Case 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.

Appeal from the United States District Court for the Northern District of California (San Francisco), Case No. 3:12-cv-04854-LB · Honorable Laurel D. Beeler, Magistrate Judge

BRIEF OF AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANT-APPELLEE AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

The American Hospital Association is a nonprofit, non-stock entity. Pursuant to Rule 26.1 and Rule 29(a)(4) of the Federal Rules of Appellate Procedure, *amicus curiae* AHA makes the following disclosures:

1) For non-governmental corporate parties please list all parent corporations: None

2) For non-governmental corporate parties please list all publicly held companies that hold 10% or more of the party's stock: None

January 10, 2023

Respectfully submitted,

/s/ Boris Bershteyn
Boris Bershteyn

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INTEREST OF *AMICUS CURIAE*[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities they serve and to helping ensure that care is available to—and affordable for—all Americans. The AHA educates its members on healthcare issues and advocates on their behalf, so that their perspectives are considered in formulating health policy. One way in which the AHA promotes its members' interests is by participating as an *amicus curiae* in cases with important and far-ranging consequences for health care.

The AHA's members face significant risks in operating their hospitals and are often forced to absorb the implications of burdensome commercial insurer practices that not only undermine their viability, but also restrict patient care and access. As the nation's largest association of hospitals, the AHA is uniquely positioned to provide this Court with an important on-the-ground perspective on the market realities and financial pressures affecting hospitals and their communities.

[1] No counsel for any party authored this brief in whole or in part, and no party, party's counsel, or any person other than the *amicus*, or its counsel, made a monetary contribution intended to fund the preparation or submission of 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). Defendant Sutter Health is a member of the AHA.

INTRODUCTION AND SUMMARY OF ARGUMENTS

To overturn a well-reasoned and amply supported jury verdict, the *amici* supporting plaintiffs make extravagant claims about hospital consolidation resulting in "[d]ominant hospital systems [that] . . . leverag[e] their market power" to raise healthcare prices and dampen the quality of patient care.[2] These claims are unmoored from the narrow evidentiary and instructional issues before this Court. They are also wrong, and the American Hospital Association respectfully submits this brief to set the record straight.

American hospitals, including those in California, navigate treacherous financial waters. They face a dire combination of high fixed costs, escalating expenses, chronic underpayment by government programs, increasingly aggressive tactics by commercial insurers, and an unprecedented pandemic environment.

[2] Br. *Amici* Consumer Action and U.S. Pub. Int. Rsch. Grp. at 3; *see also* Br. *Amicus* Cal. Healthcare Coal. at 2 (alleged conduct "will continue to undermine efforts to lower health care costs for millions of Californians and health plan constituents"); Br. *Amicus* Catalyst for Payment Reform at 8 ("[H]ealthcare 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."); Br. *Amicus* Purchaser Bus. Grp. at 4 ("[Hospitals] leverage their market power to . . . greatly increase the prices paid by insurers, employers, and patients."); Br. *Amici* Scholars at 4 (hospitals "impose higher prices on health plans"); Br. *Amici* State Att'ys Gen. at 11 (alleging conduct "coerce[s] health insurers into paying unfair rates . . . and limit[s] access and consumer choice").

Together, these factors have led hospitals to perform on razor-thin margins and some have filed for bankruptcy.

To provide care in this precarious economic environment, hospitals must guard against unanticipated revenue shortfalls—or, at the very least, ensure predictable revenue streams. Hospitals thus provide commercial health insurance networks significant discounts in exchange for receiving a higher volume of patients seeking "in-network" care. This additional patient volume is a critical benefit the hospital receives from the bargain. To protect the benefit of their bargain, hospitals negotiate contractual guarantees against insurers unilaterally changing agreed-upon terms of network participation status during the term of the contract. These provisions are (1) used with some regularity in the healthcare field[3]; (2) fully consonant with California's Health Care Providers' Bill of Rights, Cal. Health & Safety Code § 1375.7, which precludes mid-term changes to material contract terms without provider agreement; and (3) were endorsed by plaintiffs' own expert, Dr. Chipty, who testified that she does not "have a problem" with a contract

[3] *See, e.g.*, 7-SER-2034:5–10 (Stevens) ("In your view, it's unreasonable for the provider to be requesting notice and an opportunity to discuss terms with the insurance company during the term of the contract for a new product? You think it's unreasonable? A. For a big health system, I don't think it's unreasonable**.** It's fairly common."); 9-SER-2441:3–8 (Fawley) (testifying it is "customary to have a clause allowing the parties to get notice and an opportunity to negotiate").

provision that gives a hospital the right to notice of—and an opportunity to decline to agree to—changes in network participation.[4]

On the basis of a comprehensive trial record, the jury had ample basis to reject plaintiffs' challenge to these reasonable, commonplace, pro-competitive contractual protections for hospitals. Plaintiffs' *amici*'s focus on hospital consolidation is therefore a red herring designed to divert this Court from the overwhelming trial evidence and the true subject of the appeal—certain narrow evidentiary and instructional rulings of the trial court. These rulings do not concern—and plaintiffs' claims do not challenge—any acquisition by Sutter. Even so, as explained below, integration helps hospitals to increase efficiency in a challenging economic environment, and do more with less to ensure that patients and communities receive the quality health care they deserve. Because plaintiffs (and *amici* who support them) are now attacking the jury's verdict with specious policy arguments about hospital integration, the AHA appreciates the opportunity to put the parties' dispute in its accurate factual and economic context.

[4] 10-SER-2913:22–2915:15.

ARGUMENT

I. HOSPITALS FACE EXTRAORDINARY FINANCIAL CHALLENGES, AND MUST FOCUS ON PREDICTABLE REVENUE STREAMS AND EFFICIENT INTEGRATION TO MAINTAIN QUALITY PATIENT CARE

Most hospitals operate on the slimmest of margins, even as they battle escalating costs and administrative burdens—many exacerbated by the commercial health insurance system. To survive—and then to invest in modern patient care—hospitals must maintain predictable revenue streams and manage expenses, as many have done through efficient integration.

