No. 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.

On Appeal from the United States District Court
for the Northern District of California
No. 3:12-cv-04854-LB-DDP-JEM
Hon. Laurel D. Beeler, Magistrate Judge

BRIEF OF AMICUS CURIAE PURCHASER BUSINESS GROUP ON HEALTH IN SUPPORT OF PLAINTIFFS-APPELLANTS

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DISCLOSURE STATEMENT

Amicus curiae Purchaser Business Group on Health certifies that it has no parent corporation, and no publicly held corporation holds 10% or more of its stock.

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INTEREST OF AMICUS CURIAE[1]

Amicus curiae Purchaser Business Group on Health ("PBGH") is a nonprofit organization that represents a large number of U.S. employers, public and private, which spend approximately $350 billion annually on healthcare plans. PBGH's members represent diverse industries as well as state agencies, including Chevron Corporation, Cisco Systems, Hewlett Packard Enterprise, Intel Corporation, Pacific Gas & Electric Company, Walmart, Wells Fargo & Company, California Public Employees' Retirement System (CalPERS), University of California, Covered California, and the City and County of San Francisco Health Service System.

Competitive healthcare markets are crucial to achieving both the federal and state health reform and transformation goals that *amicus* PBGH has espoused and contributed to for decades. As discussed more fully herein, not only does PBGH have nearly unrivaled expertise

[1] *Amicus curiae* represents that no party's counsel authored this brief in whole or in part, and that no party, party's counsel, or any other person contributed money that was intended to fund preparing or submitting this brief. *See* Fed. R. App. P. 29(a)(4)(E). All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2).

regarding how employers purchase healthcare; it also has over two decades of direct experience with Appellee Sutter Health (Sutter), and the effects that contracting restraints at issue in this litigation, which Sutter imposed on most commercial insurance companies, have had on PBGH's members dating as far back as the early 2000s. *Amicus* therefore respectfully submits this brief to aid the Court's understanding of these complex, important issues.

INTRODUCTION

In this brief, PBGH offers factual background based on their decades of experience in the Northern California healthcare market. *Amicus* offers this background with the aim of addressing a key legal error it believes the district court committed below, which may have affected the jury's verdict.

The district court improperly imposed a blanket prohibition on the admission of any evidence pre-dating 2006, because Sutter's anticompetitive conduct began before 2006. Indeed, PBGH knows well that by 2006, many employers and insurers felt no choice but to acquiesce to Sutter's by-then well-established contracting practices. As PBGH's members can attest from their experiences in offering health plans that

negotiated with Sutter before 2006, excluding evidence from before this period kept from the jury highly relevant—and highly damning—information about Sutter's purpose in imposing its contractual restraints and the effect they had on healthcare prices.

Based on its members' experiences with Sutter during the relevant period, PBGH respectfully submits that the district court's decision to exclude *all* evidence from before 2006 precluded the jury from seeing highly probative material that demonstrated the drastic price effects Sutter's restraints created when they were first imposed.

FACTUAL BACKGROUND

This case is about one of the most pressing issues America currently faces: rising healthcare costs amid decreasing healthcare quality. In 2018, healthcare costs reached $3.6 trillion, of which $1.2 trillion was in hospital costs.[2] A recent study of the issue concluded that "[t]he dearth of competition in our health care markets is a key reason for this

[2] *See, e.g.*, Yusra Murad, *U.S. Health Spending Rose to $3.6 Trillion in 2018, Propelled by Health Insurance Tax*, Morning Consult (Dec. 5, 2019), *available at* t.ly/o8Z9.

dysfunction."[3] Absent robust competition between hospitals to be included in commercial health plans' networks, hospitals are able to leverage their market power to impose anticompetitive contracting terms that greatly increase the prices paid by insurers, employers, and patients.

Sutter's growth during the 1990s and its subsequent dominance of certain geographic hospital markets epitomizes this trend. Over the past few decades, Sutter has been steadily gaining more power in the healthcare market in California. Sutter expanded its market power based on an acquisition strategy by which it obtained monopoly hospitals in certain regions that were effectively "must have" facilities for any insurance plan wishing to offer coverage in Northern California.

