ANKUR MANDHANIA (State Bar No. 302373)
Ankur.Mandhania@mto.com
MUNGER, TOLLES & OLSON LLP
560 Mission Street
27th Floor
San Francisco, California 94105
Telephone: (415) 512-4000
Facsimile: (415) 512-4077

Attorney for Amicus Curiae American Hospital Association

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

STANFORD HEALTH CARE; Sutter Bay Medical Foundation, a California nonprofit public benefit corporation, d/b/a PALO ALTO MEDICAL FOUNDATION for Health Care, Research, and Education; CALIFORNIA HOSPITAL ASSOCIATION; and NORMAN W. RIZK, M.D.,

Petitioners,

vs.

BETH MINOR, in her official capacity as the Palo Alto City Clerk, and CITY OF PALO ALTO,

Respondents.

ELI AKERIB,

Real Party in Interest.

Case No. 18CV330068

BRIEF OF AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

Judge: Hon. James L. Stoelker
Date: July 27, 2018
Time: 9:30 a.m.
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INTEREST OF AMICUS CURIAE

The American Hospital Association (AHA) represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 43,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

INTRODUCTION

Palo Alto would not be the first government entity to impose mandatory price controls on hospitals. In the 1970s and 1980s, a small number of States—but never a city—tested out mandatory rate-setting regimes. *Amicus curiae* American Hospital Association respectfully submits that this Court would benefit from understanding the history of these hospital price control laws. After all, "[i]n resolving many complex legal issues, as Justice Oliver Wendell Holmes, Jr., observed, 'a page of history is worth a volume of logic.'" (*People v. Williams* (2013) 57 Cal.4th 776, 790 [quoting *New York Trust Co. v. Eisner* (1921) 256 U.S. 345, 349].)

This history is particularly important given the legal claims that Petitioners have raised. As to Petitioners' preemption claims, the fact that no municipality has ever imposed price controls on hospitals should, at the very least, raise red flags for this Court about whether Palo Alto has the legal authority to do so. In addition, history reveals that Congress expressly invited these earlier State rate-setting experiments. Such an invitation is not only lacking today, but the Affordable Care Act provides a powerful signal that Congress sought to bring down the costs of hospital services using measures *other than* rate caps. (See 42 U.S.C. § 300gg–18(e).)

As to Petitioners' due process claims, the history of State-level price control provides a strong indication that the Initiative is designed to fail—or at least will not achieve the objectives expressed in its "Purpose and intent" subsection. That subsection states:

> The prices charged to patients and other payers have far-reaching effects on consumers purchasing health care services and insurance, as well as taxpayers supporting public health and welfare programs. Investments in quality of care improvements can benefit patients and caregivers, and ultimately result in lower overall health care costs. For these reasons, and because neither the State nor federal governments have yet done so, this Chapter seeks to impose reasonable limits on prices that hospitals and other health facilities may charge and encourages futher investment in health care quality improvements.[1]

[1] Palo Alto Accountable and Affordable Care Initiative § 5.40.010 <http://www.seiu-uhw.org/wp-content/blogs.dir/166/files/2017/12/Palo-Alto_BallotInitiative.pdf> (hereafter Initiative).

But the Initiative does not require hospitals to invest in improvements in health care quality. Nor does it rely on any findings or evidence that price caps on hospital revenues will translate into improvements in health care quality. And perhaps most glaring of all, the Initiative does not actually limit prices charged to patients or ensure that the dollars saved will benefit those patients in any way. Instead, it targets local hospitals, clinics, and doctors, and forces them to pay rebates to *insurance companies* and other payors without any requirement that the rebates be passed on to *patients*. The Initiative and its sponsors have not explained why it makes sense to arbitrarily single-out hospitals and other health care providers for price controls. History demonstrates that this single-minded focus on hospital revenues is deeply misguided.

Perhaps most alarmingly, the Initiative places vast and standardless discretion in the hands of Palo Alto's Administrative Services Department to provide "variances" from its strict price caps. But as best as *amicus* can tell, that Department normally deals with parking tickets and revenue collections—not complex health care issues or questions requiring expertise in hospital administration. Indeed, section 2.08.150 of the Palo Alto Municipal Code, which defines the duties of the Administrative Services Department, provides no comfort that this body has any expertise in the complex health care issues the Initiative would thrust upon it.[2] Instead, it indicates that the Division is better equipped to act as a city's Chief Financial Officer than as the City's Chief Medical Officer. Standing alone, this would raise serious due process concerns. Even worse, the history described below shows that if hospital price controls have any chance of succeeding—and most do not—then officials with greater familiarity with health care issues must make the critical decisions about costs and variances.