A. Hospitals Face Enormous Financial Risk, Rising Costs, and Pressure to Maintain Predictable Revenue Flows

Our nation's hospitals care for patients in an economic environment increasingly fraught with financial risk. Many operate on miniscule margins, where even slight changes in revenue, volume, or expenses can have outsized effects.[5] In fact, hospitals on average earned *negative* operating margins in the past year, pressured by rising expenses that outpaced revenue growth.[6] To meet rising demand

[5] Am. Hosp. Ass'n, *Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems* 2 (2022) (hereinafter "*Massive Growth in Expenses Fuels Hospital Challenges*"), https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf.

[6] Kaufman Hall, *December 2022 National Hospital Flash Report* 1 (2022), https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2022-12.pdf.

for care, hospitals have had to expand treatment capacity, hire additional staff, and acquire necessary drugs, supplies, and personal protective equipment.[7] Indeed, every category of hospital expenses has experienced substantial growth.[8]

Hospitals also demand enormous capital investments and fixed costs to provide quality care to their communities. Investments in health information technology improve diagnosis and treatment through accurate, real-time results and identify best practices for more cost-effective, integrated, and streamlined care.[9] Similarly, investments in facilities and medical technology all enable hospitals to provide high-quality care for all patients walking through their doors.[10]

Record hospital expenses reflect a trend of rising input costs "that goes back at least a decade."[11] Historically, hospital revenues have "closely tracked cost

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[7] *Massive Growth in Expenses Fuels Hospital Challenges*, *supra* note 5, at 1.

[8] *Id*. at 2–6 (noting labor, drug, and ICU medical supply expenses *per patient* were up 19.1%, 36.9%, and 31.8%, respectively, from 2019 to end of 2021).

[9] Deloitte Ctr. for Health Sols. & Healthcare Fin. Mgmt. Ass'n, *Hospital M&A: When done well, M&A can achieve valuable outcomes* 9, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf.

[10] *Id*. Additionally, state-mandated seismic safety upgrades are expected to cost California hospitals tens of billions of dollars. Tom LaTourrette et al., *Seismic Safety Upgrades May Cost California Hospitals Billions, Increase Number of Hospitals in Financial Distress*, RAND (Mar. 28, 2019), https://www.rand.org/news/press/2019/03/28.html.

[11] Sarai Rodriguez, *Hospital Expenses Have Increased 23% in Less Than a Decade*, RevCycle Intelligence (Sept. 23, 2022), https://tinyurl.com/5n92ekn7.

increases" in labor and drugs, meaning that "hospital margins did not increase appreciably."[12] Labor costs—generally the largest expense for hospitals—pose particularly acute challenges to hospital operations, as even slight increases in these costs could significantly pressure hospital operating margins.[13] Indeed, labor cost increases were a primary driver of overall hospital cost growth, marked by a pandemic that caused labor costs to skyrocket even further—some estimate by over 50% *per patient*.[14] For example, staffing shortages forced hospitals to rely on contract staff, including travel registered nurses, whose wages experienced disproportionate growth in recent years.[15]

Adding further pressure to hospital finances, drug prices also experienced rapid growth in past decades, climbing 28.2% above pre-pandemic levels by the end of 2021.[16] These increases follow previous price spikes affecting drugs commonly

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[12] Margaret E. Guerin-Calvert & Guillermo Israilevich, *Assessment of Cost Trends and Price Differences for U.S. Hospitals* 2, 6 (2011) (hereinafter "*Hospital Cost Trends*"), https://www.ashe.org/system/files/content/11/11costtrendspricediffreport.pdf.

[13] *Massive Growth in Expenses Fuels Hospital Challenges*, *supra* note 5, at 2.

[14] *See Massive Growth in Expenses Fuels Hospital Challenge*, *supra* note 5, at 4; *Hospital Cost Trends supra* note 12, at 4.

[15] *Massive Growth in Expenses Fuels Hospital Challenge*, *supra* note 5, at 3. Private staffing agencies' hourly charges to hospitals climbed by more than 200%, even as their margins jumped from 15% in 2019 to 62% in January 2022. *Id*. at 4.

[16] *Id.* at 5; *Hospital Cost Trends supra* note 12, at 4; *Prescription Drugs: Spending, Use, and Prices*, Cong. Budget Off. (Jan. 2022), *(cont'd)*

used in hospitals, such as Hydromorphone (107% increase), Mitomycin (99% increase), and Vasopressin (97% increase).[17] And these are not exceptions: According to Kaiser Family Foundation, half of all drugs in Medicare Part B and D experienced price increases above the rate of inflation between 2019 and 2020.[18] Meanwhile, medical supply expenses, which have steadily increased in the past decade, shot up further during recent supply chain disruptions, with ICU and respiratory supply costs increasing by 31.5% and 22.3% above pre-pandemic levels.[19]

Administrative costs associated with commercial health insurance plan policies are another contributor to record hospital expenses. These costs are often detached from widely accepted clinical guidelines and protocols.[20] For example, prior authorization requirements—initially designed to guide and monitor providers' decision-making around new, high-cost treatments or treatments with a history of

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https://www.cbo.gov/publication/57772 (noting increase in brand-name drug prices in past decades).

[17] *Massive Growth in Expenses Fuels Hospital Challenge*, *supra* note 5, at 4.

[18] *Id.* at 5.

[19] *Id*. at 6; *Annual changes in hospital medical supply costs*, Definitive Healthcare, https://www.definitivehc.com/resources/healthcare-insights/changes-in-supply-costs-year-to-year (last visited Jan. 6, 2023).

