

CPI's North America Column Presents:

California v. Sutter Health: The State AG Takes Its Gloves Off

*Michael S. McFalls, Amy D. Paul & Christina N. Phillips
(Ropes & Gray, LLP)¹*

June, 2018



Copyright ©2016

Competition Policy International, Inc. for more information visit CompetitionPolicyInternational.com

I. INTRODUCTION

On March 30, the State of California brought a broad and far-reaching antitrust complaint against Sutter Health (“Sutter”), a sprawling health system in Northern California with 24 hospitals and over 5,000 physician employees and collaborators.² At the center of the lawsuit are three contracting practices that allegedly harm competition:

- **The All-or-Nothing Terms:** According to the Complaint, Sutter requires payors to accept all of Sutter’s sites – regardless of location, cost or attractiveness – as part of a single contract.³ Because Sutter allegedly has must-have hospitals that payors require for commercially viable networks, California contends that it can condition access to sites on the acceptance of other Sutter sites facing greater competition elsewhere.⁴
- **The Anti-Incentive Terms:** California also alleges that Sutter prohibits payors from incentivizing patients to select certain providers on the basis of cost.⁵ Absent these restrictions, payors theoretically could discipline higher pricing from Sutter by incentivizing the use of less expensive alternative healthcare providers.
- **The Price Secrecy Terms:** California also alleges that Sutter prohibits payors from informing patients about the cost of procedures and services at its facilities prior to the provision of services.⁶ This prohibition prevents consumers from selecting providers on the basis of cost and may also reduce the incentive for Sutter’s competitors to offer discounts.

According to California, these terms both reflect and reinforce market power.⁷ Absent these terms, Sutter would face greater competition, payors would enjoy more discounting by providers, and patients might be willing and able to act more like traditional consumers by comparing the cost of services.

A. *UBET & Sidibe*

The allegations themselves are not new. Two separate sets of plaintiffs have already brought these claims under the Cartwright and Sherman Acts in California. In *UFCW & Employers Benefit Trust v. Sutter Health*, No. CGC14538451 (Cal. Supr., filed Apr. 7, 2014) (“UEBT”), a putative class of self-funded payors brought claims under the Cartwright Act for price tampering, unreasonable restraint of trade, combination to monopolize,⁸ as well as for unfair competition. In *Sidibe v. Sutter Health*, No. 3:12cv4854 (N.D. Cal., filed Sept. 17, 2012) (“Sidibe”), a putative class of health plan subscribers and employers brought claims under Section 1 of the Sherman Act for unlawful tying and course of conduct,⁹ under Section 2 of the Sherman Act for monopolization and attempted monopolization,¹⁰ and under the Cartwright Act for unreasonable restraint of interstate trade and commerce.¹¹

Both UEBT and Sidibe allege that Sutter engages in improper all-or-nothing requirements to force subscribers and self-funded payors to pay inflated prices in otherwise competitive markets. UEBT alleges that Sutter’s “[a]ll-or-[n]othing contract terms” illegally tie Sutter hospitals in markets where Sutter faces little competition to its hospitals in more competitive markets to force self-funded payors and insurance companies to pay inflated prices even in

the competitive markets.¹² Similarly, Sidibe alleges that Sutter uses “‘all or nothing’ terms” to force payors to accept Sutter’s “supra-competitive rates” through use of tying arrangements.¹³

Both cases also allege that Sutter improperly employs anti-incentive terms that might otherwise serve to mitigate the impact of Sutter’s all-or-nothing approach. UEBT alleges that Sutter requires plans to accept the anti-incentive terms, which prevent price competition by forbidding plans from providing inducements for members to seek care at more affordable (non-Sutter) hospitals, in order to “eliminate[] most or all of the motivation that Health Plan Enrollees might have” to pick a hospital “based upon the value the hospital provides.”¹⁴ Sidibe similarly alleges that Sutter’s contracts required customers not to incentivize customers to seek health care at less expensive options.¹⁵

Finally, both cases allege that Sutter uses its contracts and market power to keep prices secret. Sidibe alleges, in keeping with external analysis, that Sutter has “pacts with insurers” to keep its high “prices secret.”¹⁶ Similarly, UEBT alleges that Sutter has “[p]rice [s]ecrecy [c]ontract [t]erms” by which it “forbid[s] [network vendors to self-funded payors and purchasers] from disclosing” Sutter’s prices for services and products to the self-funded payors.¹⁷ Those network vendors are forbidden from providing Sutter-related pricing information they would know from their own negotiations with Sutter over insured services and products, making it more difficult for self-funded payors to access information they would otherwise have available to them to pressure Sutter over its pricing.¹⁸

Although filed in 2014 and 2012, respectively, at this point, both *UEBT* and *Sidibe* are only in the discovery process. They demonstrate two pre-existing cases that include each of the three series of allegations, indicating that this series of claims – against Sutter Health, no less – is nothing new.