Once it became indispensable to nearly every commercial insurance plan in this manner, in the early 2000s Sutter then leveraged its monopoly power in those regions to force commercial insurance companies to accept anticompetitive restrictions in their payer/provider contracts. As of 2005, these restrictions included:

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

- **All-or-nothing contracting (*i.e.*, "tying"):** Provisions or negotiating tactics through which "Sutter forces insurers—through its systemwide contracts with them—to include (in their networks) inpatient services at Sutter hospitals in the Tied Markets as a condition to access to inpatient services at Sutter hospitals in the Tying Markets (where Sutter is the only or dominant hospital)."
- **Anti-steering provisions:** Provisions preventing insurers from using financial incentives or innovative insurance plans (such as narrow networks) to "steer[] their enrollees away from high-cost Sutter hospitals to lower-priced providers"
- **Anti-transparency provisions:** Restrictions that "blocked the health plans from disclosing Sutter's prices to plan members to inform their choice of provider.

Sidibe v. Sutter Health, No. 12-CV-04854-LB, 2021 WL 879875, at *2-*4 (N.D. Cal. Mar. 9, 2021). Through these restraints, which amplified Sutter's already significant market power, Sutter was able to consistently charge substantially higher prices than its rivals, and to preclude the introduction into Northern California of innovative insurance products that would reduce healthcare spending and increase consumer choice. The result was that employers, unions, and individuals in Sutter's service area paid substantially more for healthcare than they otherwise would have. *Id.* at *2.

In a competitive market, hospitals compete with one another for sales of their services to insurance companies; in a market where Sutter

has gained unparalleled dominance, employers and insurance companies are forced to acquiesce to Sutter's demands. Insurance companies and, in the case of self-funded plans, employers bear the initial financial burden of Sutter's contracting practices, but much of it also trickles down to patients, who may see their wages erode, their out-of-pocket costs go up at a much higher rate than inflation, or the quality of healthcare they receive decline. *See Sidibe v. Sutter Health*, 333 F.R.D. 463, 470 (N.D. Cal. 2019) ("Consequently, it is the health plans' customers — individuals and employers that buy health insurance — that ultimately bear the burden of paying Sutter's supra-competitive prices.").

Over the years, PBGH's membership expressed its frustration regarding Sutter's anticompetitive practices directly to Sutter's President & CEO. Indeed, PBGH's membership have taken issue with the fact that they have been paying significantly more for healthcare in Northern California than they have been in Southern California, where there is also more innovation and choice in healthcare services. Because its members need to contract with Sutter, PBGH has been monitoring California's healthcare markets throughout the relevant time period, and is thus uniquely positioned to illuminate the importance of Sutter's pre-

2006 conduct to the story. Moreover, PBGH is intimately familiar with Sutter's role in the California healthcare market, and is thus knowledgeable about commercial health insurers' lack of viable alternatives to Sutter.

ARGUMENT

I. THE COURT ERRED IN EXCLUDING EVIDENCE OF SUTTER'S PRE-2006 CONDUCT

Because Sutter began to impose its contractual restraints before 2006—and much of the resistance by insurance plans and PBGH thus also began before then—the district court's decision to exclude *all* evidence from before 2006, regardless of its probity, prevented the jury from hearing highly relevant information about Sutter's motivations for imposing the restraints, payers' unsuccessful efforts to resist the restraints, and the alarm at how large an impact the restraints immediately had on prices that many in the market expressed.

A. Sutter's Pre-2006 Conduct Demonstrates its Deliberate, Anticompetitive Strategy Aimed to Dominate the Marketplace.

In the late 1990s, insurance companies began to feel the crippling power of Sutter's dominance in the healthcare marketplace. Sutter began disincentivizing employers from offering lower cost, more efficient

insurance plans prior to 2006. Indeed, in a 2005 report prepared by CalPERS, the agency concluded:

> Another critical reason [for increasing cost trends] is that the market fails to reward better performing hospitals. In many cases, hospital systems prevent purchasers and health plans from differentiating high performance hospitals from lower performing hospitals in the same system.[4]

Like CalPERS, PBGH realized the impact of Sutter's anticompetitive negotiation strategies early on. Sutter's role in obstructing fair competition and pricing was widely recognized, and from discussion with insurance companies like PacifiCare Health Systems, acquired by UnitedHealth Group in 2005, PBGH understood that eliminating Sutter from insurance networks would significantly decrease prices. Despite awareness of Sutter's all-or-none and anti-steering provisions, insurance companies had to acquiesce to Sutter's aggressive negotiation tactics, in order to sell their insurance products to individuals and employers. The system of healthcare in Northern California that Sutter had developed – by becoming "big enough that it could use its market power to dominate,

[4] California Public Employees' Retirement System, Partnership for Change: Promoting Value in Hospital Care (Jan. 6, 2005).

to dictate"[5]—forced insurance companies to "reward low-performing hospitals as much as, or more than, high quality, highly efficient hospitals."[6] Indeed, insurance companies and employers understood that Sutter was "basing their prices to private insurers and patients on what they [could] get away with," something that PBGH "long suspected."[7]

PBGH also commissioned Milliman to conduct an actuarial analysis of statewide hospital pricing.[8] Milliman used California Office of Statewide Health Planning and Development (OSHPD) 2005 claims data, quarterly financial data, by hospital, to estimate the Third Party Managed Care (Commercial) allowed/billed ratio. Using the Medicare inpatient geographic adjustment factors, Milliman created an area-adjusted Buyer Cost Index that reinforced PBGH's experience that Sutter's hospital prices exceeded market norms.

