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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UFCW & EMPLOYERS BENEFIT TRUST, et al., Plaintiffs, **v.** **SUTTER HEALTH, et al.,** Defendants.	Case No. CGC-14-538451 Consolidated with Case No. CGC-18-565398 **DECLARATION OF EMILIO E. VARANINI IN SUPPORT OF THE ATTORNEY GENERAL'S DETERMINATION THAT FURTHER DELAY IS CONTRARY TO THE PUBLIC INTEREST IN PLAINTIFFS' OPPOSITION TO SUTTER'S MOTION FOR CONTINUANCE**
PEOPLE OF THE STATE OF CALIFORNIA, ex rel. XAVIER BECERRA, Plaintiff, **v.** **SUTTER HEALTH,** Defendant.	Date: July 9, 2020 Time: 9:15 am Dept: 304 Judge: Hon. Anne-Christine Massullo Action Filed: April 7, 2014

I, EMILIO E. VARANINI, declare as follows:

1. I am an attorney admitted to practice in the State of California. I am a Deputy Attorney General with the Antitrust Section in the Department of Justice of the Office of the Attorney General and am the lead attorney in this action for the People of the State of California. I have been responsible as lead counsel for many of the most complex antitrust cases in the Office, as well as serving as lead counsel or leading counsel in many of the Office's healthcare antitrust investigation cases as well as consulting on other healthcare matters. I submit this Declaration in support of the Attorney General's statement of public interest as set forth in Plaintiff's Opposition to Sutter's Motion to Continue the Preliminary Approval Hearing (Opposition). I could, if called as a witness, testify competently to the matters set forth herein.

2. Attached is a true and correct copy of the Analysis of Dr. Glenn Melnick, who previously consulted with the UEBT Plaintiffs, in support of the Attorney General's public interest statement in the Opposition as Attachment 1. The Attorney General consulted with Professor Melnick in reaching the determination that further delay would be contrary to the public interest pursuant to the process that it follows for the public interest review of nonprofit healthcare provider mergers. It has been the Attorney General's practice to request an analysis by an expert in conjunction with the Attorney General's public interest review of a nonprofit healthcare provider merger. Where such an analysis has been conducted, and factored into the Attorney General's public interest review of a merger, that analysis is made public as required by regulations and the law as part of the record in that matter. (See 11 Cal. Code Regs., § 999.5, subd. (e)(5).) Thus, the Attorney General is not submitting the Melnick Analysis for the Court's independent consideration.

3. Attached is a true and correct copy of the Declaration of Janet Lundbye of United Healthcare Services, Inc. I have attached this declaration in support of the Attorney General's public interest statement in the Opposition as Attachment 2.

4. Attached is a true and accurate copy of the Declaration of Becky La Croix-Milani of Health Net of California, Inc. I have attached this declaration in support of the Attorney General's public interest statement in the Opposition as Attachment 3.

5. Attached is a true and correct copy of the Declaration of Dr. Mark Ghaly, Secretary of the California Health and Human Services Agency (CHHS), M.D., M.P.H., who was appointed Secretary of CHHS by Governor Gavin Newsom in April of 2019 and is a Secretary in Governor Newsom's cabinet. I have attached this declaration in support of the Attorney General's public interest statement as Attachment 4.

6. The Office of the Attorney General has a particular expertise on healthcare provider competition issues: it has reviewed healthcare provider mergers for competition issues as part of a public interest inquiry under the relevant statutes governing nonprofit transactions (see, e.g., 11 Cal. Code Regs., § 999.5); it has participated in several challenges to proposed healthcare insurer mergers; and it conducted a multiyear investigation into competition issues in healthcare provider markets prior to filing its complaint in this case and consolidating it with UEBT's pre-existing class action.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 25, 2020, at Hayward, California.

EMILIO E. VARANINI

ATTACHMENT 1

Analysis of Glenn Melnick in Support of Public Interest Statement of the California Office of the Attorney General

1. My name is Glenn Alan Melnick, Ph.D. I am a Professor at the University of Southern California, where I teach health economics and health care finance and was previously a resident consultant at RAND, a non-profit research organization, where I conducted health economics research.

2. I have conducted health economics research focusing on health care competition and hospital pricing for 25+ years, including detailed analysis of health care markets in California. I have published scientific research papers on these subjects in various scientific peer-reviewed journals. I have consulted with various government agencies in the US including the Federal Trade Commission and States Attorneys General and testified to the House Ways and Means Committee in the US Congress on the issue of hospital pricing in the US. More recently, I have studied the effects of the COVID-19 epidemic on California's health care system.

3. I have been asked by the California Office of the Attorney General to provide this independent analysis in support of its public interest statement that will be submitted to the Court on the issue of whether a delay in the Settlement is to the benefit of California's health care consumers. I am doing so on my own time and without any compensation.

Background and Overview

4. As I understand it, Sutter Health (Sutter) and the Plaintiffs signed a written agreement settling their dispute in December of 2019.

5. I listened in on the phone to the public hearing last month during which Sutter requested a delay in finalizing the Settlement with the plaintiffs and I have read Sutter's recently filed motion (6/12/2020).

6. As I understand it, Sutter has now asked the court to delay approving and implementing the Settlement with the possibility that it may request changes to the agreed terms of the Settlement.

7. Further, as I understand it, Sutter has tied this request to delay approval and implementation of the Settlement largely to the sudden emergence of the COVID-19 epidemic and its impact on California's health-care system, including Sutter Health.

8. While the COVID-19 epidemic has resulted in sudden and substantial impacts on our health care system, rising health care costs are a major and growing problem for many families in California. It is my understanding that the Settlement is designed to restore price

competition to a large segment of the hospital market in Northern California with the goal that it would result in immediate and substantial savings to health care consumers.

Before COVID-19 took over our lives, Californians ranked rising health care costs and affordability of health coverage near the top of their concerns.

9. For California families with employer-sponsored insurance, the average total health-related spending is $24,104 per year (in 2018). This represents more than one-third (34%) of median household income in California ($70,489). Because of continuing increases in health-care prices, a growing share of the modest increases in household incomes is being used to pay for rising health care costs, threatening the affordability of health coverage and access to health care. A recent survey of Californians by the California Health Care Foundation reported that Californians say they are worried — in many cases very worried — about paying for all kinds of health care costs, including unexpected medical bills, out-of-pocket expenses, prescription drugs, and health insurance premiums[1]. Many Californians reported that they delay or skip care because of the cost, including those with health insurance coverage. More than 80% of Californians say they want policy makers to prioritize making health care more affordable this year. At the same time, a large and growing body of research indicates that hospital consolidation and large hospital systems, like Sutter Health, contribute to excess health-care spending as they use their market power to achieve above-market prices[2].