To be clear: the American Hospital Association recognizes that providing affordable health care in America, California, and municipalities like Palo Alto is vitally important. *Amicus* is committed to ensuring that all individuals and families have the affordable health care coverage they need to reach their highest potential for health. But by any measure, the Initiative is doubly-

[2] Palo Alto Mun. Code, § 2.08.150 <http://library.amlegal.com/nxt/gateway.dll/California/paloalto_ca/paloaltomunicipalcode?f=templates$fn=default.htm$3.0$vid=amlegal:paloalto_ca>.

myopic: it unwisely focuses on one city and unfairly penalizes one stakeholder. History teaches that the Initiative is not only misguided health care policy, but it raises profound legal concerns.

ARGUMENT

A small handful of States have experimented with hospital rate-setting laws. Beginning in the early 1970s, seven States enacted legislation establishing price control programs for hospital rates.[3] As one recent comprehensive study explained:

> Mandatory rate setting first developed in New York State in 1971 with the establishment of a program, eventually housed in the state Department of Health, that covered hospital rates paid by Medicaid and Blue Cross. Massachusetts also created an independent rate setting commission around this time that was empowered to approve Blue Cross contracts with all Massachusetts hospitals and set rates for Medicaid beginning in 1975.
>
> ….
>
> New Jersey similarly began setting rates in 1974 for only Blue Cross and Medicaid, under the aegis of the state Department of Health. Independent commissions with the authority to set rates for non-Medicare payers in Maryland, Washington, and Connecticut also started setting rates in 1974, 1975, and 1976, respectively.… The West Virginia system was implemented in 1985 and applied only to commercial insurers (including Blue Cross plans).[4]

These laws differed in many key respects, but four historical lessons from these State experiments are relevant here.

First, as best as *amicus* can determine, no municipality has *ever* imposed price controls on hospitals. Indeed, the "Palo Alto Accountable and Affordable Care Initiative" would be the first of its kind in the history of the United States.[5] While seven States have imposed such laws, the American Hospital Association has searched in vain for examples where cities, towns, counties, or

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[3] Atkinson, *State Hospital Rate-Setting Revisited* (2009) 69 Commonwealth Fund pub. 1332 <https://pdfs.semanticscholar.org/275e/9c9f8190f1fd4ca66b83bf475f58a2b01333.pdf> (hereafter Atkinson).

[4] Murray & Berenson, Urban Institute, Research Report: Hospital Rate Setting Revisited, Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform? (Nov. 2015), p. ix <https://urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf> (as of July 9, 2018) (hereafter Murray).

[5] A near-identical initiative (the "Livermore Accountable and Affordable Care Initiative"), which was drafted and promoted by the same entities as Palo Alto's initiative, will be considered on the City of Livermore's November 6, 2018 ballot.

other localities have enacted such laws. Not only has the American Hospital Association conducted extensive research into whether any municipalities have imposed such laws, but it has polled state hospital associations for examples. That research and polling turned up *nothing*.

In fact, the only non-State efforts at hospital price controls that *amicus* could identify underscore the deep flaws in Palo Alto's proposed measure. Other than the seven States mentioned above, there have been two regional hospital price control arrangements in upstate New York. In both instances, however, the local hospitals *voluntarily* agreed to self-imposed revenue limits. In the first arrangement, eight short-term general hospitals and one acute-care unit of a county hospital in the Rochester, New York area participated in an experimental program to limit total revenue from all payers.[6] This program "marked the first time a group of hospitals voluntarily signed a contract committing themselves to such a regional financing system, affecting all hospital patient care."[7] In the second arrangement, a group of eight hospitals in four rural contiguous counties in the Finger Lakes area of New York entered into a similar cooperative effort to control costs.

In both of these example, the revenue caps had the support of the key stakeholders—the hospitals themselves—as well as "business, insurers, and local government."[8] One study rightly

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[6] Friedman & Wong, *Impacts of Hospital Budget Limits in Rochester, New York* (1995) 16 Health Care Finance Review 201, 201 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193527/pdf/hcfr-16-4-201.pdf> (hereafter Friedman & Wong).

