22-15634

IN THE

United States Court of Appeals

FOR THE NINTH CIRCUIT

DJENEBA SIDIBE; JERRY JANKOWSKI; SUSAN HANSEN; DAVID HERMAN; OPTIMUM GRAPHICS, INC.; JOHNSON POOL & SPA, on Behalf of Themselves and All Others Similarly Situated,

Plaintiffs-Appellants,

v.

SUTTER HEALTH,

Defendant-Appellee.

Appeal From the United States District Court
for the U.S. District of Northern California
Case No. 3:12-cv-04854-LB, Judge Laurel D. Beeler

BRIEF OF CATALYST FOR PAYMENT REFORM AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS AND IN SUPPORT OF REVERSAL

Anne L. Rauch
Trinette S. Sachrison
BERDING & WEIL LLP
1660 Hotel Circle North, Suite 701
San Diego, California 92108
858-625-3900

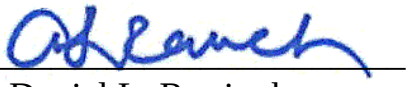
Daniel Rottinghaus
BERDING & WEIL LLP
2175 N. California Boulevard
Suite 500
Walnut Creek, California 94596
925-838-2090

Attorneys for Amicus Curiae *Catalyst for Payment Reform*

RULE 26.1(a) DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1(a), the undersigned counsel of record, on behalf of the Amicus Curiae, Catalyst for Payment Reform (CPR), declares that CPR is an independent, nonprofit, member-based, non-stock corporation. CPR does not have a parent corporation and no publicly held corporation has an ownership interest in it.

BERDING & WEIL LLP

By: 

Daniel L. Rottinghaus
Anne L. Rauch
Counsel for Amicus Curiae
CATALYST FOR PAYMENT REFORM

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Rules

Other Authorities

STATEMENT OF IDENTIFICATION

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 healthcare and improve the functioning of the healthcare marketplace. CPR is composed of approximately 30 private and public healthcare purchasers interested in pushing for higher-quality, more affordable healthcare, 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 the addendum included following the conclusion of this brief.

CPR members spend more than $80 billion on healthcare annually and cover approximately 15 million people. CPR provides thought leadership to and coordination among these employers and other healthcare purchasers who provide health insurance benefits to their employees and other health plan members. Our efforts involve demonstrating demand for high-quality, affordable healthcare and making the business case for health insurance companies to develop health insurance products that connect plan members to the healthcare providers offering the best combination of quality and costs. This work has led CPR directly to examining the

effect of the consolidation of healthcare providers on healthcare quality, costs and prices, which are rising at an unsustainable rate.[1]

Employers, who provide half of the U.S. population with healthcare benefits, are struggling to manage rising healthcare costs, which result in higher premiums, lower benefits, and lower wages for employees. See Kaiser Family Foundation, *Health Insurance Coverage of Total Population*, https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population (last accessed October 31, 2021) and Kaiser Family Foundation, *2020 Employer Health Benefits Survey*, https://www.kff.org/report-section/ehbs-2020-summary-of-findings/ (last accessed November 3, 2021). Concerned about providing affordable benefits to their employees into the future, employers see the maintenance of competition in healthcare markets as critical to quality improvement and cost reduction. Moreover,

[1] 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* https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2017/04/Provider-Market-Power-in-the-US-Health-Care-Industry.pdf

given the local nature of healthcare delivery, most individual employers only represent a small portion of any given local market and typically lack adequate leverage to impact the price of care. Therefore, ensuring competition among providers is critical to all employers' ability to afford healthcare.

Amicus Curiae's interest is to promote competition among healthcare providers as well as health insurers and limit unwarranted increases in healthcare prices due to provider market power. With half of the U.S. population receiving healthcare benefits through employers, the business community has a strong interest in antitrust enforcement to help maintain competition in healthcare markets as part of managing overall healthcare costs. See Kaiser Family Foundation, *supra*.

Amici Curiae files this brief pursuant to Rule 29(a)(2) of the Federal Rules of Civil Procedure and all parties have consented to the filing of this brief.

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.

ARGUMENT

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

Almost 155 million Americans obtain health insurance through their employers, who pay the majority of the costs, with employees footing the bill in 2021 for an average of 17% of the premium for single coverage and 28% of the premium for family coverage. In 2021, the average annual premiums for employer-sponsored health insurance were $7,739 for single coverage and $22,221 for family coverage, meaning that workers paid an average $1,299 for single coverage and $5,969 for family coverage. See Kaiser Family Foundation, https://www.kff.org/report-section/ehbs-2021-summary-of-findings/.