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[1] https://www.chcf.org/blog/californians-want-action-health-care-costs-mental-health-treatment

[2] www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf; Baker LC, Bundorf MK, Kessler DP. Vertical integration: hospital ownership of physician practices is associated with higher prices and spending. Health Aff (Millwood). 2014;33(5):756-763. doi:10.1377/hlthaff.2013.1279; Glenn Melnick, Emmett Keeler, The effects of multi-hospital systems on hospital prices, Journal of Health Economics, Volume 26, Issue 2,2007, Pages 400-413, ISSN 0167-6296,https://doi.org/10.1016/j.jhealeco.2006.10.002;Melnick, G. A., & Fonkych, K. (2016). Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. https://doi.org/10.1177/0046958016651555; Melnick, G. A., Fonkych, K, and Zwanziger, J. The California Competitive Model: How Has It Fared, And What's Next?, 2018, Health Affairs, 1417-1424, /hlthaff.2018.0418; www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0418.

10. Delay of the Settlement would, as I understand it, allow Sutter to continue to engage in anticompetitive practices and to demand above-market increases in hospital prices that are likely to drive premium levels higher for the insured population and raise prices and reduce access to needed care for the growing number of uninsured Californians.

The COVID-19 epidemic threatens to make the health care affordability problem even worse in the future for California families

11. Between March 6 and June 6, 2020 more than 5.5 million Californians had submitted applications to the California Employment Development Department for unemployment benefits.[3] While some are expected to return to their jobs and others may still have access to employer-based health insurance while on furlough or through COBRA, it is expected that millions of Californians will lose their employer-based health insurance coverage as a result of job loss. And, while many are expected to switch to the State's Medi-Cal insurance program for coverage, it is likely that many individuals and families will remain uninsured in California or may purchase health insurance through California's Covered California Exchange.[4]

Competitive Markets Benefit and Protect Consumers

12. As a result of the effects of COVID-19, providers are being forced to operate at much lower cost levels. This unexpected adjustment in hospital-cost structures presents an opportunity to bring our system back on-line at a more efficient level. Competitive markets provide the needed pressure that can incentivize providers to adopt cost-cutting efficiencies as we emerge from the epidemic.

13. The financial losses that most, if not all, hospitals have suffered from the COVID-19 epidemic should not allow hospitals with market power to demand above market prices[5]. Approving the Settlement

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[3] https://edd.ca.gov/newsroom.htm.

[4] www.**chcf.org**/publication/financial-impact-covid; www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf.

[5] https://www.beckershospitalreview.com/finance/49-hospitals-furloughing-workers-in-response-to-covid-19.html

now will, as I understand it, prevent continued use of market power by Sutter hospitals to gain higher prices and will help restore price competition to a large part of California's health care system.

Approving the Settlement Would Help to Restore Competition to the Market

14. COVID-19's negative impact on hospitals does not change or obviate the expected benefits of restoring price competition by ending Sutter's alleged anticompetitive practices, which allow it to use its market power to charge above market prices. By immediately approving and enforcing the Settlement, the court will ensure that consumers will enjoy the benefits of increased price competition as soon as possible.

15. It is important to note, that immediate approval and implementation of the Settlement would not prevent Sutter from seeking and negotiating price increases in the future. Rather, and importantly, restoring price competition to the market would ensure that any price increases that Sutter achieves going forward are disciplined by market forces rather than Sutter's supply-side market power. I understand that the Settlement allows Sutter to negotiate price increases more in line with the competitive market, while preventing it from obtaining above-market prices based on anticompetitive practices. In addition, because of Sutter's size and footprint in Northern California, forcing Sutter to operate on a more competitive basis would provide much needed competitive pressure on prices on the broader Northern California market, also benefiting consumers.

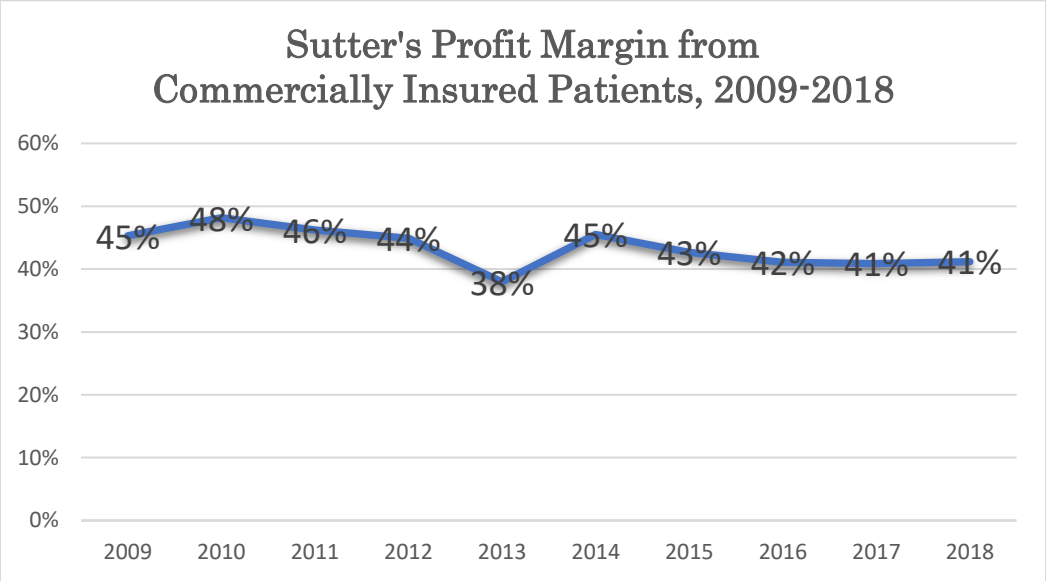
Financial Loses from COVID-19 Do Not Justify Continuing Anti-Competitive Practices

16. Again, Sutter is not alone in seeing patient volume and revenue drop from the COVID-19 epidemic. It is likely that almost all of California's hospitals have been affected by the COVID-19 outbreak and will have to adjust to the conditions.

