No. 21-2603

United States Court of Appeals for the Third Circuit

FEDERAL TRADE COMMISSION,
Plaintiff-Appellee,

v.

HACKENSACK MERIDIAN HEALTH, INC.;
ENGLEWOOD HEALTHCARE FOUNDATION,
Defendants-Appellants.

On Appeal from the United States District Court for the District of New Jersey,
No. 2-20-cv-18140, Hon. John M. Vazquez

BRIEF OF CATALYST FOR PAYMENT REFORM AS *AMICUS CURIAE* IN SUPPORT OF APPELLEE AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 29(a)(4)(A) and 26.1 and Third Circuit L.A.R. 26.1, *amicus curiae* Catalyst for Payment Reform states:

Catalyst for Payment Reform has no parent corporation, and no publicly held corporation owns 10% or more of its stock. Catalyst for Payment Reform is not aware of any publicly held corporation not a party to this appeal that has a financial interest in the outcome of this proceeding.

November 5, 2021

/s/ Eric F. Citron
Eric F. Citron

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INTEREST OF AMICUS CURIAE[1]

Amicus Curiae Catalyst for Payment Reform (CPR) is an independent, nonprofit organization working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. CPR is composed of over 30 private and public health care purchasers interested in pushing for higher-quality, more affordable health care, including General Motors, The Home Depot, Walmart, four state Medicaid agencies, four state employee and/or retiree agencies, and two multi-employer union trust funds. A full list of CPR's members is in an addendum.

CPR members spend more than $80 billion on health care expenditures annually and cover approximately 15 million people. CPR provides thought leadership to and coordination among these employers and other health care purchasers who self-fund the costs of insuring the health care of their employees and other health plan members. Our efforts involve developing strategies to implement alternative provider payment methods, to determine which providers should be included in network, and to create incentives for plan members to select high quality, more affordable care. This work has led CPR directly to examining the effect of the

[1] No party's counsel authored this brief in whole or in part, and no person other than the *amicus curiae*, its members, and its counsel contributed money intended to fund preparing or submitting this brief. This brief is filed with the consent of all parties.

consolidation of health care providers[2] on health care quality, costs and prices, which are rising at an unsustainable rate.

Employers, who provide half of the U.S. population with health care benefits, are struggling to manage rising healthcare costs, which result in higher premiums, lower benefits, and lower wages for employees.[3,4] Concerned about providing affordable benefits to their employees over time, employers see the maintenance of competition in health care markets as critical to quality improvement and cost reduction. Moreover, given the local nature of health care delivery, even national employers only represent a small portion of any given local market and typically

[2] Consolidation is defined as "the joining together of multiple parts into one whole." Specifically, in the healthcare industry, provider consolidation is the joining of one or more providers (either physicians, hospitals, or any combination of physicians and hospitals) into one entity with the ability to coordinate its overall business strategy. This consolidation often influences the level of concentration of firms within a given market. Market concentration is a function of the number of firms in a market and their respective market shares. Most studies of the relationship between competition and hospital prices have found that high hospital concentration (*i.e.,* the market is dominated by one or two hospitals or hospital systems) is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit. *See* Catalyst for Payment Reform, *Provider Market Power in the U.S. Health Care Industry: Assessing its Impacts and Looking Ahead* (Nov. 2013), *available at* http://catalyzepaymentreform.org/images/documents/Market_Power.pdf.

[3] Kaiser Family Foundation, Health Insurance Coverage of the Total Population, *available at* https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population (last accessed October 31, 2021).

[4] Kaiser Family Foundation, 2020 Employer Health Benefits Survey, *available at* https://www.kff.org/report-section/ehbs-2020-summary-of-findings/ (last accessed November 3, 2021).

lack adequate leverage to impact the price of care. Therefore, ensuring competition among providers is critical to all employers' ability to afford health care.