[20] *See* Am. Hosp. Ass'n, *Commercial Health Plan Policies Compromise Patient Safety and Raise Costs* 8 (July 2022) (hereinafter "*Commercial Health Plan Policies*"), https://www.aha.org/system/files/media/file/2022/07/Commercial-Health-Plans-Policies-Compromise-Patient-Safety-White-Paper.pdf.

questionable use—increasingly cover a wider range of services.[21] Insurance plans can deny unanticipated, medically necessary care or require that patients first try the insurer's recommended drug treatment, even where inconsistent with recommended clinical guidelines and contrary to the clinical expertise of the patient's own

[21] Prior authorization requirements increasingly cover treatment protocols that have remained unchanged for decades with no evidence of abuse. Am. Hosp. Ass'n, *Addressing Commercial Health Plan Abuses to Ensure Fair Coverage for Patients and Providers* 1 (2020) (hereinafter "*Addressing Commercial Health Plan Abuses*"), https://www.aha.org/system/files/media/file/2020/12/addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf; *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, U.S. Dep't Health & Hum. Servs. (Apr. 27, 2022) (hereinafter "*Medicare Advantage Organization Denials*"), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp.

This can lead to increased healthcare costs and dangerous delays in care, and more than one in three doctors report that prior authorization "led to a serious adverse event" such as "death, hospitalization, disability [or] permanent bodily damage, or other life-threatening event" for patient under care. Am. Med. Ass'n, *2021 AMA Prior Authorization (PA) Physician Survey* (2022), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf; *see also* Press release, Off. of the Nat'l Coordinator for Health Info. Tech., U.S. Dep't of Health & Hum. Servs., ONC Seeks Public Comment on Electronic Prior Authorization Standards, Implementation Specifications and Certification Criteria (Jan. 21, 2022), https://www.hhs.gov/about/news/2022/01/21/onc-seeks-public-comment-electronic-prior-authorization-standards-implementation-specifications-and-certification-criteria.html (noting cumbersome prior authorization requirements "result in administrative burdens" and "contribute to health care provider burnout, patient frustration and can even pose a health risk to patients when it delays their care").

physician.[22] As a result, patients can undergo periods of ineffective treatment before accessing the most clinically appropriate care—not only increasing risk of complication, but also exacerbating patient out-of-pocket costs and administrative expenses.[23] And as patient out-of-pocket costs grow, hospitals are more likely to face nonpayment from patients unable to afford their medical bills.[24] This further strains already razor-thin hospital margins.

Insurance-related administrative costs substantially weigh down the healthcare system, and various studies found administration costs to make up about

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[22] *Commercial Health Plan Policies*, *supra* note 20, at 4, 9. The Office of the Inspector General at the Department of Health and Human Services ("OIG") found that 13% of prior authorization requests that were denied by Medicare Advantage insurance companies had in fact met Medicare coverage rules, resulting in denial of services that were determined medically necessary by OIG's physician reviewers. *Medicare Advantage Organization Denials*, *supra* note 21. Although insurers also often indicated that prior authorization requests lacked sufficient documentation to support approval of medically necessary services, the OIG "found that the existing beneficiary medical records were sufficient to support the medical necessity of the services." *Id.* And over half of insurer step therapy protocols or "fail first policies," which require that patients first go with the insurer's recommended drug treatments, were more stringent than recommended clinical guidelines, often resulting in unnecessary care. *See* Kelly L. Lenahan et al., *Variation in Use and Content of Prescription Drug Step Therapy Protocols, Within and Across Health Plans*, Health Affs. (Nov. 2021); *see also Commercial Health Plan Policies*, *supra* note 20, at 8.

[23] *See Commercial Health Plan Policies*, *supra* note 20, at 8.

[24] *See* Am. Hosp. Ass'n, *Increasing Consumer Choice in Coverage and Care: Implications for Hospitals* 1 (2014) (hereinafter "*Coverage and Care: Implications for Hospitals*"), https://www.aha.org/system/files/research/reports/tw/14june-tw-consumerchc.pdf.

15% to 25% of U.S. healthcare costs.[25] These administrative costs are further driven by the complexity of insurer billing, which includes "areas of redundancy that truly serve no purpose," such as "non-standardized protocols for exchange of money and patient data."[26] A large, national hospital system will spend $15 million per month purely in administrative costs associated with managing commercial insurance plan contracts, including two to three full-time staff whose sole responsibility is to monitor insurance plan bulletins for changes to rules and policies.[27] One systematic review of peer-reviewed publications and government reports found that limiting these unnecessary administrative costs can save healthcare systems over $265 billion per year.[28]

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[25] Michael Chernew & Harrison Mintz, *Administrative Expenses in the US Health Care System: Why So High?*, 326 JAMA 1679 (2021), https://jamanetwork.com/journals/jama/fullarticle/2785479.

[26] *See* Laura Tollen et al., *How Administrative Spending Contributes To Excess US Health Spending*, Health Affs. (Feb. 20, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200218.375060/full/; Phillip Tseng et al., *Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System*, 319 JAMA 691 (2018), https://jamanetwork.com/journals/jama/fullarticle/2673148 ("Most of the administrative costs in the US health care system . . . has been attributed to billing . . . .").

[27] *See Addressing Commercial Health Plan Abuses*, *supra* note 21, at 2.

[28] William H. Shrank et al., *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, 322 JAMA 1501, 1501 (2019); *see also* Terrence Cunningham & Andrea Preisler, *Five Ways Commercial Insurer Policies Drive Up Costs and Hurt Patients*, AHA STAT (May 2, 2022), https://www.aha.org/news/blog/2022-05-02-five-ways-commercial-insurer-

(cont'd)

Unsustainable cost and revenue pressures have a particularly dire effect on smaller health care programs, which include parts of the Sutter hospital system.[29] The numbers tell the story: 72 small rural hospitals closed since 2005, with 6 small rural closures in 2020 alone.[30] California, in particular, experienced numerous closures, ranking fourth among states for most rural hospital closures since 2005.[31] Smaller, rural hospitals face an exceptional staffing shortage, and rural or partially rural areas now form 70% of this nation's primary care Health Professional Shortage Areas (HPSAs).[32] Smaller hospitals were also hit especially hard by the pandemic.[33]

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policies-drive-costs-and-hurt-patients. U.S. healthcare administrative costs are the highest among all advanced economies. Ryan Nunn et al., *A Dozen Facts about the Economics of the U.S. Health-Care System* 16 (2020), https://www.brookings.edu/wp-content/uploads/2020/03/HealthCare_Facts_WEB_FINAL.pdf.