17. At the same time, Sutter hospitals may be in a much better position to weather this storm than many other hospitals given its successful financial track record prior to COVID-19. Based on data submitted by Sutter Health for its acute-care hospitals to the Office of Statewide Health Planning and Development over the 10-year period (2009-2018) covering commercially insured patients (defined as Other Third Party):

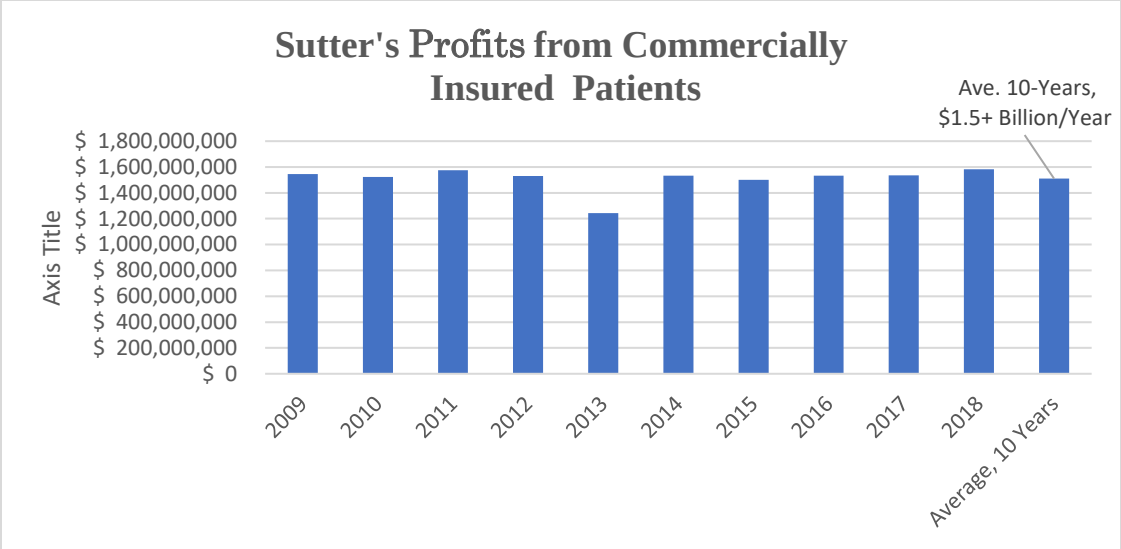
- Sutter averaged a 40+% profit margin from commercially insured patients (excess of revenue over expenses/net revenue) over the ten-year period.
- Resulting in average annual profits from commercially insured patients of $1.5+ billion per year
- A cumulative total of $15+ billion of revenue above expenses for commercially insured patients over the 10-year period.

18. The following exhibits summarize the data described in the preceding paragraph:



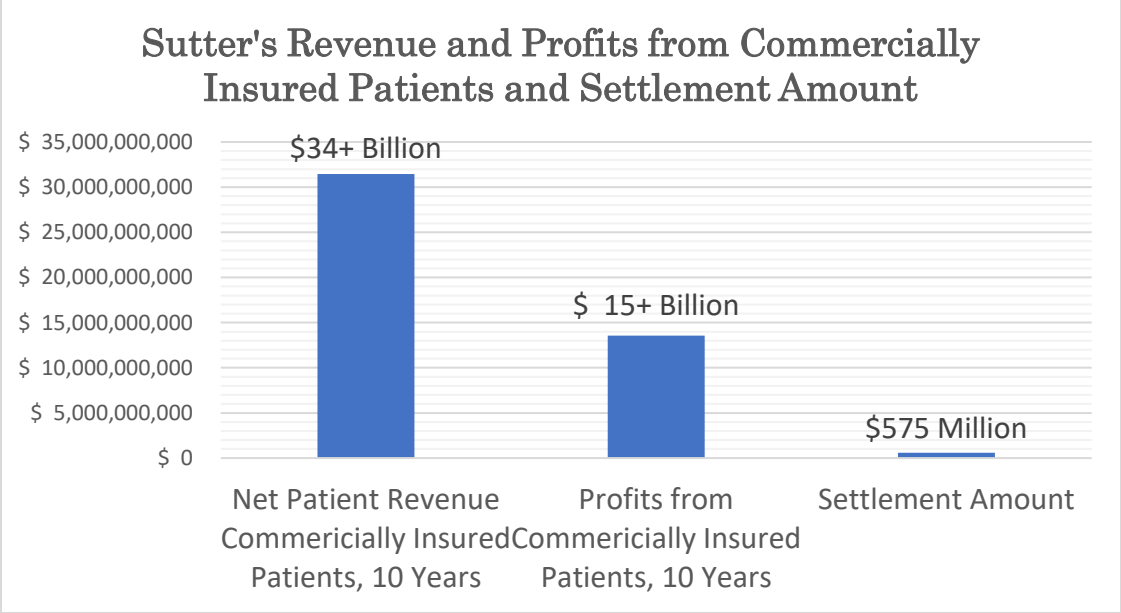
Note: Calculated as: Reported Excess of Revenue over Expenses/Net Revenue, Other Third Parties

Source: OSHPD Financial Pivot Data 2009-2018 (2018 - most recent year Pivot Data are available), Acute Care Hospitals



Note: Calculated as: Reported Excess of Revenue over Expenses, Other Third Parties, Acute Care Hospitals

Source: OSHPD Financial Pivot Data 2009-2018 (2018 most recent year Pivot Data are available)



Note: Net Revenue Calculated as: Reported Cumulative Net Revenue, 2009-2018, Other Third Parties

Source: OSHPD Financial Pivot Data 2009-2018

Policy Makers Have Developed Detailed and Extensive Programs and Policies to Help

Health Care Providers Address the COVID-19 Shock

19. The COVID-19 epidemic has had significant and widespread economic effects on our overall economy, including the health care system. Because of the size of our health care system and its importance in dealing with the epidemic, health care organizations have worked very closely with the federal government to develop targeted aid, subsidies, and other programs to expressly deal with hospital financial losses and other impacts created by the COVID-19 epidemic. This is illustrated by a sample of announcements by the President of the American Hospital Association (AHA)[6]:

