

United States District Court
Northern District of California

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

San Francisco Division

DJENEBA SIDIBE, et al.,
Plaintiffs,
v.
SUTTER HEALTH,
Defendant.

Case No. 12-cv-04854-LB

**ORDER GRANTING SUTTER'S
MOTION FOR SUMMARY JUDGMENT
FOR 2008 TO 2010 AND FOR THE § 2
CLAIMS AND OTHERWISE DENYING
THE MOTION**

Re: ECF Nos. 838 and 838-1

INTRODUCTION

In this certified class action, the named plaintiffs — four persons who paid for health insurance and two companies who paid for health insurance for their employees — challenge Sutter Health’s allegedly anticompetitive practices as (1) unlawful tying and an unlawful course of conduct in violation of the Sherman Antitrust Act § 1 and California’s Cartwright Act, (2) monopolization and attempted monopolization in violation of the Sherman Act § 2, and (3) a violation of California’s Unfair Competition Law (UCL). The plaintiffs allege that through its contracts with health plans, Sutter uses its market power for inpatient services in seven Northern California markets (the Tying Markets, where it is the only or dominant hospital) to force health plans in four other geographic markets (the Tied Markets, where it faces competition from other providers) to include (in their networks) Sutter’s inpatient services at hospitals in the Tied Markets, resulting in higher prices. The

1 Markets and the inability to change Sutter’s status as a preferred provider without Sutter’s permission
2 — as anticompetitive because the terms allegedly prevented health plans from steering their enrollees
3 away from high-cost Sutter hospitals to lower-priced providers. As a result, the plaintiffs allege,
4 health-plan enrollees (including the plaintiffs) pay higher premiums.¹

5 Sutter moved for summary judgment. It contends that its contracts with the health plans did not
6 condition the purchase of any service on the purchase of any other service and instead gave
7 discounted rates to the plans for including Sutter’s tied hospitals in the plans’ networks. That in-
8 network status, it contends, justifies the lower rates because health plans incentivize members to
9 choose in-network hospitals by paying most or all in-network expenses (and few or no out-of-
10 network expenses). Volume discounting, Sutter asserts, is not anticompetitive conduct, and the
11 contract terms protected the benefit of the bargain. Sutter also contends that there is no evidence
12 that it willfully maintained monopoly power in the Tying Markets or that there is a dangerous
13 probability of monopolization in the Tied Markets. Finally, it contends that it is entitled to summary
14 judgment on claims for 2008 to 2010 because the plaintiffs did not show class-wide damages.²

15 Triable issues of material fact preclude summary judgment on the Sherman Act § 1 and the
16 Cartwright Act claims. For one, there are fact disputes about whether Sutter’s power in the Tying
17 Market allowed it to force insurers to accept Sutter’s higher prices in the Tied Markets. The court
18 grants summary judgment on the Sherman Act § 2 claims because the plaintiffs did not produce
19 evidence showing disputed issues of material fact and on the 2008–2010 claims because the
20 plaintiffs did not show damages.

21 STATEMENT

22 The main issue is whether Sutter forces insurers — through its systemwide contracts with them
23 — to include (in their networks) inpatient services at Sutter hospitals in the Tied Markets as a
24 condition to access to inpatient services at Sutter hospitals in the Tying Markets (where Sutter is the
25

26 _____
27 ¹ Fourth Am. Compl. (4AC) – ECF No. 204; Orders – ECF Nos. 714, 823 (certifying classes). Citations
28 refer to material in the Electronic Case File (ECF); pinpoint citations are to the ECF-generated page
numbers at the top of documents.

1 only or dominant hospital), resulting in higher prices. (In this motion, Sutter does not dispute that it
2 has power in the Tying Markets for the time periods relevant to the lawsuit.³)

3 Before 2002, insurers negotiated with Sutter hospitals individually when they assembled their
4 provider networks.⁴ Then, Sutter moved to systemwide contracts, forcing insurers to participate.⁵
5 For example, when one insurer (Anthem) pushed back, Sutter terminated its individual hospital
6 contracts with Anthem. Anthem then folded and entered into a systemwide contract.⁶

7 The systemwide contracts had allegedly anticompetitive provisions: (1) penalty non-par rates;
8 (2) anti-steering and anti-tiering terms; and (3) secrecy provisions about price and quality.