[29] *See* Katie Adams, *2023 Will Be a Year of Shrinking Margins and More Consolidation for Hospitals, Expert Says*, MedCity News (Dec. 20, 2022), https://medcitynews.com/2022/12/2023-will-be-a-year-of-shrinking-margins-and-more-consolidation-for-hospitals-expert-says/; Am. Hosp. Ass'n, *Rural Hospital Closures Threaten Access* 5 (Sept. 2022), https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.

[30] *Rural Hospital Closures*, Univ. N.C. Sheps Ctr. for Health Servs. Rsch., https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited Jan. 6, 2023).

[31] *California is the #4 state with the most rural hospital closures since 2005*, Stacker (Dec. 9, 2021), https://stacker.com/california/california-4-state-most-rural-hospital-closures-2005.

[32] *Rural Hospital Closures Threaten Access*, *supra* note 30, at 3.

[33] *See id.* at 8.

Meanwhile, rural hospitals serve patient populations that are poorer, sicker, and older than the national average. This means rural hospitals are more likely to treat uninsured patients, and our annual study found that rural hospitals provided $4.6 billion in uncompensated care.[34] Rural patient populations are also more likely to rely on Medicare and Medicaid, and the bulk of rural hospitals' revenue indeed comes from these two programs.[35] Yet Medicaid and Medicare reimburse less than the cost of providing services, saddling rural hospitals with $7 billion in annual combined Medicare and Medicaid underpayments.[36] This means receiving *less than 90 cents for every dollar* spent caring for rural Medicare and Medicaid patients.[37]

Hospitals' extraordinarily challenging economic environment makes predictable revenue essential to maintaining effective patient care, covering fixed costs, and making critical investments.[38] As increases in hospital expenses continue to outpace revenue growth, razor-thin margins are expected to shrink even further,

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[34] *Id.* at 6.

[35] *Id.*

[36] *Id.*

[37] Am. Hosp. Ass'n, *Fact Sheet: Underpayment by Medicare and Medicaid* (Feb. 2022), https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid; Am. Hosp. Ass'n, *Fact Sheet: Uncompensated Hospital Care Cost* (Feb. 2022), https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost.

[38] *See generally Rural Hospital Closures Threaten Access*, *supra* note 30, at 8.

leaving smaller hospitals vulnerable to bankruptcy or closure.[39] Predictability is particularly important to these smaller hospitals, which often serve communities with heightened health needs.[40] Loss of outpatient revenue can determine whether a smaller hospital remains viable—shortfalls have left some hospitals struggling to maintain access to healthcare services.[41]

B. Integrating Into Hospital Systems Reduces Costs and Improves Care

What plaintiffs' *amici* deride as harmful "consolidation" is, in fact, hospitals' efficient response to financial pressures—a response that marshals the resources

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[39] Adams, *supra* note 29.

[40] *See Rural Hospital Closures Threaten Access*, *supra* note 30, at 5; *see generally* Nat'l Acad. for State Health Pol'y, *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools* (2015), https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf (noting Medicaid supplemental payment programs are important for safety-net hospitals due to predictability).

[41] Adams, *supra* note 29; *Rural Hospital Closures Threaten Access*, *supra* note 30, at 8. The federal government helped sustain smaller hospitals' services during the pandemic, but these revenue streams are expiring and leave many hospitals in financial peril. *Id*. Federal funds proved to be a lifeline to countless small hospitals and led to a temporary slowdown in the alarming trend of closures. *Id.* But two vital programs that support smaller hospitals in offsetting financial vulnerabilities associated with low volumes—Medicare-Dependent Hospital and enhanced Low-Volume Adjustment programs—expired in 2022. Ctrs. for Medicare & Medicaid Servs., *Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program* (2022), https://www.cms.gov/files/document/mm12970-extension-changes-low-volume-hospital-payment-adjustment-and-medicare-dependent-hospital.pdf.

needed to effectively care for patient communities.[42] One of the most comprehensive econometric analyses of contemporary hospital acquisitions recently concluded that hospital consolidations *reduced* costs while *increasing* quality, including through increasing scale, standardizing clinical practices, reducing cost of capital, and avoiding duplicative capital expenditures.[43]

These efficiencies, in turn, can generate substantial benefits for patients. Integration can enable struggling hospitals to remain open and even expand the scope of services offered, thereby preserving—and often enhancing—patient access

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[42] *See* Kaufman Hall, *Partnerships, Mergers, and Acquisitions Can Provide Benefits to Certain Hospitals and Communities* 9 (2021); *see also Antitrust Applied: Hospital Consolidation Concerns and Solutions: Hearing before the Subcomm. on Competition Pol'y, Antitrust, & Consumer Rts. of the Sen. Comm. on the Judiciary*, 117th Cong. (2021) (statement of Rod Hochman, Chair of the Board of Trustees, American Hospital Association) (hereinafter "AHA Testimony"), https://www.aha.org/system/files/media/file/2021/05/AHAWrittenTestimonyJudiciaryHearing-051921.pdf.

Due to unsustainable margin compression, many smaller hospitals are expected to either shut down or integrate into larger systems in 2023. Tina Wheeler, *2023 Outlook for Health Care*, Deloitte: Health Forward (Dec. 13, 2022), https://www2.deloitte.com/us/en/blog/health-care-blog/2022/2023-outlook-for-health-care-could-margins-staffing-stall-progress-to-future-of-health.html.

