Case No. 22-15634

**IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

DJENEBA SIDIBE, *et al.*,

Plaintiffs-Appellants,

v.

SUTTER HEALTH,

Defendant-Appellee.

BRIEF OF AMICI CURIAE PROFESSORS OF LAW AND ECONOMICS, ECONOMISTS, AND HEALTH POLICY RESEARCHERS IN SUPPORT OF PLAINTIFFS-APPELLANTS

Filed with the Consent of All Parties

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

CORPORATE DISCLOSURE STATEMENT 1

IDENTITIES AND INTERESTS OF AMICI CURIAE 2

INTRODUCTION AND SUMMARY OF ARGUMENT 5

ARGUMENT 7

I. Background: How Health Care Systems Can Exercise Market Power 7

II. The District Court Erroneously Refused to Instruct the Jury that Health Plans Are the Relevant Consumers for Purposes of Analyzing Markets and Restraints of Trade 15

III. The District Court's Exclusions of Pre-2006 Evidence and Evidence of the Purpose of Sutter's Restraints Were Clear Error 19

A. Binding Precedent Required the Court to Allow the Jury to Receive Evidence Regarding the Purpose of Sutter's Restraints 20

B. The Exclusion of Pre-2006 Evidence Precluded the Jury from Receiving Highly Probative Evidence Central to Plaintiffs' Case 21

IV. The District Court's Errors Merit Reversal 27

CONCLUSION 28

CERTIFICATE OF COMPLIANCE 31

CERTIFICATE OF SERVICE 32

TABLE OF AUTHORITIES

Cases

Blumenthal Distributing, Inc. v. Herman Miller, Inc., 963 F.3d 859 (9th Cir. 2020) 27

Boyd v. City & Cty. of San Francisco, 576 F.3d 938 (9th Cir. 2009).....................28

Brown Shoe v. United States, 370 U.S. 294 (1962) 18

California v. Sutter Health Sys., 130 F. Supp. 2d 1109 (N.D. Cal. 2001).................9

Chicago Board of Trade v. United States, 246 U.S. 231 (1918) 20

Continental Ore Co. v. Union Carbide & Carbon Corp., 370 U.S. 690 (1962) 26, 28

Corwin v. Los Angeles Newspaper Service Bureau, Inc., 22 Cal. 3d 302 (1978) ..20, 25

FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016)...................16

FTC v. Advocate Health Care, 2017 WL 1022015 (N.D. Ill. 2017) 10

FTC v. Hackensack Meridian Health Inc., 30 F.4th 160 (3d Cir. 2022).......... 10, 18

FTC v. Penn State Hershey Medical Center, 838 F.3d 327 (3d Cir. 2016).. 9, 10, 16

FTC v. Sanford Health, 926 F.3d 959 (8th Cir. 2019)...16

In re Cipro Cases I & II, 61 Cal. 4th 116 (9th Cir. 2015) 21

Jerden v. Amstutz, 430 F.3d 1231 (9th Cir. 2005) 28

Los Angeles Memorial Coliseum Comm. v. Nat'l Football League, 726 F.2d 1381 (9th Cir. 1984)...21

McWane Inc. v. FTC, 783 F.3d 814 (11th Cir. 2015)...24

PLS.com v. Nat'l Ass'n of Realtors, 32 F.4th 824 (9th Cir. 2022) 17

Sidibe v. Sutter Health, 2019 WL 2078788 (N.D. Cal. Apr. 12, 2019)...................17

Sidibe v. Sutter Health, 333 F.R.D. 463 (N.D. Cal. 2019) 22

Sidibe v. Sutter, 2021 WL 879875 (N.D. Cal. Mar. 9, 2021) 22, 23, 26

St. Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd., 778 F.3d 775 (9th Cir. 2015) 16, 18

UAS Management v. Mater Misericordiae Hospital, 169 Cal. App. 4th 357 (2008) 17, 23

United States v. Apple, 791 F.3d 290 (2d Cir. 2005)..25

United States v. Grinnell Corp. 384 U.S. 563 (1966)..14

United States v. Haney, 203 F.3d 1160 (9th Cir. 2000)...28

United States v. Monzon-Silva, 791 Fed.Appx. 671 (9th Cir. 2020) 28

United States v. The Charlotte-Mecklenburg Hospital Auth. (W.D.N.C. 2017) 14

United States v. WR Grace, 504 F.3d 745 (9th Cir. 2007) 27

Vasquez v. Indiana University Health, F.4th 2022 WL 2582368 (7th Cir. 2022)...16

Statutes

Cal. Bus. & Prof. Code 16720 20

Other Authorities

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Consolidation in California's Health Care Market 2010–2016: Impact on Prices and ACA Premiums, NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE <http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf> (March 26, 2018) 12

Cory S. Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L. J. 441, 490 (2019) 16

Cory S. Capps et al., *The Long Slow Decline of Elzinga-Hogarty and What Comes After*, CPI ANTITRUST CHRONICLE (July 2017) 8, 12

DAVID DRANOVE & LAWTON R. BURNS, BIG MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTHCARE IN AMERICA (2021) 8, 10, 25