As we near the end of 2022, the outlook for individuals, small and large groups in the commercial healthcare market looks grim. Experts predict that healthcare costs will spike in 2023 and for the next several years to come. As of August 2022, the projected average premium increase in 2023 will hover at 5.6 percent. While this figure lags behind overall inflation (8.5 percent year over year), this is likely a temporary reprieve, born in part out of the fact that health insurers negotiate multi-year contracts with healthcare providers and cannot react in real time to fluctuations in the consumer price index (CPI). See Wager, E., Ortaliza, J., Rakshit, S., Hughes-Cromwick, P., Amin, K., & Cox, C., *Overall Inflation Has Not Yet Flowed Through*

to the Health Sector, Peterson-KFF Health System Tracker (2019). https://www.healthsystemtracker.org/brief/overall-inflation-has-not-yet-flowed-through-to-the-health-sector/ This isn't just speculative; there are clear indicators that healthcare costs are poised to increase:

- Health insurers grossly underestimated service demand in 2021, resulting in $1.3 billion and $1.7 billion losses in the large group and individual markets, respectively – losses that are projected to carry over into premium increases in the years to come. Mark Farrah Associates, *An Analysis of Profitability for the Individual and Small Group Health Insurance Markets in 2021*, Healthcare Business Strategy Archive, July 12, 2022. https://www.markfarrah.com/mfa-briefs/an-analysis-of-profitability-for-the-individual-and-small-group-health-insurance-markets-in-2021/

- Provider markets continue to consolidate, further eroding competition and purchaser market power. Today, 75 percent of hospital markets in the United States are either highly concentrated or very highly concentrated, and the rate of hospital "mega mergers" (under which the smaller of the merging hospitals has an annual revenue of greater than one billion dollars) nearly doubled in 2021, along with the rate of physician group mergers and acquisitions. Health Care Cost Institute, *An Analysis of U.S. Hospital Market Concentration* (2022). https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-

Index; Japsen, B., *Hospital Mergers Just Keep Getting Bigger*. Forbes (2022). https://www.forbes.com/sites/brucejapsen/2022/01/17/hospital-mergers-just-keep-getting-bigger/?sh=480290f975be; Landi, H., PwC reports. *Here are Key Trends that Could Impact Dealmaking Next Year*. Fierce Healthcare, 2021. See also https://www.pwc.com/us/en/industries/health-industries/library/health-services-deals-outlook.html

American businesses, their employees, and their families cannot absorb the coming wave of commercial healthcare cost inflation. In a survey of small businesses conducted by the Commonwealth Fund in 2019, prior to the COVID pandemic, the most commonly cited answer to the question "Which one of these do you consider the biggest challenge facing your business?" was "the cost of providing healthcare to employees." This challenge was more commonly cited than competition with big business, taxes, and government regulations, among others. Buttle, R., Wonnenberg, K.V., Simaan, A., *Small Business Owners' Views on Health Coverage and Costs*, The Commonwealth Fund, September 9, 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/small-business-owners-views-health-coverage-costs.

When it comes to individuals, already, nearly 1 in 3 households do not have enough savings to pay typical deductibles under employer-based coverage and the rising out of pocket costs for medical care and prescription drugs strains the health

and well-being of the US workforce. See Young, G., Rae, M., Claxton, G., Wager, E., & Amin, *How Many People Have Enough Money to Afford Private Insurance Cost Sharing*? Peterson-KFF Health System Tracker, 2022. https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/ Raidt, J., *To Compete Globally, America Must Up Its Game*. U.S. Chamber of Commerce Foundation (2017). https://www.uschamberfoundation.org/reports/compete-globally-america-must-its-game. In the last six months, according to a new poll conducted by West Health and Gallup, higher healthcare costs pushed approximately 98 million Americans (38% of U.S. adults) to delay or skip healthcare treatments, curb routine expenses, or borrow money to pay for their medical expenses. Advisory Board, *The Impact of Rising Health Care Costs, In 4 Charts*, August 9, 2022, https://www.advisory.com/daily-briefing/2022/08/09/health-care-inflation. Our healthcare system acts as a weight around the neck of the US economy.