[43] Sean May et al., *Hospital Merger Benefits: An Econometric Analysis Revisited* (Aug. 2021) (hereinafter "*Hospital Merger Benefits*"), https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf; *see also* Monica Noether et al., *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis–An Update* (Sept. 2019), https://www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-f.pdf.

and quality of care, particularly in at-risk communities.[44] One recent study of more than 400 smaller, rural hospitals found that inpatient mortality for several common conditions (heart attack, heart failure, acute stroke, and pneumonia) declined significantly more among patients at merged rural hospitals.[45] Among other things, integrated hospital systems can consolidate the provision of certain types of care, such as cardiac surgery, at a single site to improve utilization and efficiency, which can help identify best practices on integrating and streamlining care.[46] And

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[44] Kaufman Hall, *supra* note 42, at 5. Four out of five bankrupt hospital acquisition targets were saved from bankruptcy in 31 recent hospital transactions. *Id.* at 9. Moreover, almost four in 10 acquired hospitals added one or more services post acquisition, including tertiary and quaternary services. *Id.* at 11. As a result, patient outcomes in at-risk communities often improve. *See* H. Joanna Jiang et al., *Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals*, JAMA Network Open (Sept. 20, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342; Erwin Wang et al., *Quality and Safety Outcomes of a Hospital Merger Following a Full Integration at a Safety Net Hospital*, JAMA Network Open (Jan. 6, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652 (finding significant reductions in mortality for a number of common conditions among patients at merged safety-net hospitals).

[45] Jiang et al., *supra* note 44; *see also* Wang et al., *supra* note 44 (finding that "a full-integration approach to a hospital merger was associated with an absolute reduction in crude and adjusted mortality rates").

[46] *See generally* Norman Armstrong & Subramaniam Ramanarayanan, *Taking Stock of the Efficiencies Defense: Lessons from Recent Health Care Merger Reviews and Challenges*, 82 Antitrust L.J. 579, 581 n.6 (2019).

eliminating administrative redundancies reduces operating costs or shifts resources to patient care—thereby improving patient outcomes.[47]

Integration efficiencies also empower hospitals to make critical infrastructure and information-technology investments that are increasingly important to delivering high-quality, cost-effective care.[48] One study found that close to 80% of hospital consolidations infused capital into the acquired hospital, expanding treatment capacity—including through health information technology systems that have consistently been shown to improve patient outcomes and quality of care.[49] These systems require substantial fixed costs and are largely inaccessible to

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[47] *See* Ken Summers, *FTC Crackdowns on Mergers Could Harm Rural Healthcare*, RealClear Mkts. (Dec. 13, 2021), https://www.realclearmarkets.com/articles/2021/12/13/ftc_crackdowns_on_mergers_could_harm_rural_healthcare_807469.html.

[48] Sutter made critical investments into capital-intensive health technologies, including electronic health record system EPIC. 6-SER-1543:16–1546:1; 14-SER-3928:12–3929:23. Sutter's investments also enabled hospitals within its system to add services and expand treatment capacity. 5-SER-1415:2–16.

[49] Deloitte Ctr. for Healthcare Sols. & Healthcare Fin. Mgmt. Ass'n, *supra* note 9, at 9. Positive effects of health information technology systems on patient outcomes are well documented. *See, e.g.*, Am. Hosp. Ass'n, *Improving Patient Safety and Health Care Quality through Health Information Technology* (2018), https://www.aha.org/system/files/2018-07/18-07-trendwatch-issue-brief3-patient-safety-quality-health-it.pdf; Off. of the Nat'l Coordinator for Health Info. Tech., *Improved Diagnostics & Patient Outcomes*, HealthIT, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/improved-diagnostics-patient-outcomes (last visited Jan. 6, 2023) (collecting research).

independent hospitals.[50] They also proved especially important during COVID-19 surges, allowing integrated hospital systems to optimize constrained resources and capacity—for example, reconfiguring space to focus on infected patients and to separate them from the uninfected—and to redeploy health workers to meet rapidly changing needs across multiple locations.[51] As the result, hospitals delivered not only cost savings, but also better patient outcomes and greater access.[52] And according to an econometric analysis of hospital integrations, "savings that accrue to merging hospitals are passed on to health plans" and, ultimately, to the patient.[53] In short, the reality of hospital finances and hospital integration is a far cry from the "market power" story told by plaintiffs and the *amici* supporting them.

II. PLAINTIFFS CHALLENGED HOSPITALS' EFFICIENT, PRO-COMPETITIVE RESPONSES TO THEIR ECONOMIC ENVIRONMENT

Sutter Health responded to economic challenges in well-established, reasonable, and efficient ways, so it is hardly surprising that a jury rejected plaintiffs' ill-conceived claims under California competition laws. Because predictable revenue is essential to their financial survival, hospitals like Sutter negotiate with

[50] Wheeler, *supra* note 42; AHA Testimony, *supra* note 42, at 3.

[51] AHA Testimony, *supra* note 42, at 5.

[52] *See id.*

[53] *See Hospital Merger Benefits*, *supra* note 43, at 2.

insurance companies by giving discounts in exchange for a steady volume of covered patients. And if such a bargain is struck, hospitals commonly negotiate contracts to secure the bargain's benefits by requiring that mid-contract changes to network participation be the subject of further negotiation and consent. There is nothing novel—let alone anticompetitive—about these contracts.