Gregory Vistnes, Hospitals, Mergers, and Two–Stage Competition, 67 ANTITRUST L.J. 671 (2000) 16

H.E. Frech III et al., *Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets,* 71 ANTITRUST L.J. 921 (2004) 8

Hearings before the Sen. Com. on the Judiciary, Subcom. on Competition Policy, Antitrust, and Consumer Rights on Antitrust Applied: Hospital Consolidation Concerns and Solutions, 117th Congress, 1st Sess. (2021) testimony of Professor Martin Gaynor, E.J. Barone University Professor of Economics and Public Policy Carnegie Mellon University 7, 13, 24

Jaime S. King et al., *Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L.J. (forthcoming May 2023) 11

Joint Stipulation and Order (July 19, 2021) *Pasadena Hospital Assoc. and Cedar-Sinai Health System v. California Department of Justice* (Cal. Super. Ct. L.A. Cnty. 2021) No. 21STCP00978....................15

Judgment (August 27, 2021) *UFCW & Employers Benefit Trust v. Sutter Health* (Cal.App.1st 2015) No. CGC 14-538451, consolidated with *People of the State of California, ex rel. Xavier Becerra v. Sutter Health* (Cal. Super. Ct. S.F. City and Cnty. 2019) No. CGC-18-565398....................14

Leemore Dafny et al., *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286 (2019)................11

Lewis & Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, RAND J. ECON. 579 (2017)....................11

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Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON BUS. 65 (2011) 8, 9, 10, 27

Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564 (2017) 8

Vistnes & Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253 (2013) 12

Vogt & Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON FOUNDATION SYNTHESIS PROJECT (2006) 8

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure, the undersigned counsel of record certifies that none of the *Amici Curiae* is a nongovernmental entity with a parent corporation or a publicly held corporation that owns 10% or more of its stock.

Dated: October 10, 2022

/s/ Dean M. Harvey
Dean M. Harvey

Counsel for Amici Curiae

IDENTITIES AND INTERESTS OF AMICI CURIAE

The *amici* are professors of law and economics, economists, and health policy researchers. *Amici* have testified before Congress as well as state legislatures regarding the harms of consolidation within healthcare markets in the United States. They have also conducted extensive research and have published widely on topics of healthcare consolidation, anticompetitive conduct and contracting practices of dominant health systems, and the role of states and the federal antitrust enforcement agencies in addressing that system power. Their interest in this case is to illustrate the harms of system power in healthcare markets and the resulting anticompetitive effects that must be reined in. In this case, they have examined the district court's trial and pre-trial rulings, jury instructions, and other relevant evidence, and based on their expertise and other publicly available information discussed herein, *Amici* have concluded that the lower court erroneously instructed the jury and excluded highly probative evidence central to plaintiffs' case at trial. Given critical errors that misguided the jury verdict, the following *Amici* submit this brief to aid the Court's consideration of reversing the final judgment:

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Amici professors, lawyers, economists, and scholars file this brief pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure with the consent of all parties to this appeal.

Counsel for the Appellee did not author the brief in whole or in part. Appellee's counsel did not contribute financial support intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This important case addresses a significant problem plaguing health care markets—the cost-increasing, anticompetitive conduct of some large acute care hospital systems—which several authors of this brief have termed "system power." System power enables large health systems that often span multiple markets, states, or regions to leverage power from their cumulative holdings to harm competition and raise prices when negotiating with insurers (or other payers) that serve those same geographic areas. The tactics, employed by the Sutter Health system, are paradigmatic examples of the harms associated with health system market dominance arising from system power. By forcing health plans to contract for all their hospitals at rates higher than they would pay absent restraints and interfering with plans' efforts to steer their enrollees to lower cost alternatives, Sutter has been able to secure durable market power in Northern California markets and charge supra-competitive prices to health plans.

Vigilant oversight of the conduct of dominant health systems under state and federal antitrust laws is essential due to a vacuum in hospital merger enforcement over several decades. In particular, the acquisition of a hospital or system in a separate geographic market by another health system—so called "cross market mergers"—have gone almost entirely unchecked and unmonitored by antitrust enforcers despite economic evidence finding large price increases following such

mergers. For dominant health systems, like Sutter, that operate "must have" hospitals, expanding their geographic footprint has created an opportunity to impose illegal tying conditions and other contractual provisions that substantially increase the prices health plans and their subscribers ultimately pay. Private enforcement of antitrust standards and monetary damages for those who have paid excessive premiums provide a much-needed deterrent to the anticompetitive conduct of the growing number of dominant hospital systems.