9 First, for Sutter hospitals that were out of network, the contracts imposed a rate (called a non-
10 participating provider rate or “non-par rate”) that generally was 95% of billed charges.⁷ The health
11 plans/insurers in this case objected to the provisions but ultimately acceded to them.⁸ The non-par
12 rates were higher than the insurers’ customary out-of-network rates.⁹ As a result, the health plans
13 could not build narrow networks that excluded Sutter because there were no costs saved in the
14 narrow network (compared to a network that included Sutter hospitals).¹⁰

15 _____
16 ³ Opp’n – ECF No. 861-1 at 12–13 (evidence regarding Sutter’s market power in the Tying Markets);
Reply – ECF No. 877-1 at 7 (challenging only whether there is a tie, not whether there is market power).

17 ⁴ Joyner Decl., Ex. P75 to Cantor Decl. – ECF No. 862-3 at 4–5 (¶ 7).

18 ⁵ *Id.* at 5 (¶ 8).

19 ⁶ Sutter Health Mem. P27 to Cantor Decl. – ECF No. 791-4 at 153; Sutter 1/12/1998 Letter, P25 to *id.*
– ECF No. 791-4 at 116–18; Johnson Dep., P35 to *id.* – ECF No. 791-4 at 221–22.

20 ⁷ *See, e.g.*, 2015 Blue Shield Systemwide Agreement – ECF No. 887-2 at 13 (§ 2.01.2); Aetna 2016
Systemwide Agreement – ECF No. 887-3 at 12 (§ 2.01.2).

21 ⁸ *See, e.g.*, Brendt Dep., P138 to Cantor Decl. – ECF No. 863-6 at 25; Welsh Dep., P120 to *id.* – ECF
No. 863-1 at 305.

22 ⁹ *See, e.g.*, Barnes Decl., Ex. P74 to Cantor Decl. – ECF No. 862-2 at 6 (¶ 16) (Sutter’s rates “are
23 much higher than the ‘reasonable and customary’ rates or its contracted rates”); Melody Decl., Ex. P71
to *id.* – ECF No. 862-1 at 7 (¶ 18).

24 ¹⁰ *See, e.g.*, Miranda Dep., P141 to *id.* – ECF No. 863-6 at 66–67 (“the practical implication of [the
25 non-par rate] was for Blue Shield is that there were effectively two choices: You either included Sutter
in a product, which typically drove the cost of that product up, or you excluded Sutter from that
26 product, which, because of that 95 percent penalty, also drove the cost of that product up”); Joyner
Decl., Ex. P75 to *id.* – ECF No. 862-3 at 14 (¶ 40) (“payment of 95% of Sutter’s full billed charges
erases any possible benefit of excluding some higher-priced Sutter providers from a network”); De La
27 Torre Email, Ex. P148 to *id.* – ECF No. 863-7 at 68–69 (“When members land in the [non-
28 participating] Sutter ER we are exposed to 100% of billed charges . . . the result is that the savings

1 Second, the plaintiffs challenge contract terms that prevented the insurers from changing
 2 Sutter's status in the networks (by, for example, putting Sutter providers into less preferred tiers)
 3 without Sutter's consent:

4 Provider Participation in Company Benefit Programs/Networks. Sutter has negotiated this
 5 Agreement, including the rates and terms applicable to Payers, on behalf of an integrated
 6 network of Providers and based on the assumption that Payers will treat Providers,
 7 individually and collectively, in the same manner that it treats all of their participating
 8 providers. In order to assure that Sutter and the Providers continue to obtain the benefit of
 9 the agreement that the Parties have negotiated and that the assumptions made by both
 10 Parties continue to apply, the Parties agree that Providers shall participate in Payer's
 11 programs, Benefit Programs and participating provider networks . . . in accordance with
 12 the following provisions:

13 2.06.1 No Change to Provider Status. During the term of this Agreement, Payer shall not
 14 make any changes to any Provider's participating status in Payer's Benefit Programs and
 15 Networks without Sutter's prior written consent.

16 . . .

17 2.06.3 Equal Treatment. Payer shall treat Provider as an equal member of all of the
 18 provider panels for all Benefit Programs and Networks in which that Provider participates
 19 and shall make the services of each Provider equally available within the Benefit Programs
 20 and Networks covered by this Agreement. In no event shall the Member be financially
 21 penalized for accessing any Provider that participates in the Member's Benefit Program
 22 and Network.

