No. 21-271

# In the Supreme Court of the United States

RAYMOND BENITEZ, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

*Petitioner,*

v.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY, D/B/A CAROLINAS HEALTHCARE SYSTEM, D/B/A ATRIUM HEALTH,

*Respondent.*

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit**

# BRIEF OF ANTITRUST AND HEALTH POLICY SCHOLARS AND THE AMERICAN ANTITRUST INSTITUTE AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

JAMIE CROOKS
ALISON NEWMAN
FAIRMARK PARTNERS LLP
1499 MASSACHUSETTS AVE., NW
WASHINGTON, DC 20005
(619) 507-4182

J. CARL CECERE
*COUNSEL OF RECORD*
CECERE PC
6035 MCCOMMAS BLVD.
DALLAS, TX 75206
(469) 600-9455
CCECERE@CECEREPC.COM

SEPTEMBER 24, 2021

*COUNSEL FOR AMICI CURIAE*

SUPREME COURT PRESS ♦ (888) 958-5705 ♦ BOSTON, MASSACHUSETTS

## TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ..................................... iii

INTEREST OF THE AMICI CURIAE ....................... 1

SUMMARY OF THE ARGUMENT ........................... 2

ARGUMENT ............................................................. 3

I. ANTICOMPETITIVE BEHAVIOR BY DOMINANT HOSPITALS IS A NATIONAL PROBLEM THAT SIGNIFICANTLY HARMS COMPETITION AND CONSUMERS....................................................... 3

A. Recent Consolidation in the Hospital Industry Has Driven a Stark Increase in Hospital Prices....................................... 3

B. Dominant Hospitals Drive up Costs Through Anticompetitive Contracting Terms, Like Those Atrium Used. ............... 6

II. PRIVATE ANTITRUST SUITS ARE AN IMPORTANT SUPPLEMENT TO GOVERNMENT ENFORCEMENT. .......................................... 9

III. THE ABUSE OF MARKET POWER THAT A BROAD READING OF THE LGAA WOULD INVITE IN THE HOSPITAL MARKET DEMONSTRATES WHY THE LGAA, LIKE ALL ANTITRUST EXEMPTIONS, MUST BE CONSTRUED NARROWLY. .................. 13

A. The LGAA Should Be Interpreted in Line with the Court's State-Action Jurisprudence, Which Views Delegations to Market Actors Skeptically. ........................ 13

**TABLE OF CONTENTS – Continued**

Page

B. Expanding Immunities for Hospital Systems Would Substantially Harm Competition in Health Care Markets. ..... 19

CONCLUSION.......................................................... 24

APPENDIX. LIST OF AMICI PROFESSORS

## TABLE OF AUTHORITIES

Page

### CASES

*Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977) .................................................... 9

*California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980)............................................... 16

*City of Lafayette v. Louisiana Power & Light Co.*, 435 US 389 (1978)...................................... 14

*FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216 (2013) .................................. passim

*FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992) ........................................... 15

*Hoover v. Ronwin*, 466 U.S. 558 (1984) ........................................... 15

*Lorillard v. Pons*, 434 U.S. 575 (1978) ........................................... 15

*Martin v. Mem'l Hosp.*, 86 F.3d 1391 (5th Cir. 1996) ............................ 14

*Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614 (1985) ................... 9

*N. Carolina State Bd. of Dental Examiners v. FTC*, 574 U.S. 494 (2015)......................... 16, 18

*Rotella v. Wood*, 528 U.S. 549 (2000) ........................................... 15

*Tarabishi v. McAlester Regional Hosp.*, 951 F.2d 1558 (10th Cir. 1991) ........................ 23

*Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985) ....................................... 16, 17

**TABLE OF AUTHORITIES – Continued**

Page

*United States v. Charlotte-Mecklenburg Hosp. Auth. ("Atrium Health")*, No. 16-cv-311, ECF 1 (W.D.N.C. June 9, 2016) .......................... 7

*Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100 (1969) ............................................... 9

**STATUTES**

15 U.S.C. § 34 *et seq* ..................................................... 1

15 U.S.C. § 34(1)(a) .................................................. 18

15 U.S.C. § 34(1)(b) .................................................. 18

15 U.S.C. § 35(a) ....................................................... 18

15 U.S.C. § 36(a) ........................................................ 17

**JUDICIAL RULES**

Sup. Ct. Rule 10(a) ..................................................... 23

**LEGISLATIVE MATERIALS**

H.R. Rep. No. 98-965, 21 (1984) ................................. 14

**OTHER AUTHORITIES**

Am. Hosp. Ass'n, *2021 AHA Hospital Statistics* (Jan. 2021), *available at* t.ly/mTEj ........................ 8

Amanda P. Reeves & Maurice E. Stucke, *Behavioral Antitrust*, 86 INDIANA L. REV. 1527 (2011) .......................... 9

**TABLE OF AUTHORITIES – Continued**

Page

Anna Wilde Mathews,
*Behind Your Rising Health-Care Bills: Secret Hospital Deals that Squelch Competition*, WSJ (Sept. 18, 2018), *available at* t.ly/61PGx .................. 7

Avik Roy,
*Affordable Hospital Care Through Competition and Price Transparency*, Found. for Research on Equal Opportunity (Jan. 2020), *available at* t.ly/91Es ............................................................ 4

B. D. Fulton,
*Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFFAIRS (Sept. 2017), *available at* t.ly/EJuc ......................................... 5

Cal. Dep't of Justice,
*Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices*, Press Release (Aug. 27, 2021) ........................................................... 12

Cory Capps, et al.,
*The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, J. OF HEALTH ECON. (May 2018), *available at* t.ly/QUxd .................... 6

Ctrs. for Medicare & Medicaid Servs.,
*National Health Expenditure Fact Sheet* (Dec. 16, 2020), *available at* t.ly/8i06.................. 4