The district court's erroneous pre-trial and trial rulings prevented the jury from becoming fully informed about the nature and purpose of Sutter's conduct. These errors include: first, the court ignored clear precedent in the Ninth Circuit, three other Circuits, and undisputed economic analyses that the relevant consumers for antitrust analyses of provider-payer interactions are health plans, not their subscribers; second, the court disregarded the plain language of the Cartwright Act and legal precedent mandating that jurors consider whether the purpose of defendant's conduct was to restrain competition; and third, it refused to allow evidence of pre-2006 statements and documents despite the fact that plaintiffs' case asserted a continuing and durable course of conduct dating back to at least 2002. The second and third errors are highly interrelated and are discussed together in Part III. These errors deprived the jury of vital information that would have undermined Sutter's principal defense, i.e., that Kaiser Permanente provided

a meaningful check on the market power Sutter wielded on other health plans. Viewed individually or collectively, these errors substantially prejudiced Plaintiffs and warrant reversal of the final judgment.

ARGUMENT

I. BACKGROUND: HOW HEALTH CARE SYSTEMS CAN EXERCISE MARKET POWER

Market power, which is pervasive throughout the health care sector, is a leading driver of the high health care costs in America. This is particularly so with regard to inpatient hospital care. Price competition among hospitals takes place in localized markets, as hospitals bargain with health plans for inclusion in their networks. The majority of inpatient hospital markets are highly concentrated according to antitrust standards which a wide body of literature demonstrates is associated with higher prices without offsetting gains in improved quality or enhanced efficiency. *Hearings before the Sen. Com. on the Judiciary, Subcom. on Competition Policy, Antitrust, and Consumer Rights on Antitrust Applied: Hospital Consolidation Concerns and Solutions*, 117th Congress, 1st Sess. (2021) testimony of Professor Martin Gaynor, E.J. Barone University Professor of Economics and Public Policy, Carnegie Mellon University (hereafter Testimony of Professor Martin Gaynor); Vogt & Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON FOUNDATION

SYNTHESIS PROJECT (2006). Much of the increased concentration in hospital markets is attributable to the failure of enforcement agencies and the courts to accurately define markets and identify problematic mergers. This oversight gave rise to an extended period when highly concentrative mergers went unchallenged owing in part to flawed economic methodologies that resulted in courts finding overly broad relevant geographic markets. *See* Cory S. Capps et al., *The Long Slow Decline of Elzinga-Hogarty and What Comes After*, CPI ANTITRUST CHRONICLE (July 2017); Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1565 (2017).

Economic research in the early 2000s identified major problems in the methods commonly used in litigation and generated new empirical tools for analyzing hospital markets. Capps, et al., *supra*; DAVID DRANOVE & LAWTON R. BURNS, BIG MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTHCARE IN AMERICA (2021); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON BUS. 65 (2011); H.E. Frech III et al., *Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets*, 71 ANTITRUST L.J. 921 (2004) (observing that the methodology employed in evaluating the Summit-Alta Bates merger resulted in implausibly broad geographic market definitions). Many of these tools, including willingness-to-pay (WTP) analysis, recognized the importance of

analyzing a transaction's impact on payers, rather than consumers, because the preponderance of the competitive impact on price occurs in negotiations between payers and providers, rather than the interaction of patients with providers. In addition, a series of retrospective studies of consummated hospital mergers initiated by the Federal Trade Commission revealed that courts had defined geographic markets too broadly. *See FTC v. Penn State Hershey Medical Center*, 838 F.3d 327, 340-41 (3d Cir. 2016) (explaining deficiencies in methodology for defining geographic markets adopted by the district court, citing *Amici Curiae* Br. of Economics Professors). A noteworthy example of the consequences of the flawed economic analysis is the decision of the District Court for Northern California approving Sutter's acquisition of the Summit Hospital System in Oakland. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001). That merger united Sutter's Alta Bates hospital in Berkeley, California with Summit, a nearby hospital in Oakland. A retrospective study of the competitive effects of that merger revealed that both hospitals had raised prices significantly after the merger, with Summit's increases ranging from 19% to 72% for various health plans, which were "among the largest of any comparable hospital in California." Tenn, *supra* at 75. The study lends support to the prediction raised by the Attorney General of California's challenge to the merger that the transaction would have anticompetitive consequences. Notably, it also undermines the

contention raised in this case that Kaiser serves as a check on hospital pricing in the region, as its presence did not appear to curb Sutter's sudden price increases. Tenn, *supra* at 79 (noting that the presence of other hospitals in the area, including Kaiser, was insufficient to constrain anticompetitive price increases); *see also* DRANOVE & BURNS, *supra* at 93 (concluding that the district court's decision in the Sutter/Summit case "opened the floodgates for further expansion by urban health care systems").

Although the new economic tools empowered antitrust enforcers to successfully challenge a series of highly concentrative proposed mergers in federal court in recent years, *see, e.g., Penn State Hershey*, 838 F.3d at 336 ; *FTC v. Advocate Health Care*, 2017 WL 1022015 at *12 (N.D. Ill. 2017), many local markets remain dominated by a single "must have" hospital or system. In many other localities, the geographic isolation of a hospital insulates it from competition, so that health plans have no alternative but to pay supra-competitive prices in order to include them in their networks. As has been recognized in several cases, certain "must have" hospitals have extraordinary bargaining power that they can exercise in their negotiations with health plans. *See, e.g., FTC v. Hackensack Meridian Health Inc.*, 30 F.4th 160 (3d Cir. 2022) (combination of two closest competitors in a market would make it impossible for health plans to offer a commercially viable

product without the merged system). Plaintiffs have shown that Sutter operates "must have" hospitals in several Northern California markets.