Amicus Curiae's interest is to promote competition in health care markets and limit unwarranted increases in health care prices due to provider market power. With half of the U.S. population receiving health care benefits through employers, the business community has a strong interest in antitrust enforcement to help maintain competition in health care markets as part of managing its overall health care costs.[5]

ARGUMENT

I. Employers Have a Strong Interest in Lowering the Costs and Improving the Quality of the Health Services They Offer Their Employees

Patients, purchasers, health plans,[6] providers, and policymakers all agree today's health care system does not consistently provide value, *i.e.*, high-quality care delivered efficiently at an affordable price. Perhaps the most difficult challenge to achieving value is lowering health care spending or at least slowing its growth. Health care expenditures account for nearly all projected structural deficits at the

[5] Kaiser Family Foundation, *supra* note 3.

[6] The term health plan is meant to be synonymous with health insurers, insurers, commercial insurers, commercial insurance, commercial payers and payers.

federal level[7] and for a major component of state budget outlays each year.[8] National health expenditure projections show spending on health care services will increase to almost 20% of Gross Domestic Product by 2028.[9,10] It would be a worthwhile investment if the health and health outcomes of Americans were among the best in the world, but instead the United States spends significantly more per capita on health care than any other country in return for outcomes that are significantly worse.[11]

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[7] Peter G. Peterson Foundation, "Key Drivers of the National Debt" *available at* https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers.

[8] The Urban Institute, State and Local Finance Initiative, *available at* https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/health-and-hospital-expenditures#Question1Health (last accessed November 3, 2021).

[9] Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2019-2028, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

[10] Andrea M. Sisko, Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Sheila D. Smith, Andrew J. Madison, Kathryn E. Rennie, James C. Hardesty, "National Health Expenditure Projections 2018-2027: Economic and Demographic Trends Drive Spending and Enrollment Growth,"38 *Health Affairs* Vol. 38., No. 3 (February 20, 2019) *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05499.

[11] The Commonwealth Fund, Issue Brief: "U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?" *available at* https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019.

With employers footing the bill for the 50%[12] of Americans enrolled in employer-sponsored insurance today, representing approximately 19%[13] of the nation's overall health care spending, the unsustainable growth of health care costs is a critical concern. Health care benefits represent 8% of total compensation paid out by employers.[14] Facing unsustainable increases in the cost of care, employers have been shifting an increasing proportion of the cost to their employees. The average dollar contribution for family coverage has increased 40% since 2010 and 13% since 2015.[15] Ultimately, the increases in health care costs are passed on to consumers in the form of higher premiums, lower benefits, and lower wages.[16] Employers are at the point where they no longer feel they can pass a higher share of health care costs onto their employees.[17] Moreover, given the tight labor market,

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[12] Kaiser Family Foundation, *supra* note 3.

[13] California HealthCare Foundation, *Health Care Costs 101* (2021 Edition), *available at* https://www.chcf.org/wp-content/uploads/2021/06/HealthCareCosts Almanac2021.pdf (last accessed November 3, 2021).

[14] Bureau of Labor Statistics, News Release "Employer Costs for Employee Compensation – June 2021," *available at* https://www.bls.gov/news.release/pdf/ ecec.pdf (last accessed November 3, 2021).

[15] Kaiser Family Foundation, *supra* note 3.

[16] The Effect of Rising Health Insurance Premiums on Employment," describing Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," NBER Working Paper 11160 (February 2005), *available at* http://www.nber.org/aginghealth/spring05/w11160.html.