> **Rick Pollack, President and CEO, American Hospital Association April 21, 2020:** "The AHA thanks the Administration and leaders in Congress for working to boost funding for the emergency relief fund for hospitals and other providers on the front lines in this legislative package. The efforts to secure additional funding are greatly appreciated by hospitals and health systems across the country who will now be able to continue their efforts on behalf of their patients and communities. Hospitals and health systems are in a unique position because of the loss of revenue from non-emergency medical procedures while incurring increased costs due to preparing and responding to this public health emergency as it continues to spread throughout the country. The initial CARES Act funds are already being used by hospitals and health systems to increase capacity and provide care, and in some cases to keep access to care available by keeping the doors open. This additional funding will help ensure that critical care can continue to be provided by front line providers throughout the country. We also welcome the increased funding for the Paycheck Protection Program, which will help some smaller hospitals meet payroll and other operating costs through forgivable loans."
>
> **Rick Pollack, President and CEO, American Hospital Association, May 1, 2020:** "America's hospitals and health systems appreciate CMS issuing additional regulatory waivers, urged by the AHA, which will help provide needed tools, flexibility and relief in the fight against COVID-19. In particular, we are pleased that CMS will allow teaching hospitals to increase their number of temporary beds without facing reduced payments for indirect medical education. We also thank CMS for expanding telehealth services for patients, mitigating financial penalties for ACOs because of costs associated with responding to the pandemic, and for ensuring that certain hospital outpatient departments that relocate off-campus have the resources needed to

[6] https://www.aha.org/press-release.

continue delivering care. The AHA looks forward to working with CMS on additional waiver suggestions so hospitals and health systems on the front lines can provide the right care in the right location."

Rick Pollack, President and CEO, American Hospital Association June 9, 2020: "The AHA is pleased that HHS will be distributing additional funds from the CARES Act emergency relief fund to hospitals serving high numbers of Medicaid and uninsured patients, as we have suggested. These hospitals care for our nation's most vulnerable patients and communities, which have suffered disproportionately from the pandemic. Due in large part to underlying health conditions, the patients these hospitals treat have been hospitalized at greater rates and require more care and resources once hospitalized. This emergency funding will help these hospitals, many of which were already facing serious financial pressures before the pandemic, continue to deliver care to their patients and communities. While we appreciate the emergency funds released by HHS to date, the AHA continues to urge the department to distribute substantial additional funds to hospitals and health systems in an expedited manner as the COVID-19 virus continues to spread, hospitalizations continue to occur, and many Americans continue to forgo care, including primary care and other specialty care visits."

20. Similarly, the website of the California Hospital Association lists programs that have been developed to assist health care providers as a result of the epidemic (Updated May 6, 2020)[7]:

Provider Relief Fund: Under the CARES Act, $100 billion in total funds is available to hospitals, health systems, and other providers. The Paycheck Protection Program and Health Care Enhancement Act increased the funds available by an additional $75 billion, for a total of $175 billion in provider relief funds. These are payments, not loans, and do not need to be repaid so long as the stated conditions are met.

Accelerated and Advanced Medicare Payments: Under an expanded option through the Medicare Hospital Accelerated and Advanced Payment programs, eligible providers may request payments that cover a period of up to six months. The payment is calculated based on Medicare inpatient, outpatient, and pass-through payment amounts.

[7] https://www.calhospital.org/COVID-19grant; https://www.calhospital.org/sites/main/files/file-attachments/federal_funding_options_050620_final_0.pdf.

Medicare Payment Increase for COVID-19 Patients: Payment increase for Medicare patients with a positive COVID-19 diagnosis

State Hospital Association Grants to Hospitals: The Assistant Secretary for Preparedness Response is authorized to distribute $50 million in grants to state hospital associations with the direction that they distribute the funds within 30 days to local hospitals. California was allocated $4.1 million.

Small Business Loans (for hospitals with fewer than 500 employees): Loan opportunities up to $10 million are available through the Small Business Administration's (SBA) Paycheck Protection Program. Loans may be awarded for up to the lesser of $10 million or 250% of average monthly payroll costs (excluding any compensation above an annual salary of $100,000).

Federal Communications Commission (FCC) Telehealth Program: The CARES Act required the FCC to establish the $200 million emergency COVID-19 Telehealth Program to promote access to connected care services and devices. Up to $1 million per applicant may be available. Support will be based on the estimated costs of the services and connected devices eligible providers intend to purchase. Applicants who exhaust initially awarded funding may request additional support.

21. Regulators have also recognized the importance of developing policies to facilitate the responses by hospitals and other health-care providers to deal with COVID-19. For example, The Antitrust Division of the Department of Justice ("the Division") and the Bureau of Competition of the Federal Trade Commission (the "Bureau," and collectively the "Agencies") have issued guidance to health care providers regarding enforcement of antitrust regulations during the COVID-19 period[8]:

> "….to make clear to the public that there are many ways firms, including competitors, can engage in procompetitive collaboration that does not violate the antitrust laws… Since joint ventures may be necessary for businesses to bring goods to communities in need, to expand existing capacity, or to develop new products or services, the Agencies will also work to expeditiously process filings under the National Cooperative Research and Production Act (as amended by the Standards Development Organization Advancement Act)…."

[8] www.ftc.gov/system/files/documents/public_statements/1569593/statement_on_coronavirus_ftc-doj-3-24-20.pdf.

> "The Agencies will also account for exigent circumstances in evaluating efforts to address the spread of COVID-19 and its aftermath. For example, health care facilities may need to work together in providing resources and services to communities without immediate access to personal protective equipment, medical supplies, or health care".

22. At the same time, regulators are concerned with the need to protect markets from anticompetitive behavior during the COVID-19 period:

> "While many individuals and businesses have and will demonstrate extraordinary compassion and flexibility in responding to COVID-19, others may use it as an opportunity to subvert competition or prey on vulnerable Americans. The Division and the Bureau will not hesitate to seek to hold accountable those who do so".

23. By far the largest Federal COVID-19 related program to date has been the federal CARES Act, with $100 billion in funding targeted to the health care system, as well as the suspension of Medicare sequestration, the delay of Disproportionate Share Hospital payment reductions for hospitals, and deferral of payment (starting in March of 2020) of an employer's share of Social Security taxes. It has been reported that Sutter Health is amongst the top 10 systems recipients of federal aid under this program[9].