A. Data demonstrate that healthcare prices continue to be the largest driver of healthcare cost growth

According to the 2020 Health Care Cost and Utilization Report from the Health Care Cost Institute, prices are the single biggest driver today of healthcare cost growth. In fact, prices are responsible for about two thirds of healthcare cost inflation for commercial payers. Hargraves, J., Change, J., Kennedy, K., Sen, A., & Bozzi, D, *2019 Health Care Cost and Utilization Report*. Health Care Cost Institute,

2021, https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf. This means that prices, which are the result of negotiations between healthcare providers and payers, contribute more to healthcare costs than how many healthcare services are delivered, changes in the mix of services delivered or changes in the demographics of patients. In other words, healthcare costs represent an increasingly large share of household expenses simply because healthcare providers are more and more able to command the prices they want as their market power grows. On the flip side, this means that if there were laws or law enforcement to ensure that healthcare providers with market power did not abuse that power by charging higher than competitive prices, healthcare spending would grow at a slower rate.

B. Employers will be unable to stave off increases unless they can steer plan members to lower cost, quality healthcare providers

Research suggests that when employers implement innovative health insurance benefit designs and selective networks of healthcare providers, they can successfully connect plan members to higher-value providers and generate significant savings for themselves and their plan members; a study in Massachusetts found that a tiered network resulted in a 5% savings for the payer. Sinaiko, A.D., Landrum, M.B. & Chernew, M.E., *Enrollment In A Health Plan With A Tiered*

Provider Network Decreased Medical Spending By 5 Percent, Health Affairs 36, No. 5; 870-875 (2017). See also Mazurenko, O., Taylor, H.L & Menachemi N., *The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review.* Medical Care Research and Review, 79(5):607-617 (2022). These designs require transparency into healthcare prices and quality. They also depend on the ability to encourage or even steer health plan members to higher-quality, lower-cost providers and steer them away from lower-value (higher cost and/or poorer quality) providers. These network and benefit strategies have started to gain traction. Willis Towers Watson, *With Healthcare Cost Increases Returning to Pre-Pandemic Levels, U.S. Employers Focus on Affordability and Wellbeing,* Global Newswire, October 6, 2021. https://www.globenewswire.com/news-release/2021/10/06/2309656/0/en/With-healthcare-cost-increases-returning-to-pre-pandemic-levels-U-S-employers-focus-on-affordability-and-wellbeing.html. As stated in a December 14, 2014, Sutter Pricing Strategy Memo, for consumers, "[h]aving a low premium is 3.75x more important than having a broad hospital network." Trial Exhibit "TE" 3072. According to a 2014 Sutter/BCG Consumer Survey, 64% of all consumers are open to narrow networks, while 47% of non-Kaiser consumers are open to them. *Ibid.*

Within Northern California, and in other markets where there is a significant provider consolidation, it is a different story. For example, in Northern California

where Sutter Health has acquired a vast number of hospitals and medical practices, prices are high and the availability of innovative health insurance benefit design and provider network options are rare. In the greater San Francisco Bay Area, businesses and individuals pay approximately 50% more for healthcare than residents in and around Los Angeles, where there are more hospitals and health systems competing for patients. Data from Anthem Blue Cross illustrate that steered products flourished in Southern California (where between 25-30% of inpatient claims were associated with a steered product) while they remained quite rare in Northern California (where less than 10% of inpatient claims were associated with a steered product). Volume 19, Trial Transcript, March 9, 2022 (Dkt. No. 1594), at 73:25-74:16.

We need competitive healthcare markets as a counterweight against healthcare price inflation. With the economy struggling, employers and other healthcare purchasers have less money than ever to spend on healthcare and need every tool at their disposal to keep expenses under control. Without a prohibition of Sutter Health's anti-competitive and anti-transparency practices, employers and other healthcare purchasers in Northern California, and their plan members, will be in a far worse position to control costs going forward. Employers across the country will be watching to see if this case will serve as a warning to other dominant providers, or if anticompetitive behavior will be given a hall pass.

II. The District Court's Erroneous Application of Well-Settled Antitrust Law in This Case Undermines the Important Public Policy of Avoiding Harm to Millions of Consumers Caused by Market Control Through Excessive Consolidation or Monopoly

As explained by the California Supreme Court, the purpose of the Cartwright Act and related antitrust laws is to promote free competition by penalizing companies that engage in market domination and control. The fact that the statutory scheme provides not only for criminal penalties but also for double and treble damages in civil actions is a strong expression of legislative intent that civil actions are intended to have a deterrent effect. *Clayworth v. Pfizer, Inc.* 49 Cal.4th 758, 783 (2010).