A. Volume Discounting Is a Well-Established, Efficient Practice in Insurer-Hospital Contracting

Volume discounting reflects well-established, competitive, and efficient price setting in healthcare markets—and has been a longstanding practice in this industry. In a typical health plan negotiation, insurers and health care providers (like hospitals) each submit proposals and counterproposals in order to reach an agreement.[54] An insurer promises "greater budgetary certainty" to the hospital in exchange for lower rates.[55] By discounting to secure greater volume, a hospital can achieve economies of scale—a core driver of efficiencies in the industry. Scale enables the hospital to spread substantial fixed costs across a larger patient population, facilitating access to clinical information systems, infrastructure, and other investments that improve

[54] Thomas McCarthy & Scott Thomas, *Antitrust Issues Between Payers and Providers*, Antitrust Health Care Chronicle (Mar. 1, 2002), at 1, https://www.nera.com/publications/archive/2002/antitrust-issues-between-payers-and-providers.html.

[55] *Id*. at 2.

diagnoses and treatment.[56] As extensive research has shown, mitigating financial pressures directly improves patient access while enhancing quality of care—with the resulting savings passed onto patients and their communities.[57]

Sutter's practices that plaintiffs challenged in this case are part and parcel of efficient volume discounting. As a corollary to volume discounts for in-network services, providers charge higher rates for services that do not benefit from in-network volume. Both caselaw and extensive testimony before the jury in this case—including testimony by plaintiffs' expert Dr. Chipty—affirm this practice as a cornerstone of insurer-provider contracting.[58] Plaintiffs, in turn, offered no evidence at trial to challenge the reasonableness of this practice.

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[56] *See* Deloitte Ctr. for Healthcare Sols. & Healthcare Fin. Mgmt. Ass'n, *supra* note 9, at 9.

[57] *See supra* section I.B.

[58] Ample trial testimony established that higher rates for out-of-network care is a longstanding feature of volume discounting in this industry. *E.g.*, 9-SER-2440:13–15 (Fawley) ("the expectation of volume . . . drives the discounted rates."); 10-SER-2917:7–18 (Chipty) (testifying the same).

Numerous judicial decisions have also recognized this well-established practice. *E.g.*, *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003) ("Providers in such networks agree to render health-care services to the HMOs' subscribers at discounted rates" and, in return, "receive the benefit of patient volume higher than that achieved by nonnetwork providers who lack access to petitioners' subscribers."); *Med. Ctr. at Elizabeth Place, LLC v. Atrium Health Sys.*, 817 F.3d 934, 941 (6th Cir. 2016) ("Hospitals generally seek to become 'in-network' or 'preferred' providers for a number of insurers, often accepting lower rates from the insurance companies in exchange for a higher volume of patients."); *32nd St. Surgery Ctr., LLC v. Right Choice Managed Care*, 820 F.3d 950, 952 (8th Cir. 2016) *(cont'd)*

The uncontroversial economic principles justifying Sutter's discounted rates do not change because Sutter operates an integrated hospital system. While negotiation outcomes depend in part on the relative bargaining strength of the parties, "bargaining strength is *not* the same things as market power," and a consolidation that enables hospitals to better participate in this price-setting process "[o]ften . . . simply restructures the market toward greater efficiency and more realistic, long-term levels of capacity."[59]

("The benefits of participating in an insurer's networks include increased patient volume and marketing and promotion by the insurer. In exchange for these benefits, a network provider generally agrees to receive discounted reimbursement rates."); *HCA Health Servs. of Ga., Inc. v. Emps. Health Ins. Co.*, 240 F.3d 982, 1002 (11th Cir. 2001) ("In return for . . . steerage, the providers in PPO A discount their usual and customary fees for medical services."); *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 189 (D.D.C. 2017) ("[P]roviders agree to accept payment for services supplied to plan members at a discount in return for the volume of patients that the carrier will deliver to them as in-network providers."); *Goel v. Coal. Am. Holding Co.*, No. CV 11-2349 GAF (Ex), 2011 U.S. Dist. LEXIS 160745, at *2-3 (C.D. Cal. July 5, 2011) (In a PPO arrangement, "medical providers receive an increased patient volume in exchange for the discounts they offer."); *First State Orthopaedics v. Concentra, Inc.*, 534 F. Supp. 2d 500, 505 (E.D. Pa. 2007) ("A provider who contracts with a PPO agrees to become a 'preferred provider' in the PPO network and accept discounted rates in exchange for anticipated increased patient volume.").

[59] *See* McCarthy & Thomas, *supra* note 54, at 2. Courts have acknowledged that bargaining strength, which includes "the ability to impose costs or benefits somewhere else . . . is not necessarily market power." *See, e.g.*, *Gumwood HP Shopping Partners, L.P. v. Simon Prop. Grp., Inc.*, No. 3:11-CV-268 JD, 2016 U.S. Dist. LEXIS 144712, at *32-34 (N.D. Ind. Oct. 19, 2016); *Acuity Optical Laboratories, LLC v. Davis Vision, Inc.*, No. 14-cv-03231, 2016 U.S. Dist. LEXIS 112423, at *61 (C.D. Ill. Aug. 23, 2016) (finding failure to state a tying claim where the defendant did "not allege that . . . bargaining power comes from market power").

In the commercial insurance market, smaller hospitals with low patient volume are often "forced to accept below average rates or are left out of plan networks entirely."[60] When these hospitals are excluded from network plans, patients in their communities suffer from diminished access to care.[61] Integration into larger health systems is the very least smaller hospitals can do to compete with large insurers in negotiations, resulting in "greater efficiency and more realistic, long-term levels of capacity"[62] through a volume discounting practice that is generally recognized as "beneficial, bringing higher output and lower prices" especially in "markets with high fixed costs."[63] While integration is rarely sufficient for smaller hospitals to compete with commercial insurers with large market shares, health systems can provide much-needed predictability in revenue to offset the unsustainable financial pressures facing them—especially in communities with pronounced health needs.

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[60] *Rural Hospital Closures Threaten Access*, *supra* note 30, at 6.

[61] *See id*.

[62] *See* McCarthy & Thomas, *supra* note 54, at 2.

[63] Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 1807b2 (May 2020).

