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13 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**

14 **FOR THE CITY AND COUNTY OF SAN FRANCISCO**

15 **CGC-18-565398**

16 **PEOPLE OF THE STATE OF**
17 **CALIFORNIA EX REL. XAVIER BECERRA,**
18 **Plaintiff,**
19 **v.**
20 **SUTTER HEALTH,**
21 **Defendant.**

**COMPLAINT FOR VIOLATIONS OF
THE CARTWRIGHT ACT (BUS. &
PROF. CODE § 16720 et seq.)**

22 California Attorney General Xavier Becerra brings this civil antitrust action on behalf
23 of the People of the State of California, in his law enforcement capacity, to enjoin defendant
24 Sutter Health and its affiliates ("**Sutter**") from unlawful conduct in violation of California's
25 Cartwright Act, for disgorgement of overcharges, and to restore competition in healthcare
26 markets in California. The People of the State of California, ex rel. Xavier Becerra, Attorney
27 General ("**the People**") allege the following:
28

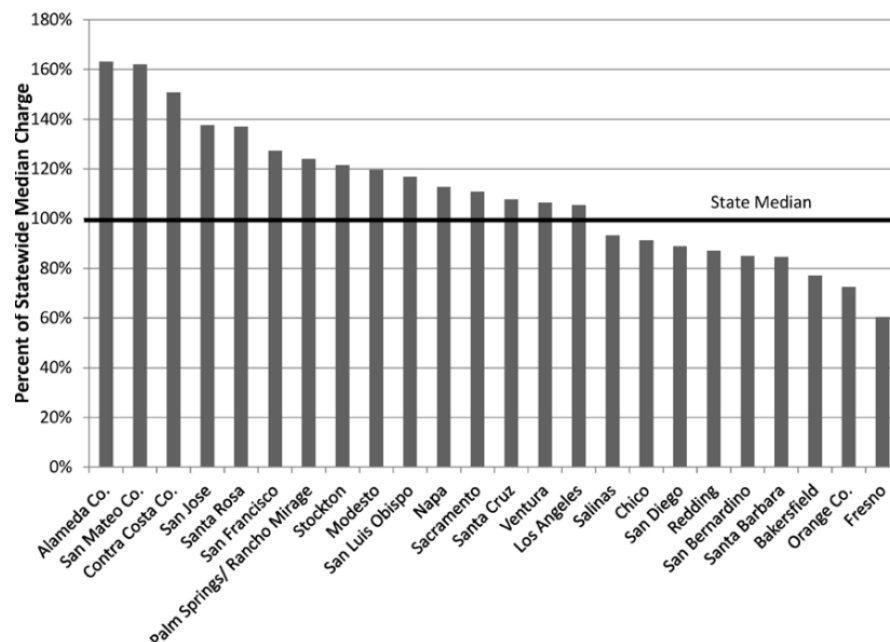
I. INTRODUCTION

1. Healthcare costs in California have rapidly increased, far outstripping population growth or inflation. For example, hospital revenue in California over the ten-year period from 1999-2009 increased 111% while population increased some 15% during the same time period and utilization of hospitals only increased from 4% to 9%.

2. Healthcare costs in Northern California are higher than in other areas of the state. This is a trend that has long existed. For example, a March 2011 analysis from *The Los Angeles Times* concluded that “[o]n average, hospitals in Northern California’s six most populous counties collect **56% more revenue** per patient per day from insurance companies and patients than hospitals in Southern California’s six largest counties”

3. A July 2012 CALPIRG Education Fund report focused on the significant geographic variation in hospital charges in California for common, elective, inpatient surgeries performed at hospitals across the state—and created an index set forth below that can be used to compare charges for the 12 most common surgeries by regions:

Charge Index for 12 Common Surgeries by Region



4. These increased healthcare costs in Northern California endure today. For example, a 2015 study found that insurance premiums offered through Covered California,

1 the state-run health insurance Exchange established by the Affordable Care Act, are 16 to 48
2 percent more expensive in San Francisco than in Southern California.

3 5. In turn, these increased healthcare costs have adverse consequences for the
4 general economy of Northern California and thus for the state as a whole. Most employer-
5 sponsored insurance requires cost-sharing, through contributions towards premiums,
6 deductibles, coinsurance and other out of pocket costs for employees. Higher prices from
7 health care providers can thus be passed on to employees through each of these cost-sharing
8 arrangements.