This case has far-reaching consequences. CPR members have frequently held up Sutter Health as an example of a health system that uses its market power to inhibit or prohibit competition, by effectively eliminating narrow or tiered network insurance options by health insurers. This has left a significant number of purchasers unable to reduce the premiums for employees through insurance product offerings that would reduce costs by eliminating the most expensive providers from the provider network through narrow or tiered network options. Beyond expressing frustration about the lack of insurance product options in Northern California, employers feel quite powerless to do anything about it. None of them feel they represent enough business on their own to push Sutter Health to be more transparent and willing to participate in or step aside to allow for more affordable health

insurance products; market forces are not sufficient in this case to make market corrections. As a result, antitrust enforcement through legal actions exactly like this one is an essential mechanism for ensuring that market power does not lead to deleterious effects for those who use and buy healthcare in Northern California.

As Sutter has demonstrated, those in control of the market will not conform to the tenets of the antitrust laws voluntarily. When legal action is necessary, faithful application of the state and federal antitrust laws is essential. Here, the trial court's wholesale exclusion of relevant evidence of Sutter's unlawful purpose (the "pre-2006 evidence") – relevant under California's antitrust statutory scheme -- coupled with the erroneous jury instruction which removed Sutter's "purpose" from the definition of the wrongful conduct, constituted prejudicial error which undermines the fundamental purpose of the antitrust law.

A. Research repeatedly demonstrates that hospitals and health systems with market power command higher prices regardless of the quality of their care

A wide body of research has shown that provider consolidation leads to higher healthcare prices for private insurance; this is true for both horizontal and vertical consolidation. Schwartz, K., Lopez, E., Rae, M. & Neuman, T, *What We Know About Provider Consolidation*, KFF, Health Costs, September 9, 2020. https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/. In 2020, the Medicare Payment Advisory Commission reviewed the

published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices." MedPAC, *March 2020 Report to the Congress: Medicare Payment Policy*, March 13, 2020. If higher prices were correlated with higher quality healthcare, those who use and pay for healthcare may be more willing or able to absorb them (i.e., if higher quality meant more efficient care). Unfortunately, there is no evidence that higher prices are correlated with higher quality care. Schwartz, K., Lopez, E., Rae, M. & Neuman, T, *What We Know About Provider Consolidation*, KFF, Health Costs, September 9, 2020. https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

1. Sutter Health has a national reputation for using its market power to charge higher than competitive prices

Among the employer and other healthcare purchaser members of CPR, many of whom have covered lives in Northern California, there is a common understanding that Sutter Health uses its market power to charge higher than competitive prices. Evidence in the underlying action from Health Net and Blue Shield of California not only illustrate that Sutter Health's prices are higher than others, but that both Health Net and Blue Shield have communicated this to Sutter Health. TE 663 and TE 2258. Sutter executives have also admitted that their prices were higher. 5-ER-1067.

2. In addition to their higher than competitive prices, their contracting practices are anticompetitive and constrain the options insurers and thus employers have to offer affordable, high-quality care

Sutter Health pushed insurers to contract with its entire system against the business interests of the insurers. TE 63. Not only did insurers have to pay higher prices for Sutter Health's services, if they wanted to offer any services from Sutter Health, they had to contract with all of Sutter Health's hospitals, even in areas where they did not want to do so. This can lead to higher cost hospitals being in a provider network even when there are lower cost hospitals nearby.

Furthermore, if an insurer wanted to exclude a Sutter hospital from its provider network, Sutter Health insisted that the insurer had to agree to pay 95% of billed charges to the Sutter hospitals that were not in network. Volume 3, Trial Transcript, February 11, 2022 (Dkt. No. 1572), at 517:13-520:25. See also https://www.courthousenews.com/sutter-health-defends-contracts-with-health-insurers-in-antitrust-trial/.

Billed charges are typically much higher than the payment rates that result from a contract negotiation between a healthcare provider and a payer. This nonparticipating hospital penalty rate keeps premiums high as it became infeasible for insurers to offer a less expensive product without increasing premiums; Sutter's practices made it more expensive to have hospitals outside of the network than

included in it. Volume 18, Trial Transcript, February 18, 2022 (Dkt. No. 1577), at 154:20-24.