**TABLE OF AUTHORITIES – Continued**

Page

Dennis P. Scannlon, Richard Lindrooth, & Jon B. Christianson, *Steering Patients to Safer Hospitals? The Effect of a Tiered Hospital Network on Hospital Admissions*, HEALTH SERVS. RESEARCH 43:5, Part II (Oct. 2008)......... 8

FTC, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), *available at* t.ly/mPkA ...................................... 21

FTC, *Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System* (Sep. 11, 2020), *available at* t.ly/fqAL .............................. 22

Health Care Cost Inst., *Healthy Marketplace Index* (Sept. 2019), *available at* t.ly/Nl4B........................ 5

Hendrick Health, *Hendrick Health finalizes purchase of Abilene and Brownwood Medical Centers*, Press Release (Oct. 26, 2020)............................ 22

James C. Robinson, *More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits*, Nat'l Inst. for Health Care Mgmt. (Nov. 2011), *available at* t.ly/OG7M............................................................. 5

**TABLE OF AUTHORITIES – Continued**

Page

Jennifer Henderson,
*This Tactic Helps Hospitals Ease Merger Scrutiny*, MEDPAGE TODAY (Apr. 1, 2021), *available at* twtr.to/TZTM................................ 21

Jodi L. Liu, et al.,
*Impact of Policy Option for Reducing Hospital Prices Paid by Private Health Plans*, RAND Corporation (2021) (collecting empirical research), *available at* twtr.to/MS33 ................................................ 21

Lawrence C. Baker, et al.,
*Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending*, HEALTH AFFAIRS (2014), *available at* t.ly/RkOq ................. 4

Leemore Dafny,
*Hospital Industry Consolidation: Still More to Come?*, 370 N. ENG. J. MED. 198 (Jan. 2014) ........................................................ 11

Leslie Stahl,
*How a Hospital System Grew to Gain Market Power and Drove up California Health Care Costs*, CBS NEWS (Dec. 13, 2020), *available at* t.ly/gY0n ............................ 13

Martin Gaynor, Farzad Mostashari, & Paul B. Ginsburg, *Making Health Care Markets Work: Competition Policy for Health Care*, Brookings Inst., (Apr. 2017), *available at* t.ly/u4zg........................................ 4, 5

**TABLE OF AUTHORITIES – Continued**

Page

Michael Kades,
*The State of U.S. Federal Antitrust Enforcement*, Washington Ctr. for Equitable Growth (September 2019), *available at* is.gd/MZZATy ................................ 12

Noam Bauman et al.,
*Hospital Networks: Updated National View of Configurations on the Exchanges*, McKinsey Ctr. for U.S. Health System Reform (June 2014) ............................................ 7

Reed Abelson,
*When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), *available at* t.ly/GBip ......................... 6

Robert H. Lande & Joshua P. Davis,
*Benefits from Private Antitrust Enforcement: An Analysis of Forty Cases*, 42 U.S.F. L. REV. 879 (2008) ............................. 10

Steven Porter,
*Nonprofit Hospitals and Antitrust Enforcement: Should FTC Have Jurisdiction?*, HEALTHLEADERS (Sept. 17, 2019), *available at* t.ly/I3Df .............................. 11

The Kaiser Family Found and Health Research and Educ. Trust, *Employer Health Benefits: Annual Survey* (2014) ........................... 8

Timothy T. Brown and
James C. Robinson, *Reference Pricing with Endogenous or Exogenous Payment Limits: Impacts on Insurer and Consumer Spending*, HEALTH ECON. (2015) ........................... 7

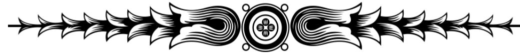
**TABLE OF AUTHORITIES – Continued**

Page

Traci Prevost, et al.,
*The Potential for Rapid Consolidation of Health Systems*, Deloitte (Dec. 2020), *available at* twtr.to/347V .................................... 5

U.S. Dep't of Justice, Antitrust Div.,
*Summary of Antitrust Division Health Care Cases (Since August 25, 1983)*, *available at* t.ly/xulS ........................................ 11

Zack Cooper, Martin Gaynor, et al.,
*Hospital Prices and Health Spending Among the Privately Insured*, NBER DIGEST (Feb. 2016), *available at* t.ly/gB4N.......... 5



## INTEREST OF THE AMICI CURIAE[1]

*Amici* antitrust and health policy scholars[2] and the American Antitrust Institute are experts in the antitrust and/or hospital contracting issues underlying this significant case. Their sole interest in filing this brief is to ensure that federal antitrust law—in particular the Local Government Antitrust Act, 15 U.S.C. § 34 *et seq.* ("LGAA")—is applied consistently with this Court's precedents, Congress's intent in passing the LGAA, and the longstanding policy favoring robust market competition that undergirds all federal antitrust policy.

*Amicus* the American Antitrust Institute ("AAI") is an independent non-profit organization devoted to promoting competition that protects consumers, businesses, and society. It serves the public through research, education, and advocacy on the benefits of competition and the use of antitrust enforcement as a vital component of national and international competition policy. AAI enjoys the input of an Advisory Board that consists of over 130 prominent antitrust lawyers, law professors, economists, and business leaders. *See* http://www.antitrustinstitute.org.[3]

---

[1] Counsel for *amici* state that no counsel for a party authored this brief in whole or in part, and no person other than *amici* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

[2] *Amici* antitrust and health policy scholars are listed in the Appendix.

[3] Individual views of members of AAI's Board of Directors or Advisory Board may differ from AAI's positions.

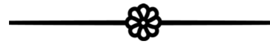
*Amici* are concerned that the decision below, 992 F.3d 229 (2021), effectively grants Respondent—the Charlotte-Mecklenburg Hospital Authority, which does business as Atrium Health, ("Atrium")— total immunity from private antitrust suits for damages. Such a ruling will prevent those directly harmed by anticompetitive conduct, such as Atrium's contracting practices at issue here, from having incentive to sue and supplement government enforcement of federal antitrust law. *Amici* are particularly concerned that other hospital monopolists and similar multi-state, multi-billion dollar competitive enterprises will follow Atrium's playbook and evade financial liability for antitrust violations.