To date, little has been done to address mergers that give rise to large regional health systems. Operating under the assumption that hospital competition is entirely confined to local markets, enforcers have paid scant attention to acquisitions that extend hospital systems across geographic regions. *See* Jaime S. King et al., *Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L.J. (forthcoming May 2023). In fact, as of 2019, 67 percent of community hospitals were part of multi-hospital systems, and almost half of all community hospitals are within the largest systems (those with eleven or more hospitals). Brent Fulton et al., *The Rise of Cross-Market Hospital Systems and Their Market Power*, 41 HEALTH AFF. (forthcoming Dec. 2022).

The cost of allowing system growth to go unchecked is now becoming apparent. Several economic studies have documented the price increases associated with so-called cross market mergers—those that combine hospitals in multiple, distinct local markets. *See* Leemore Dafny et al., *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286 (2019); Lewis & Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, RAND J. ECON. 579 (2017); Vistnes & Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79

ANTITRUST L.J. 253 (2013). Indeed, Northern California may well be the prime example of the adverse effects of system power, as Northern California prices are on average 24% higher than Southern California for the same services. Richard Scheffler et al., *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, CALIFORNIA HEALTH CARE FOUNDATION (2019) (specifically citing the state lawsuit against Sutter for its anticompetitive conduct in driving prices); *See also Consolidation in California's Health Care Market 2010–2016: Impact on Prices and ACA Premiums*, NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE <http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf> (March 26, 2018) (finding "stark differences in prices and ACA premiums between Northern and Southern California").

Hospitals are as far removed from the imaginary standardized product of Economics 101 "widgets," as any product or service in the American economy. They differ significantly in sophistication, geographic location, availability of alternatives, quality of care, and, most importantly in this case, the degree of market power they can exercise in bargaining with payers. *See* Capps et al., *supra*. As discussed above, health systems can accrue market power by their ownership of "must have" hospitals. They exercise that power by deploying anti-competitive strategies such as those at issue in this case.

Payers and employers have only a few tools at their disposal to combat the market power of dominant health systems. One form of defensive insurance design is tiering. Under these contractual provisions health plans' enrollees pay less out of their own pockets for care received from providers in a more favorable group (or "tier") and pay more if they see a provider in a less favorable tier. These provisions incentivize hospitals to give favorable prices in order to be in the more favorable tier. A related contractual approach is steering—directing health plan enrollees to preferred hospitals. Similarly, some plans offer narrow networks that exclude high-priced providers. Finally, a fourth defensive tool employed by insurers is transparency—providing enrollees with information about the costs or quality of care of different providers. Transparency provides health plans' enrollees information they can use to choose the most cost-effective, high-quality hospitals. *See generally* Testimony of Professor Martin Gaynor, *supra*, 117th Congress, 1st Sess. (2021). Sutter's conduct at issue in this case involved efforts specifically focused on thwarting the procompetitive effects of each of these tools.

To be sure, the formation of health systems can enable hospitals to realize economies of scale and improve the quality of care provided. However, the deployment of tactics by large systems that limit rivalry from other hospitals completely undermines the motivation to improve care or provide lower cost services. As has long been recognized by antitrust precedent, monopoly power

deadens incentives to improve quality and empowers firms to "control prices or exclude competition." *United States v. Grinnell Corp.*, 384 U.S. 563, 571 (1966). The contractual terms insisted upon by Sutter at issue in this case—system-wide pricing, all or nothing contracts, excessive non-participating pricing when out-of-network, and prohibitions on tiering and steering by health plans—are precisely the kinds of competition-blocking strategies that antitrust enforcement is designed to prevent.

Recognizing the "system power" harms to competition resulting from these strategies, state and federal antitrust enforcers have directly challenged them in recent years. For example, the U.S. Department of Justice challenged the use of anti-steering and anti-tiering clauses in a case involving a large multi-hospital system in North Carolina, which was settled when the system agreed not to use these restrictive clauses. *United States v. Charlotte-Mecklenburg Hospital Auth.*, 248 F.Supp.3d 720 (W.D.N.C. 2017). Likewise, the Attorney General of California settled its case against Sutter involving many of the same allegations in this suit when Sutter agreed to abandon their use. Judgment (August 27, 2021) *UFCW & Employers Benefit Trust v. Sutter Health* (Cal.App.1st 2015) No. CGC 14-538451, consolidated with *People of the State of California, ex rel. Xavier Becerra v. Sutter Health* (Cal. Super. Ct. S.F. City and Cnty. 2019) No. CGC-18-565398. In an administrative proceeding, the California attorney general pre-

emptively imposed competitive impact conditions on the cross-market merger of Cedars-Sinai Health System and Huntington Memorial Hospital that prohibits the use of all-or-nothing contracting and interference with narrow and tiered network design or tiering and steering practices. Joint Stipulation and Order (July 19, 2021) *Pasadena Hospital Assoc. and Cedar-Sinai Health System v. California Department of Justice* (Cal. Super. Ct. L.A. Cnty. 2021) No. 21STCP00978; *see also* Consolidated Class Action Complaint, *In re Mission Health Antitrust Litigation* (W.D.N.C. 2022) (municipalities and counties of North Carolina sued HCA Healthcare, a large health system similar to Sutter Health, for use of its market power garnered from merger with Mission Health to force insurers to enter all-or-nothing, anti-steering and anti-tiering, and gag clauses). In each case, the allegations involved the potential for large health systems, like Sutter, to use their market power in certain markets to drive up healthcare prices more broadly by deploying anticompetitive tactics.