B. Hospitals Have Sound, Pro-competitive Reasons to Protect Against Unilateral Mid-Contract Tiering and Steering by Insurers, Which Can Harm Patients and Healthcare Providers Alike

Once hospitals agree to give insurers discounts in exchange for greater patient volume, they understandably draft contracts to protect the benefit of their bargain—that is, to prevent insurers from unilaterally reneging on the deal during the term of the contract by changing a hospital's network participation status and depriving it of the expected volume. (Recall that predictable revenue is a critical objective for hospitals struggling with financial pressures.) These contractual protections are uncontroversial and pro-competitive; without them, hospitals would have been unable to cut prices in the first place.

Volume discounts depend on commitments on which the parties can *rely*.[64] Contractual protections against reneging by insurers are especially important because large insurers could engage in bait-and-switch tactics that unilaterally change the coverage of their enrollees during the term of the policy.[65] These tactics not only are detrimental to the operations of hospitals—which rely on expectations

[64] McCarthy & Thomas, *supra* note 54, at 2 (in agreeing to volume discounting, "the insurer often *promises* to steer a significant proportion of its enrollees to the provider" in exchange for lower rates (emphasis added)).

[65] *See* Am. Hosp. Ass'n, *Comment Letter on Proposed Horizontal and Vertical Merger Guidelines* 6 (Mar. 30, 2022), https://www.aha.org/system/files/media/file/2022/03/aha-urges-two-changes-to-ftc-doj-merger-guidelines-letter-3-30-22.pdf.

of higher patient volume and predictable revenue to preserve their volume-discounting bargain—but also unexpectedly restrict patients' access to care, separate patients from their selected providers, and lead to substantially higher out-of-pocket costs.[66] Courts have recognized insurers as counterparties with significant bargaining power—and contractual protections for hospitals are the product of arms-length negotiations between large, sophisticated parties.[67] Allowing insurers to sidestep these contractual protections would undermine a negotiating process that is integral to price-setting in this industry and an important mechanism hospitals use to predict revenue—and on that basis, make meaningful investments in improving quality of care.[68]

And Sutter is hardly unique in negotiating these protections against bait-and-switch by insurers. As trial testimony amply established, other providers also require notice and an opportunity to negotiate material network changes proposed by insurers during the term of a contract—a common practice in the insurer-provider contracting environment.[69]

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[66] *See id.* at 6.

[67] *See, e.g.*, *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 562 (2011) ("[P]rivate health insurers are well equipped to conduct sophisticated arm's-length price negotiations.").

[68] *See supra* section I.

[69] *See, e.g.*, 7-SER-2034:5–10, 9-SER-2405:23–2406:5, 9-SER-2441:3–8, 10-SER-2913:22–2915:14.

Nor is insurers' practice of designing restricted—that is, narrow or "tiered"—networks an unadorned economic good that deserves special protection. These insurer practices can transfer risk to patients and substantially restrict patient access, which adversely impact patient care and hospital operations.[70] Narrowed networks often exclude a substantial number of providers serving an area and can result in network inadequacy, thereby restricting patient access to healthcare.[71] While affordability is a key factor for enrollees, and narrowed networks tend to offer lower premiums, restricted networks should be assessed for their "broader affordability" to consumers, including out-of-network costs.[72] In some instances, restricted networks will not offer *any* in-network coverage for certain provider types and specialties and can surprise patients with staggering out-of-pocket costs from out-

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[70] *See* Matthew B Frank et al., *The Impact of a Tiered Network on Hospital Choice*, 50 Health Serv. Rsch. 1628, 1642 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4600365/; *see also* Troyen A. Brennan et al., *Do Managed care plans' tiered networks lead to inequities in care for minority patients?*, 27 Health Affs. 1160 (2008); Am. Heart Ass'n, *Insuring Access to Quality Healthcare: Network Adequacy* (2020), https://www.heart.org/-/media/Files/About-Us/Policy-Research/Fact-Sheets/Access-to-Care/Network-Adequacy-2020.pdf.

[71] *See* Alyssa Schatz & Katy Winckworth-Prejsnar, *Survey of NCI-Designated Cancer Centers Finds Most Are Out-of-Network on Exchanges*, Am. J. Managed Care (2018) (finding "93% of designated cancer centers are out of network for some or all health exchange carriers in their state."); *Coverage and care: Implications for Hospitals*, *supra* note 24 (showing narrow networks often exclude a substantial number of large hospitals serving an area).

[72] *See generally id.*

of-network providers.[73] Indeed, the California Department of Insurance has concluded that some restricted networks "failed to provide sufficient capacity for specialty care," exposing consumers to "large and unexpected out-of-network bills" when they seek treatment for conditions that are de facto excluded from their restricted network plans.[74] Especially at risk are patients with serious or chronic conditions—whose health needs are not discretionary—and research suggests that the "selection of less costly providers into narrow networks may exclude providers that treat high-risk patients."[75]

Furthermore, when insurers engage in bait-and-switch tactics that unilaterally downgrade providers' network status without adequate notice, patients are left

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[73] One study found 15% of restricted networks in the federal marketplace lacked coverage of in-network physicians for at least one specialty. Stephen C. Dorner et al., *Adequacy of outpatient specialty care access in marketplace plans under the affordable care act*, 314 JAMA 1749, 1750 (2015), https://jamanetwork.com/journals/jama/fullarticle/2466113. Some restricted networks lacked neurosurgery coverage for certain areas. Rimal H. Dossani et al., *Is Access to Outpatient Neurosurgery Affected by Narrow Insurance Networks? Results From Statewide Analysis of Marketplace Plans in Louisiana*, 84 Neurosurgery 50 (2019).

[74] Cal. Dep't Ins., Network Adequacy Regulation (Permanent): Initial statement of reasons 1, 2, 5, 10 (2015).