## SUMMARY OF THE ARGUMENT

Over the past two decades the U.S. hospital industry has been transformed by consolidation, which has resulted in a worrisome increase in the market power of hospital systems in local and regional markets across the country. Now, three in five Americans live in a region in which the market for hospital services is "highly concentrated" based on the measure the U.S. Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") use to evaluate the threat of market power. Because the academic literature makes clear that this market consolidation has led directly to significantly higher hospital prices, due in large part to anticompetitive contracting practices engineered by Atrium and many others, the decision to grant such a system immunity from private antitrust litigation as a "local government" under the LGAA is an important one warranting this Court's consideration.

Moreover, the Fourth Circuit's decision below conflicts with both the plain meaning of the LGAA and Congress's purpose in enacting it. The Act is designed to protect local political bodies from interference in performing their regulatory functions. It is not designed to prevent multi-state, multi-billion dollar organizations like Atrium—which has an annual revenue "several times larger than the entire City of Charlotte," Pet. at 21—from paying for the harm their anticompetitive conduct has caused.

*Amici* respectfully submit that, in order to provide lower courts with the guidance necessary for interpreting the LGAA's immunity provisions, and to resolve the clear circuit split the Fourth Circuit's decision created, *see* Pet. at 15-20, certiorari is warranted.



## ARGUMENT

### I. ANTICOMPETITIVE BEHAVIOR BY DOMINANT HOSPITALS IS A NATIONAL PROBLEM THAT SIGNIFICANTLY HARMS COMPETITION AND CONSUMERS.

#### A. Recent Consolidation in the Hospital Industry Has Driven a Stark Increase in Hospital Prices.

In recent years, domestic spending on hospital care has risen to shocking and unprecedented heights. In 2019, before the COVID-19 pandemic disrupted healthcare markets, hospital care spending grew by 6.7% to reach $1.2 trillion. This spending constitutes approximately one third of all healthcare expenditures, or roughly 5.6% of the United States economy writ

large. *See*, *e.g.*, Ctrs. for Medicare & Medicaid Servs., *National Health Expenditure Fact Sheet* (Dec. 16, 2020), *available at* t.ly/8i06. This means that hospital care amounts to 14.7% of median household income, three times more than what is spent on prescription drugs, and more than families pay in income and payroll taxes combined. Avik Roy, *Affordable Hospital Care Through Competition and Price Transparency*, Found. for Research on Equal Opportunity (Jan. 2020), *available at* t.ly/91Es.

One "key reason" for the immense growth of hospital care spending has been "the dearth of competition" brought on by the recent surge in mergers and acquisitions in hospital markets nationwide. Martin Gaynor, Farzad Mostashari, & Paul B. Ginsburg, *Making Health Care Markets Work: Competition Policy for Health Care*, Brookings Inst., (Apr. 2017), *available at* t.ly/u4zg. Since 2010, the volume of hospital mergers has increased by 50% and shows little sign of slowing. Remarks of FTC Commissioner Rebecca Kelly Slaughter to the Center for American Progress (May 14, 2019), *available at* t.ly/GGoL; Lawrence C. Baker, et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending*, HEALTH AFFAIRS (2014), *available at* t.ly/RkOq. Acquisitions have rapidly increased as well, with the share of U.S. physician practices owned by hospitals more than doubling from 2002 to 2008. *Ibid.* By 2019, 90% of metropolitan areas and nearly 75% of hospital markets were deemed "highly concentrated" under the Herfindahl-Hirschman Index ("HHI"), the standard DOJ and FTC uses for assessing concentration in relevant markets. Health Care Cost Inst., *Healthy Marketplace Index* (Sept. 2019), *available at*

t.ly/Nl4B. By the end of 2020, the top 10 health systems in the country controlled 24% of the national market—and their revenue grew twice as fast as that of the rest of the industry. Traci Prevost, et al., *The Potential for Rapid Consolidation of Health Systems*, Deloitte (Dec. 2020), *available at* twtr.to/347V.

Today, three-fifths of Americans live in a highly concentrated hospital market, and tens of millions live in markets with only one or two hospital providers, including metropolitan areas such as Boston, San Francisco, Cleveland, Pittsburgh, and Milwaukee. *See* B. D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFFAIRS (Sept. 2017), *available at* t.ly/EJuc; Gaynor, et al., *Making Health Care Markets Work*, *supra* p.4, at 7.

The causal relationship between these two trends —the increase in market concentration and the increase in the costs of hospital care—is well documented. In one study comparing the costs of six common procedures across markets, costs were 44% higher in markets with above-average concentration. James C. Robinson, Nat'l Inst. for Health Care Mgmt., *More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits* (Nov. 2011), *available at* t.ly/OG7M. Across the board, hospitals with monopoly power charge 15.3% more than hospitals that have to compete with three or more local rivals. Zack Cooper, Martin Gaynor, et al., Nat'l Bureau of Econ. Research, *Hospital Prices and Health Spending Among the Privately Insured* (Feb. 2016), *available at* t.ly/gB4N. Research focused on the effects of individual mergers or acquisitions show a similar effect: After being acquired by a larger system,

the price of the same service provided by the same physician increases by an average of more than 14%. Cory Capps, et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, J. OF HEALTH ECON. (May 2018), *available at* t.ly/QUxd. And in highly concentrated areas, the price of an average hospital stay went up between 11 and 54% in the years after a merger. *See* Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), *available at* t.ly/GBip.