24. While recent data suggest that the economic impact to providers in California has begun to moderate (https://www.chcf.org/blog/hospital-ed-visits-in-california-five-other-states-bounce-back-but-remain-well-below-pre-pandemic-levels/), the federal government and other policy makers are continuing to monitor the effects of the COVID-19 epidemic on the US health care system and are expected to continue their support. For example, on May 15, 2020 the House of Representatives voted to approve The HEROES Act to provide an additional $100 billion to reimburse hospitals and other eligible healthcare providers for eligible expenses and lost revenue to prevent, prepare for and respond to COVID-19.[10] In sum, policy makers appear to be continuing working with health care

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[9] https://www.beckershospitalreview.com/finance/which-health-systems-received-the-biggest-cares-act-bailouts.html; Sutter Mot. for Continuance, Decl. of James A Conforti, Exh. A [Sutter Health Voluntary Notice of Event Relating to COVID-19], pages 8-9.

[10] https://www.jdsupra.com/legalnews/u-s-house-passes-heroes-act-12-18945/.

providers and other interested parties to provide needed assistance and other policy changes to monitor the effects of the COVID-19 epidemic and to develop additional policies as needed.

25. It is important to note, all providers are dealing with the COVID-19 epidemic and as such the effects of COVID-19 will be felt market wide and policies are continuously being developed and implemented to ameliorate the negative effects. Although higher market prices may be needed in the future to restore system capacity, any price increases should be determined by the interaction of supply and demand under competitive conditions to protect consumers. The essential point is that Sutter should not be allowed to continue its anti-competitive practices to gain higher prices but rather should participate in the market according the rules of fair competition.

Market Conditions Permitting, Sutter Would Be Able to Increase Its Net Revenue Without Relying on Higher Billed Charges

26. Hospitals and health care providers have suffered unexpected financial losses as a result of patients staying home and disrupting their normal patterns of care utilization.[11] How providers respond to these changes will have significant impacts on affordability of health insurance and health care in California.

27. In addition to requesting a delay in the approval and implementation of the Settlement, Sutter has indicated that it may request changes to the Settlement:

> "Sutter may need to increase its chargemasters above the current limit in the proposed injunction to ensure that it can cover the increased costs of additional PPE and other expenditures necessary to respond to COVID-19."

28. In addition, Sutter appears to support the need to raise billed charges in the following manner:

> "A chargemaster is a primary driver of the revenue necessary to cover the costs of patient care. Conforti Decl. ¶ 17. It includes a list of all the billable procedures, services and items, as well as the associated charge amount. *Id.* In general, providers like Sutter negotiate contracted rates with payers at a discount off the chargemaster."

[11] www.**chcf.org**/publication/financial-impact-covid.

29. As I understand these statements, Sutter is suggesting that it will not be able to negotiate increased net revenue (actual net revenue collected as opposed to "gross revenue") from commercial health plans due the chargemaster limitation in the Settlement. However, a limitation on total chargemaster increases does not provide a binding constraint on increases in net revenue. Research shows that billed charges are generally only one price term used in contracts between hospitals and health plans[12]. Other price terms can include fixed, negotiated price terms that are not based on billed charges, such as:

    - Per-diem-based fixed-dollar payment to hospitals for inpatient stays;
    - Diagnosis-related-group-based fixed-dollar payment for inpatient stays (e.g., the Medicare inpatient methodology);
    - Global-budget hospitals;
    - Bundled episode fixed dollar payments (case rates); and
    - Population-based payments, including capitation, that do not depend on the actual amount of services provided.

30. In fact, the Medicare program pays most hospitals almost entirely on fixed amounts per unit of service (assuming that the fixed amount is more than the billed-charge amount). The essential point here is that should Sutter, in a competitive market, be able to negotiate higher prices in the future, it could use multiple price terms to achieve net-revenue increases that do not rely on billed-charge levels.

31. It is also important to note that a limitation in chargemaster increases can benefit uninsured patients since many uninsured patients received services priced at full billed charges. Removing the Settlement's limitation on annual chargemaster increases would allow Sutter to raise its prices to the uninsured population, since this population in not covered by pre-negotiated price terms.

32. Some uninsured patients may qualify for low-income discounts. Even so, the uninsured population is likely to increase and the number of uninsured patients who receive invoices for payment based on chargemaster rates (full-billed charges) is likely to grow. A Sutter increase in its billed charges could negatively affect this vulnerable population in addition to those covered by commercial insurance. That would be an additional hit to those least able to afford it.

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[12] www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf .

Policy Makers, Both Public and Private, Are Working Together to Address Needed Changes to Normal Operating Conditions as a Result of COVID-19

33. The COVID-19 epidemic has created unforeseen situations that challenge existing systems developed under normal market conditions. However, given the size and importance of the health-care system to the welfare of all citizens, policy makers in both the public and private sector are working together to deal with those unique challenges by adjusting pre-existing systems, protocols, rules, regulations and payment streams. For example, the Federal Government has changed regulations and payment policies specific to COVID-19 care.[13]

34. As I understand it, Sutter feels that it may need to request a change to the Settlement to allow Sutter hospitals to work together in different ways in the event of a future surge. Sutter states: "The rules regarding conditional participation were negotiated based on how Sutter existed and coordinated care in the fall of 2019."

35. Sutter then raises as an example of the potential negative impact on patients if Sutter closes down a service in one of their hospitals and patients need to be referred to a different hospital:

> "If the other hospital is out-of-network during the surge, patients may be forced to make a choice between seeing their Sutter healthcare provider but paying higher out-of-network rates or switching providers during the pandemic. Patients may also choose to wait until the pandemic subsides and the services are restored before seeking care to avoid having to pay out-of-network rates. Ultimately, the lack of an exception could result in discouraging vital treatment during a pandemic."

36. If I understand these statements correctly, Sutter appears to be concerned that in the event of a surge, an in-network Sutter hospital might have to close a specific service and refer these patients to a different Sutter hospital, and, since all-or-none contracting is not allowed under the Settlement, the referred-to Sutter hospital may be out of network. In that scenario, Sutter hypothesizes that the patients could face a higher out-of-pocket cost if they chose to go to that out-of-network Sutter hospital.

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[13] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

37. While this scenario is theoretically possible, immediate approval of the Settlement is not likely to pose an increased risk to consumers in the event of a future surge.