Sutter Health also used hospitals that were in essential locations – where insurers had no other options – to force contracting with hospitals in other areas where there were alternatives.

Sutter Health's "all or nothing" anticompetitive practices improperly guarantee it placement within narrow networks, or in the top tier of tiered networks, in health insurance plans even if it does not meet the criteria. Sutter Health's "all or nothing" contracting practice had the effect of prohibiting insurers from creating curated networks of lower-cost healthcare providers that could have brought prices (premiums) down. Volume 4, Trial Transcript, February 14, 2022 (Dkt. No. 1573), at 60:8-9; Volume 8, Trial Transcript, February 18, 2022 (Dkt. No. 1577), at 196:7-10. And yet, despite Sutter Health's higher prices, evidence suggests that the quality of care delivered by Sutter Health is no higher than average. TE 4715.

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

As healthcare costs rise, they directly erode workers' earnings as employers make tradeoffs between wages and benefits. Lucia, L. & Jacobs, K., *Increases in health care costs are coming out of workers' pockets one way or another: The tradeoff between employer premium contributions and wages,* January 29, 2020, UC Berkeley Labor Center. https://laborcenter.berkeley.edu/employer-premium-

contributions-and-wages/ Furthermore, when healthcare expenditures rise, as individuals and as a nation we have fewer resources to devote to meeting other needs, such as housing, education and infrastructure. U.S. Gen. Accountability Office, *State and Local Governments' Fiscal Outlook* (December 2019), https://www.gao.gov/assets/gao-20-269sp.pdf. Because the single biggest driver of healthcare cost growth is prices, when prices go up, costs rise and when insurers anticipate that healthcare costs will rise, they increase premiums. Volume 2, Trial Transcript, February 10, 2022 (Dkt. No. 1571), at 134:14-17; Volume 7, Trial Transcript, February 17, 2022 (Dkt. No. 1576), at 34:10-13; Volume 16, Trial Transcript, March 3, 2022 (Dkt. No. 1585), at 38:2-5; TE 4682. For individual consumers, according to a December 4, 2014, Sutter Pricing Strategy Memo, "Cost related attributes make up 80% of a consumer's decision when selecting a health insurance plan." TE 3072.

4. Antitrust enforcement is a critical tool

Antitrust laws are meant to ensure there is adequate competition in the marketplace. In healthcare this means that healthcare providers compete to win patients by offering the highest quality of care efficiently and at the lowest prices with incentives in the marketplace to create new and better offerings. However, when a healthcare provider engages in anticompetitive practices, such as when Sutter Health prohibits its exclusion from narrow provider networks or from the most

desirable tier of a tiered provider network, antitrust enforcement is a critically important tool to ensure Sutter and other providers do not unreasonably harm consumers. Without enforcement, antitrust laws will not have their intended deterrent effect. *Clayworth v. Pfizer, Inc.*, *supra*, 49 Cal.4th at 783.

B. The correct market to examine is the market in which health insurers, and thus ultimately employers and other healthcare purchasers and their health plan members, have options for selecting healthcare providers and offering health insurance products that utilize tiering and steering to keep costs affordable

Healthcare is unlike most other markets for goods and services. First, there information asymmetry due to the long history of a lack of transparency by healthcare providers regarding their prices and quality of care. Second, there is also almost always a third and sometimes fourth party that comes between the provider of services, which in this case is Sutter Health, and those who use those services, e.g., individuals, employers, employees and their family members comprising the plaintiff.

The consequences of artificially high healthcare costs driven by anticompetitive practices like those challenged in this case are felt across the board by the health plans, employers, and ultimate consumer of the services. Individuals and fully insured employers rely on health insurers to contract with providers, administer claims and more. Thus, it is the health insurer that purchases the artificially inflated services and the health insurer, its individual and employer

customers who must pay the premiums driven up by the artificially inflated services and who jointly feel the financial consequences of the cost of those services. Furthermore, the employees of these employer customers suffer lower wages and other consequences as their employers struggle to survive with the skyrocketing insurance premiums.

Health insurers compete with each other to win covered lives and use their volume of covered lives to strengthen their negotiating position with healthcare providers; the greater the number of lives, the greater the discount they may be awarded by the provider. However, when there are no choices of providers, such as in rural areas or in urban areas where a dominant healthcare provider has only Kaiser facilities (a closed system and thus not part of the relevant market) sharing the field, health insurers may have no ability to balance the market dominance enjoyed by the provider, resulting in higher prices.