### B. Dominant Hospitals Drive up Costs Through Anticompetitive Contracting Terms, Like Those Atrium Used.

As is the case for dominant firms in almost every industry, when hospitals have monopoly power, they extract supracompetitive prices for their services.[4] Once they become a "must have" system that insurers need to include in their network, dominant hospitals demand higher prices for the same services. *See* Cooper, et al., *supra* p.5. But in recent years, hospital monopolies have gone beyond charging insurers higher prices directly, to engage in a variety of anticompetitive contracting mechanisms that reduce patient choice and drive up costs. One such mechanism is "anti-steering" provisions: contractual terms that are designed to inhibit competition between hospitals

[4] Indeed, this phenomenon is especially pronounced for hospitals due to the very high financial and regulatory barriers to entry. Unlike most industries, "it is not true, as a general matter, that competing providers can easily overcome a hospital's must-have status by replicating its services. The required investment could be enormous and barred by state law or regulators." Amicus Brief of DOJ, *Marion Healthcare LLC v. S. Ill. Healthcare*, 12-cv-871, ECF 361, at 6 (S.D. Ill. Feb. 8, 2018).

and which raise costs for insurers, employers, and patients. These strategies prevent patients from getting treatment from lower-cost physicians, reducing co-payments, or even obtaining information about the costs and quality of alternative procedures. *See generally* Anna Wilde Mathews, *Behind Your Rising Health-Care Bills: Secret Hospital Deals that Squelch Competition*, WSJ (Sept. 18, 2018), *available at* t.ly/61PGx.

For years, Atrium forced these anticompetitive restrictions on all major insurers until the DOJ and North Carolina's Department of Justice sued it to enjoin the practice. *See* Complaint, *United States v. Charlotte-Mecklenburg Hosp. Auth. ("Atrium Health")*, No. 16-cv-311, ECF 1, at 7-8 (W.D.N.C. June 9, 2016) ("DOJ Complaint"). This antitrust enforcement action was, in part, precipitated by a growing academic literature demonstrating that, in many circumstances, when insurers are permitted to steer their members to cheaper and better alternative hospitals, prices go down and health outcomes improve. Specifically, studies have demonstrated that steering can lower insurers' costs significantly,[5] reduce patients' premiums by approximately 20%,[6] and cause patients more often

---

[5] *See*, *e.g.*, Timothy T. Brown and James C. Robinson, *Reference Pricing with Endogenous or Exogenous Payment Limits: Impacts on Insurer and Consumer Spending*, HEALTH ECON. (2015) (finding lower costs when pension fund steered through use of reference price on joint replacements); *Hospital Networks: Updated National View of Configurations on the Exchanges*, McKinsey Ctr. for U.S. Health System Reform (June 2014) (nationally nearly 70% of lowest-price products built around narrow or tiered networks), *available at* t.ly/KlFC.

[6] *Id.*

to choose safer hospitals.[7] Patients also generally prefer plans that offer steering—if given the choice.[8]

In filing its case against Atrium, the DOJ and the North Carolina Department of Justice recognized that Atrium's imposition of anti-steering provisions on all its major contracting partners caused significant financial harm to insurers, employers, and patients. DOJ Complaint, at 7. But while anti-steering provisions are highly prevalent in today's consolidated hospital markets, antitrust litigation led by federal or state enforcers is rare. Moreover, the only remedy obtained in the DOJ action was an injunction to stop future anticompetitive practices, offering no recompense to the hundreds of thousands of patients affected by these practices. Granting immunity under the LGAA from private damages actions to quasi-public entities like Atrium—of which there are hundreds in the United States, *see* Am. Hosp. Ass'n, *2021 AHA Hospital Statistics* (Jan. 2021), *available at* t.ly/mTEj—will seriously hamper effective policing of dominant hospital systems' use of anti-steering and other anticompetitive contracting terms.

---

[7] *See*, *e.g.*, Dennis P. Scannlon, Richard Lindrooth, & Jon B. Christianson, *Steering Patients to Safer Hospitals? The Effect of a Tiered Hospital Network on Hospital Admissions*, HEALTH SERVS. RESEARCH 43:5, Part II (Oct. 2008).

[8] The Kaiser Family Found and Health Research and Educ. Trust, *Employer Health Benefits: Annual Survey* at 6 (2014) (nationally 19% of employers that offer health benefits have high performance or tiered networks in the most heavily enrolled plan), *available at* t.ly/kuKF.

## II. PRIVATE ANTITRUST SUITS ARE AN IMPORTANT SUPPLEMENT TO GOVERNMENT ENFORCEMENT.

Unlike in most Western countries, where antitrust enforcement falls exclusively to the government, in the United States enforcement is divided between both the government and private plaintiffs. The authors of the Sherman Act included a treble damages provision to incentivize private parties to investigate and bring claims against anticompetitive actors, as well as to ensure that those injured by violations would be compensated. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 486 n.10 (1977) (Sherman Act was "conceived of primarily as a remedy for '[t]he people of the United States as individuals,' especially consumers," and the treble-damages provision of the Clayton Act was "conceived primarily as 'open[ing] the door of justice to every man . . . and giv[ing] the injured party ample damages for the wrong suffered.'" (citations omitted)); *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 130-31 (1969) ("[T]he purpose of giving private parties treble-damage and injunctive remedies was not merely to provide private relief, but was to serve as well the high purpose of enforcing the antitrust laws."). Thus, the Court has recognized that the Sherman Act's "treble-damages provision . . . is a chief tool in the antitrust enforcement scheme," and "a crucial deterrent to potential violators." *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 635 (1985); *see also* Amanda P. Reeves & Maurice E. Stucke, *Behavioral Antitrust*, 86 INDIANA L. REV. 1527, 1567-70 (2011) (noting industry-wide responses to significant antitrust prosecutions and settlements).

Private antitrust litigation also often serves as a catalyst for government action against the same anti-competitive conduct. As Professors Lande and Davis explain:

> As a practical matter, the government cannot be expected to do all or even most of the necessary enforcement for various reasons including: budgetary constraints; undue fear of losing cases; lack of awareness of industry conditions; overly suspicious views about complaints by "losers" that they were in fact victims of anticompetitive behavior; higher turnover among government attorneys; and the unfortunate, but undeniable, reality that government enforcement (or nonenforcement) decisions are, at times, politically motivated.