II. THE DISTRICT COURT ERRONEOUSLY REFUSED TO INSTRUCT THE JURY THAT HEALTH PLANS ARE THE RELEVANT CONSUMERS FOR PURPOSES OF ANALYZING MARKETS AND RESTRAINTS OF TRADE

The district court denied plaintiffs' requested jury instruction that health plans are the relevant customers with regard to the Sutter's restraints of trade. In doing so, it disregarded the strong consensus among courts evaluating healthcare markets in antitrust cases and unimpeached economic analyses that hospital prices

are determined by negotiations between insurers and hospitals. *St. Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.*, 778 F.3d 775, 784-85 (9th Cir. 2015) (health plans, not patients, are the direct purchasers of health care and thus pay the hospital's price increases); *Penn State Hershey*, 838 F.3d at 342 (relevant consumers responding to a hospital's price increases are health plans, not the health-plan enrollees); *Vasquez v. Indiana University Health*, 40 F.4th 582 (7th Cir. 2022) (insurers are the relevant consumers because they are "the most directly affected buyers" of hospital services); *see also FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016); *FTC v. Sanford Health*, 926 F.3d 959, 964 (8th Cir. 2019).

The numerous courts concluding that health plans are the relevant customer for antitrust analysis have relied upon economic studies demonstrating that hospital and physician prices are set pursuant to a "two stage" process. Gregory Vistnes, *Hospitals, Mergers, and Two–Stage Competition*, 67 ANTITRUST L.J. 671, 674–75 (2000); *see also* Cory S. Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L. J. 441, 490 (2019). In the first stage, providers compete on price and non-price dimensions to be included in insurers' networks. In the second stage, in-network providers compete to be selected by patients. Because having health insurance largely eliminates differences in out-of-pocket costs for patients who choose in-network providers, the second stage of

competition turns primarily on non-price dimensions. Hence, the critical point at which hospital prices are at issue—and the pivotal point for antitrust analyses—is the first stage of competition. As a group of leading health economists (including Sutter's expert, Dr. Gowrisankaran) pointed out to this court in the *St. Alphonsus* merger litigation, "the locus of price competition for healthcare providers is [] centered on competition among providers for inclusion in insurers' networks." *See Amici Curiae* Br. of Economics Professors, *St. Alphonsus* at 4. Indeed, the district court itself noted the "binding" effect of this court's holding on the relevant purchaser issue in the *St. Alphonsus* appeal when it denied Sutter's motion for summary judgment in 2019. *Sidibe v. Sutter Health*, 2019 WL 2078788, at *24 fn 196 (N.D. Cal. Apr. 12, 2019); *see also PLS.com v. Nat'l Ass'n of Realtors*, 32 F.4th 824 (9th Cir. 2022) (reversing district court decision for failing to direct antitrust injury analysis on the direct purchasers of a multiple listing services—real estate agents—rather than home buyers and sellers); *UAS Management v. Mater Misericordiae Hospital*, 169 Cal. App. 4th 357, 369 (2008) (analyzing tying allegations under Cartwright Act as agreement between health plan and hospital).

This error enabled defendant to sew confusion as to the importance of Kaiser's presence in Northern California markets. Plaintiffs' claims of tying and unreasonable restraint of trade required the jury to consider the relevant markets in which Sutter competed and whether it had the market power to effectively force

health plans to include unwanted hospitals in their network and pay inflated levels of reimbursement. The nub of plaintiffs' case was that Sutter could extract high prices from health plans *other than* Kaiser competing in the relevant markets. It could do so for the obvious reason that Kaiser does not make its hospitals available to rival plans. Simply put, it is a closed system. As recognized by this court, the proper focus for analyzing hospital market competition in antitrust cases must be on effects on "direct purchasers," viz., health plans. *St. Alphonsus*, 778 F.3d at 784. Without a clear signal that the market affected by restraints must include only practical alternatives, *Brown Shoe v. United States*, 370 U.S. 294, 346 (1962), the jury was left to speculate as to the appropriate standard for inclusion or exclusion of meaningful alternatives that affected hospital prices. *Id.*; *see also Hackensack Meridian*, 30 F.4th at 167 (citing *Brown Shoe* and holding that "commercial realities" indicate that health plans understood they could not sell their products outside the FTC's proposed geographic market). The evidence at trial left little room for doubt that the judge should have instructed the jury that Kaiser could not be an alternative in the relevant market alleged by plaintiffs for the unchallenged reason that Kaiser did not sell its inpatient hospital services to rival health plans.