9 6. Moreover, economists have shown that when health insurance premiums increase,
10 workers' wages fall or rise more slowly. Thus, higher prices from health care providers
11 further harm workers by increasing premiums and thus placing downward pressure on
12 wages. This implies that every excess dollar that health care providers charge insurers for
13 treating enrollees in employer-sponsored plans comes, to a large extent, directly out of
14 workers' pockets. Rising premiums may affect workers in other ways with one Harvard
15 University study estimating that, on average, the effects of a 10% economy-wide increase in
16 health insurance premiums include the following:

- 17 • A 1.2 percentage point reduction in the aggregate probability of employment;
- 18 • Among the employed population, a 1.9 percentage point reduction in the probability of
- 19 working full time instead of part time;
- 20 • A 2.4% reduction in hours worked; and
- 21 • Among workers who have insurance coverage, a 2-3% decrease in wages.

22 7. Economic studies have found that the increased costs in providing healthcare
23 services that arise from increased market concentration do not lead to improvements in the
24 quality of healthcare.

25 8. That these increased costs are due to increased market concentration in healthcare
26 provider markets in Northern California, and no other factors, has been observed by studies
27 and public analysis. For example, a 2018 study found unadjusted inpatient procedure prices
28 are 70% higher in Northern California than Southern California corresponding to hospital market

1 concentration being 110% higher in Northern California than Southern California, while input
2 cost adjusted inpatient procedure prices are 32% higher in Northern California than Southern
3 California.

4 9. Much of the increased cost of healthcare in Northern California is attributable to
5 Sutter and its anticompetitive contractual practices which it has imposed as a result of its
6 market power. Specifically, Sutter embarked on an intentional, and successful, strategy of
7 securing market power in certain local markets in Northern California.

8 10. Sutter's market power in certain markets has enabled it to increase prices, and
9 thus costs, for its healthcare services. A 2008 U.S. Federal Trade Commission retrospective
10 study of the merger of Alta Bates, owned by Sutter, and Summit Medical Center found that
11 the contracted price increases for Summit following the merger ranged from approximately
12 29% to 72% depending on the insurer, compared to approximately 10% to 21% at Alta
13 Bates, and that the Summit post-merger price increases were among the highest in California.

14 11. Even though Sutter intentionally embarked on its strategy of acquiring market
15 power at the time of that merger, the district court reviewing the Attorney General's legal
16 challenge to that merger found that Sutter would be unable to use its market power to raise
17 prices because insurers could employ steering and tiering practices to incentivize patients to
18 use lower-cost alternatives to Alta Bates or Summit for medical care. As the district court
19 explained in relying on Sutter documents and Sutter expert testimony:

20 When faced with price increases, there are numerous mechanisms through
21 which health plans can discipline hospitals. (Defs.' Ex. 1021; Defs.' Ex. 1012,
22 Decl. of Jay M. Gellert at 14–15; Hr'g Tr. at 716:18–718:17.) The simplest, but
23 rarely used, is to exclude hospitals from the plans' provider networks. (Defs.'
24 Ex. 1026, Dep. of John Sweeney at 17–21.) The primary mechanism by which
25 MCOs and IPAs keep prices low is through the “steering” of patients. In
26 managing their patients' illnesses, physicians are often responsible for deciding
27 the components to be used in providing treatment, including the hospitals to
28 which their patients are admitted. In steering, MCOs or IPAs provide incentives
to or direct physicians to refer their patients to certain hospitals. Such incentives
may include direct financial incentives as well as more general risk-sharing
arrangements that reward physicians for providing care in the most cost-

1 effective environment. When faced with rising prices, MCOs can attempt to
2 steer patients to lower cost health care providers and away from the hospital
3 imposing a price increase, thereby pressuring the hospital to eliminate the price
4 increase. (Defs.' Ex. 1013, Pugh Report ¶ 57.) As one witness who has been on
5 both sides of the table explained, “there is a discipline going both ways” because
6 “we need them, but simultaneously they need us.” (Defs.' Ex. 1012, Gellert Decl.
7 at 18, 40.)

8 Hospitals, in general, have high fixed costs, both in terms of the physical plant
9 and equipment as well as the high cost of maintaining a highly skilled staff. At
10 the same time, their profit margins are thin. (Hr'g Tr. at 508:3–12; 706:21 –
11 707:17; Defs.' Ex. 1013, Pugh Report ¶ 59; Defs.' Ex. 1001, Guerin–Calvert
12 Report ¶ 63.) Steering has been quite effective in disciplining prices because
13 hospitals are sensitive to declines in volume. (Defs.' Ex. 1001, Guerin–Calvert
14 Report ¶¶ 63–64; Defs.' Ex. 1013, Pugh Report ¶¶ 59–61; Defs.' Ex. 1012,
15 Gellert Decl. at 14.)