Robert H. Lande & Joshua P. Davis, *Benefits from Private Antitrust Enforcement: An Analysis of Forty Cases*, 42 U.S.F. L. REV. 879, 906 (2008). Given these realities, government enforcers often must rely on private litigants to uncover wrongdoing, which the enforcers can then assist in rectifying by intervening or bringing their own enforcement action. In the same article quoted above, the authors empirically evaluated 40 of the largest antitrust actions that had occurred in the two decades prior, and concluded that "almost half of the underlying violations were first uncovered by private attorneys, not government enforcers, and that litigation in many other cases had a mixed public/private origin." *Id.* at 880. In short, private antitrust enforcement is an important supplement to—and often catalyst for—enforcement by government agencies.

This is especially true when it comes to monopolistic behavior by hospitals. *See generally* Leemore Dafny, *Hospital Industry Consolidation: Still More to Come?*, 370 N. ENG. J. MED. 198, 199 (Jan. 2014) ("[U]nless new public and private initiatives are developed to discourage consolidation and to support enforcement of antitrust law, most of these [hospital] deals will proceed unchallenged."). One FTC commissioner, when talking about the lack of hospital antitrust enforcement, offered this laundry list of impediments: "resource constraints, pre-merger reporting limitations, a legal shield for anticompetitive conduct by non-profit hospitals, high evidentiary burdens, threatened loss of high quality public data, and state laws or actions that inhibit enforcement." Remarks of Commissioner Rebecca Kelly Slaughter to the Center for American Progress (May 14, 2019), *available at* t.ly/GGoL. To its credit, the FTC has recently begun to step up pre-merger review of hospitals—but after a hospital merger is consummated, if the entity is a non-profit (as most hospitals are) the FTC does not have jurisdiction to bring a case to enjoin anticompetitive conduct. Steven Porter, *Nonprofit Hospitals and Antitrust Enforcement: Should FTC Have Jurisdiction?*, HealthLeaders (Sept. 17, 2019), *available at* t.ly/I3Df.

The DOJ has also been largely unable to devote resources to policing misconduct in this increasingly consolidated industry. Its anti-steering case against Atrium was one of just ten antitrust cases it has filed against a hospital in the past decade. U.S. Dep't of Justice, Antitrust Div., *Summary of Antitrust Division Health Care Cases (Since August 25, 1983)*, *available at* t.ly/xulS; Michael Kades, *The State of U.S. Federal*

*Antitrust Enforcement*, Washington Ctr. for Equitable Growth (September 2019) at 7, *available at* is.gd/MZZATy. And most of these cases were focused on market segmentation (competing hospitals agreeing to divide up the market geographically), *id.*, rather than on anticompetitive monopoly practices, which hospitals likely have more ability to impose given the past decade's consolidation and which are much more directly related to hospital prices. *See supra* pp.3-8.

By contrast, private antitrust litigation has been especially impactful with respect to hospital monopolies —and has been an important catalyst for government intervention. This is best exemplified by the recently settled case against Sutter Health in California, the most significant anti-steering case to date. Only after years of litigation, precipitated by a private antitrust suit, was it revealed that Sutter's restrictive practices imposed immense harm, including price increases of more than 15%. The California Attorney General later intervened, which led to a preliminary (and eventually court-approved) settlement reached on the eve of trial for $575 million. Cal. Dep't of Justice, *Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices*, Press Release (Aug. 27, 2021). Health and Human Services Secretary Xavier Becerra, who was California's Attorney General when the State intervened, said that the Sutter settlement "is gonna change the life for hundreds of thousands of Californians. And I'd say millions of Americans because I think you're gonna see other states take what we did and say, 'Ah-hah. We've got some facilities that are behaving the same way. Let's push.'" 60 Minutes, *How a Hospital System Grew to Gain Market Power*

*and Drove up California Health Care Costs*, CBS NEWS (Dec. 13, 2020), *available at* t.ly/gY0n. Given how commonly anticompetitive contracting terms are imposed by hospital monopolies, Secretary Becerra was right about the Sutter suit's national importance. And that case was brought because injured private litigants were motivated to pursue the damages they had suffered.

## III. THE ABUSE OF MARKET POWER THAT A BROAD READING OF THE LGAA WOULD INVITE IN THE HOSPITAL MARKET DEMONSTRATES WHY THE LGAA, LIKE ALL ANTITRUST EXEMPTIONS, MUST BE CONSTRUED NARROWLY.

### A. The LGAA Should Be Interpreted in Line with the Court's State-Action Jurisprudence, Which Views Delegations to Market Actors Skeptically.

For several decades, the Court has rightfully been hesitant to grant immunity to market participants that have been delegated general powers by state or sub-state government bodies and that use that power to act anticompetitively. That skepticism, which the Court has articulated repeatedly in the closely related doctrine of the state-action defense, should inform courts' interpretation of the LGAA, which was modeled on the Court's state-action jurisprudence. Specifically, when determining whether a quasi-public market participant like Atrium is a "special function governmental unit" entitled to LGAA immunity, courts should not only interpret that term in light of its neighbors; they should also consider whether the relevant entity resembles the kinds of "local governments" Congress sought to protect, in light of the

backdrop against which Congress passed the statute. Interpreted properly, the LGAA cannot serve to immunize Atrium—a multi-state, multibillion dollar health system that competes in the marketplace against other hospitals.