III. THE DISTRICT COURT'S EXCLUSIONS OF PRE-2006 EVIDENCE AND EVIDENCE OF THE PURPOSE OF SUTTER'S RESTRAINTS WERE CLEAR ERROR

In a series of pre-trial and trial rulings, the district court wrongfully excluded key evidence, declined to craft jury instructions consistent with plaintiffs' legal theory, and prevented the jury from receiving a complete and accurate understanding of the nature and effect of Sutter's conduct. Two interrelated legal errors barred the jury from seeing critical evidence that went to issues at the heart of plaintiffs' case. First, the district court ignored the plain language of the Cartwright Act and longstanding precedent that leave no doubt that proof of defendants' purpose in imposing a restraint is relevant and highly probative evidence that can shed light on the effects of alleged restraints of trade. Second, in pre-trial and trial rulings that excluded critical historical evidence, especially proof of Sutter's pricing "before and after" it imposed its "all-or-nothing" strategy, the district court threw up an impenetrable barrier to the introduction of highly pertinent economic studies and telling admissions by Sutter executives. Evidence revealing that its purpose was to raise price demonstrates Sutter's knowledge that Kaiser could not constrain its ability to do so. Deprived of vital, common-sense proof of the nature, purpose, and impact of defendant's restraints of trade, the jury likely fell victim to defendant's misdirection as to how hospitals bargain with

insurance plans, and in particular, the potential for Kaiser to inhibit Sutter's ability to raise prices to commercial health plans.

A. Binding Precedent Required the Court to Allow the Jury to Receive Evidence Regarding the Purpose of Sutter's Restraints

The importance of history and purpose evidence has long been recognized as highly relevant in evaluating anticompetitive effects and related issues such as market definition under both the Cartwright Act and Sherman Act. The classic formulation of relevant evidence for restraints of trade is found in the Supreme Court's decision in *Chicago Board of Trade v. United States*:

> [T]he court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be obtained, are all relevant facts.

Chicago Board of Trade v. United States, 246 U.S. 231, 238 (1918). Indeed, the language of the Cartwright Act specifically mandates consideration of the purpose of restraints. Cal. Bus. & Prof. Code § 16720 ("A trust is a combination of capital, skill or acts by two or more persons for any of the following *purposes*: (a) To create or carry out restrictions in trade or commerce...") (emphasis added). California precedent affirms the centrality of purpose evidence. *Corwin v. Los Angeles Newspaper Service Bureau, Inc.*, 22 Cal. 3d 302, 310 (1978) (quoting *Chicago Board of Trade*); *see also In re Cipro Cases I & II*, 61 Cal. 4th 116, 157

(9th Cir. 2015) (the rule of reason requires that courts evaluate the "nature and history" of a restraint and "the reasons for its adoption").

The inescapable truth is that antitrust cases present complex and challenging factual questions to juries. Accordingly, trial courts' instructions and evidentiary rulings need to "insure [sic] that the jury fully understood the issues," *Los Angeles Memorial Coliseum Comm. v. Nat'l Football League*, 726 F.2d 1381, 1398 (9th Cir. 1984), and afford jurors the opportunity to render common sense judgements. This obligation is particularly important in antitrust cases where the risk of confusion is acute. *Id.* ("where... abstract legal principles are not self-explanatory to a lay jury, and the facts to which they must be applied are complex," courts must provide "well-tailored and specific instructions" in conformance with plaintiffs' legal theory).

B. The Exclusion of Pre-2006 Evidence Precluded the Jury from Receiving Highly Probative Evidence Central to Plaintiffs' Case

In pre-trial rulings, the court excluded evidence of Sutter's conduct prior to January 1, 2006, based on the plainly erroneous basis that evidence regarding Sutter's conduct prior to 2006 had "minimal relevance" and was "too attenuated from the relevant period." ECF No. 1282 at 1-2; *see also* ECF No. 1167 at 8-9. Quite to the contrary, the district court's sweeping exclusionary rulings deprived the jury of telling admissions that would have helped clarify the complex issues in

this case. Rather than "collateral" or merely a historical footnote, the excluded evidence on Sutter's conduct in the early 2000s supplied critical information that pertained to a *continuing course of conduct,* conceived and implemented during that nascent period.

1. *The Exclusion of Pre-2006 Evidence Precluded the Jury from Learning About Admissions by Sutter Executives that were Highly Relevant to Multiple Elements of Plaintiffs' Case*

The excluded pre-2006 evidence included probative, material admissions that bore directly on the anticompetitive purpose and effects of Sutter's conduct, which notably the district court had relied on in its pre-trial rulings. *Sidibe v. Sutter Health*, 333 F.R.D. 463 (N.D. Cal. 2019) (granting class certification); *Sidibe v. Sutter*, 2021 WL 879875 (N.D. Cal. Mar. 9, 2021) (denying Sutter's motion for summary judgment). For example, the district court's bar prevented the jury from reviewing Sutter executive admissions that a goal of system wide contracting was to "get better prices" and exercise "the increased leverage that twenty-one hospitals can achieve by working together." Another executive stated that Sutter made the switch to system-wide contracting in order "to increase leverage" and did so "because they could." Other documents spoke to the significant increase in revenue Sutter anticipated achieving through its tactics and conceded that it was "forcing" health plans to go along with its demands. ECF No. 1282 at 1-2; *see also* ECF No. 1167 at 8-9.

