[Sutter Case Watch] Sidibe v. Sutter Health Class Action Headed to Appeal

See case page: Sidibe v. Sutter Health

The antitrust action against Northern California hospital giant Sutter Health is a saga that continues to give and capture the attention of antitrust regulators and stakeholders around the country. After Sutter's landmark settlement with the California attorney general in state court in 2019 and a jury verdict in March 2022 clearing Sutter of anticompetitive allegations in a decade-long federal class action, many thought the Sutter chapter had finally closed, albeit somewhat anti-climatically. Not so fast. In late April, plaintiffs in the federal action filed a notice of appeal to the Ninth Circuit Court of Appeals, citing inaccurate jury instructions and exclusion of key evidence that impacted the final outcome of the case. In this post, we take a look at what went down at the month-long jury trial, the jury instructions and the verdict that resulted, and examine the legal issues in contention that may be litigated on appeal.

The Road So Far: Quick Recap

Sidibe v. Sutter Health is a class action filed in September 2012 by individuals and employers (estimated to be 3 million in the certified class) who purchased fully insured health plans from the five largest commercial health insurance companies in California. Plaintiffs allege that Sutter engaged in anticompetitive contracting practices with these insurers that inflated their premiums and co-pays by about $411 million. The alleged practices used were also the subject of the high-profile state action in *UEBT v. Sutter Health*, which settled out of court, including all-or-nothing provisions and resulting geographic tying arrangements and anti-

tiering/anti-steering provisions that prevented health plans from steering members to lower-cost providers. Specifically, plaintiffs claim that Sutter used its market power in certain rural areas in Northern California, where it is a dominant or the only provider for inpatient services, to force insurers to include other Sutter hospitals in their networks in more competitive regions, namely San Francisco, Sacramento, Modesto, and Santa Rosa. (Read more about the case background, legal claims, and procedural history in the **Source case brief** on the case.)

After nearly a decade of litigation, a month-long jury trial took place in February-March 2022 in front of Magistrate Judge Laurel Beeler of the Northern District of California in San Francisco. The jury heard testimonies from economic experts and witnesses including insurance-buying plaintiff representatives, executives from insurance companies including Health Net, BCBS, Anthem, United Healthcare, and Aetna, as well as representatives from Sutter. On March 11, a nine-person jury delivered a unanimous verdict finding that Sutter did not engage in anticompetitive conduct and did not cause consumers to pay higher prices or premiums as alleged by the class plaintiffs. The jury answered "no" on two key questions to plaintiffs' case, finding that 1) Sutter did not use tying practices in its insurer contracts; and 2) Sutter did not force insurers into contracts that would prevent health plans from steering patients to lower cost hospitals.

This verdict sent shockwaves through the healthcare antitrust world. Given that plaintiffs requested a jury trial in its original complaint,[1] presumably to increase the chances of the jurors as ordinary consumers finding for the class plaintiffs, the outcome begs the question of what went wrong for the plaintiffs? An attorney for the plaintiffs pointed to two major issues on appeal. First, the court made prejudicial evidentiary rulings throughout the case that precluded plaintiffs from presenting key evidence as to the two major claims. In addition to this limitation, plaintiffs' case was further impaired by the jury instructions that were allegedly inaccurate and confusing.

Exclusion of Evidence

One important issue on appeal is the court's pre-trial rulings that specifically

precluded plaintiffs from presenting evidence to the jury regarding Sutter's conduct prior to 2006. In March 2021, the court granted partial summary judgment for Sutter and dismissed claims from 2008 to 2010 because plaintiffs could not show damages for the class during that period. Given that the class period starts in 2011, the court reasoned that "the relevant contracts took effect shortly before the class period" and assumed the case "is not about conduct that predates the contracting practices by more than five years." Accordingly, the court granted Sutter's motion to exclude evidence from before 2006, holding that "pre-2006 evidence had minimal relevance, was too attenuated from the relevant period, was cumulative and confusing, and would waste time and delay the proceedings."[2]

Plaintiffs argue, however, that pre-2006 evidence is highly relevant because it includes "a time period during which Sutter allegedly began a process of system-wide contracting so that it could increase prices."[3] In fact, the pre-2006 time frame is so crucial that Sutter intentionally destroyed 192 boxes containing millions of highly relevant evidence dating from 1995 to 2005. This highly prejudicial act was uncovered by plaintiffs in the *UEBT v. Sutter Health* case, which involved similar contracting practices involved in this case, and spurred the California attorney general to join in the state case and resulted in court sanctions including relevant jury instructions in the *UEBT* case which has since settled. The fact that Sutter acted so egregiously to destroy the evidence hints at how that period was crucial to show how Sutter moved from individual hospital contracts to a systemwide hospital contract to set up their system to enable anticompetitive pricing practices. While much of the specific contracting in *Sidibe* occurred long after the 1995-2005 time period, that period contained substantial evidence of Sutter's market power, tying conduct, and the anticompetitive effects of those arrangements.