16 12. Thus, Sutter understood and argued to that court that steering and tiering by
17 insurers are important tactics by which insurers can provide access to competitively priced
18 healthcare services and provide insurers with bargaining leverage against healthcare
19 providers with dominant positions in local markets.

20 13. But through its anticompetitive conduct, Sutter leveraged and maximized its
21 market power in certain local healthcare markets across all markets and prevented insurers
22 from using steering and tiering to counter its excessive pricing. And it cloaked its conduct to
23 prevent awareness by employers, enrollees, and the public. Sutter is not merely a provider
24 with a few hospitals or one whose dominance is limited to a county or part of a county with
25 geographical impediments preventing easy access to alternatives. Rather, Sutter became a
26 large multi-market healthcare system with at least 24 state-licensed hospitals throughout
27 Northern California. Sutter reports that within its network are 24 separately-licensed
28 hospitals and 4,311 acute care beds; 35 outpatient centers; physicians' organizations with
5,500 members and 12,000 other physicians who partner with Sutter; medical research
facilities; region-wide home health, hospice, and occupational health services; and long-term
care centers.

1 14. Multicounty hospital systems with dominance in certain markets have an outsized
2 impact on healthcare costs. In California, multi-county hospital systems as a system have
3 charged higher prices for their services than other providers. A 2016 study conducted by
4 economists analyzed data involving Sutter and another healthcare system finding:

5 Our data show that hospital prices in California grew substantially (+76% per
6 hospital admission) across all hospitals and all services between 2004 and 2013
7 and that prices at hospitals that are members of the largest, multi-hospital
8 systems grew substantially more (113%) than prices paid to all other California
9 hospitals (70%). Prices were similar in both groups at the start of the period
10 (approximately \$9200 per admission). By the end of the period, prices at
11 hospitals in the largest systems exceeded prices at other California hospitals by
almost \$4000 per patient admission.

12 15. Thus, Sutter's illegal anticompetitive conduct on a system-wide basis has
13 discouraged competition, impaired price-conscious consumer choice, and resulted in inflated
14 prices on a system-wide basis that exceed its competitors and exceed the prices its hospitals
15 and its other providers could charge in a free, competitive market. Sutter's conduct injured
16 the general economy of Northern California and thus of the state.

17 16. Sutter employs its surpluses from its excessive pricing in several ways. It uses
18 them to finance succeeding waves of acquisitions of healthcare providers. It spends surplus
19 funds to implement and expand its money-losing and so-far-unsuccessful Commercial
20 Insurance Plan. It also uses its windfall to bestow extremely high salaries for its officers and
21 upper management as set out in its Form 990 filings. These expenditures of funds correspond
22 with anticompetitive monopolist behavior in which excessive surpluses can go to protect or
23 enhance market power, to wasteful innovation, or to further inequality.

24 17. Sutter need not engage in anticompetitive conduct and charge excessive prices to
25 be included in the provider networks of Network Vendors in order to fund the seismic
26 retrofitting of its hospitals.

1 18. Sutter need not engage in anticompetitive conduct and charge excessive prices to
2 be included in the provider networks of Network Vendors.

3 19. Sutter need not engage in anticompetitive practices and charge excessive prices to
4 be included in the provider networks of Network Vendors in order to cover its Medicare and
5 Medicaid patients.

6 **II. SUMMARY OF FACTUAL ALLEGATIONS**

7 20. Millions of people employed in Northern California, and often their dependents,
8 are enrolled, as a benefit of employment, in group health insurance plans that pay for the
9 medical services and healthcare products they require (“**Health Plans**”). Each Health Plan
10 allows its individual enrollees (“**Health Plan Enrollees**”) to obtain general acute care
11 hospital services (including inpatient and outpatient services) and ancillary services (such as
12 x-rays and diagnostic testing) from a select group of hospitals, ambulatory surgery centers,
13 and other healthcare facilities (together “**Healthcare Providers**”) at established rates.

14 21. Sometimes those healthcare benefits are funded directly by the Health Plan
15 Enrollee’s employer (the “**Employer**”). Sometimes the healthcare benefits are funded
16 instead through a trust that is established and maintained under the terms of a collective
17 bargaining agreement between a labor union and one or more Employers (a “**Healthcare**
18 **Benefits Trust**”).

19 22. Each Health Plan has a network of Healthcare Providers that collectively provide
20 Health Plan Enrollees with reasonable access to the eligible healthcare services and ancillary
21 products they are likely to require (a “**Provider Network**”).