23 2.06.4 Tiered Products, Restricted or Limited Networks. Providers have not agreed to
 24 participate in any tiered products, plans, benefit designs, Benefit Programs or Networks
 25 offered by a Payer that ranks participating Providers, and the rank directly affects the
 26 Member's cost share(s), the employer's premium or both or restricts or limits network
 27 access Further, Providers have not agreed to participate in any restricted or limited
 28 network or products that would require Members (or those who pay for their coverage) to
 29 pay more for the same (or substantially similar) product or benefit design to access all
 30 Sutter Providers compared to a network that did not include all Providers. If a Payer wants
 31 some or all Sutter Providers to participate in such New Plans, Company will provide prior
 32 written notice to Sutter that explains in detail how the New Plan or new Network and
 33 benefit design will work, including specifically the basis for determining the tiers or
 34 establishing the Provider's rank or inclusion in the restricted network. Company and Sutter
 35 shall then meet and confer to determine which, if any, Providers will participate in such
 36 New Plan or new Network, and the terms and conditions that will apply to their
 37 participation. Notwithstanding the foregoing, nothing in this Agreement shall limit a
 38 BlueCard Plan from being able to develop and/or market; Tiered Restricted or Limited
 39 Networks or products within its own home service area, outside of California.¹¹

11 2015 Blue Shield Systemwide Agreement – ECF No. 887-2 at 22 (§§ 2.06, 2.06.1, 2.06.3–2.06.4);
 12 2016 Blue Shield Systemwide Agreement – ECF No. 887-2 at 22 (§§ 2.06, 2.06.1, 2.06.3, 2.06.4)

1 The health plans/insurers in this case objected to the provisions but ultimately acceded to
 2 them.¹² The provisions allegedly prevented the health plans from steering their enrollees away
 3 from high-cost Sutter plans to lower-priced providers (called tiering) — through means such as
 4 higher co-pays or deductibles — without Sutter’s permission.¹³ Sutter’s expert confirmed that
 5 tiered networks (with lower-cost providers) can lower hospital prices.¹⁴ Sutter denied the health
 6 plans’ requests to put Sutter hospitals in non-preferred tiers.¹⁵ When the health plans tried to
 7 market tiered networks that did not include Sutter in the most-favored tier, Sutter threatened to
 8 terminate the contracts and to initiate litigation.¹⁶

9 Third, the contracts blocked the health plans from disclosing Sutter’s prices to plan members
 10 to inform their choice of provider.¹⁷ Blue Shield stated that “Sutter was restricting our ability to be
 11 transparent with our customers regarding their relevant cost, quality, or clinical data.”¹⁸

12 The complaint has six counts: (1) unlawful tying in violation of Sherman Act § 1 and the
 13 Cartwright Act (counts I and III); (2) an unlawful course of conduct in violation of Sherman Act §
 14 1 and Cartwright Act (counts II and III); (3) monopolization and attempted monopolization in
 15 violation of Sherman Act § 2 (counts IV and V); and (4) a violation of the UCL (count VI).¹⁹

18 ¹² See, e.g., Joyner Decl., Ex. P75 to Cantor Decl. – ECF No. 862-3 at 15–18 (¶¶ 45–55); Lundbye
 19 Decl., Ex. P78 to *id.* – ECF No. 862-6 at 6 (¶ 12), 8–9 (¶¶ 17–19).

20 ¹³ Chipty Report, Ex. P2 to *id.* – ECF No. 791-3 at 313 (¶ 160), 317 (¶ 164).

21 ¹⁴ Willig Dep., Ex. P154 to *id.* – ECF No. 863-7 at 334.

22 ¹⁵ *E.g.* Brendt 10/22/2008 Email, Ex. P162 to *id.* – ECF No. 863-7 at 426; Vine 12/6/2001 Letter, Ex.
 23 P167 to *id.* – ECF No. 863-7 at 466.

24 ¹⁶ See, e.g., Joyner Decl., Ex. P75 to *id.* – ECF No. 862-3 at 15–18 (¶¶ 45–55) (describing Blue
 25 Shield’s inability to put Sutter hospitals into lower tiers despite Sutter’s higher prices); Lundbye Decl.,
 26 Ex. P78 to *id.* – ECF No. 862-6 at 8–9 (¶¶ 17–19) (UnitedHealthcare objected to Sutter’s anti-tiering
 27 and equal treatment provisions because the provisions “prevented United from launching products it
 28 otherwise would have launched”); Brendt 12/5/2003 Letter, P174 to *id.* – ECF No. 863-7 at 522–23
 (excluding Sutter from a network without Sutter’s written consent could be “an anticipatory breach of
 the Systemwide Amendment” and noting that “Sutter is hopeful that the parties can resolve this issue
 without having to resort to the dispute resolution procedures”).

¹⁷ 2015 Blue Shield Systemwide Agreement – ECF No. 887-2 at 38–40 (§ 6.06), 41–43 (§ 6.08).

¹⁸ Joyner Decl., Ex. P75 to Cantor Decl. – ECF No. 862-3 at 21 (¶ 64).

¹⁹ *Id.* – ECF No. 862-3 at 38–40 (¶¶ 164–170).

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