B. Similar Challenges

Nor is the challenge to “anti-incentive terms” novel. The Department of Justice’s (“DOJ”) Antitrust Division is pursuing a similar case alleging that a leading healthcare system uses anti-steering provisions to prevent payors from incentivizing their insureds to select cheaper or better quality alternatives.¹⁹ In fact, the issues are conceptually very similar to American Express’s anti-steering provisions that were challenged by the DOJ in 2010, and were litigated by 17 states in front of the United States Supreme Court in February 2018.²⁰

The challenge to the “All-or-Nothing” terms is superficially novel. After all, why should it be problematic for a multi-hospital system to contract with payors for all sites in a single contract at a single rate? In fact, it would seem odder if Sutter and other entities refused to do so. But the Complaint alleges more than just the provision of a full-network option. It alleges that it is the *only* option Sutter is willing to offer.²¹ Thus, the theory is more akin to tying by a dominant firm in any industry – a long-standing theory of potential antitrust harm in many contexts. And the theory in this Complaint builds substantially on arguments that have percolated at the Federal Trade Commission (“FTC”) in its hospital merger enforcement actions, where the agency has persuaded courts in large part to accept its competition model, premised on the incremental increase in bargaining power that some hospitals may gain by acquiring relatively close competitors in terms of services and location. And although the FTC

has not challenged specifically a cross-market hospital merger based on a non-horizontal theory of harm – that the combination of a must-have hospital with other hospitals in other geographic markets would enable the acquirer to raise prices at other hospitals – the DOJ is using a similar conceptual framework in the AT&T/Time-Warner merger challenge.²² One wonders how closely FTC hospital-merger-enforcement actions might follow, especially with the uniform unpredictability of the antitrust agencies in the current Administration.²³

II. SIGNIFICANCE OF THE CALIFORNIA COMPLAINT

Thus, the California complaint is arguably not as novel as it initially seems. But it does mark an important and noteworthy development in antitrust enforcement for several other reasons. *First*, it reflects a potential expansion of antitrust enforcement from state attorneys general where federal enforcers may be reluctant to intervene. This has been a traditional role for state antitrust enforcers, especially during Republican administrations, which have often reined in the scope of FTC and DOJ enforcement, particularly with respect to dominant firm conduct. *Second*, the initiation of a complaint with these theories by the State of California gives them more weight than they might otherwise have if brought solely by private plaintiffs. *Third*, unlike private plaintiffs, state attorneys general may be more likely to surmount and avoid traditional obstacles to antitrust recovery, such as standing, antitrust injury, or even general judicial skepticism about the motivation of private antitrust plaintiffs and their lawyers. *Fourth*, if California does indeed succeed, the precedent could have wide-ranging implications for multi-hospital system healthcare contracting in the United States, particularly for the many such systems that have one or more geographies in which they enjoy dominant or near-dominant positions. *Fifth*, the nature and extent of behavioral remedies – if adopted by the court – would be a substantial departure from any behavioral remedies that we have seen in modern antitrust law, with review and arbitration of potentially numerous contractual disputes. It will be interesting to see what payors and others think about remedies that would essentially require multi-hospital systems to stagger otherwise unitary contracts by site. *Sixth*, the magnitude of disgorgement – a remedy rarely pursued by antitrust enforcers – could be substantial here. The private plaintiffs have alleged over \$700 million in damages before trebling.²⁴

Given the existence of two private lawsuits, it might be worth asking why the California AG has taken so long to pursue its own case. There are a number of explanations. *First*, the private cases may end or settle on grounds either irrelevant or objectionable to the State. The progress of these cases has not been rapid or positive from an antitrust enforcement perspective.²⁵ Thus, by bringing its own complaint, the State may be able to pursue remedies more rapidly and successfully (including a settlement that would achieve comparable objectives). *Second*, some might have viewed the merits as weak. If other hospitals without substantial market power use similar provisions, then the State, all things equal, may have a difficult time showing that the use of such provisions reflects market power. But other hospital systems similar to Sutter should remain mindful that antitrust law routinely prevents leading or dominant firms from using the same kinds of contracting tools that may be benign or even procompetitive when used by smaller firms (such as exclusivity or bundling). *Third*, the State may have had trouble getting potential witnesses for its case. One of the most difficult things to prove in this case will be the very existence of the “All-or-Nothing” terms. The fact that

Sutter offers pricing negotiated at a single point in time and covering all sites is extraordinarily unremarkable.²⁶ Only if Sutter is not willing to contract on other terms might there be potential tying, and only if there is “coercion” can there be an *unlawful* tie. Thus, it is likely that the State will need to establish tying and coercion through witnesses, and such witnesses may prove unwilling to confront an important healthcare system in court. Perhaps the pursuit of these theories under the Cartwright Act may enable the State to argue that it need not prove coercion to show the existence and illegality of “All-or-Nothing” terms.²⁷

Assuming that the State prevails, the pursuit of these theories under the Cartwright Act may provide other courts a way to distinguish this case in other enforcement actions brought under the Sherman²⁸ and Clayton Acts.²⁹ Nevertheless, given the trajectory of federal antitrust enforcement, and cross-party political interest in keeping health care delivery costs down, we should not be surprised to see more frequent investigations and potential litigation involving similar contractual provisions. Nor should we be surprised to see cross-market merger enforcement based on the same underlying premises.