38. First, if COVID-19 were to surge this summer or fall, Sutter's existing contracts with health plans will likely determine a Sutter hospital's in-network or out-of-network status. As such, to the extent these referral relationships exist, they are already in place and are covered by existing contracts, and, depending on contract expiration dates, are not likely to change significantly in the short run.

39. With respect to future pandemics or COVID-19 surges, as discussed, policy makers in both the public and private sectors are working to protect our health care system for the benefit of patients and consumers. This scenario has been considered and the Department of Health and Human Services has offered the following guidance[14]:

> "Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer's prevailing in-network rate. If the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider."

40. Based on experience to date, in the event of a future COVID-19 surge, it is likely that health plans, hospitals, regulators, public health agencies and other interested parties will work closely with each other to facilitate the availability of needed medical care.

41. For example, while Sutter may prefer to keep a referred patient in its network if forced to close a needed service, other nearby non-Sutter-in-network providers may be available to provide that service. That alternative may be better for the patient's social and medical needs. In addition, health plans often work with hospitals to establish protocols, such as Letters of Agreement, to arrange for transfers of patients when the sending hospital cannot furnish the care.

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[14] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

42. Presumably, if a surge were to occur in the future and hospitals needed to close services at specific locations to accommodate COVID-19, health plans and state regulators and other interested parties would work together to address these issues since these issues would likely affect normal referral patterns for patients treated by multiple different providers.

43. A key point here is that should a future surge or similar public health emergency occur, the effects would likely involve providers beyond Sutter hospitals and, as such, policy makers would likely work to develop policies to protect all patients and consumers, including Sutter's patients.

44. Again, as I understand the Settlement, it is designed to restore competition to the hospital market in Northern California and provide immediate and substantial benefits to consumers by restoring price competition to the hospital market in Northern California. At the same time, if the COVID-19-driven concerns raised by Sutter occurred in the future, policy makers would likely address them explicitly to the benefit of our entire health care system.

Date: June 24, 2020

Glenn Melnick

ATTACHMENT 2

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UNITED HEALTHCARE SERVICES, INC.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UFCW & EMPLOYERS BENEFIT TRUST, et al.,

Plaintiffs,

v.

SUTTER HEALTH, et al.,

Defendants.

PEOPLE OF THE STATE OF CALIFORNIA, EX REL. XAVIER BECERRA,

Plaintiffs,

v.

SUTTER HEALTH, et al.,

Defendants.

CASE NO. CGC 14-538451

Consolidated with CGC 18-565398

Assigned for all purposes to
Hon. Anne-Christine Massullo, Dept. 304

DECLARATION OF JANET LUNDBYE

Complaint Filed: April 7, 2014

I, Janet Lundbye, declare the following:

1. I am over the age of 18 and am competent to make this declaration. I have personal knowledge of or am informed and believe the facts in this declaration, and they are true and correct to the best of my knowledge and belief. If called as a witness to testify, I would and could testify as follows:

2. I am currently employed by United Healthcare Services, Inc. ("United") as Vice President of Network Management, responsible for contracting and managing the Northern California provider delivery system. Prior to that, I was employed by United as Regional Vice

President, responsible for value based contracting strategies across the West Region states. Through my employment at United, I have become familiar with United's insurance network product offerings and United's efforts to pursue and build insurance networks in Northern California.

3. United's Systemwide Agreement with Defendant Sutter Health expires at the end of 2020.

4. Earlier this year, United began negotiating a new Systemwide Agreement with Sutter to take effect on January 1, 2021. United sent a proposed amendment and revisions to Sutter in March.

5. United's proposal included the amendment of contract provisions that United believed violated the Proposed Final Judgment as agreed between the parties and filed in this Court.

6. Sutter did not respond to those amended terms, thereby rejecting amendment or removal of those terms in accordance with the Proposed Final Judgment, including anti-tiering and anti-steering provisions.

7. Sutter's rejection of United's proposed amendments was not limited to those provisions of the Proposed Final Judgment that I understand Sutter raises in its Motion for a Continuance.

8. Sutter informed United that it did not want to negotiate provisions United believes violate the Proposed Final Judgment because the final judgment might be amended and would likely be delayed, after which United will need to execute a new contract amendment with Sutter based on the final judgment.

9. United has long offered tiered and premium savings products to its members across the country, and it would like to make these offerings available for Northern California members in light of the provisions in the Proposed Final Judgment, and in anticipation of its approval.

10. Because of that work and because of the expiration of United's contract with Sutter at the end of this year, United has substantial concerns with any delay in the approval

process for the settlement that allows Sutter to delay amendment or removal of provisions that violate the terms of the Proposed Final Judgment in connection with its contract negotiations with United.

11. United respects the sacrifice of healthcare providers on the front lines in responding to the COVID-19 pandemic and has committed substantial resources and effort to support providers, patients, members, and our communities in that fight. Based on our experience, however, United does not view the COVID-19 pandemic as having changed, or as changing, market fundamentals and the critical importance of competition in securing better prices for and higher quality of medical care for patients. These fundamentals are of even greater importance in the COVID-19 era given the unprecedented pressures employers and employees now face.

12. I understand that Sutter states in its Motion for a Continuance that it may need a modification to the injunctive relief in Proposed Final Judgment that bars Sutter's conditional participation contractual provision also known as all-or-nothing contracting in order to accommodate future surges of COVID-19 patients. (Mot. at 15:9-23.) Based on what we know to date, however, it remains speculative as to whether there will be surges, as well as the magnitude of any such surges. Furthermore, based on our experience, there may be alternatives available to out-of-network Sutter providers for patients at the time of any such surges. And based on our experience, United and other payers might agree in the event of surges to benefit waivers under which Sutter patients who were required to use out-of-network providers would be treated as if they remained in-network in order to ensure that Sutter could treat COVID-19 patients.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. This declaration is executed on June 15th in Concord, California.

Janet Lundbye

ATTACHMENT 3

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Senior Assistant Attorney General
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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UFCW & Employers Benefit Trust, on behalf of itself and all others similarly situated

Plaintiffs,

vs.

Sutter Health, et al.,

Defendants.

People of the State of California, ex. rel. Xavier Becerra,

Plaintiff,

vs.

Sutter Health,

Defendant.