These admissions address issues central to plaintiffs' allegations of anticompetitive tying under the Cartwright Act. They provide compelling evidence that Sutter (1) had market power in several relevant tying markets, (2) that it coerced the purchase of the tied product, and (3) that the plaintiffs sustained pecuniary losses in the form of higher prices paid by health plans as a consequence of the tie. *See UAS Management*, 169 Cal. App. 4th at 369 (setting forth legal standards governing antitrust tying claims under the Cartwright Act). Other evidence barred by the pre-2006 exclusion spoke directly to plaintiffs' claim that Sutter's conduct constituted an unreasonable course of conduct under the Cartwright Act. For example, one witness testified that the change to system-wide contracting in 2002 led to "dramatically higher prices" and sharply reduced price competition. Further, it sheds important light on the history, purpose, and effects of Sutter's contracting tactics. In fact, as discussed below, the district court itself relied on pre-2006 evidence in denying Sutter's motion for summary judgment. *Sidibe v. Sutter Health*, 2021 WL 879875 *2.

Critically, the excluded admissions would serve to severely undermine Sutter's principal defense, viz., that Kaiser presence in the market prevented the anticompetitive restraints from having a market effect. The clear implication of that evidence is that Sutter executives intended their tactics to have price increasing effects on commercial plans throughout Northern California

notwithstanding the existence of Kaiser's closed system. Likewise, the executives plainly anticipated that Kaiser's presence did not pose an obstacle to achieving their ends.

2. *The Exclusion of Pre-2006 Evidence Precluded the Jury from Receiving Vital "Before and After" Historical Evidence Showing Anticompetitive Purpose and Effect*

The bar on pre-2006 evidence also deprived the jury of vital economic testimony, routinely relied upon in antitrust cases, that spoke directly to the effects of Sutter's restraints on competition and prices. Ample precedent under both the Cartwright Act and Sherman Act speak to the importance of "before and after" evidence probative of defendant's intent, market power, and the effects of its acts in restraint of trade. A standard tool used for evaluating the price effects of conduct and mergers is to compare price levels before and after an event. *See generally* Testimony of Professor Martin Gaynor, *supra*, 117th Congress, 1st Sess. (2021) (summarizing studies finding significant increase in hospital prices following mergers of close competitors and recommending increased enforcement efforts by antitrust authorities); *see also McWane Inc. v. FTC*, 783 F.3d 814 (11th Cir. 2015) (requiring evidence that an exclusive dealing arrangement has affected price or output). Indeed, the retrospective economic studies discussed above undertook "before and after" analyses of price effects of consummated mergers. These studied eventually led to a wholesale revision of market definition

methodology by enforcers and the courts. *See* DRANOVE & BURNS, *supra* at 95-103. The California Supreme Court has recognized the importance of such evidence. *Corwin,* Cal. 3d at 311 (noting relevance of before and after evidence); *see also United States v. Apple*, 791 F.3d 290, 328 (2d Cir. 2005) (applying before and after analysis in case brought under Sherman Act and state antitrust laws).

The relevance and materiality of such evidence in this case should be obvious. A significant upward change in prices shortly after a contractual restraint has been imposed gives rise to a strong inference of causation and anticompetitive effects. As plaintiffs' expert, Dr. Chipty, was prepared to show, "after" Sutter's switch to system-wide contracting in 2002, prices substantially increased from the levels prevailing "before." This persuasive proof of direct anticompetitive effect would not be possible without evidence from the early 2000s period, which was excluded by the lower court. Hence, the jury never got to receive highly relevant evidence that Sutter was able to raise its prices just as intended soon after instituting its system wide pricing scheme.

The case law leaves little doubt about the importance of historical evidence. For example, in an opinion concerning facts closely analogous to this case, the Supreme Court mandated close attention to the history and purpose of alleged anticompetitive restraints. In *Continental Ore Co. v. Union Carbide & Carbon Corp.*, plaintiffs sought to show the monopolization and anticompetitive restraints

that began in the early 1930s although plaintiffs did not enter the market until 1938 and the harm did not occur until that time. The Supreme Court reasoned that "it was pursuant to this anticompetitive scheme" that was established well before 1938 that defendants eliminated plaintiffs from the vanadium industry. *Continental Ore Co. v. Union Carbide & Carbon Corp.,* 370 U.S. 690, 709-10 (1962). Hence, the Supreme Court held that this pre-1938 evidence was "clearly material" and should have been admitted, vacating the jury verdict and remanding the case for a new trial. *Id*.