[17] Mercer, News Release, "Employers expect a 4.7% increase in health benefit costs for 2022 as they focus on improving employee benefits rather than cost-cutting, Mercer survey finds," *available at* https://www.mercer.com/newsroom/

offering robust health care coverage is particularly important for employers who need to retain and attract employees.[18]

Based on CPR's experience serving its employer members, it understands that employers typically consider several things when they select commercial payers and the health insurance benefit plans they offer to their employees. Of great importance to employers is the unit costs of hospitals and other health care providers, meaning the prices that the insurance company has agreed to pay for different types of care, whether it is hospital inpatient services, office visits, surgical procedures or diagnostic tests. Employers also want health care providers that have demonstrated high quality of care and a favorable patient experience and have strategies for improving the quality and efficiency with which they deliver care. Employers also consider the total cost of care, which is a function of the prices per unit of care delivered, the quantity of these units delivered, and costs that result from poor quality and efficiency, including the costs of preventable complications, duplicate tests, and unnecessary procedures. Given that hospital costs represent the largest

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employers-expect-an-increase-in-health-benefit-costs-for-2022-as-they-focus-on-improving-employee-benefits-rather-than-cost-cutting.html (last accessed November 3, 2021).

[18] Hartford Business Journal, "Rising health insurance costs, tight labor market put employers in bind this open enrollment season" October 4, 2021, *available at* https://www.hartfordbusiness.com/article/rising-health-insurance-costs-tight-labor-market-put-employers-in-bind-this-open-enrollment (last accessed November 3, 2021).

portion of health care expenditures, having access to local hospitals that provide high and continuously improving quality at an affordable price is of the utmost importance.

II. Antitrust Enforcement, Including the District Court's Approval of the Preliminary Injunction of the Merger in Question, Is a Critical Tool for Addressing Provider Market Power and the Higher Health Care Prices That Result from Excessive Consolidation

It would be in the best interest of those who use and pay for health care services if there were high levels of competition among health care providers. Ideally, providers would compete with each other to demonstrate the highest levels of quality, best patient experience, and the most affordable prices and total cost of care. However, the health care marketplace lacks sufficient competition and transparency on these dimensions to make this a reality. While employers and other health care purchasers can, and sometimes do, use their own purchasing power to send signals that they seek high-value care these signals are easily ignored by health care providers who have amassed market power through consolidation. Given that hospital market concentration is high in more than 70% of markets in the United States,[19] there has been significant opportunity to study its impact, and it most often has negative consequences for those who use and pay for care. Because it is very

[19] Health Care Cost Institute, Healthy Marketplace Index, *available at* https://healthcostinstitute.org/research/hmi-interactive (last accessed November 3, 2021). Based on the market shares of the FTC's proposed market, Bergen County would meet the definition of a highly concentrated hospital market.

difficult, if not impossible, to undo consolidation once it has happened, it is critical to intervene before it occurs as the FTC has done in this case. Based on substantial research, the merger desired by Hackensack and Englewood is likely to result in higher prices without a commensurate improvement in quality.

A. Research repeatedly demonstrates that hospital mergers lead to higher prices and either unchanged or worsened quality of care

1. *Hospital mergers and concentration increase the price of hospital services*

Unfettered health care price inflation has been spurred in part by hospital consolidation, giving big hospitals and health care systems the market power to demand high prices. This claim is supported by decades of research. The Medicare Payment Advisory Commission (MedPAC), which advises the U.S. Congress on the Medicare program, reviewed the published research on hospital consolidation last year, including research often cited by the American Hospital Association (AHA) in defense of consolidation. The Commission's review determined that "Taken together, the preponderance of evidence suggests that hospital consolidation leads to higher prices."[20] There are many examples of research supporting this conclusion from the last decade. A study by academics published in 2019 used health insurance claims data representing 28% of Americans with employer-sponsored coverage, and

[20] MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy," March 13, 2020, *available at* http://www.medpac.gov/-documents-/reports#.

found that the prices of monopoly hospitals (defined as those lacking competition within a 15-mile radius) were 12% higher than the prices of hospitals in markets with four or more competitors.[21] Petris Center researchers at the University of California, Berkeley examined the 25 metropolitan areas with the highest rates of hospital consolidation from 2010 through 2013 for the *New York Times*. They found that in the years following the mergers, the commercial insurance payments for the average hospital stay rose in most of the 25 geographies by between 11% and 54%.[22] A study published by the National Bureau of Economic Research (NBER) in 2016 and authored by independent academic researchers found that mergers of two hospitals in the same state, but in different markets within that state, increased the prices paid to the acquiring hospital by 7% to 9%.[23]