Case No. CGC 14-538451
Consolidated with
Case No. CGC-18-565398

DECLARATION OF BECKY C. LACROIX-MILANI

Date: July 9, 2020
Time: 9:15 am
Judge: Hon. Anne-Christine Massullo
Dept.: 304

Action Filed: April 7, 2014

I, Becky C. Lacroix-Milani, declare the following:

1. I am a Senior Director, Contracting & Network Development at Health Net of California, Inc. ("Health Net"). I have worked in Health Net's network management department for over 20 years, including in my current role as Senior Director, Contracting & Network Development. I am, and have been during much of this period, the primary Health Net employee responsible for negotiating provider agreements with Sutter Health and its affiliated hospitals and medical groups ("Sutter"), as well as for certain other hospitals and providers in California. Through my employment at Health Net, I have become familiar with Health Net's insurance network product offerings and its efforts to pursue and build insurance networks in Northern California. I have knowledge of the facts set forth in this declaration and, if called to testify, could and would testify competently thereto.

2. Health Net's Systemwide Agreement with Sutter expires at the end of 2020.

3. Health Net and Sutter will begin negotiating a new Systemwide Agreement soon. Typically, Health Net begins negotiations with Sutter for a new contract between April and August of the year that the old contract expires.

4. Health Net believes that its new contract with Sutter should comply with the provisions of the Proposed Final Judgment ("PFJ") in this case. Health Net is concerned that if the PFJ has not been entered by the Court before the end of the year, Sutter will not agree to exclude the provisions that have been in Health Net's prior Systemwide Agreements with Sutter but which are prohibited by the PFJ. Health Net believes that excluding these provisions from its new contract with Sutter would promote competition in Northern California healthcare markets and would allow Health Net to negotiate more competitive prices with Sutter and other Northern California providers.

5. Additionally, Health Net believes that delay in entering the PJF will unnecessarily complicate negotiations with Sutter by requiring that the parties draft and implement additional

language to retroactively address terms of the PJF that may not become final until after Health Net and Sutter execute an agreement.

6. Health Net has long offered narrow network products in Southern California and to a lesser extent in Northern California. Health Net would like to expand its offerings of such products in Northern California, and may be able to do so in 2021 if the provisions barred by the PFJ were excluded from its forthcoming Systemwide Agreement with Sutter.

7. Based on Health Net's experience to date with the COVID-19 pandemic, I believe that Health Net and other payers likely would agree in the event of surges in COVID cases to benefit waivers under which COVID patients who needed to use out-of-network providers would be treated as if they remained in network.

I declare under penalty of perjury under the laws of California that the foregoing is true and correct.

Executed on June 24, 2020 in Chico, California.

Becky C. Lacroix-Milani

ATTACHMENT 4

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Kathleen Foote
Senior Assistant Attorney General
Michael Jorgenson
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Lead Counsel for Plaintiff UFCW & Employers Benefit Trust and the Class (Additional Counsel not listed)

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UFCW & Employers Benefit Trust, on behalf of itself and all others similarly situated Plaintiffs, vs. Sutter Health, et al., Defendants.	Case No. CGC 14-538451 Consolidated with Case No. CGC-18-565398 **DECLARATION OF DR. MARK GHALY ISO ATTORNEY GENERAL'S STATEMENT IN PLAINTIFFS' OPPOSITION TO SUTTER'S MOTION FOR A STAY**
People of the State of California, ex. rel. Xavier Becerra, Plaintiff, vs. Sutter Health, Defendant.	Date: July 9, 2020 Time: 10:00 am Judge: Hon. Anne-Christine Massullo Dept.: 304 Action Filed: April 7, 2014

I, Dr. Mark Ghaly, hereby declare as follows:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Secretary of the California Health and Human Services Agency (CHHS). I was appointed Secretary of CHHS by Governor Gavin Newsom in April of 2019. I am a Secretary in Governor Newsom's cabinet. My duties as Secretary of CHHS include supervising CHHS departments and offices in administering and overseeing state programs for health care and social services. I am also a pediatrician by training, and I have earned a Master's Degree in Public Health.

3. CHHS is the state's largest agency, overseeing twelve departments and five offices that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians from all walks of life. More than 33,000 people work for departments in CHHS at state headquarters in Sacramento, regional offices throughout the state, state institutions and residential facilities serving the mentally ill and people with developmental disabilities.

4. CHHS oversees the Department of Aging, the Department of Child Support Services, the Department of Community Services & Development, the Department of Developmental Services, the California Emergency Medical Services Authority, the Department of Health Care Services, the Department of Managed Health Care, the Department of Public Health, the Department of Rehabilitation, the Department of Social Services, the Department of State Hospitals, the Office of Health Information Integrity, the Office of Law Enforcement Support, the Office of Statewide Health Planning and Development, the Office of Systems Integration, and the Office of the Patient Advocate. CHHS and its departments and offices are central players in the State's response to the threats posed by COVID-19.

5. On March 4, 2020, Governor Newsom proclaimed a State of Emergency to exist in California as a result of the threat of the Coronavirus Disease 2019 (COVID-19) pandemic. On

March 13, 2020, President Donald Trump declared the COVID-19 outbreak a National Emergency. COVID-19 rapidly spread throughout the nation and California, necessitating urgent guidance, leadership, and action by federal, state and local public health officials.

6. On March 19, 2020, to limit the spread of COVID-19, the State Public Health Officer (who is also the Director of the California Department of Public Health (CDPH)) ordered all individuals living in the State of California to stay at home, except as needed to maintain operation of critical infrastructure sectors or certain other essential needs. This protective measure rapidly changed the lives of Californians, including significant shifts in health care delivery and in the conduct of State business, and was directly responsible for California's relative success in mitigating the worst effects of the COVID-19 pandemic thus far.

7. CHHS and CDPH led the State's efforts to build capacity in California's health care system to treat the expected surge in COVID-19 cases, which included identifying available hospital facilities, negotiating leases, and making arrangements for staffing and operations of hospitals, skilled nursing facilities (SNFs), and alternative care sites. CHHS and CDPH supported existing SNFs and reopening closed facilities. CHHS and CDPH also made arrangements for alternative care sites (e.g., sports facilities and hotels) that could be converted for the treatment of less acute patients, ensuring as many hospital beds were available as possible for patients that need them. Additionally, CHHS has coordinated with various departments and licensing boards to waive or relax provider licensing requirements, maximizing the pool of available providers as cases surge.

