The Source Looks at Federal Court's Dismissal of Antitrust Class Action Against Sutter

The Source has been following *Sidibe v. Sutter Health*, a putative class action filed in federal court in San Francisco in September 2012, wondering whether it would affect the way hospitals contract with health plans in California and elsewhere. The plaintiffs in the case alleged that Sutter used provisions in its contracts with health plans to create healthcare monopolies and charge above-market prices, which were passed on by the plans to consumers. Seven months after the case was refiled for the second time, on Friday, June 20, the federal district court for the Northern District of California granted defendant Sutter Health's motion to dismiss, this time with prejudice (i.e., the plaintiffs may not refile the case). The following week, on Friday, June 27, the plaintiffs filed their appeal with the Court of Appeals for the Ninth Circuit. On appeal, that Court will review the case *de novo*, meaning it will review the complaint and related motions anew, applying the same standard as the lower court to determine whether the case should have survived the motion to dismiss. If the appellate court does decide that the lower court decided the motion incorrectly, the case will be sent back to the lower court to proceed. This post will take you through the allegations in the case, the court's opinion, and opine in its conclusion what might have changed the outcome.

The Allegations

The plaintiffs, purchasers of commercial health insurance from certain health plans that contracted with Sutter, claim they paid inflated premiums, co-pays, and other charges as a result

of Sutter's anticompetitive conduct. In their third amended complaint, the plaintiffs alleged that Sutter effected its anticompetitive conduct through the provider's contracts with health plans. First, Sutter included "all-or-nothing" clauses in its contracts that required plans to contract for *all* of Sutter's services if it were to buy *any* of those services. The plaintiffs alleged that these clauses resulted in illegal tying arrangements whereby health plans were forced to contract for inpatient hospital services in certain markets as a condition of contracting for those same services in other markets. In other words, if a health plan wanted to include Berkeley, Burlingame, Castro Valley, Davis, Roseville, San Leandro, Tracy, and Vallejo (the "tying markets") in its provider network, it would also have to include San Francisco, Oakland, Sacramento, Modesto, and Santa Rosa (the "tied markets"). The plaintiffs claimed that the tying markets are where Sutter has market power, which is generally defined as the ability to raise the price of a good or service without affecting the demand for it. Accordingly, those markets are where Sutter could charge the highest prices. The plaintiffs alleged that Sutter used the "all-or-nothing" clauses in the geographic tying scheme to leverage that market power to also charge higher prices in markets where the provider faced more competition (and therefore could not charge such high prices). Under the alleged scheme, Sutter would force the health plans to contract for services in the tied markets, and then would charge the plans the same high prices it charged in the tying markets.

Second, the plaintiffs alleged that Sutter used a second anticompetitive contractual strategy called an "anti-steering" clause, which prevented health plans from encouraging their members to seek care from other lower-cost, in-network providers. Under the contracts, the health plans would be penalized with higher rates for failing to "actively encourage" members to use Sutter services, as opposed to cheaper alternatives.

The legal claims included in the third amended complaint are: (1) unlawful tying (*per se* or rule of reason) in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1|(2) "Section 1 Course of Conduct" that causes an unreasonable restraint of trade|(3) unreasonable restraint of trade in violation of the Cartwright Act, Cal. Bus. &amp|Prof. Code Section 16720, et. seq.|(4)-(5) monopolization and attempted monopolization in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2|and (6) unfair competition in violation of California's Unfair Competition Law, Cal. Bus. &amp|Prof. Code Section 17200, et. seq. TAC ¶¶ 116-62. Plaintiffs sought monetary damages (including treble damages as appropriate), restitution, disgorgement, injunctive and declaratory relief, and fees, costs, and interest.

Sutter's Motion to Dismiss

Sutter moved to dismiss the third amended complaint on several grounds. First, Sutter challenged the sufficiency of the relevant market definitions. Second, Sutter argued that the complaint fails to allege that the alleged tying caused anticompetitive effects in the tied products market. Third, Sutter argued that the allegations based on the "anti-steering" clauses fail because the referenced language does not support Plaintiffs' position. Fourth, Sutter argued that the monopolization claim also fails for the same reasons the first three claims fail, and because Plaintiffs have not alleged facts demonstrating that Sutter unlawfully acquired or maintained its monopoly power. Fifth, the attempted monopolization claim fails to allege a "specific intent" to monopolize or a dangerous probability of achieving monopoly power in the Tying Markets. Finally, Sutter argues that Plaintiffs California Unfair Competition Law claim should be dismissed because it is predicated on the other claims, which all fail.

The Court's Ruling

The district court based its dismissal entirely on Sutter's first grounds for dismissal: the plaintiffs failed to allege plausible relevant markets. The court explained that each of the plaintiffs' claims—tying, unreasonable restraint of trade, monopolization, and attempted monopolization—requires that the plaintiffs establish that Sutter had market power in a relevant market. It is up to the plaintiffs to define both a product market and a geographic market in pleading these claims. Sutter did not dispute the plaintiffs' product market definition: the sale of inpatient hospital services to commercial health plans. Accordingly, the court's dismissal of the third amended complaint rests entirely on its finding that the plaintiffs' *geographic* market definition was unsupported by factual allegations.

The plaintiffs pled the geographic markets for the sale of inpatient hospital services to health plans as roughly congruent with "hospital service areas," or HSAs as defined by the Dartmouth Atlas of Health Care. An HSA is a local market for healthcare. It is comprised of the collection of zip codes whose residents receive most of their inpatient hospital services in that area. The plaintiffs encouraged the court to accept the Dartmouth Atlas as a reputable industry source, whose HSA definition is regularly used by policy makers and other legal and economic authorities to assess the economics of hospital markets (although never before used by a court to define a relevant market in an antitrust action).

The court declined to accept plaintiffs' HSAs as plausible relevant markets. It was dissatisfied with the plaintiffs' failure to allege facts that supported its claim that the HSAs were appropriate markets for antitrust purposes. In an antitrust case, typically a court defines the geographic market by looking to see whether buyers substitute for products supplied by a different region when a seller raises the price of local goods in a small but significant way (this is called a small, significant non-transitory increase in

price, or “SSNIP” and the analysis is called the “hypothetical monopolist test”). If buyers do substitute in response to the change, the proposed market definition is incorrect. The court noted that plaintiffs asserted that there were “no economic substitutes” for the services provided in the alleged geographic markets|however, the court repeatedly bemoaned the plaintiffs’ lack of factual support for its proposed HSA market definition. The court found that the plaintiffs argued that the court should accept geographic markets defined by where health plan members *actually* go for Inpatient Hospital Services and not where they *could* go in response to an SSNIP.

Conclusion

The upshot of the opinion is that the plaintiffs asked the court to accept an unorthodox measure for antitrust markets in healthcare, and the court was not persuaded by the plaintiffs’ arguments to break faith. Ultimately, it seemed that had the plaintiffs made greater efforts to assure the court that their geographic market definition passed the hypothetical monopolist test by alleging more facts about the economics of healthcare in Northern California, they might have survived the motion. Allegations that focused on the availability of substitute products, perhaps pled through facts gathered by an economist might have helped (if they indeed bore out that the HSAs constituted appropriate geographic markets). In the end, the court appeared willing, but unable to allow the case to proceed with the facts as pled by the plaintiffs. The Source will continue to track this important case as it goes before the Ninth Circuit. The plaintiffs’ opening brief is due October 6, 2014.