[7] Block, Regenstreif & Griner, *A Community Hospital Payment Experiment Outperforms National Experience* (Jan. 9, 1987) 257 JAMA193, 194.

[8] Friedman & Wong, *supra*, at p. 201; Hall & Griner, *Cost-Effective Health Care: The Rochester Experience* (1993) 12 Health Affairs 58, 63 <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.12.1.58> (hereafter Hall & Griner) ("There is a long history of cooperation and innovation among the various parties interested in health care in Rochester."). One study has suggested that Rochester was able to succeed at this effort, in part, because hospitals and academic medical centers cooperated and were invited to "become active members of the[] community partnerships." (Hall & Griner, *supra*, at p. 68.) *Palo* Alto's compulsory approach flies in the face of these important keys to success, thereby suggesting that the arbitrary means included in the proposed ballot initiative will not achieve its stated goals of "impos[ing] reasonable limits on prices that hospitals and other health facilities may charge and encourage[ing] further investment in health care quality improvements." (Initiative, *supra*, § 5.40.010 <http://www.seiu-uhw.org/wp-content/blogs.dir/166/files/2017/12/Palo-Alto_BallotInitiative.pdf>.)

observed that these cooperative conditions "might not be easily replicated in other areas."[9] But Palo Alto and the sponsors of the Initiative never even tried to replicate such cooperation. They did not attempt to bring local hospitals together, along with other relevant stakeholders, to address what they apparently perceived as a problem of rising hospital costs or diminishing health care quality. Instead, the Palo Alto initiative will foist stringent price controls on its hospitals at the municipal level. That has never been done before.

The total absence of any examples of a city like Palo Alto affirmatively imposing price controls on hospitals is, in itself, quite telling. "Of course, not every proposition of law that is unprecedented is necessarily wrong or invalid." *d'Elia v. d'Elia* (1997) 58 Cal.App.4th 415, 427. But "the absence of precedent ought to give lawyers and judges a clue that they are on the wrong track." *Id*. at 428. This commonsense maxim applies with particular force in this case. The fact that Palo Alto is attempting to do what no other city has ever done before should cause this Court to think twice about whether State and federal law permits this kind of municipal overreach.

Second, many of these State initiatives were preceded by massive increases in hospital spending, which policymakers believed necessitated strict rate caps. As one study observed, from "1970 to 1975, spending on hospital services grew at an annual rate of 13.4 percent."[10] In vivid contrast, present-day growth in hospital spending is dramatically lower. According to a recent report by the Altarum Institute's Center for Sustainable Health Spending, national spending for hospital care grew just *1.9%* over the 12 months that ended in September 2017.[11] And looking forward, projections for hospital spending growth are *less than half* than the high rates that occurred in the early 1970s. According to the Centers for Medicare & Medicaid Services' Office

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[9] Friedman & Wong, *supra*, at p. 201.

[10] Atkinson, *supra*.

[11] Altarum's Center for Sustainable Health Spending, Health Sector Economic Indicators, Spending Brief (Nov. 9, 2017) p. 1 <https://altarum.org/sites/default/files/uploaded-related-files/CSHS-Spending-Brief_November_2017.pdf> (as of July 9, 2018). The report concluded that this low growth rate "may reflect the continuing shift in the delivery of care from inpatient to outpatient settings and in hospitals' ongoing efforts to control costs." (*Id*. at p. 2.)

of the Actuary, hospital spending will grow about only 5.5% each year between 2018 and 2026.[12] This data reveals a critical distinction between the circumstances that gave rise to state-level revenue caps in the 1970s and the contemporary situation.

