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 plaintiffs challenge contract terms — such as high rates for out-of-network Sutter services in the Tied

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

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

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

STATEMENT

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

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

[2] Mot. – ECF No. 838-1 at 10–11

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

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

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

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

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[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).

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

[5] *Id*. at 5 (¶ 8).

[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.

[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).

[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.

[9] *See, e.g.*, Barnes Decl., Ex. P74 to Cantor Decl. – ECF No. 862-2 at 6 (¶ 16) (Sutter's rates "are 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).

[10] *See, e.g.*, Miranda Dep., P141 to *id.* – ECF No. 863-6 at 66–67 ("the practical implication of [the 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 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 Torre Email, Ex. P148 to *id.* – ECF No. 863-7 at 68–69 ("When members land in the [non-participating] Sutter ER we are exposed to 100% of billed charges . . . the result is that the savings

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

> Provider Participation in Company Benefit Programs/Networks. Sutter has negotiated this Agreement, including the rates and terms applicable to Payers, on behalf of an integrated network of Providers and based on the assumption that Payers will treat Providers, individually and collectively, in the same manner that it treats all of their participating providers. In order to assure that Sutter and the Providers continue to obtain the benefit of the agreement that the Parties have negotiated and that the assumptions made by both Parties continue to apply, the Parties agree that Providers shall participate in Payer's programs, Benefit Programs and participating provider networks . . . in accordance with the following provisions:
>
> 2.06.1 No Change to Provider Status. During the term of this Agreement, Payer shall not make any changes to any Provider's participating status in Payer's Benefit Programs and Networks without Sutter's prior written consent.
>
> . . .
>
> 2.06.3 Equal Treatment. Payer shall treat Provider as an equal member of all of the provider panels for all Benefit Programs and Networks in which that Provider participates and shall make the services of each Provider equally available within the Benefit Programs and Networks covered by this Agreement. In no event shall the Member be financially penalized for accessing any Provider that participates in the Member's Benefit Program and Network.
>
> 2.06.4 Tiered Products, Restricted or Limited Networks. Providers have not agreed to participate in any tiered products, plans, benefit designs, Benefit Programs or Networks offered by a Payer that ranks participating Providers, and the rank directly affects the Member's cost share(s), the employer's premium or both or restricts or limits network access . . . . Further, Providers have not agreed to participate in any restricted or limited network or products that would require Members (or those who pay for their coverage) to pay more for the same (or substantially similar) product or benefit design to access all Sutter Providers compared to a network that did not include all Providers. If a Payer wants some or all Sutter Providers to participate in such New Plans, Company will provide prior written notice to Sutter that explains in detail how the New Plan or new Network and benefit design will work, including specifically the basis for determining the tiers or establishing the Provider's rank or inclusion in the restricted network. Company and Sutter shall then meet and confer to determine which, if any, Providers will participate in such New Plan or new Network, and the terms and conditions that will apply to their participation. Notwithstanding the foregoing, nothing in this Agreement shall limit a BlueCard Plan from being able to develop and/or market; Tiered Restricted or Limited 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);

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

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

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

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

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

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

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

[16] *See, e.g.*, Joyner Decl., Ex. P75 to *id.* – ECF No. 862-3 at 15–18 (¶¶ 45–55) (describing Blue Shield's inability to put Sutter hospitals into lower tiers despite Sutter's higher prices); Lundbye Decl., Ex. P78 to *id.* – ECF No. 862-6 at 8–9 (¶¶ 17–19) (UnitedHealthcare objected to Sutter's anti-tiering and equal treatment provisions because the provisions "prevented United from launching products it 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] 4AC – ECF No. 204 at 38–43 (¶¶ 124–170).

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