[Sutter Case Watch] Jury Trial in Federal Class Action Against Sutter Health Provides Sneak Peek at Alleged Anticompetitive Contracting Practices

See case page: Sidibe v. Sutter Health

Northern California hospital giant Sutter Health is again in the spotlight this month as the jury trial began in *Sidibe v. Sutter Health* in the District Court for the Northern District of California after nearly ten years of litigation. Many may recall the recent antitrust lawsuit led by California attorney general against Sutter Health, *UFCW & Employers Benefit Trust (UEBT) v. Sutter Health*, which settled in state court on the eve of trial in October 2019. While the settlement sent shockwaves across the healthcare industry and had significant implications for antitrust enforcement in health care, many antitrust experts lamented the quick settlement out of court allowed Sutter to continue to conceal evidence and the missed opportunity of a sneak peek into Sutter's inside dealings and alleged anticompetitive practices over the years. Now in federal court, take two of the Sutter Health antitrust saga provides a rare look at evidence of a major health system's internal operations and alleged anticompetitive dealings, which may finally be brought to light and put on fully display in front of a jury.

Case Background

Sidibe v. Sutter Health, a class action filed in September 2012, stems from largely the same facts as the high-profile state action in *UEBT v. Sutter Health* and alleges that Sutter Health restricted competition in the healthcare market using

anticompetitive tactics. Plaintiffs are individuals and employers (estimated to be 3 million in the certified class) who purchased fully insured plans from the five largest commercial health insurance companies in California, namely Aetna, Anthem, Blue Cross Blue Shield (BCBS) of California, Health Net, and UnitedHealthcare.

Class plaintiffs allege that Sutter engaged in anticompetitive contracting practices with these insurers that inflated their premiums and co-pays. The alleged practices used were also the subject of the state action in *UEBT v. Sutter*, which involved self-insured plans, including all-or-nothing provisions and resulting geographic tying arrangements and anti-steering provisions that prevented health plans from steering members to lower-cost providers. The lawsuit claims Sutter's practices caused the class to pay about $411 million more for health insurance. If found liable, Sutter may pay treble damages of approximately $1.2 billion. (Read more about the case background, legal claims, and procedural history in the Source case brief on the case.)

Expected to last four weeks, the trial is scheduled from February 9 to March 9 in front of Magistrate Judge Laurel Beeler in San Francisco. In proceedings so far, the jury heard testimonies from experts and witnesses including insurance-buying plaintiff representatives, executives from insurance companies including Health Net, BCBS, and Aetna, as well as representatives from Sutter. The question at trial centers on whether Sutter used its market power in certain rural areas in Northern California, where it is the only or dominant provider for inpatient services, to force insurers to include in their networks other Sutter hospitals in the more competitive regions, namely San Francisco, Sacramento, Modesto, and Santa Rosa.

Market Power and Anticompetitive Terms

In Sutter's opening statement, they emphasized that the hospital system does not have the requisite market power in Northern California to demand the alleged terms from insurers. Counsel for Sutter argued that Sutter faces vigorous competition from Kaiser Permanente, which has greater market share in Northern California. On the other hand, counsel for plaintiffs argued that Kaiser is a closed network that is not in the same market and does not contract with these commercial insurers.

At trial, two insurance company executives gave testimony regarding Sutter's "must-have" providers. Chandra Welsh, VP at Aetna, testified that some of Sutter's hospitals in Northern California are the only facilities in the area, so Aetna had less leverage in negotiating contract terms with Sutter, because "we needed them more than they needed us." Becky LaCroix Milani, a Health Net VP, also noted that "not having a contract with Sutter at all would have been extremely consequential," because some patients would not have coverage to hospitals within a reasonable distance of their home.

- Tying and All-or-nothing Provisions

Plaintiffs claim that because Sutter is the only provider in town in some regions of Northern California, making it a "must-have" provider to health plans in those markets, it was able to "tie" its hospitals in other more competitive markets and require "all-or-nothing" provisions in contracts with insurers, which demand insurers to contract with all its hospitals as a condition of contracting with the must-have hospital. Kristen Miranda, a former VP at BCBS testified that Sutter was a difficult negotiator and made it clear that they didn't want insurers "cherry-picking" which hospitals they covered, forcing BCBS to contract for all of Sutter's hospitals or none.