In passing the LGAA, Congress deliberately and explicitly modeled the statute on the Court's doctrine conveying antitrust immunity for "state action." *See* H.R. Rep. No. 98-965, at 21-22 (1984) ("House Report"); Pet. at 8-10. It passed the statute for a particular, narrow purpose: to ensure that municipalities and local agencies would not be held liable for antitrust damages for regulatory actions even if those actions were not taken pursuant to a clearly articulated State policy. House Report, at 14. But otherwise, it left the state-action doctrine intact, and indeed "endorsed and expanded on it." *Martin v. Mem'l Hosp.*, 86 F.3d 1391, 1397 (5th Cir. 1996) (the LGAA "endorsed and expanded the state action doctrine"). It certainly did not seek to insulate private actors from antitrust damages that would not be entitled to protection under the state-action doctrine.[9]

Under this Court's statutory interpretation precedents, when Congress legislates against the backdrop of a body of law with settled meaning, courts should

---

[9] Indeed, in the House Report accompanying the LGAA, the Judiciary Committee quoted approvingly from this Court's decision in *City of Lafayette v. Louisiana Power & Light Co.*, with emphasis: "<u>If municipalities were free to make economic choices counseled solely by their own parochial interests and without regard to their anticompetitive effects, a serious chink in the armor of antitrust protection would be introduced at odds with the comprehensive national policy Congress established</u>." House Report, at 14.

look to that settled meaning when interpreting the later-enacted statute. *See*, *e.g.*, *Rotella v. Wood*, 528 U.S. 549, 557 (2000) (looking to the Clayton Act to interpret RICO because "there is a clear legislative record of congressional reliance on the Clayton Act when RICO was under consideration"); *Lorillard v. Pons*, 434 U.S. 575, 581 (1978) ("[W]here, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."). In the context of the LGAA, this means that courts should interpret the statute's definition of "local government"—*i.e.*, the entities Congress desired to be immune from private antitrust damages—in light of the state-action immunity framework Congress legislated against when it passed the statute.

As a general matter, state-action immunity "'is disfavored, much as are repeals by implication.'" *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216, 217 (2013) (quoting *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992)). But the Court has made clear that a key factor in determining the doctrine's applicability is the nature of the entity being sued and its relation to the State's sovereign authority.

Specifically, the Court's state-action cases reveal three relevant categories of state actor, each treated differently. First, when the State itself takes an action as sovereign—*e.g.*, through the legislature or the state supreme court acting legislatively—the action is *per se* immune from antitrust liability. *See Hoover v. Ronwin*, 466 U.S. 558, 569 (1984) ("When the conduct is that of the sovereign itself * * * the danger of unauthorized restraint of trade does not arise.").

Second, when a sub-state political body, such as a city or county government, displaces competition through a local regulation, that regulation can be defended from antitrust liability if it was enacted pursuant to a "clearly articulated and affirmatively expressed state policy." *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 44 (1985) (citation omitted). Third, when the State delegates authority to a private actor, the actor can assert this delegation as an antitrust defense only if it meets the "clear articulation" requirement and is "actively supervised by the State." *Phoebe Putney*, 568 U.S. at 225 (quoting *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)). With respect to this third category, the Court has noted that antitrust law treats an actor as private (and thus in need of state supervision) whenever it is an active market participant, regardless of whether state law delegated authority to the actor or treated it as public or quasi-public. *See N. Carolina State Bd. of Dental Examiners v. FTC*, 574 U.S. 494, 496 (2015) ("*Midcal*'s active supervisions test is an essential prerequisite of [state-action] immunity for any non-sovereign entity—public or private—controlled by active market participants." (emphasis added)); *id.* at 510 ("State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal*'s supervision requirement was created to address."); *id.* at 505 ("Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants."). While the state-action doctrine protects States' sovereign prerogatives, "[i]t does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade

associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity * * * is to be invoked." *Id.* at 515 (emphasis added); *id.* at 515 ("[T]he state supervisor may not itself be an active market participant.").

The LGAA's text reflects that a similar framework should apply to local governments and their delegees. Like the first category described above—when the State itself acts as sovereign—the LGAA similarly grants absolute immunity from damages to "any local government, or official or employee thereof acting in an official capacity." 15 U.S.C. § 35(a) (emphasis added). Second, damages are barred "against a person" if that person takes an action "based on any official action directed by a local government, or official or employee thereof acting in an official capacity," *id.* § 36(a), which mirrors the state-action doctrine's requirement that for sub-state actors immunity is only available when they act pursuant to a policy that the State "clearly articulated and affirmatively expressed." *Town of Hallie*, 471 U.S. at 44.

This case involves the third category—not a local political body, nor a private entity taking action at a local political body's direction, but rather a market participant created as a sub-local entity and whose challenged conduct (*i.e.*, imposing anti-steering provisions) was not undertaken pursuant to any local government's direction. Under the state-action doctrine, such an entity would be entitled to an antitrust defense only if it were acting pursuant to a clearly articulated State policy and it was actively supervised by the State, because "the need for supervision turns not on the formal designation given by States to

regulators but on the risk that active market participants will pursue private interests in restraining trade." *N. Carolina Bd. of Dental Examiners*, 574 U.S. at 510.

Under the LGAA, the question of whether such actions taken by a quasi-public entity are entitled to such a defense is answered by looking to the statute's definition of "local government." That term has two defined meanings. The first, which is irrelevant here, covers sub-state political bodies: "a city, county, parish, town, township, village, or any other general function governmental unit established by State law." 15 U.S.C. § 34(1)(a). Like the State itself under the state-action doctrine, these entities are immunized by the LGAA whenever they "act in their official capacity." *Id.* § 35(a).

The second category of "local government" is "a school district, sanitary district, or <u>any other special function governmental unit</u> established by State law in one or more States." *Id.* § 34(1)(b) (emphasis added). Under normal rules of statutory interpretation, and the particular context in which Congress passed the LGAA, the term "special function governmental unit" should not be read to immunize market participants that take profit-motivated anticompetitive actions that serve no express local government policy and that are not actively supervised by such governments.

As the petition details, the *noscitur a sociis* canon and the plain meaning of the term "local government" should resolve this case. The term "special function governmental unit" follows two more specific examples—"school district" and "sanitary district"—that should inform the catch-all term's interpretation and preclude immunizing profit-maximizing entities like

Atrium that come nowhere close to resembling the listed examples. Pet. at 30-31. Courts should also be mindful when interpreting "special function governmental unit" that the phrase is ultimately part of a definition of a well-understood term—"local government"—that Congress clearly did not expect to apply to a multi-state, multi-billion-dollar entity. *Id.* at 21-25.