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[5] Interview with Xavier Becerra & Glenn Melnick, Univ. of Southern California, in Sacramento, Cal (Dec. 13, 2020), https://www.cbsnews.com/news/california-sutter-health-hospital-chain-high-prices-lawsuit-60-minutes-2020-12-13/.

[6] Press Release, California Public Employees' Retirement System, Report Shows Hospital Costs and Charges Vary Widely Throughout the State (Jan. 15, 2008).

[7] *Id.*

[8] Will Fox & John Pickering, *Cost Efficiency at Hospital Facilities in California: A Report Based on Publicly Available Data*, Milliman (October 17, 2007).

If permitted, pre-2006 evidence would show that payers in the relevant market (1) recognized that they had little choice but to accede to Sutter's demands, and (2) that as early as 2003, Sutter's restraints were causing healthcare prices to rise dramatically in the region. Indeed, the most dramatic uptick in prices occurred right after Sutter implemented its all-or-nothing contracting policy, and it was during this period that payers first resisted Sutter's demands.

Without the benefit of a full evidentiary timeline and context, the jury could not have adequately analyzed the trajectory of Sutter's exclusionary policies and monopolistic growth.

B. The Jury Cannot Properly Analyze the Extent and Consequences Sutter's Anticompetitive Conduct Without Considering Its Pre-2006 Conduct.

Because the jury was unable to consider evidence of Sutter's pre-2006 conduct, they were unable to track Sutter's conduct from its nascent stages, and they did not see evidence relating to how this conduct led to a significant spike in prices prior to 2006. Restraints on competition put in place by Sutter over the last two decades slowly, but steadily, dampened competition in the market for insurance products. Consequences of Sutter's conduct are evidenced in the disparity in

healthcare costs in Northern and Southern California; as of 2011, "hospitals in Northern California's six most populous counties collect[ed] 56% more revenue per patient per day from insurance companies and patients than hospitals in Southern California's six largest counties."[9]

Insurance companies began noticing increasing hospital prices in Northern California as early as 2004, with companies like PacifiCare writing to express concern about the significant difference in healthcare costs between Northern and Southern California. In a statement about CalPERS's report on hospital costs throughout California, Peter V. Lee, then-CEO of PBGH, explained:

> There are wide and unexplained regional differences in what hospitals are charging private insurers and patients. For example, the average price paid to hospitals in the Sacramento region was 30 percent higher than the statewide average for the same mix of hospital services – even after adjusting for wage differences. Across the state, the markup for some hospitals is about five times that of others.[10]

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[9] Duke Helfand, *Hospital stays cost more in Northern California than Southern California*, Los Angeles Times (Mar. 6, 2011), https://www.latimes.com/health/la-xpm-2011-mar-06-la-fi-hospital-cost-20110306-story.html.

[10] Press Release, California Public Employees' Retirement System, Report Shows Hospital Costs and Charges Vary Widely Throughout the State (Jan. 15, 2008).

Insurance companies like PacifiCare began undergoing similar investigations to determine the cause of the cost and quality disparities between Northern and Southern California hospitals. These studies generally concluded that structural differences between the two regions' hospital systems accounted for the difference.

Northern California is still plagued by unreasonably high healthcare costs, when compared to those of Southern California. As of 2018, "healthcare costs in Northern California outstrip[ped] Southern California by 30 percent," with a wider gap in inpatient procedures, specifically:

> [T]he average inpatient procedure price in Southern California is $131,586. In Northern California that number is $223,278, a difference of 70 percent. When adjusting for costs, [the] difference between the two geographies is still more than 30 percent.[11]

Confirming the continued, widening gap in costs, a 2020 study by the University of California, Berkeley, observed "[h]igher levels of concentration are associated with higher prices: Northern California

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[11] Kevin Truong, *It's not just housing; Northern California healthcare costs are 30% higher than rest of state*, San Francisco Business Times (Mar. 28, 2018), https://www.bizjournals.com/sanfrancisco/news/2018/03/28/northern-california-healthcare-costs.html.

healthcare procedures are often 20 to 30 percent higher than in Southern California, even after adjusting for wages."[12] By obstructing the formation of narrow networks and lower cost insurance models, as well as its all-or-none negotiating policy, Sutter has been permitted to inflate its prices in Northern California and collect the additional revenue.