- Anti-tiering/Anti-steering

Plaintiffs allege that not only does Sutter require all-or-nothing provisions to force insurers to include all of its hospitals in their networks, but it also refused to participate in narrow insurance networks and tiered plans as the second, more expensive tier. Such tiering plans would steer patients to lower-cost hospitals or providers, but several witnesses testified that Sutter Health won't agree to such insurance products that narrow coverage or tier health providers by cost. According to Becky LaCroix Milani, when Health Net tried to launch narrow and reduced-price products, "Sutter wouldn't allow their hospitals to be in those networks." BCBS was similarly denied such tiering contracts with Sutter according to the testimony of Catherine Dodd, who was the director of San Francisco's health service system and had requested tiering options for Sutter providers through BCBS coverage.

A few witnesses also provided testimony that these anticompetitive contracting

practices were not commonly used by other providers. Kristen Miranda from BCBS confirmed that these contract terms were not required by other hospital systems like Adventist Health and Tenet Healthcare. Kenneth Kizer, an expert witness who served as the chief medical officer for California's DMHC and retired from the U.S. Department of Veteran Affairs, also testified for plaintiffs that such restrictive contracting practices were unique to Sutter. Sutter countered at trial that such contract terms were not used with CalPERS and Medicare Advantage HMO.

Higher Prices Not Explained by Quality

At trial, another question centered around Sutter's alleged higher prices compared to other hospitals. Several plaintiff representatives testified to this, including Djeneba Sidibe, one of the lead plaintiffs, who purchased insurance from Aetna. Susan MacAusland, owner of another lead plaintiff Optimum Graphics, gave testimony that her company was paying $500 per month for its one employee under the Anthem plan. Catherine Dodd testified that Sutter's prices under BCBS coverage for the employees of the city and county of San Francisco were higher than other hospitals in the city. As a result of the higher premiums under BCBS, many members had switched to Kaiser Permanente. This was confirmed by Kristen Miranda of BCBS, who confirmed that Sutter was more expensive relative to other providers in Northern California.

Former Sutter executives also weighed in. Robert Reed, who was Sutter's longtime CFO, also confirmed that Sutter was more expensive than the community average and that he had heard complaints about Sutter's prices. Another former Sutter executive, Jim Harrison, who was a former Sutter VP, testified that in his position, he had created a slide presentation that indicated Sutter's prices were 32% above other providers in the Bay Area and 15% above Sutter's direct competitors.

Jim Harrison also testified that he had told higher-ups at Sutter in 2011 that such higher prices were could not be justified by higher value because Sutter's patient ratings of care were inconsistent and not clearly superior to its competitors. Former VA and DMHC health official Kenneth Kizer also believed that Sutter's higher prices are not linked to better patient care and quality. First of all, he corroborated

Harrison's statement that Sutter's higher prices could not be explained by a higher quality given its inconsistent ratings. Moreover, he noted that other hospitals get high patient ratings without using the restrictive contract provisions and charging the high prices that Sutter does.

Sutter's Defense for Alleged Practices

In addition to the lack of connection between Sutter's high prices and contracting practices with the quality of patient care, the plaintiffs sought to show that there were no other legitimate justification for such practices. Several Sutter executives called to the stand tried to defend Sutter's practices by stating that Sutter's practices were necessary for the operation of the hospital system. Melissa Brendt, who is Sutter Health's chief contracting officer, said that the contract terms Sutter demands from insurers were necessary to offset costs of charity care required by Sutter's nonprofit status. She testified that if Sutter was placed in the more expensive tier, it would be difficult to collect from the patients and affect revenue and patient volume. Sutter's former CFO Robert Reed also denied that Sutter used its market power to demand anticompetitive terms and charge higher prizes. He claimed that as a nonprofit, Sutter merely needed funds for state-mandated improvements such as earthquake updates and other investments like electronic health record system. However, Dr. William Isenberg, Sutter's chief medical officer, testified that there is no connection between the contract terms demanded by Sutter and the need for clinical integration.

Executive Compensation

Sutter's financials and revenue were called into question at trial as the focus is placed on the health system's nonprofit status. Plaintiffs' counsel sought to introduce evidence about Sutter's executive salaries, in response to Sutter's claim that it didn't have high net-wealth executives because it's a nonprofit. While Judge Beeler ruled pretrial that the court would exclude such evidence at trial because it is prejudicial and marginally relevant, the court allowed counsel for the plaintiffs to

present evidence to the jury that in 2016, Sutter's 24 executives earned a total of $47 million. Sutter's human resources executive Jill Ragsdale further testified that in 2019, 20 of Sutter's top executives were paid a total of $25.5 million, or more than $1 million per executive.

As the trial continues, more details of Sutter's practices and operations stand to be divulged. Stay tuned to the Source Blog as we continue to bring the latest updates in the Sutter Case Watch series.