Similarly, in this case, "before and after" evidence serves to clarify rather than confuse. It supplies information at the heart of the central issue this case posed: Did the restraints limit competition and result in higher prices? Not only would pre-2006 documents evidence defendant's purposes in imposing the restraints, but they also shed light on their anticompetitive effects. Indeed, the district court's holding rejecting Sutter's motion for summary judgment itself relied on pre-2006 evidence and explained its relevance to issues of forcing and the effect on payers. *Sidibe v. Sutter*, 2021 WL 879875, at *2 (N.D. Cal. Mar. 9, 2021) (noting that Sutter's move to system-wide contracting around 2002 forced reluctant insurers such as Anthem to acquiesce).

Once again, the court's exclusionary rulings denied the jury access to information that would undermine Sutter' "Kaiser defense." Expert testimony

demonstrating the price effects of system-wide contracting and health plans' responses would provide the jury highly relevant evidence that Kaiser did not temper the price-increasing effects of Sutter's tactics. Likewise, the court's rulings barred the presentation of the study discussed above regarding the post-merger effects of the acquisition by Sutter of its close rival in Oakland, Summit Health. Tenn, *supra*. Together this evidence casts considerable doubt on the argument that Kaiser should be considered in the relevant market or deemed a constraining force on Sutter's conduct.

IV. THE DISTRICT COURT'S ERRORS MERIT REVERSAL

In sum, the court made clear errors in excluding the admission of highly probative evidence that is crucial to the plaintiffs' case that warrant a reversal under both evidentiary rules and well-established legal precedents. The material and highly probative evidence excluded in this case falls squarely within well-established precedent mandating reversal where judicial error occurs. The bar for excluding evidence is extremely high, and *de novo* review is applied where an error of law has occurred. *United States v. WR Grace*, 504 F.3d 745, 754 (9th Cir. 2007). Likewise, jury instructions are reviewed *de novo* and erroneous instructions require reversal unless the error is "more probably than not harmless." *Blumenthal Distributing, Inc. v. Herman Miller, Inc.*, 963 F.3d 859, 869 (9th Cir. 2020). The district court contravened the legal standard for invoking the "extraordinary

remedy" of exclusion. *United States v. Monzon-Silva*, 791 Fed.Appx. 671, 672 (9th Cir. 2020) (Fed. R. Evid. 403 generally favors admissibility and only allows the court to exclude relevant evidence in the extraordinary situation where the potential for prejudice and confusion *substantially* outweighs its probative value); *see also United States v. Haney*, 203 F.3d 1160, 1772 (9th Cir. 2000) (placing high burden on the proponent of exclusion). By preventing plaintiffs from presenting clearly pertinent historical evidence, the district court committed reversible error.

Each of the district court's legal errors merits reversal in this case. *Boyd v. City & Cty. of San Francisco*, 576 F.3d 938, 949 (9th Cir. 2009) ("When error is established, we must presume prejudice unless it is more probable than not that the error did not materially affect the verdict"). Moreover, as this court has held, erroneous rulings and jury instructions should not be viewed in isolation. *Jerden v. Amstutz,* 430 F.3d 1231, 1240-41 (9th Cir. 2005) ("cumulative error in a civil trial may suffice to warrant a new trial even if each error standing alone may not be prejudicial."); *see also Continental Ore*, 370 U.S. at 699 (a continuing course of conduct should not be evaluated by "dismembering it and viewing its separate parts, but only by looking at it as a whole").

CONCLUSION

The errors of the district court discussed in this brief—rulings and jury instructions concerning (1) the actual "buyer" of hospital services, (2) Sutter's

purposes in imposing its restraints, and (3) pre-2006 evidence—severely prejudiced plaintiffs' case. These rulings denied the jury access to evidence that went to the heart of the Cartwright Act violations at issue, such as the actual effects, before and after, of system-wide pricing, which could not be attenuated by Kaiser's availability to consumers; admissions by Sutter executives regarding their plans to force terms on commercial plans and the effects they anticipated; and the response of health plans to defendant's tactics, which could not and did not involve substituting Kaiser providers for Sutter providers. Importantly, the errors also enabled defendant to misdirect attention to the competitive significance of Kaiser. The jury should have been able to receive important rebuttal evidence including economic evidence of the actual price effects of Sutter's tactics and the fact that Sutter's executives intended and anticipated the anticompetitive outcomes.

For the foregoing reasons, this Court should reverse the final judgment and remand this matter to the district court for further proceedings.

Dated: October 10, 2022 Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure ("FRAP") 32(a), the undersigned counsel certifies that this Brief complies with: (1) the type-volume limitation of FRAP 29(a)(5) and FRAP 32(a)(7)(B) because this brief contains 6,251 words, excluding the parts of the brief exempted by FRAP 32(f); and (2) the typeface requirements of FRAP 32(a)(5) and the type style requirements of FRAP 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word in Times New Roman type style, 14-point font.

Dated: October 10, 2022

/s/ Dean M. Harvey
Dean M. Harvey

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 Ninth Circuit by using the appellate CM/ECF system on October 10, 2022. All participants in this case are registered CM/ECF users, and will be served by the appellate CM/ECF system.

Dated: October 10, 2022 *<u>/s/ Dean M. Harvey</u>*
Dean M. Harvey