1. Kaiser's presence in Northern California does not supply adequate competition among healthcare providers for the other health insurance companies who must contract with Sutter Health because Kaiser is a closed system

Hospitals and health systems compete to be included in the networks of health insurers. Health insurers then sell their products to employers and to individuals. Health insurers are the relevant customers except in rare cases when employers contract directly with healthcare providers for services or an individual chooses to

self-fund their care. In trial testimony, internal emails, and depositions, Sutter Health executives and experts repeatedly stated that Sutter Health's customers were health plans and that they do not compete with Kaiser due to its closed network of healthcare providers. Volume 13, Trial Transcript, February 28, 2022 (Dkt. No. 1582), at 253:3-12; TE 551; Volume 19, Trial Transcript, March 9, 2022 (Dkt. No. 1594), at 55:7-19. While Kaiser may co-exist in a particular geography with other healthcare providers, such as Sutter Health, the only health insurer that Kaiser facilities will contract with is Kaiser Foundation Health Plan, so Kaiser facilities do not directly compete with other providers for patient volume. That competition exists only at the health insurer level.

2. Evidence from Sutter Health also demonstrates that Kaiser's presence does not exert downward pressure on Sutter Health's prices

Kaiser's presence does not provide competition for Sutter Health in its sale of services to health insurers. Sutter Health calculated that lowering its prices would not help its contracted insurers lower their premiums enough to compete with Kaiser. 5-ER-982-989. Instead, it continues to charge high prices and raise its prices year over year, including in markets where Kaiser operates. TE 9114 and TE 9047.

CONCLUSION

For the forgoing reasons, the Ninth Circuit Court of Appeals should reverse the ruling of the United States District Court for the Northern District of California

given the evidence that Sutter Health engaged in anticompetitive conduct and caused consumers to pay higher prices or premiums. The trial court's erroneous exclusion of relevant evidence of Sutter's purpose in its anticompetitive practices, coupled with the erroneous jury instruction, was reversible error. The healthcare market in Northern California rests on an uneven playing field, where those who use and pay for care do not have equal bargaining power with Sutter Health. Faithful adherence to the law governing antitrust actions is critical, and where it is lacking there are significant economic impacts to the already suffering economy. Sutter Health's anticompetitive practices should not be given the green light to stand so plainly in the way of health insurers offering more affordable healthcare insurance options. At the very least, the jury should have been provided all the relevant evidence and properly instructed on the law. CPR respectfully submits reversal and remand is essential and in the interests of justice.

BERDING & WEIL LLP

By: 

Daniel L. Rottinghaus
Anne L. Rauch
Counsel for Amicus Curiae
CATALYST FOR PAYMENT REFORM

ADDENDUM: List of Catalyst for Payment Reform Members

- 32BJ Health Fund
- Aon
- Arizona Health Care Cost Containment System (Medicaid)
- 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
- Ohio Public Employees Retirement System
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Purdue University
- Qualcomm Incorporated
- San Francisco Health Service System
- Self-Insured Schools of California
- State of Tennessee
- TennCare (Medicaid)
- Unite Here Health
- Walmart Inc.
- Washington State Health Care Authority
- WTW

CERTIFICATE OF COMPLIANCE

Case No. 22-15634

I am the attorney or self-represented party.

This brief contains 4,882 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

I certify that this brief:

[ ] complies with the word limit of Cir. R. 32-1.

[ ] is a cross-appeal brief and complies with the word limit of Cir. R. 28.1-1.

[X] is an amicus brief and complies with the word limit of Fed. R. App. P. 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).

[ ] is for a death penalty case and complies with the word limit of Cir. R. 32-4.

[ ] complies with the longer length limit permitted by Cir. R. 32-2(b) because (select only one):
- [ ] it is a joint brief submitted by separately represented parties;
- [ ] a party or parties are filing a single brief in response to multiple briefs; or
- [ ] a party or parties are filing a single brief in response to a longer joint brief.

[ ] complies with the length limit designated by court order dated _____.

[ ] is accompanied by a motion to file a longer brief pursuant to Cir. R. 32-2(a).

Dated: October 11, 2022 /s/ Anne L. Rauch

CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeal for the Ninth Circuit by using the appellate CM/ECF system on October 11, 2022. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: October 11, 2022 /s/ Anne L. Rauch