What is more, the financial condition of American hospitals is not what it was in the 1970s. According to the Harvard Business Review, "[s]ince the beginning of 2016, the financial performance of hospitals and health systems in the United States has significantly worsened. This deterioration is striking because it is occurring at the top of an economic cycle."[13] This report provided some basic explanations for this deep decline in hospital revenues:

> Increases in operating expenses outpaced growth in revenues. After a modest surge in inpatient admissions from the Affordable Care Act's coverage expansion in the fall of 2014, hospitals have settled in to a lengthy period of declining hospital admissions.
>
> At the same time, hospitals have seen their prices growing at a slower rate than inflation. Revenues from private insurance have not fully offset the reductions in Medicare payments stemming from the Affordable Care Act and federal budget sequestration initiated in 2012.…
>
> The main cause of the operating losses, however, has been organizations' lack of discipline in managing the size of their workforces, which account for roughly half of all hospital expenses. Despite declining inpatient demand and modest outpatient growth, hospitals have added 540,000 workers in the past decade.[14]

And these are not the only financial challenges facing American hospitals. In addition to declining admissions, decreased insurance revenue, and increased labor spending:

- Skyrocketing regulatory costs have deeply impacted hospitals' bottom line. Nationally, it is estimated that hospitals, health systems, and post-acute care providers spend nearly $39 billion annually on the administrative aspects of regulatory compliance. An average-sized community hospital spends $7.6 million per year, or $1,200 per admission, to support compliance with regulations from just four federal agencies. Compounding the burden associated with this patchwork of federal regulatory requirements, hospitals also must contract with more than 1,300

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[12] Commins, *Hospital Spending Growth Forecast at 5.5% Annually Though 2026* (Feb. 14, 2018) HealthLeadersMedia <https://healthleadersmedia.com/finance/hospital-spending-growth-forecast-55-annually-though-2026> (as of July 9, 2018).

[13] Goldsmith, *How U.S. Hospitals and Health Systems Can Reverse Their Sliding Financial Performance* (Oct. 5, 2017) Harvard Business Review, at p. 1 <https://hbr.org/2017/10/how-u-s-hospitals-and-health-systems-can-reverse-their-sliding-financial-performance> (as of July 9, 2018).

[14] *Id*. at pp. 2-3.

commercial insurers nationally, each with their own reporting and administrative requirements.[15]

- Hospitals are forced to pay far too much for prescription drugs. While retail spending on prescription drugs (what consumers pay) increased by 10.6 percent between 2013 and 2015, hospital spending on drugs in the inpatient space rose 38.7 percent per admission.[16]

- America's hospitals and health systems also continue to provide a significant amount of uncompensated care. In 2016 alone, hospitals provided $38.3 billion in uncompensated care—up more than $2 billion from 2015.[17]

Despite these many financial challenges, the Palo Alto initiative would place the burden of controlling health care costs *solely* on hospitals and other health care providers. In today's health care market, hospitals cannot and should not be expected to bear the burden of reducing costs throughout the entire health care system.

It perhaps should come as no surprise that the Initiative takes such a myopic approach. By imposing these price controls through a top-down ballot initiative process, rather than through reasoned legislative debate that includes all stakeholders, the Initiative predictably fails to account for the effects it will have on hospitals. For example, the Initiative includes *no findings* about spending on hospital services in Palo Alto, California, or the United States, or how those services compare to other drivers of health care spending. Nor does the Initiative attempt to connect its price controls to its stated goal of improving health care quality. The Initiative simply assumes that imposing stringent price caps on hospitals will lead to "[i]nvestments in quality of care improvements" that "can benefit patients and caregivers, and ultimately result in lower overall

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[15] Am. Hospital Assn., Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers (Oct. 2017), p. 4 <https://aha.org/guidesreports/2017-11-03-regulatory-overload-report> (as of July 9, 2018); Am. Hospital Assn., Statement of the Am. Hospital Assn. for the Committee on Health, Education, Labor and Pensions of the U.S. Senate (June 27, 2018) Hearing on How to Reduce Health Care Costs, p. 2 <https://www.aha.org/system/files/2018-06/180627-statement-help.pdf> (as of July 9, 2018) (hereafter Statement of the Am. Hospital Assn.).

[16] NORC at the Univ. of Chicago for the Am. Hospital Assn. and the Federation of Am. Hospitals, (Oct. 11, 2016) Final Report: Trends in Hospital Inpatient Drug Costs: Issues and Challenges, p. 1 <https://www.aha.org/system/files/2018-01/aha-fah-rx-report.pdf> (as of July 9, 2018); Statement of the Am. Hospital Assn., *supra*, p. 2.