8. The CDPH's Laboratory in Richmond is among the twenty-two public health labs in California testing specimen samples for COVID-19. CHHS has partnered with the private sector through the Testing Task Force to expand testing infrastructure and capacity. Thanks to these efforts, on average more than 60,000 tests are now being performed statewide every day. The Testing Task Force is also working with CDPH to increase the state's ability to trace contacts of individuals who have become infected with COVID-19. Additionally, CHHS is working to assess and build the supply chain for swabs, viral media, and other testing processing and

specimen collection supplies, the availability of which has limited the ability to scale testing rapidly.

9. Consistent with Executive Order N-27-20 (Mar. 15, 2020), licensing and enforcement staff at CHHS departments, including CDPH, are now focused on providing technical assistance and supporting compliance with infectious disease protocols, and prioritizing enforcement actions for the most serious violations affecting public health and safety.

10. To support the public health during this State of Emergency, and under the direction of CHHS, CDPH works to obtain medical equipment and supplies; distributes personal protective equipment to health care personnel throughout the state; provides technical support to local health departments, providers, and facilities; issues guidance to protect patients and health care personnel across the continuum of care, with a focus on SNFs and other settings most affected by COVID-19; conducts daily outreach to every SNF to access status and needs; and collaborates with the Department of Social Services (DSS) for infection control trainings for all 14,000 DSS-licensed facilities. Two of CDPH's All Facilities Letters to SNFs provide guidance explaining how a patient's COVID-19 status or testing can affect readmission to a SNF, including an instruction to consult local public health departments before readmitting a patient with confirmed or suspected diagnosis of COVID-19.

11. CDPH has also developed dashboards to provide daily updates on the number of COVID-19 cases, hospitalizations and associated deaths across the state. This includes tracking of COVID-19 infections specifically at SNFs. This information is posted on the CDPH website at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/SNFsCOVID_19.aspx. As of April 28, 2020, CDPH is monitoring COVID-19 infections at 1224 SNFs statewide.

12. Consistent with Executive Order N-27-20, CDPH continues to investigate the most serious complaints to protect the State's most vulnerable residents; conduct enforcement surveys and initiate enforcement actions when surveyors find imminent jeopardy situations in health care facilities; and conduct on-site focused infection control surveys at all SNFs, Intermediate Care Facilities for Individuals with Intellectual Disability, General Acute Care Hospitals, Ambulatory Surgery Centers, and Dialysis Centers.

13. The Department of Health Care Services (DHCS) is also actively engaged in the State's response to the COVID-19 pandemic, working with the federal Centers for Medicare & Medicaid Services (CMS) on multiple Social Security Act section 1135 emergency relief requests, section 1115 waivers, and requests for amendments to the State Plan. These requested flexibilities in federal authority will allow California to quickly and effectively provide care to approximately 13 million Medi-Cal beneficiaries. DHCS also assisted the Governor's Office in preparing an executive order granting flexibility to DHCS and Medi-Cal providers on a variety of deadlines and requirements to ensure the continuity of service to patients is not impacted by the effects of the COVID-19 pandemic.

14. In addition to the efforts described above, CHHS is actively involved with efforts to house individuals experiencing homelessness, a population particularly vulnerable to the spread of COVID-19. This includes procuring travel trailers from the Federal Emergency Management Agency and private vendors and identifying and leasing hotels and motels to provide quarantine capacity for homeless individuals who have tested positive for COVID-19, are symptomatic, or are otherwise at significant risk.

15. CHHS and the Department of Aging have issued guidance supporting older Californians in accessing critically needed resources while the stay-at-home order and social distancing recommendations remain in effect. The State recently announced the new first-in-the-nation program that will deliver three locally prepared nutritious meals by local restaurants each day to qualifying older Californians, at no cost to the recipient.

16. CHHS drafts, revises or reviews the majority of the executive orders and guidance documents advising the public, health care providers, and other entities regarding the safe conduct of business and essential matters during the COVID-19 pandemic. Since the declaration of the State of Emergency, CHHS has provided assistance for at least 20 executive orders issued by Governor Newsom, as well as for guidance issued by CDPH and other departments and offices within CHHS. New and revised guidance will be required as circumstances evolve.

17. Finally, CHHS is working, with the Administration and public health officials, to modify the stay-at-home order as the data and trends support. This includes monitoring data,

consistent with public health recommendations, to determine when it will be safe to ease social distancing requirements, and implementing strategies for appropriate phases of reopening, balancing the health, economic, and social needs of the State.

18. To date, California has not experienced the significant surge that other states and countries have experienced and that stretched their health care systems to capacity. Accordingly, the State has closed or is in the process of closing the surge facilities it has prepared to expand capacity to address COVID-19. The State is readying some of the alternative care sites for use in case they are needed as COVID-19 cases rise, but it is not planning to reopen any State-sponsored surge hospitals.

19. At no point has the Governor directly, or indirectly through state agencies, used his emergency powers to override or supersede antitrust law or excuse anticompetitive actions by any hospital or health care system.

20. Although other state agencies, including the Department of Managed Health Care, have some jurisdiction to address competition in the health care industry, the Attorney General has primary jurisdiction to address provider competition issues on behalf of the State through such vehicles as the Cartwright Act and charitable trusts statutes.

21. Based on my review of the Attorney General's settlement with Sutter Health, including the Proposed Final Judgment setting out the injunctive relief, it is my belief that this settlement does not interfere with the regulation of the health care industry by other entities within CHHS, including the Department of Managed Health Care, in a meaningful way. Although the Department of Managed Health Care has limited jurisdiction over anti-competitive behavior by health care service plans, this jurisdiction is not exclusive. Moreover, Sutter Health is not a health care service plan subject to the jurisdiction of the Department of Managed Health Care.

22. In my view, COVID-19 has not prevented health care providers from compliance with state statutes, regulations, and/or court orders in any respect relevant to the Attorney General's settlement with Sutter Health.

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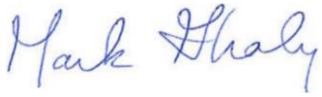
I declare under penalty of perjury of the laws of the State of California that the foregoing is true and correct. Executed this 23rd day of June, 2020, in Sacramento, California.



Dr. Mark Ghaly