22 23. There is a small group of specialized insurers that possess the expertise necessary
23 to develop and assemble Provider Networks that will be useful to all of the people enrolled in
24 the Health Plans offered by a variety of Employers and Healthcare Benefits Trusts operating
25 in a variety of locations in Northern California (“**Network Vendors**”).

26 24. Network Vendors are in the business of assembling Provider Networks and
27 negotiating the prices for the services and products sold by the Healthcare Providers that are
28 included in those networks. The Network Vendors then offer Employers and Healthcare

1 Benefits Trusts access to the Provider Networks they have created so that, in turn, the
2 Employers and Healthcare Benefits Trusts may offer healthcare coverage to their Health Plan
3 Enrollees as a benefit of employment. The Network Vendors operating in Northern
4 California include such insurers as Blue Shield of California, Anthem Blue Cross, Aetna,
5 CIGNA, United Healthcare.

6 25. Many Employers and Healthcare Benefits Trusts prefer to pay Healthcare
7 Providers for their services and products out of their own funds (**“Self-Funded Payors”** also
8 known as **“self-insured entities”**). Self-Funded Payors enter into contracts with Network
9 Vendors to obtain access to their pre-assembled Provider Networks. Often, they also
10 purchase specified Health Plan administrative services from the chosen Network Vendor.
11 Approximately 50 percent of California’s workers now receive healthcare benefits for
12 themselves-and often their dependents-through Self-Funded Payors.

13 26. Some Employers and Healthcare Benefits Trusts prefer to purchase a healthcare
14 insurance policy (**“Commercial Healthcare Insurance”**) on behalf of their Health Plan
15 Enrollees, often from a Network Vendor that also is in the business of selling insurance
16 coverage (a **“Commercial Insurance Company”**). Thereafter, the Commercial Insurance
17 Company is solely responsible for paying the costs of healthcare services and products that
18 are covered by Commercial Healthcare Insurance. Employers and Healthcare Benefits Trusts
19 that purchase Commercial Healthcare Insurance make regular insurance premium payments
20 to a Commercial Insurance Company to obtain a risk avoidance product that insulates them
21 from any liability to Healthcare Providers for the cost of the healthcare services and ancillary
22 products utilized by their Health Plan Enrollees.

23 27. Regardless of whether healthcare benefits are provided to Health Plan Enrollees
24 in the form of payments to Healthcare Providers out of the funds of a Self-Funded Payor or
25 in the form of a Commercial Healthcare Insurance policy that makes the necessary payments
26 to the Healthcare Providers, the prices charged by a hospital Healthcare Provider will be the
27 prices that were previously established through negotiations between the hospital and the
28 Network Vendor. Those negotiations begin with the hospital’s list of undiscounted prices for

1 all of the healthcare services and ancillary products the hospital offers (the
2 **“Chargemaster”**). The Network Vendor then negotiates simplified pricing arrangements
3 that generally result in pricing that is significantly lower than the undiscounted prices listed
4 in the hospital’s Chargemaster. Instead of agreeing to the separate individual prices for each
5 item included on the Chargemaster, the Network Vendors can negotiate formulas for
6 determining lower reimbursement rates for broad categories of services and products.

7 28. The creation of Health Plans that are sufficiently comprehensive to address the
8 healthcare needs of a variety of Health Plan Enrollees and sufficiently useful to a variety of
9 Employers and Healthcare Benefits Trusts operating in different locations requires Network
10 Vendors to contract with numerous Healthcare Providers and negotiate pricing that will
11 apply to all of the healthcare services and products they offer.

12 29. Since at least 2002, Sutter has compelled all, or nearly all, of the Network
13 Vendors operating in Northern California to enter into unduly restrictive and anticompetitive
14 written Healthcare Provider agreements that have:

- 15 • Established, increased and maintained Sutter’s power to control prices and
- 16 exclude competition;
- 17 • Foreclosed price competition by Sutter’s competitors; and
- 18 • Enabled Sutter to impose prices for hospital and healthcare services and
- 19 ancillary services that far exceed the prices it would have been able to charge in
- 20 an unconstrained, competitive market.

21 30. The impetus for including anticompetitive terms in the agreements between
22 Sutter and the Network Vendors comes entirely from Sutter. In many respects, the
23 anticompetitive terms harm the Network Vendors. The offending terms constrain the types of
24 Provider Networks the Network Vendors can offer to their customers and severely limit the
25 ability of Network Vendors to promote price competition among hospitals and between
26 hospitals and other providers. Moreover, because most Network Vendors also sell
27 Commercial Healthcare Insurance, the higher hospital prices that result from the
28 anticompetitive terms are and will be borne by the Network Vendors, and/or will be passed-

1 on to Self-Funded Payors when the enrollees in their Commercial Healthcare Insurance plans
2 choose Sutter hospitals as their Healthcare Providers. No Network Vendors would have
3 agreed to the offending contract terms if Sutter did not insist upon them. However, Network
4 Vendors are coerced and/or compelled to agree to Sutter's terms.