Jury Instructions

Against the backdrop of limited evidence, the specific language in the jury instructions also further hindered the plaintiffs' case and raised likely issues for appeal. Next, we break down the jury instructions on the two major claims under the federal Sherman Act and California's Cartwright Act and examine the specific

elements at issue that could be argued on appeal.

1. "Unlawful Tying" Claim

Verdict Form Question: *Did Sutter sell inpatient hospital services in one or more of the tying hospitals only if the buyer also purchased inpatient hospital services at one or more of the tied hospitals?* Answer*: No.* ***[4]***

Jury Instructions (excerpts):

- *Introductory explanation of market power: the concept[ ] of* ***"market power" … appl[ies] to both claims,*** *[which is] the* ***ability to increase prices or reduce output without losing market share*** *(emphasis added). The higher a seller's market share, the more likely it has market power. In deciding whether a seller has market power, you should consider how difficult it is for a potential competitor to successfully enter the market…****[5]***
- *Treating inpatient hospital services at the tying hospitals and inpatient hospital services at the tied hospitals as separate and distinct, the jury must find that plaintiffs presented enough evidence to show that: Sutter has* ***sufficient economic power in the market*** *(emphasis added) for inpatient hospital services at one or more of the tying hospitals to coerce at least some buyers of inpatient hospital services at one or more of the tying hospitals into purchasing inpatient hospital services at one or more of the tied hospitals…****[6]***

    1. *In determining whether Sutter has sufficient economic power in one or more of the tying markets for inpatient hospital services, you may consider whether Sutter has such a large share of the market for inpatient hospital services in the tying markets that* ***buyers do not have alternate sources*** *of inpatient hospital services or a* ***reasonably available substitute*** *(emphasis added)…*
    2. *You may also consider whether a* ***buyer would be unable to locate a similar or equally desirable service*** *(emphasis added) in the marketplace. If buyers do not generally consider other services to be substitutes, this fact may give Sutter economic power over its inpatient hospital services at the tied Hospitals…*

Who is the Relevant "Buyer" in Market Power Analysis:

The key term in determining whether an entity has sufficient market power to demand tying is "buyer". In other words, whether an entity has "market power" depends on who the "buyer" is: patients or insurers. In the healthcare market, health insurers contract with hospitals for healthcare services and form provider networks which are then offered to patients who enroll in the health plans. Hospital prices are hence determined by bargaining between hospitals and health insurers, and enrollees pay the resulting insurance premium and additional out-of-pocket costs for specific healthcare services. Patients who enroll in the health plans typically pay lower out-of-pocket costs for care at hospitals that are in-network versus out-of-network.

In this case, small businesses and individuals who purchased commercial health insurance from health plans that contracted with Sutter claimed that Sutter's anticompetitive practices in contracting with the health insurers inflated their premiums and out-of-pocket costs. As such, commercial health plans are the relevant buyers as direct purchasers of Sutter's inpatient hospital services, not patients. The notion of insurers being the relevant demand market is consistent across modern healthcare antitrust cases. Several courts have held that the relevant buyer for defining markets and assessing the degree of market power are the payers.[7] Most recently, it was raised by healthcare economists and antitrust experts in the FTC challenge of the Hackensack Meridian and Englewood Healthcare merger in New Jersey. On appeal to the 3rd Circuit, the court affirmed FTC's "willingness to pay" analysis that examined the negotiating leverage that a hypothetical monopolist of Bergen County hospitals would have as to insurers, who are the relevant purchasers or buyers.[8]

Wrongful Inclusion of Kaiser Hospitals in the Relevant Market:

The jury instructions, as seen above, did not properly define the relevant market because it did not specify who the relevant "buyer" of inpatient hospital services was for purposes of determining market power. To the average juror, it was unclear whether the market power was as to health plans or individual patients. This distinction in buyer is an important one and pivotal to plaintiffs' case. At trial,

plaintiffs presented evidence on the issue of market power with testimony from insurance company executives from Aetna, United Healthcare, and Health Net. They testified that Sutter is a "must-have" provider to health plans in some regions of Northern California, where its rural hospitals were the only facilities in the area and indispensable for emergency service. This gave insurers less leverage in negotiating contract terms and Sutter used that to "tie" its hospitals in other more competitive markets and require all-or-nothing systemwide agreements for its hospitals. Additionally, plaintiffs presented evidence that Sutter had admitted its prices were higher than the community average, and that this ability to raise prices above the competitive level is a manifestation of market power.[9]