[75] Lucas Higuera et al., *Narrow provider networks and willingness to pay for continuity of care and network breadth*, 60 J. Health Econ. 90, 90 (2018). The California Medical Association found restricted networks often led to network inadequacy of specialists, making it difficult for patients to be referred to in-network specialists, "particularly in fields that treat patients with chronic conditions, such as cardiology, oncology, and nephrology." Cal. Dep't Ins., *supra* note 74, at 5.

vulnerable to higher and unexpected out-of-pocket costs when they simply return to providers they had selected based on the coverage they originally purchased.[76] Shifting healthcare costs to patients can lead to delayed or avoided care—and ultimately result in adverse patient outcomes that can compound expenses for both patients and providers.[77] And as patients take on a greater share of their own healthcare costs, providers face increased risk of nonpayment from patients unable to afford their medical bills, exacerbating systemic underpayment and uncompensated care—all on top of revenue shortfalls from avoided care and decreased utilization.[78]

Restricted networks and insurer steering can also disrupt continuity of care and create perverse outcomes for patients and providers.[79] Continuity is "an essential feature" of quality care,[80] and consumers highlight it among the most

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[76] *See* Am. Heart Ass'n, *supra* note 70, at 2-3.

[77] Wheeler, *supra* note 42; Cal. Dep't Ins., *supra* note 74, at 6; *Coverage and Care: Implications for Hospitals*, *supra* note 24, at 1, 4–5.

[78] *See Coverage and Care: Implications for Hospitals*, *supra* note 24, at 1.

[79] Higuera et al., *supra* note 75, at 90; *see* Chima D. Ndumele et al., *Network Optimization And The Continuity Of Physicians In Medicaid Managed Care*, 37 Health Affs. 929 (2018) (finding tiered networks can disrupt continuity).

[80] Continuity of care is "an essential feature" of quality care and provides benefits through multiple channels. *See* Anne Kuusisto et al., *Contents of Informational and Management Continuity of Care*, 264 Stud. Health Tech. Info. 669, 669 (2019). Informational continuity focuses on extended use of data infrastructures to assess conditions; management continuity allows for consistent and coherent treatment of patients' changing needs; and relational continuity focuses on ongoing therapeutic *(cont'd)*

important characteristics of a health plan.[81] One analysis comparing narrow and broad networks found that consumers were willing to pay between $84 and $275 more per month for a broader network that includes their primary care physician and up to $115 more per month to keep their current specialist physician.[82] Meanwhile, studies extensively link disruptions in continuity of care to higher healthcare spending and negative patient outcomes, including increased hospitalization, complication risk, readmission, and mortality.[83] This is especially the case for patients with chronic conditions, who typically require extended assessments of health conditions and ongoing coordination and management of therapies.[84]

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relationships, which improve patient satisfaction. *See generally* Jeannie L. Haggerty et al., *Continuity of care: a multidisciplinary review*, 327 Brit. Med. J. 1219 (2003).

[81] Higuera et al., *supra* note 75, at 90.

[82] *Id*.

[83] *E.g.*, Denis J. Pereira Gray et al., *Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality*, Brit. Med. J. Open, Jun. 2018, at 1 (finding association with lower mortality rates); Reena Gupta & Thomas Bodenheimer, Commentary, *How primary care practices can improve continuity of care*, 173 JAMA Internal Med. 1885 (2013); Richard Baker et al., *Primary medical care continuity and patient mortality: a systematic review*, 70 Brit. J. General Prac. 600, 605 (2020); Andrew Bazemore et al., *Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations*, 16 Annals Fam. Med. 492 (2018); Kam-Suen Chan et al., *Effects of continuity of care on health outcomes among patients with diabetes mellitus and/or hypertension: a systematic review*, 22 BMC Fam. Prac. 145 (2021).

[84] *See, e.g.*, Michael D. Cabana & Sandra H. Jee, *Does continuity of care improve patient outcomes?*, 53 J. Fam. Prac. 974 (2004); Gupta & Bodenheimer, *supra* note 83; Chan et al., *supra* note 83.

Moreover, the contractual protections hospitals seek are in line with California's Health Care Providers' Bill of Rights, Cal. Health & Safety Code § 1375.7, which precludes changes to material contract terms without provider agreement. (Other states' laws also commonly restrict the circumstances in which insurers can make unilateral changes to provider contracts.[85]) This statute seeks to "level the playing field for Providers during contract negotiations with Plans" in order to "ensure that consumers . . . have continuity of care" and to prevent the frequent unilateral "severing" of patient-provider relationships by insurers wielding "bad contracts."[86] Thus "[b]etter contracting can result in better outcomes for consumers."[87]

Better outcomes of patients are also the result of the contractual protections plaintiffs seek to eliminate here. By requiring material changes to the insurer-provider arrangement be negotiated and mutually agreed upon, Sutter's contracts merely gave effect to the lawful volume discount bargain—in service of high-quality, integrated, continuous patient care—reached by sophisticated parties in

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[85] *See, e.g.*, 215 Ill. Comp. Stat. Ann. 5/368b; Conn. Gen. Stat. Ann. §§ 38a-478h, 38a-479b; Tex. Ins. Code Ann. § 1301.057; R.I. Gen. Laws § 27-18.8-3(d).

[86] *See* Cal. Bus., Transp. & Hous. Agency, Enrolled Bill Rep. on Assembly Bill No. 2907, at 15 (2002) (hereinafter "Enrolled Bill") (governor's signing message to state legislature). The California Supreme Court has "routinely found enrolled bill reports . . . instructive on matters of legislative intent." *Elsner v. Uveges*, 34 Cal. 4th 915, 934 n.19 (2004).

[87] Enrolled Bill, *supra* note 86, at 15.

arm's-length negotiations. Like the California Health Care Providers' Bill of Rights, these contractual safeguards protect against unnecessary interruption of care and disruption of patient-provider relationships.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment and allow the jury verdict—soundly determined after extensive deliberation and based on ample evidence—to stand.

Dated: January 10, 2023

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 10, 2023, I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system. 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: January 10, 2023

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Boris Bershteyn

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