The effects of Sutter's restraints can also be seen by how the price increases it imposed on insurers changed the structure of the health insurance market in California. One example is the effect that Sutter's higher prices had on the makeup of the Northern California health insurance market, particularly the growing membership of the Kaiser Foundation Health Plan ("Kaiser"), which began before 2006.

At trial, Sutter argued that it competed with Kaiser for patient admissions, but Kaiser is a closed system that insures patients who receive care from hospitals owned by Kaiser and staffed by Kaiser-employed physicians. Thus, when it comes to Sutter's ability to impose

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[12] Laurel Lucia, *High Health Care Prices are the Primary Driver of California Workers' Health Care Cost Problems*, UC Berkeley Labor Center (Feb. 20, 2020), https://laborcenter.berkeley.edu/high-health-care-prices-are-the-primary-driver-of-california-workers-health-care-cost-problems/#:~:text=Higher%20levels%20of%20concentration%20are,even%20after%20adjusting%20for%20wages.

its restraints on commercial health insurers (*e.g.*, Aetna, Anthem, Blue Shield of California, Health Net and UnitedHealthcare), the presence of nearby Kaiser hospitals does not lessen Sutter's market power, because these insurers by definition cannot contract with Kaiser as an alternative to Sutter. *See, e.g.*, *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 & n.10 (9th Cir. 2015) (noting that in hospital cases, the relevant "antitrust analysis focuses on the first stage of competition," in which "providers compete for inclusion in health plans" (quoting John J. Miles, 1 *Health Care & Antitrust L.* § 1:5 (2014)).

However, Kaiser *is* a competitor of health insurers, and the effect Sutter's prices had on commercial insurance prices led to insurers losing members to Kaiser. Thus, the California Health Care Foundation found that as of 2017, "[s]ix insurers accounted for more than two-thirds of the" $183.7 billion in revenues generated by the insurance industry in California; Kaiser is named as one of the six insurers.[13]

Because Kaiser competes with *insurers*, the increased costs Sutter's restraints created for insurers led them to lose patients to Kaiser. Plan

[13] California Health Care Foundation, *California Health Care Almanac* 2, 4 (May 2019).

purchasers, such as employers, typically offer a choice of health plans, and Sutter's rate actions were driving trends up in these plans at a much faster rate than experienced by Kaiser. For example, in 2006, PacifiCare noted that its membership in certain Northern California regions was shrinking at the same time as Kaiser's membership in the same regions was increasing.

Thus, Sutter's high cost accelerated enrollment changes in these Northern California's health insurers' makeup, making them less affordable, and ultimately contributing to enrollment growth in self-funded plans and Kaiser.[14] Evidence of this effect, which began before 2006, would also have been relevant to understanding the impact of Sutter's market power, but because of the district court's blanket prohibition on all pre-2006 evidence, much of it was kept from the jury.

CONCLUSION

Employers—including *amicus* PBGH and its member employers—experienced stark increases in the prices they paid for health insurance

[14] *See, e.g.*, Katherine Wilson, *HMO Enrollment in California: The Dynamics of Decline, 2004-2015*, California Health Care Foundation (Nov. 7, 2016), *available at* https://www.chcf.org/publication/hmo-enrollment-in-california-the-dynamics-of-decline-2004-2015/.

before 2006. During that period, many of these employers and the insurers from which they purchased health plans for their employees tried, unsuccessfully, to resist Sutter's contracting restrictions. By 2006, it was widely understood that resisting Sutter was futile, and insurance plans had no choice but to accept Sutter's anticompetitive restraints. Preventing the jury from hearing key evidence from the period before 2006 therefore artificially limited their scope of Sutter's conduct.

PBGH submits this brief to illustrate for the Court the importance of some of the evidence that was excluded by the district court's blanket prohibition on pre-2006 evidence. As the experience laid out above makes clear, much of the effects of Sutter's restraints were felt by employers before 2006, when Sutter first imposed its restraints. PBGH therefore submits that the jury should have been permitted to hear at least some of this evidence, rather than having it altogether excluded.

Dated: October 11, 2022

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with Fed. R. App. P. 29(a)(5) because it contains 2,907 words, excluding the portions exempted by Fed. R. App. P. 32(a)(7)(B)(iii). The brief's typeface and type style comply with Fed. R. App. P. 32(a)(5) and (6).

Date: October 11, 2022

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