Judge Beeler's mistaken jury instruction as to the "relevant purchaser," however, undermined plaintiffs' persuasive documentary and testimonial evidence as to Sutter's market power and opened the door for Sutter to argue its main counterpoint: Kaiser Permanente. Aside from denying tying all of its hospitals and arguing that insurers all wanted broad networks that include all Sutter hospitals anyway, Sutter claimed that it did not have the requisite market power to engage in tying arrangements because it faces vigorous competition from Kaiser Permanente, which they claimed to be the elephant in the room that had a large and increasing market share in Northern California.

Kaiser, however, should never have been considered in the market power analysis. Given that Kaiser is an integrated system that provides healthcare services with its own health insurance to members, it is a closed network and its providers do not contract with these commercial insurers. A closed network changes market power vis-a-vis insurers but not patients. While Kaiser could be considered a "substitute" or "alternate source of inpatient hospital services" for *patients,* the perspective of patients is irrelevant because the relevant buyers here are the *insurers*, not patients. From the perspective of health insurers, they could not choose to contract with Kaiser's hospitals as an alternative or substitute when Sutter raised prices, so Kaiser was never an option no matter how competitive its prices. Even Sutter's economic expert and executives agreed that the relevant market is defined from the perspective of the health plans and that Kaiser does not compete for inclusion in the health plans' networks,[10] which makes it irrelevant for market power analysis.

By not clearly identifying the relevant buyer as the insurer, the court's jury instructions created confusion that allowed the irrelevant discussion of market power related to patient markets. Sutter's defense deliberately used this lack of clarity to muddle the market for patients and the market for insurers, using Kaiser's presence as defense even though it is not available as a substitute. Apparently persuaded that Kaiser has market power as to patients,[11] which is irrelevant, the jury erroneously concluded that Sutter did not have market power and hence could not tie its hospitals to raise prices to health plans.

2. "Unreasonable Course of Conduct" Claim

Verdict Form Question: *Did Sutter force the class health plan to agree to contracts that had terms that prevented the plans from steering patients to lower-cost non-Sutter hospitals within the plan network?* Answer*: No.**[12]*

Jury Instructions (excerpts):

- *Introductory explanation of market power: the concept[ ] of* ***"market power" … appl[ies] to both claims,*** *[which is] the* ***ability to increase prices or reduce output without losing market share*** *(emphasis added)…*
- *Plaintiffs must prove that Sutter and insurance companies entered into agreements that contain terms that* ***prevented the insurance companies from steering patients*** *(emphasis added) to lower-cost non-Sutter hospitals within the health-plan network.**[13]*

Trial Evidence Regarding Sutter's Anticompetitive Conduct:

In addition to the evidence presented on market share (see tying claim above), plaintiffs presented evidence as well as witness testimony from Health Net and BCBS that Sutter would not agree to insurance products that narrow coverage or tier health providers by cost.[14] A few witnesses also testified that these anticompetitive contracting practices were not commonly used by other providers like Adventist, Tenet Healthcare, and Stanford and were unique to Sutter. Sutter attempted to counter these allegations with evidence that such contract terms were not used with CalPERS and Medicare Advantage HMO. Moreover, Sutter argued

that antitrust laws don't require them to agree to every tier or network and that tiered and narrow networks lead to surprise bills for consumers which Sutter didn't want to create.

The jury answered no on the very first question under the unreasonable course of conduct claim—Sutter did not enter contracts that that would prevent health plans from steering patients to lower cost hospitals—and follow-up verdict questions such as anticompetitive effect vs. beneficial effect, damage, and causation were never considered. Again, the issue of market power was at play in this claim, as the introductory jury instructions noted that market power applied to both claims. Sutter repeatedly emphasized the market share of Kaiser to convince the jury that Sutter did not have market power and thus could not force insurers to agree to anticompetitive terms that prevent tiering and steering, which likely played a big role in the jury's verdict on this question. However, as raised in plaintiffs' objections to the final jury instructions, market power is not a requirement for the unreasonable course of conduct claim and thus the jury instructions improperly stated "the concept of market power applies to both [ ] claims."[15]

Also notably missing from the instructions was consideration of anticompetitive purpose to Sutter's conduct, as required under California law.[16] In addition to anticompetitive effects, the purpose and history of the restraint is a factor routinely considered in antitrust rule of reason and monopolization cases. As such, the court's exclusion of evidence regarding the conditions "before and after" the restraint will likely be one of the issues raised on appeal.