[17] Am. Hospital Assn., Uncompensated Hospital Care Cost Fact Sheet (Dec. 2017), p. 3 <https://aha.org/statistics/2018-01-03-uncompensated-hospital-care-cost-fact-sheet-december-2017-update> (as of July 9, 2018).

health care costs."[18] And not only does the Initiative fail to demonstrate that its price controls will cure any asserted problems, it also fails to account for the many offsetting economic and social benefits that hospitals provide to the local community.[19] While the municipal initiatives process may be "free from any such fact-finding prerequisite," the lawfulness of the Initiative depends on the existence of sufficient facts to justify it as a "curative measure."[20] Those facts are entirely absent here.

Third, the history of State-level price controls demonstrates that almost all of them were quickly abandoned. Of the seven States that experimented with such controls, only *two* (Maryland and West Virginia) continue to impose them. There is a simple reason why most States dumped their rate-setting regimes: they did not work as well as their promoters hoped.[21]

Perhaps somewhat surprisingly, the American Hospital Association initially supported these regimes in the 1970s.[22] This support clearly demonstrates that *amicus* is not reflexively or

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[18] Initiative, *supra*, § 5.40.010.

[19] Am. Hospital Assn., Hospitals are Economic Anchors in Their Communities (Jan. 2017) <https://aha.org/statistics/2018-03-29-hospitals-are-economic-anchors-their-communities> (as of July 9, 2018). In fact, data released last week shows that in the first half of 2018, hospitals added more than 40,000 jobs nationally. (News Release, Bureau of Labor Statistics, U.S. Dept. of Labor, The Employment Situation (June 2018), Table B-1 <https://www.bls.gov/news.release/archives/empsit_07062018.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top> (as of July 9, 2018).) Health care, and hospital employment in particular, has been a jobs engine for years. Even though the Palo Alto initiative would treat "salaries, wages, and benefits of nonmanagerial hospital, medical clinic, or other provider staff" as a "reasonable cost," (Initiative, *supra*, § 5.40.030(b)(1)), it does not provide evidence that more staff inherently leads to improved quality of care, nor does its definition of "reasonable costs" account for the full range of services hospitals provide to their patients and the community.

[20] *Birkenfeld v. City of Berkeley* (1976) 17 Cal.3d 129, 145, 160.

[21] Even in the Maryland, where the price control remains, the results are mixed. Hospital costs per case grew less rapidly in Maryland than nationwide, but hospital cost per capita and total personal health spending grew more rapidly in Maryland. (Pauly & Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency* (Aug. 2012) 37 Journal of Health Politics, Policy and Law 697, 698-99.) A recent CMS report on Maryland's system also indicated mixed results in achieving its goals. (See RTI Internat., Centers for Medicare & Medicaid Services, Evaluation of the Maryland All-Player Model (Mar. 2018) Third Annual Report <https://downloads.cms.gov/files/cmmi/md-all-payer-thirdannrpt.pdf> (as of July 9, 2018).)

[22] Crozier, *State Rate Setting: A Status Report* (1982) 1 Health Affairs 66, 68 <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.1.3.66> (hereafter Crozier).

dogmatically anti-rate-setting. But by 1980, the Association's House of Delegates voted formally to abandon its promotion of state rate setting because it was not working. And by 1982, the Association submitted testimony to the Senate Finance Subcommittee on Health explaining:

> State rate review is not a sound alternative for addressing hospital cost increases. While such review has resulted in temporary benefits in some states, it poses numerous potential problems. These include: failure to address the demand side of health care costs; creation of ponderous bureaucracies with unwieldy reporting systems; unfair preferences for certain payers, which create inequities; high costs of operating rate review agencies, complying with their regulations, and resolving through litigation the inequities they create; rates so low that hospitals deplete their capital resources, jeopardizing their future financial stability, their ability to serve the poor, and their very existence; and revenue controls without costs controls.[23]

There is no reason to think that Palo Alto's price control system can avoid these flaws. In fact, there is every reason to think that it will suffer those same flaws—and more. For example, even the historical studies that favor some forms of price setting conclude that *the design* of such systems is critical to success. According to one historical study, for example, "the logic and promise of state-based rate setting lies in the potential of all-payer rate setting, through the approval of a Medicare waiver to give the program authority over Medicare spending rates, subject to meeting strict performance tests."[24] The Palo Alto initiative, however, completely carves out Medicare, a transparent recognition that a municipality cannot regulate public prices as would be necessary for the scheme to work.[25]

Similarly, the same favorable historical study concludes that a "governing board should comprise part-time, volunteer (as opposed to full-time, paid) commissioners, who have a strong interest and expertise in health care financing, delivery, and policy issues, and who have no affiliation with a regulated entity."[26] But the Initiative places complete and standardless control in the hands of the Administrative Services Department, a pre-existing government entity ostensibly

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[23] *Ibid.*

[24] Murray, *supra*, p. 75.

