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CLIENT ALERT

Court Preliminarily Approves $575 Million Antitrust Settlement Limiting Sutter Health's Contracting Practices, While Another Grants Partial Summary Judgment for Sutter

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A California state court has preliminarily approved a settlement of an antitrust suit by the state and class action plaintiffs against Sutter Health that will require the health system to pay $575 million and make significant changes to its contracts with payers. The suit and settlement stem from allegations that Sutter's system-wide contracting, anti-steering/tiering terms, and other contract terms violated state antitrust laws. Meanwhile, in a parallel federal class action, a judge has granted in part and denied in part Sutter's motion for summary judgment on federal antitrust claims involving those same practices. These cases, along with a similar prior case that was settled in North Carolina, show that healthcare providers with a significant presence in local markets face increased antitrust scrutiny of their contracting practices and may bolster payers'—and antitrust enforcers'—willingness to challenge those practices.

State Case Settlement

On March 9, 2021, Judge Anne-Christine Massulo of the San Francisco Superior Court, preliminarily approved a settlement in a consolidated antitrust case (*UFCW & Emps. Benefit Tr. v. Sutter Health*) brought by California Attorney General Xavier Becerra and a union against Sutter Health, the largest hospital system in Northern California. The plaintiffs alleged that Sutter violated state antitrust laws (Cartwright Act), resulting in inflated prices for healthcare services, by leveraging its market power and engaging in a combination of the following contracting practices:

- **"All or Nothing" Terms.** Sutter's contracts with payers allegedly required payers to include all Sutter hospitals and providers in their provider networks or none. Plaintiffs alleged that the effectiveness of these terms were reinforced by Sutter's imposition of excessive out-of-network prices where the in-network rates do not apply.
- **Anti-Tiering/Anti-Steering Terms.** Sutter's contracts allegedly prohibited payers from offering incentives to patients to utilize lower-cost or higher-quality provider competitors of Sutter through steering or tiering. Other contracts allegedly contained such severe penalties—such as near elimination of payers' negotiated price discounts—that the terms effectively foreclosed the commercial viability of payers incentivizing more cost-effective or better-quality provider choices.
- **"Price Secrecy" Terms**. Sutter allegedly prohibited payers from disclosing the price of Sutter's healthcare services to anyone, including self-funded employer payers, before the services were utilized and billed. The plaintiffs alleged that this left self-funded payers and enrollees unable to compare Sutter's prices to its competitors' prices.

Additionally, the complaint alleged that Sutter Health used the excessive profits received through its illegal practices for "waves of acquisitions, extreme levels of executive compensation, and financing its own insurance arm."

The key terms of the preliminarily approved settlement require Sutter to:

- Make a $575 million payment to employers, unions, and others covered under the private class action;
- Cease "all or nothing" contracting practices, thereby allowing insurers to contract with discrete Sutter inpatient and outpatient facilities, rather than all;
- Stop anti-steering/tiering contract terms in order to allow payers to steer patients to lower cost providers and to place Sutter providers in less attractive tiers of tiered networks;
- Stop bundling provider services unless a standalone price is also separately offered that is lower than the bundled-services price;
- Allow payers and employers to share pricing and quality information with plan members;
- Limit out-of-network charges to patients where Sutter's in-network rates do not apply, in an attempt to protect patients from unexpectedly costly medical bills;
- Establish definitions for clinical integration that require close coordination resulting in less costly, higher quality care, in order to ensure that "mere" sharing of electronic health records and claims of regional closeness do not mask market consolidation; and
- Cooperate with a court-appointed monitor who will oversee Sutter's business practices for the next ten years to ensure compliance with the terms of the settlement.

A hearing for final approval of the settlement is set for July 19, 2021.

Partial Summary Judgment in Federal Case

Notably, on the same day that the state court preliminarily approved the settlement, the U.S. District Court for the Northern District of California, in a parallel federal class action (*Sidibe v. Sutter Health*), granted Sutter partial summary judgment dismissing plaintiffs' Sherman Act § 2 monopolization and attempted monopolization claims, but rejected Sutter's bid for summary judgment on Sherman Act § 1 and Cartwright Act claims. In the federal case, plaintiffs alleged that Sutter's contracting practices constituted an unlawful tying arrangement, which required payers to contract with Sutter hospitals in areas where there were competing alternatives, if payers wanted to contract with Sutter's "must have" providers in other areas.

The court granted summary judgment to Sutter on the monopolization claim because, although there was a material dispute about whether Sutter had monopoly power, the plaintiffs did not produce evidence showing disputed issues of material fact that Sutter willfully acquired or maintained monopoly power. The court ruled for Sutter on the attempted monopolization claim because plaintiffs had provided no evidence that Sutter had a "dangerous probability of monopolization" in light of Sutter's flat or declining market share.

The court, however, denied Sutter's motion for summary judgment on the Sherman Act § 1 and Cartwright Act claims because there was a material dispute about whether Sutter's contracting practices constituted unlawful tying or an unlawful course of conduct.

Takeaways

Attorney General Becerra has signaled that the state is focused on ensuring that "dominant" healthcare providers in California do not engage in anticompetitive conduct that limits competition, impairs consumer choice, and results in higher prices for

healthcare services. Combined with a prior enforcement action brought by the Antitrust Division of the U.S. Department of Justice and the State of North Carolina alleging similar contracting practices by Atrium Health, which also resulted in a settlement, these actions show that federal, state, and private antitrust enforcers are actively scrutinizing—and challenging—provider contracts that may limit payers' ability to selectively contract with and tier providers, or their ability to steer and provide price information to enrollees.

Consequently, health systems and payers should be aware that antitrust enforcers are likely to give greater scrutiny to contract terms when (1) the provider is a large health system spread across multiple geographies, (2) the provider has a high market share in at least one of those markets, and (3) the contract contains one or more of the following terms:

- Requires all-or-nothing contracting for all of the health system's providers;
- Restricts payers from tiering or steering away from the health system or, alternatively, that require the health system to be in the most favored tier;
- Prevents payers from providing price, cost, or quality information to enrollees; and/or
- Contains significantly high out-of-network rates for facilities or products for which contractual rates do not apply, especially when combined with the provisions above.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Alexis J. Gilman
Partner – Washington, D.C.
Phone: +1.202.624.2570
Email: agilman@crowell.com

Brian C. Lewis
Counsel – Washington, D.C.
Phone: +1.202.624.2962
Email: blewis@crowell.com