*Amici* agree with these interpretive arguments that Petitioner raises. *Amici* write separately to emphasize that the meaning of "special function governmental unit" should also be informed by the policies underlying this Court's state-action jurisprudence, and with an understanding that an overly broad reading of "local government"—like the Fourth Circuit's below—risks effectively immunizing broad swaths of anticompetitive conduct that risks damaging patients. Moreover, this would impute to Congress a perverse intent to confer greater protection to private delegations made by non-sovereign local entities than the protection afforded to private delegations by sovereign state entities under the state-action doctrine. This is particularly true in the context of the hospital sector, an extremely consolidated industry that has already suffered from overly broad grants of antitrust immunity to dominant systems, as discussed below.

### B. Expanding Immunities for Hospital Systems Would Substantially Harm Competition in Health Care Markets.

*Amici*'s concern about overly broad immunity for hospital monopolies leading to higher prices is not hypothetical—this path has been tried in States across the country. Each time, the result has been the

same: Once they enjoy immunity, dominant hospital systems only grow larger and displace more competition, and they use their unchecked market power to raise prices significantly. Because this kind of anticompetitive harm cannot be what Congress sought to protect when it legislated to immunize "local governments," this experience should also inform courts' interpretation of the LGAA.

This Court confronted the hospital consolidation problem in *Phoebe Putney*, a recent state-action case. There, a state-created hospital system claimed the right to violate federal antitrust law (by merging to monopoly) because such conduct was a "foreseeable result" of Georgia granting the system the authority to acquire other hospitals. 568 U.S. at 223. The Court rightly rejected that argument, noting that "when a State grants an entity a general power to act, it does so against the backdrop of federal antitrust law," and Georgia had not made clear that it desired Phoebe Putney to eliminate all of its competitors. *Id.* at 231. Absent a clear expression from the State that it wished the hospital authority to displace all competition, the Court recognized that Phoebe Putney—despite being a quasi-state actor—should not enjoy the antitrust protection reserved for truly state action, at least absent some clearer indication that that is what Georgia intended. *Id.*

Unfortunately, States have all too often been impelled to substitute anticompetitive regulation for federal antitrust law without appreciating the harm this inflicts on hospital markets and patients. This has occurred primarily through Certificates of Public Advantage, or COPAs, statutes or regulations that, if they satisfy the state-action doctrine's requirements,

*see supra* pp.14-15, may protect hospitals from antitrust scrutiny in exchange for limited oversight by the State. *See*, *e.g.*, Jennifer Henderson, *This Tactic Helps Hospitals Ease Merger Scrutiny*, MEDPAGE TODAY (Apr. 1, 2021), *available at* twtr.to/TZTM. According to the FTC, "States are increasingly using COPAs to allow certain hospital mergers to proceed despite clear antitrust concerns, with the assumption that state regulatory oversight will mitigate the effects resulting from the elimination of competition and allow the hospitals to achieve certain efficiencies." FTC, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), *available at* t.ly/mPkA. But instead "[e]merging evidence suggests that the antitrust immunity granted by COPAs leads to higher prices." Jodi L. Liu, et al., *Impact of Policy Option for Reducing Hospital Prices Paid by Private Health Plans*, RAND Corporation (2021) at 33 (collecting empirical research), *available at* twtr.to/MS33.

Despite this evidence, dominant hospital systems have been highly successful in lobbying for immunity under COPAs,[10] over the FTC's strong objections. For instance, in 2020, in response to a proposed merger between two Texas hospitals that were the sole competitors in a region, the FTC filed an expansive report opposing the merger and the proposed COPA that would insulate it from federal antitrust scrutiny. *See*

---

[10] Dominant hospitals often enjoy natural local political power, given that they are commonly the largest employer in their region. And the hospital industry spends more in lobbying than nearly any other industry—in 2017, for instance, hospitals and nursing homes spent more in lobbying than the automotive, defense/aerospace, and commercial banking industries. Roy, *supra* p.4.

FTC, *Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System* (Sep. 11, 2020), *available at* t.ly/fqAL. The Commission rejected the hospitals' claim that the merger would lead to increased efficiency, accessibility, and higher quality of care, arguing that "supplanting antitrust laws with a regulatory scheme that allows for provider consolidation in highly concentrated markets likely undermines these laudable goals." *Id.* at 2. Instead, "[c]ompetition has proven to be a more reliable and effective mechanism for controlling healthcare costs" than supposed efficiency-enhancing mergers. *Id.* at 3. Nonetheless, a COPA was issued, rendering the resulting monopoly likely immune from federal antitrust law, and the merger was consummated. *See* Hendrick Health, *Hendrick Health finalizes purchase of Abilene and Brownwood Medical Centers*, Press Release (Oct. 26, 2020).

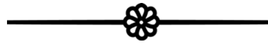
While COPAs are an increasing cause for concern, they at least offer the prospect of oversight by politically accountable state officials, because under the state-action doctrine and this Court's *Phoebe Putney* and *North Carolina Board of Dental Examiners* decisions—COPAs only immunize hospital monopolies from antitrust scrutiny to the extent the systems pursue a clearly articulated state policy under the active supervision of the State. *See supra* p.14-16. By contrast, the Fourth Circuit's decision that Atrium was entitled to LGAA immunity turned not at all on the existence of such oversight and accountability. Instead, having found that Atrium is a "special function governmental unit" because it was "established by State law" as a quasi-public entity, the court below immunized Atrium's conduct from private antitrust

damages without inquiring whether this conduct served *any* express local government interest at all. *See* 992 F.3d at 238-40.