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[21] Zack Cooper, Stuart V Craig, Martin Gaynor, and John Van Reenen. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." The Quarterly Journal of Economics, Volume 134, Issue 1, February 2019, Pages 51–107, *available at* https://doi.org/10.1093/qje/qjy020.

[22] Reed Abelson, "When Hospitals Merge to Save Money, Patients Often Pay More," *N.Y. Times*, November 18, 2018, Sec. B., *available at* https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html.

[23] Leemore Dafny, Kate Ho, and Robin Lee. "The Price Effects of Cross-Market Hospital Mergers." Cambridge, MA: National Bureau of Economic Research, March 2016, *available at* https://www.nber.org/system/files/working_papers/w22106/w22106.pdf.

2. *Hospital mergers often reduce quality*

When analyzing studies looking at the correlation of market concentration with the quality of care, it is critical to look at research by independent researchers whose funding poses no conflict of interest. The studies with the most stringent scientific methods and independence tend to conclude that where there is less competition, quality suffers, or at best, does not improve. The reason for poorer quality is not fully understood, but a history of different protocols, resources, and cultures could lead clinical practices at the merging hospitals to clash, working against positive outcomes for patients. There are many studies concluding that mergers can negatively impact quality or fail to live up to promises to improve quality. For example, research published in 2011 on the merger of Evanston Northwestern and Highland Park hospitals concluded the merger had no effect on certain quality indicators, while worsening performance on others.[24] A study published the following year found that hospital mergers in California were followed by much higher mortality rates for heart disease patients.[25] A 2018 examination of health system expansions (such as mergers or acquisitions) identified an increase in

[24] Romano, P. and Balan, D. (2011). A retrospective analysis of the clinical quality effects of the acquisition of Highland Park hospital by Evanston Northwestern healthcare. International Journal of the Economics of Business, 18(1):45–64.

[25] Hayford, T. B. (2012). The impact of hospital mergers on treatment intensity and health outcomes. Health Services Research, 47(3pt1):1008–1029.

patient safety risks.[26] A study published in 2020 compared the quality of hospitals in the three years post-merger to hospitals that did not change ownership. The rates of 30-day readmission and mortality for patients discharged from the hospital did not improve post-merger. Furthermore, the hospitals that underwent a merger performed more poorly after the merger on measures of patient experience, such as whether patients would recommend the hospital.[27]

The Amicus Brief filed in this case by the AHA[28] cites two studies with findings of improved quality of care following hospital consolidation. However, one study was funded by the AHA[29] and the other[30] was published by a consulting firm along with a mergers and acquisitions firm with no transparency into how they chose their sample of interviewees or the rate at which those asked to be interviewed agreed. Without this we cannot know whether the responses they report are representative or are skewed by sample bias – solely comprising respondents who

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[26] Haas, S., Gawande, A., and Reynolds, M. E. (2018). The risks to patient safety from health system expansions. JAMA, 319(17):1765–1766.

[27] Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams. "Changes in Quality of Care after Hospital Mergers and Acquisitions." The New England Journal of Medicine, 382, no. 1 (02 2020): 51–59.

[28] Docket 41.

[29] Monica Noether & Sean May, Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis, CHARLES RIVER ASSOC'S (Jan. 2017).

[30] Gay Casey et al., Hospital Mergers and Acquisitions — Studying Successful Outcomes, BERKELEY RESEARCH GRP. (2020).

see the benefits of mergers. Furthermore, none of these parties is impartial to the outcomes of their analyses and, therefore, the studies cited by the AHA cannot be viewed as having the same scientific rigor as the studies cited in the prior paragraph. A recent MedPAC report considered[31] these reports and in reference to the last study described in the prior paragraph concluded: "…[W]hile the American Hospital Association asserts that readmission and mortality rates improve following mergers, a more recent study suggests that mortality and readmission rates do not improve and patient satisfaction declines slightly after mergers."

