public policy arguments. In short, they are charges that hardly anyone pays, and which fail to reflect any economically meaningful metric like price, cost, or revenue. Accordingly, if this Court affirms the Court of Appeal decision below, thereby ensuring that other public insurers in California are not forced to pay such charges, there is no reason to believe that it will result in the grave and sweeping public policy outcomes that Appellant Hospitals allege will ensue.

III.

THE ISSUES RAISED IN THIS CASE WILL NOT LEAD TO COST-SHIFTING

The Appellant Hospitals warn that a decision to uphold the County's immunity here could force hospitals to increase charges for nonemergency services to compensate for the resulting revenue shortfalls. (Op. Br. at p. 41.) For all the reasons described in Section II, there are no real shortfalls here,

but even if there were, the research evidence reveals that this will not happen. Simply put, cost-shifting does not exist in hospital markets in any significant form.

Historically, many health policy observers believed there was hospital cost-shifting. Specifically, it was widely believed that hospitals would respond to reduced payments from public insurers like Medicare or increased numbers of uninsured patients by increasing prices for the privately insured. (Glied, *COVID-19 Overturned the Theory of Medical Cost Shifting by Hospitals* (June 2021) JAMA Health Forum 1.) This was, however, a theory based on inferences from the available data concerning public and aggregate private payments to hospitals. The theory could not be adequately tested because there were no data available on private insurer payments to hospitals at the transaction level. (*Ibid.*)

Importantly, this theory never extended to for-profit hospitals, like the Appellant Hospitals in this case. After all, if a for-profit hospital had the ability to raise prices paid by a private insurer, it would do so, not wait until another payer (like Medicare) reduced its prices (otherwise it would not be maximizing profits and thereby neglecting its responsibilities to its shareholders). A for-profit hospital has the fiduciary responsibility to maximize profits, and there is no justification for waiting to raise prices on some patients until payments from other patients decline.

Regardless, this theory has now effectively been disproven even for non-profit hospitals. Once detailed data on

private insurance became available in the mid-2000s, it became clear that cost-shifting was not taking place as had been previously believed. (Frakt, *The End of Hospital Cost Shifting and the Quest for Hospital Productivity* (Feb. 2014) 49 Health Services Research, pp. 1-10 ["In light of the evidence, any continued assumptions that most or all of the shortfalls in Medicare rates can be shifted to private payers . . . should be relegated to the dustbin of history."]; Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration* (July 2011) 30 Health Affairs 7, 1269.) Far from it, the evidence shows that when Medicare lowered hospital payments, **private insurance payments also declined**. (White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates* (May 2013) 32 Health Affairs 5, 935 (hereafter White).)

One study found that a 10 percent reduction in Medicare payment rates led to an estimated reduction in private insurance prices of approximately 3 to 8 percent. (White at p. 939.) Research demonstrates that hospitals do not shift the burdens of lower public payments onto the shoulders of private payors. The Appellant Hospitals' arguments to the contrary are unsupported and rejected by the research evidence.

CONCLUSION

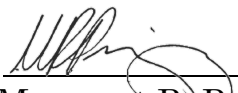
For the above reasons, Amici respectfully submit that the Court need not be concerned that affirming the Court of

Appeal decision below will lead to the public policy outcomes described by the Appellant Hospitals.

Dated: March 3, 2013

Respectfully submitted,

OLSON REMCHO, LLP

By: 

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BRIEF FORMAT CERTIFICATION PURSUANT TO RULE 8.204 OF THE CALIFORNIA RULES OF COURT

Pursuant to Rule 8.204 of the California Rules of Court, I certify that this brief is proportionately spaced, has a typeface of 13 points or more and contains 3,644 as counted by the Microsoft Word 365 word processing program used to generate the brief.

Dated: March 3, 2023

Margaret R. Prinzing

PROOF OF SERVICE

I, the undersigned, declare under penalty of perjury that:

I am a citizen of the United States, over the age of 18, and not a party to the within cause of action. My business address is 555 Capitol Mall, Suite 400, Sacramento, CA 95814.

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(By United States Mail)

☒ **BY UNITED STATES MAIL:** By enclosing the document(s) in a sealed envelope or package addressed to the person(s) at the address above and

☐ depositing the sealed envelope with the United States Postal Service, with the postage fully prepaid.

☒ placing the sealed envelope for collection and mailing, following our ordinary business practices. I am readily familiar with the business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, located in Sacramento, California, in a sealed envelope with postage fully prepaid.

☐ **BY OVERNIGHT DELIVERY:** By enclosing the document(s) in an envelope or package provided by an overnight delivery carrier and addressed to the persons at the addresses listed. I placed the envelope or package for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

☐ **BY MESSENGER SERVICE:** By placing the document(s) in an envelope or package addressed to the persons at the addresses listed and providing them to a professional messenger service for service.

☐ **BY FACSIMILE TRANSMISSION:** By faxing the document(s) to the persons at the fax numbers listed based on an agreement of the parties to accept service by fax transmission. No error was reported by the fax machine used. A copy of the fax transmission is maintained in our files.

☒ **BY EMAIL TRANSMISSION:** By emailing the document(s) to the persons at the email addresses listed based on a court order or an agreement of the parties to accept service by email. 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, that the foregoing is true and correct. Executed on March 3, 2023, in Sacramento, California.

Eva Alfaro

(00483860-5)