Given past abuses by hospitals of government-granted antitrust immunity, *amici* fear that the decision below will serve as a playbook for dominant hospital systems to evade damages actions for anticompetitive conduct across the country. Of the 6,090 community hospitals in the United States, 962—nearly 16%—are "State and Local Government Community Hospitals." Am. Hosp. Ass'n, *2021 AHA Hospital Statistics* (Jan. 2021), *available at* t.ly/mTEj. After *Phoebe Putney*, state-action immunity will only protect such systems, at a minimum, to the extent state legislatures have made explicit their desire to eliminate competition. But the Fourth Circuit's decision, if allowed to stand, would permit any hospital system that is "quasi-municipal"—even those like Atrium with revenues that dwarf their locality's total budget, *see* Pet. at 21—to enjoy total immunity from private antitrust damages, a key enforcement tool aiding government enforcement of anticompetitive behavior. *See supra* pp.9-13.

In light of the foregoing, *amici* submit that the question of whether a multi-state, multi-billion dollar hospital system can reasonably be considered a "local government" immune from private antitrust damages is an important one warranting this Court's review. *See* Sup. Ct. Rule 10(a). This is especially true given the conflict between the Fourth Circuit's decision below and the Tenth Circuit's contrary decision denying LGAA immunity to a highly similar quasi-governmental hospital authority in *Tarabishi v. McAlester Regional Hosp.*, 951 F.2d 1558 (10th Cir. 1991). *See*

Pet. at 15-20. Given the enormous economic stakes, the need for lower courts to have guidance when confronting similar hospital systems, and the tension between the Fourth Circuit's decision and decades of this Court's well-considered state-action jurisprudence, *amici* believe that review of the decision below on the merits is warranted. *Amici* therefore respectfully urge the Court to grant the petition.



## CONCLUSION

For the foregoing reasons and those stated in the Petition, the Court should grant the petition for writ of certiorari.

Respectfully submitted,

J. CARL CECERE
*COUNSEL OF RECORD*
CECERE PC
6035 MCCOMMAS BLVD.
DALLAS, TX 75206
(469) 600-9455
CCECERE@CECEREPC.COM

JAMIE CROOKS
ALISON NEWMAN
FAIRMARK PARTNERS LLP
1499 MASSACHUSETTS AVE., NW
WASHINGTON, DC 20005
(619) 507-4182

*COUNSEL FOR AMICI CURIAE*

SEPTEMBER 24, 2021

## APPENDIX
## LIST OF AMICI CURIAE PROFESSORS

**Note*: University affiliations are listed for informational purposes only; the views expressed in the accompanying brief do not necessarily reflect the views of *amici*'s academic institutions.

**Peter Carstensen**

Professor Emeritus, Fred W. & Vi Miller Chair in Law Emeritus, University of Wisconsin-Madison Law School

**Thomas Cheng**

Associate Professor, Hong Kong University

**Zack Cooper**

Associate Professor of Public Health (Health Policy), Economics, and in the Institution for Social and Policy Studies, Yale School of Public Health

**David M. Cutler**

Otto Eckstein Professor of Applied Economics, Harvard University

**Guy David**

Alan B. Miller Professor, Professor of Health Care Management, Professor of Medical Ethics and Health Policy, Perelman School of Medicine, Chair, Health Care Management Department, Wharton School of the University of Pennsylvania

**Einer R. Elhuage**

Carroll and Milton Petrie Professor of Law, Harvard Law School

**Randall P. Ellis**

Professor, Boston University Department of Economics

**Roger Feldman**

Professor Emeritus, Division of Health Policy and Management, University of Minnesota School of Public Health

**H.E. Frech, III**

Professor of Economics and Technology Management, University of California, Santa Barbara

**Ezra Friedman**

Professor of Law, Northwestern University Pritzker School of Law

**Martin S. Gaynor**

E.J. Barone University Professor of Economics and Public Policy, Carnegie Mellon University

**Paul B. Ginsburg**

Professor of the Practice of Health Policy and Management, University of Southern California Sol Price School of Public Policy, Director of Public Policy, USC Schaeffer Center, Director, USC-Brookings Schaeffer Initiative for Health Policy

**Matthew Grennan**

Associate Professor of Economic Analysis and Policy, University of California Berkeley Haas School of Business

**Hiba Hafiz**

Assistant Professor of Law, Boston College Law School

**Barton H. Hamilton**

Robert Brookings Smith Distinguished Professor of Economics, Management & Entrepreneurship and Academic Advisor Center for Experiential Learning, Washington University in St. Louis Olin Business School

**Igal E. Hendel**

Ida C. Cook Professor, Northwestern University Department of Economics

**Vivian Ho**

James A. Baker III Institute Chair in Health Economics, Professor of Economics, Rice University

**Max Huffman**

Professor, Indiana University Robert H. McKinney School of Law

**John B. Kirkwood**

Professor of Law, Seattle University School of Law

**Robert H. Lande**

Venable Professor of Law, University of Baltimore

**Thomas McGuire**

Professor of Health Economics, Harvard Medical School Blavatnik Institute of Health Care Policy

**Salil K. Mehra**

Charles Klein Professor of Law and Government, Temple University Beasley School of Law

**Fiona M. Scott Morton**

Theodore Nierenberg Professor of Economics, Yale University School of Management

**Joseph P. Newhouse**

John D. MacArthur Research Professor of Health Policy and Management, Harvard Kennedy School

**Stephen T. Parente**

Professor Minnesota Insurance Industry Chair of Health Finance, University of Minnesota Carlson School of Management

**Mark V. Pauly**

John M. Bendheim, W'40 and Thomas L. Bendheim, WG'90 Professor Emeritus of Health Care Management, Wharton School of the University of Pennsylvania

**Robert Porter**

William R. Kenan, Jr. Professor, Northwestern University Department of Economics

**Barak Richman**

Katharine T. Bartlett Professor of Law, Professor of Business Administration, Duke University

**Mark Satterwhaite**

Professor Emeritus of Strategy, Kellogg School of Management at Northwestern University

**Alan T. Sorensen**

Professor of Economics, University of Wisconsin

**Amanda Starc**

Associate Professor of Strategy, Kellogg School of Management at Northwestern University

**Ashley T. Swanson**

Assistant Professor of Economics, Columbia Business School

**Katherine Swartz**

Adjunct Professor of Health Policy of Economics, Harvard T.H. Chan School of Public Health