B. If hospital mergers lower the cost of delivering care, they do not result into lower prices for employers and their health plan members

There is a difference between lower costs to the hospitals in their delivery of care and lower costs to those who use and pay for care – employers, other health care purchasers and consumers. If hospital consolidation generally led to lower costs and hospitals always shared the savings with purchasers and consumers, the correlation between hospital consolidation and higher prices would not exist.

1. *Appellants claim that mergers will lower costs but never state that they will lower prices as a result*

The Appellants' case, along with the amicus curiae brief submitted by the AHA, argue that the merger between Hackensack and Englewood will lead to lower

[31] MedPAC, "March 2021 Report to the Congress: Medicare Payment Policy," March 13, 2021, page 13, *available at* http://www.medpac.gov/-documents-/reports#.

operating expenses and costs. However, if the merging hospitals are truly able to reduce their operating costs as a result of the merger, there is no guarantee that the hospitals will not also raise their prices if their market power allows them to do so. This would enable them to increase their margin. Indeed, in this specific case, Hackensack already had "acquisition clauses" in its payer contracts requiring payers to pay any hospitals newly acquired by Hackensack at the same rate they pay other similar Hackensack facilities.[32] Furthermore, as the District Court opinion notes in reference to the Appellants' expert witness on cost savings and efficiencies for healthcare provider transactions: "Critically, however, Ahern failed to conduct any analysis as to what percentage of the identified cost savings would be passed on to commercial insurers. Tr. at 1402:16-18. Similarly, [Hackensack] has a history of mergers and acquisitions. The corporate restructuring cost savings should, to some degree, result from any merger or acquisition. But [Hackensack] failed to present any evidence of its historical performance as to the relevant cost savings being passed on to commercial insurers."[33]

Additionally, if Hackensack enhances its negotiating leverage as a result of acquiring Englewood, it will be in a stronger position to refuse payment reforms that could potentially provide an incentive for the merged entity to improve quality and

[32] ECF 368 at 14.

[33] ECF 368 at 29.

reduce costs for both itself and those who purchase its services. As a means to improve the value of health care spending, there is a significant push in the United States to adopt alternative payment models,[34] the most common of which requires hospitals to share any savings they accrue with payers.[35] Not only are Hackensack's prices likely to rise, but they are also more likely to insist on commercial insurance contracts that ensure they are paid fee-for-service, rather than agree to contracts that put them at financial risk for quality performance and overspending on the delivery of health care services as compared to an established budget.

2. *Higher prices impact plan members as higher premiums, higher cost sharing and forgone wages*

In the course of making the argument that "the district court erred in relying on measures of patients' non-price preferences to find that insurers would agree to pay higher prices to the hospitals after a merger,"[36] Appellants argue that patients are insensitive to health care prices.[37] While it is true that research now suggests

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[34] Health Care Payment Learning and Action Network, https://hcp-lan.org/.

[35] See page 2, category 3A for the commercial market focus on upside rewards for appropriate care at https://hcp-lan.org/workproducts/apm-infographic-2019.pdf.

[36] Op. Br. 41.