[25] Initiative, *supra*, § 5.40.020(g).

[26] Murray, *supra*, p. 75.

more associated with revenue collection and receiving payment for parking tickets than complex areas of health care policy.[27] Yet the Initiative would grant this revenue-collecting office the unfettered authority to make determinations about appropriate hospital costs and expenditures.

In these and other ways, the sponsors' failure to subject its policy proposal to considered legislative debate has led to a price control regime that is designed to fail, just as similar systems failed in virtually of all of the States that explored such regimes decades ago.

Fourth, unlike today, the federal government invited these state-level attempts at hospital rate-setting. In 1972, Congress enacted an amendment to the original Medicare legislation that expressly permitted States to develop innovative programs that "included both voluntary and mandatory rate setting programs that covered commercial insurers."[28] In particular, section 222 expressly allowed the Secretary of Health, Education, and Welfare to "develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals."[29]

Today, by contrast, Congress has indicated no such support for hospital rate-setting measures. In fact, the Affordable Care Act (ACA) sends precisely the opposite message. The ACA contains a section entitled "Bringing down the cost of health care coverage." (See 42 U.S.C. § 300gg–18.) By its own terms, this provision imposes a range of measures designed to control costs throughout the health care system. The contrast between the ACA's cost-control measures for insurers, on the one hand, and hospitals, on the other hand, is instructive.

Subsection (b) of this provision contains a classic price control measure for insurer premiums on a state-wide basis. It provides that "a health insurance issuer offering group or individual health insurance coverage" must issue a rebate if it fails to spend a specified percentage of its collected premiums on health care costs. (*Id*. § 300gg–18(b)(1)(A).) Under this subsection,

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[27] City of Palo Alto, Administrative Services <https://cityofpaloalto.org/gov/depts/asd/default.asp> (as of July 9, 2018); Palo Alto Mun. Code, § 2.08.150.

[28] Murray, *supra*, p. 7.

[29] Pub.L. No. 92-603, § 222(a)(1) (Oct. 30, 1972) 86 Stat. 1379, 1390.

a health care insurer that spends less than 85 percent (80 percent for certain smaller employers) of the health care premium dollars it receives to provide medical care (*e.g.*, doctors and hospital bills) must rebate the percentage difference directly to policy holders.

A different subsection addresses how to "[b]ring down the cost" of hospital expenses. Subsection (e) provides that "[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title." (*Id.* § 300gg–18(e).) In other words, rather than imposing a price control on hospitals, Congress chose a different route. It sought to influence hospital costs through transparency—not through direct price regulation.

The contrast between the 1970s and today is striking. As studies have recognized, "[t]hroughout the 1970s, the federal government was more or less a friend of the state rate-setting concept. Be the administration Democratic or Republic, there was a general propensity to encourage interested states—through federal financial support and other policy steps—to pursue health care cost containment through rate setting."[30] The absence of such express support in the ACA (or, for that matter, Department of Health and Human Services policy pronouncements or the wider health care policy debate) indicates that Palo Alto's outlier approach should be treated with great skepticism.

CONCLUSION

Amicus American Hospital Association respectfully submits that the historical lessons described above support Petitioners' request that this Court remove the Palo Alto Accountable and Affordable Care Initiative from Palo Alto's November 6, 2018 ballot.

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[30] Crozier, *supra*, at p. 66; McDonough, *Tracking the Demise of State Hospital Rate Setting* (January/February 1997) 16 Health Affairs 142, 142 ("Rate setting was developed with the encouragement of the federal government through two acts of Congress in 1972 and 1983 and with support from successive administrations. Indeed, President Jimmy Carter's ill-fated 1979 hospital cost containment legislation was an attempt to replicate nationally this favored cost containment tool.").

DATED: July 13, 2018

MUNGER, TOLLES & OLSON LLP

By: /s/ Ankur Mandhania
ANKUR MANDHANIA

Attorney for Amicus Curiae American Hospital Association