Reactions and Implications

The outcome of the jury verdict has many healthcare and antitrust experts scratching their heads but also highlights the uncertain nature of litigation, particularly in a jury case. Plaintiffs had hoped that a jury made of laypersons would sympathize with the class plaintiffs as average consumers and find that Sutter's practices in overcharging for healthcare services were anticompetitive and egregious. At the same time, however, Sutter took advantage of the layperson's common knowledge of the presence of Kaiser Permanente in Northern California to

drive home the notion that Sutter did not have the required market power for anticompetitive contracting given Kaiser's market share. The question of who is the relevant purchaser of Sutter's services, the health plan or patients, for purposes of considering market power and competition can be confusing and understandably challenging for the average juror with no legal or economic background, especially when Sutter's defense purposely muddled the analysis to their advantage. In fact, some have argued that even judges find the complex economic analyses required in these types of cases difficult to wade through.[17] In that sense, it is not surprising that a jury did not return a verdict that antitrust experts would have expected.

This appeal marks a return of *Sidibe v. Sutter Health* to the 9th Circuit Court, as the case had appeared in the appeals court in July 2016 after initially being dismissed in the lower court for insufficient relevant market definitions and factual allegations.[18] Having gained a greater profile and national attention, there is much more on the line now that *Sidibe* is back to the 9th Circuit for a second time. Importantly, some of the conduct alleged in this case—all or nothing, anti-steering, and anti-steering contracting—are tools that are used by other large health systems and have drawn the attention of state legislators.[19] If plaintiffs lose the appeal, it would no doubt have far-reaching ramifications including a chilling effect that could weaken the resolve of private plaintiffs and attorneys to bring similar cases in the future. On the other hand, a win for plaintiffs on appeal would not only set important legal precedents but also encourage more private actions in healthcare antitrust against large health systems like Sutter to help rein in potential anticompetitive behavior. Stayed tuned to The Source's Sutter Case Watch for detailed analysis of legal arguments as plaintiffs file their upcoming appellate brief in the Ninth Circuit.

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[1] Demand for jury trial pursuant to Rule 38(b) of the Federal Rules of Civil Procedure on all triable claims asserted in the Complaint.

[2] Order, *Sidibe et al. v. Sutter Health*, No. 12-cv-04854 (October 28, 2021).

[3] Tara Bannow, *Federal antitrust case against Sutter Health headed for appeal*,

Stat (April 26, 2022).

[4] Verdict Form, *Sidibe et al. v. Sutter Health*, No. 12-cv-04854 (March 11, 2022).

[5] Final Jury Instructions, at 8, *Sidibe et al. v. Sutter Health*, No. 12-cv-04854 (March 7, 2022).

[6] Id. at 10.

[7] See *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015); *FTC v. Penn State Hershey Med. Center,* 838 F.3d 327 (3d Cir. 2016).

[8] Opinion of the Court, at 10, *Federal Trade Commission v. Hackensack Meridian Health, Inc.; Englewood Healthcare Foundation*, USCA No. 21-2603 (Mar. 22, 2022).

[9] Plaintiffs' Closing Argument, at 46-47, *Sidibe et al. v. Sutter Health*, No. 12-cv-04854 (March 9, 2022).

[10] Id. at 55, 60, 70.

[11] Maria Dinzeo, Sutter Health cleared of wrongdoing in landmark antitrust trial, Courthouse News Service (March 11, 2022).

[12] Verdict Form, at 3.

[13] Final Jury Instructions, at 11.

[14] Plaintiffs' Closing Argument, at 114-116.

[15] Plaintiffs' Objections to Final Jury Instructions and Verdict Form, *Sidibe et al. v. Sutter Health*, No. 12-cv-04854 (March 8, 2022).

[16] *Corwin v. Los Angeles Newspaper Bureau*, 4 Cal. 3d 842 (1971).

[17] Michael R. Baye and Joshua D. Wright, *Is Antitrust Too Complicated for Generalist Judges? The Impact of Economic Complexity and Judicial Training on Appeals*, The Journal of Law and Economics, Volume 54, Number 1 (February 2011).

[18] See Amy Y. Gu, *Sidibe v. Sutter Health: The Oldest Chapter in the Sutter Antitrust Saga Sees New Light for Class Plaintiffs*, The Source Blog (May 17, 2021).

[19] Katherine L. Gudiksen, Erin Fuse Brown, and Johanna Butler, *A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts*, NASHP (April 12, 2021).