[37] At the second stage of competition, in contrast, "[p]atients are largely *insensitive* to healthcare prices because they utilize insurance, which covers the majority of their healthcare costs." *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016) (emphasis added); *see* App-597–601, 616–619. Because of this divided market dynamic, it is an economic and legal error to assume "that there is no fundamental difference between analyzing the likely response" of patients

that most patients are unlikely to shop for individual health care services based on price, rising health care prices impact them in a significant way. Health care prices rose twice as fast as workers' earnings between 2008 and 2018.[38] Wages for lower- and middle-income workers have barely kept up with inflation because their would-be wage increases have gone instead to cover increased health care costs, largely stemming from rising prices. Many employers and businesses would be in a stronger financial position today but for years of overspending on healthcare. According to a report by Price Waterhouse Coopers, "…employer health spending grew from 6% of total wages in 1988 to more than 12% in 2018."[39] Employers—especially small to mid-sized employers—react to higher health care costs by hiring fewer workers,[40] providing less frequent raises, or modifying benefits, including health benefit plans.

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versus the likely response of insurers to a hospital merger. *Hershey*, 838 F.3d at 342. "[P]atients, in large part, do not feel the impact of price increases. Insurers do." *Id.* Thus, although patients may be "relevant to the analysis," the price analysis must be performed "through the lens of the insurers."

[38] The Commonwealth Fund, Trends in Employer Health Care Coverage, 2008-2018: Higher Costs for Workers and Their Families, *available at* https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018 (last accessed November 2, 2021).

[39] "Medical cost trend: Behind the numbers 2019," PWC (June 2018), *available at* https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pdf/hri-behind-the-numbers-2019.pdf at 5.

[40] Katherine Baicker and Amitabh Chandra. "The Labor Market Effects of Rising Health Insurance Premiums," National Bureau of Economic Research (February 2005), *available at* https://www.nber.org/papers/w11160.

Thus, the argument that patients are insensitive to health care prices ignores the bigger picture – that these high and rising prices are eating into workers' earnings, their likelihood of employment and their overall economic wellbeing. Few Americans are insensitive to this reality.

CONCLUSION

For the forgoing reasons, the Third Circuit Court of Appeals should uphold the ruling of the United States District Court, District of New Jersey to block the acquisition of Englewood by Hackensack. The District Court correctly concluded that: 1) The assertions of Hackensack and Englewood that their merger would lead to lower health care spending and higher quality are not adequately supported by research and, in fact, are contradicted; 2) It is unlikely that any cost savings realized by Hackensack will be passed through to the payors, or thus to employers and their health plan members.

November 5, 2021

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CERTIFICATES OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(B), I hereby certify that this brief was produced in Microsoft Word 2016 Times New Roman 14-point type and contains 3,740 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

I further certify pursuant to L.A.R. 31.1(c) that the text of the electronic copy of this brief filed with the Court is identical in all respects to the hard copy that will be filed with the Court, and that a virus check was performed on the electronic version using McAfee LiveSafe version 16.0. No computer virus was detected.

November 5, 2021 /s/ Eric F. Citron
Eric F. Citron

CERTIFICATION OF BAR MEMBERSHIP

Pursuant to L.A.R. 28.3(d), I hereby certify that I am a member of the Bar of the United States Court of Appeals for the Third Circuit and remain a member in good standing of the Bar of this Court.

November 5, 2021 /s/ Eric F. Citron
Eric F. Citron

ADDENDUM: List of Catalyst for Payment Reform Members

- 32BJ Health Fund
- Aircraft Gear Corporation
- Aon
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- CalPERS
- Compassion International
- Covered California
- Equity Healthcare LLC
- General Motors
- Group Insurance Commission, MA
- Hilmar Cheese Company, Inc.
- The Home Depot
- Independent Colleges and Universities Benefits Association
- Mercer
- Miami University (Ohio)
- Ohio Department of Medicaid
- OhioPERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- San Francisco Health Service System
- Self-Insured Schools of California
- South Carolina Health & Human Services (Medicaid)
- Teacher Retirement System of Texas
- TennCare (Medicaid)
- Unite Here Health
- Walmart Inc.
- Washington State Health Care Authority
- Wells Fargo & Company
- Willis Towers Watson

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Third Circuit by using the appellate CM/ECF system on November 5, 2021. All participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Eric F. Citron
Eric F. Citron