¹ The authors are, respectively, Partner and Associates in the litigation department of Ropes & Gray, LLP. The authors appreciate the contributions and comments of both Jane E. Willis and Jonathan S. Klarfeld, also Partners in the litigation department of Ropes & Gray, LLP.

² Complaint, *California ex rel. Xavier Becerra v. Sutter Health*, CGC-18-565398, ¶ 46 (Cal. Supr., filed Mar. 29, 2018) (“California”), available at https://oag.ca.gov/system/files/attachments/press_releases/Sutter%20Complaint.pdf.

³ California Compl. ¶¶ 113-14.

⁴ See *id.* ¶¶ 114-20.

⁵ See *id.* ¶¶ 121-28.

⁶ See *id.* ¶¶ 129-32.

⁷ See *id.* ¶¶ 57, 75, 100-08, 112.

⁸ See UEBT Compl. at 38, 39, 41 (Counts I-III).

⁹ See Sidibe Fourth Amended Complaint (“FAC”), at 36, 37 (First, Second Claims).

¹⁰ See *id.* at 39, 40 (Fourth, Fifth Claims).

¹¹ See *id.* at 38 (Third Claim).

¹² See UEBT Compl. ¶¶ 104-08.

¹³ See Sidibe FAC ¶¶ 5, 6.

¹⁴ UEBT Compl. ¶ 116.

¹⁵ Sidibe FAC ¶¶ 7, 41 (“For example, Sutter contracts prohibited steering away from Sutter facilities through financial incentives and/or penalties.”).

¹⁶ See Sidibe FAC ¶ 89.

¹⁷ UEBT Compl. ¶ 117.

¹⁸ *Id.* ¶ 118; see *id.* ¶¶ 117-119.

¹⁹ *United States v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311 (W.D.N.C., filed June 9, 2016).

²⁰ See generally Am. Compl., *United States v. Am. Express Co.*, No. 1:10-cv-04496, No. 57 (E.D.N.Y. Dec. 21, 2010).

-
- ²¹ California Compl. ¶¶ 113-14 (alleging this is required in “all contract negotiations” and “requiring every Health Plan” to meet this requirement).
- ²² See *United States v. AT&T Inc.*, No. 1:17-cv-02511 (D.D.C., filed Nov. 20, 2017).
- ²³ It also is worth noting that Greg Vistnes – one of the intellectual godfathers of the bargaining model for analyzing horizontal mergers – also articulated these potential theories of harm in a 2013 article. See Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253, 258-60 (2013), <https://www.crai.com/sites/default/files/publications/Cross-market-hospital-mergers-a-holistic-approach.pdf>. Likewise, Leemore Dafny, a recent Deputy Director of the Bureau of Economics at the FTC, has made this cross-market concern a particular area of theoretical and empirical interest in her recent work. See generally Leemore S. Dafny et al., *The Price Effects of Cross-Market Hospital Mergers*, (Nat’l Bureau of Econ. Research, Working Paper Series, No. 22106), <http://www.nber.org/papers/w22106>; Leemore S. Dafny et al., *Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth*, 36 HEALTH AFF., no. 9, Sept. 2017; Leemore S. Dafny et al., *Narrow Networks on the Health Insurance Exchanges: What Do They Look Like and How Do They Affect Pricing? A Case Study of Texas*, 105 AM. ECON. REV.: PAPERS & PROC., no. 5, May 2015; Leemore S. Dafny et al., *More Insurers, Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces*, 1 AM. ECON. REV.: PAPERS & PROC., no. 1, Winter 2015.
- ²⁴ California Attorney General Xavier Becerra claimed that new data leads them to believe “damages are likely to exceed \$700 million,” prior to trebling. Cathie Anderson, *Sutter Health Unfairly Inflates Medical Costs in Northern California, AG Alleges*, MSN (April 1, 2018), <http://www.msn.com/en-us/news/other/sutter-health-unfairly-inflates-medical-costs-in-northern-california-ag-alleges/ar-AAviDhp>.
- ²⁵ As of April 2018, the dockets reflect that both cases are still in the discovery process, even though *UEBT* began in 2014 and *Sidibe* in 2012.
- ²⁶ Cf. California Compl. ¶¶ 113-14.
- ²⁷ Cartwright Act, Cal. Bus. & Prof. Code § 16720, *et seq.*
- ²⁸ 15 U.S.C. §§ 1-7.
- ²⁹ 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53.