5 31. Sutter exerts control over the sale of general acute care hospital services
6 (including inpatient and outpatient services) and ancillary services in Northern California
7 through the anticompetitive terms of its contracts with the Network Vendors. Sutter has the
8 power to impose those anticompetitive contract terms for all of its providers because there
9 are geographic markets for hospital healthcare within Northern California where Sutter has
10 "must have" hospitals, that is hospitals desired by employees because of referrals, reputation,
11 or the lack of alternatives in their geographic location, such that it would be impossible to
12 assemble a viable healthcare Provider Network in those markets without including those
13 Sutter hospitals. Sutter's market power in those specific geographic markets is magnified by
14 the disruption that would be caused to any Health Plan that is forced to simultaneously
15 exclude all of Sutter hospitals from its Provider Network. Sutter uses its resulting economic
16 power to compel acceptance of anticompetitive contract terms that are applied to all of its
17 providers in all geographic markets in Northern California.

18 32. Sutter's illegal conduct has allowed Sutter to impose prices for its healthcare
19 services above competitive levels.

20 33. There is no legitimate explanation for Sutter's persistent ability to so thoroughly
21 immunize itself from price competition other than the illegal and anticompetitive conduct
22 described in this complaint.

23 34. The anticompetitive agreements that Sutter imposes upon the Network Vendors
24 leave Self-Funded Payors, Healthcare Benefits Trusts, and other Employers with no
25 alternative other than to pay Sutter's illegally inflated prices. Those contracts make it
26 impossible for Self-Funded Payors and others to offer their Health Plan Enrollees a Provider
27 Network that substitutes the hospital services of high-quality and/or lower-priced, hospital
28 and non-hospital competitors for the costlier services provided at Sutter's hospitals. Sutter's

1 illegal contracts also expressly prohibit any effort to incentivize Health Plan Enrollees to
2 choose a lower-priced or higher quality hospital, ambulatory surgery center, ancillary service
3 provider, or other healthcare provider over a competing Sutter hospital.

4 35. Specifically, Sutter has successfully demanded that all, or nearly all, of its
5 contracts with the Network Vendors include implicitly or explicitly:

- 6 a. A de facto anticompetitive agreement requiring that all Sutter Hospitals and
7 Healthcare Providers throughout Northern California be included in the
8 Provider Network. Sutter thereby abuses its market power derived from its
9 “must have” hospitals, or other “must have” providers in some geographic
10 areas, to force Health Plans to include all Sutter hospitals and Healthcare
11 Providers in their Healthcare Provider Networks—even those Sutter hospitals
12 and providers that are located in areas where it would be far less costly to
13 assemble a Provider Network using Sutter's lower-priced and/or higher-
14 quality competitors instead of Sutter;
- 15 b. An anticompetitive agreement that prohibits anyone offering access to a
16 Provider Network from giving incentives to patients that encourage them to
17 use the healthcare facilities of Sutter’s competitors—even when those
18 competitors could offer higher quality healthcare and/or lower pricing; and
- 19 c. An anticompetitive agreement requiring that Sutter’s inflated prices for its
20 general acute care hospital services (including inpatient and outpatient
21 services) and ancillary and other provider services may not be disclosed to
22 anyone before the service is utilized and billed. The inflated pricing in
23 Sutter’s agreements with the Network Vendors is thereby concealed from
24 everyone else—including historically from the Self-Funded Payors and
25 Healthcare Benefits Trusts that ultimately would have to pay those prices.

26 36. Each of Sutter’s anticompetitive contract terms works in combination with the
27 others to mutually reinforce and enhance their collective anticompetitive effects. Together,
28

1 they allow Sutter to leverage its market power in certain Northern California local markets to
2 illegally create and/or enhance market power in other local markets. They also create barriers
3 to entry and expansion for existing and potential general acute care competitors (hospitals,
4 ambulatory surgery centers, and non-hospital providers of ancillary services) in each of the
5 geographic markets where Sutter's hospitals are located. Those barriers are utilized by Sutter
6 to illegally maintain and increase its market power in all of its locations and to leverage
7 further that market power as to other healthcare services that it provides.

8 37. Because of Sutter's anticompetitive contract terms, patients have no ability and
9 little or no incentive to choose a better-quality and/or lower-cost competing hospital or other
10 provider over Sutter's hospitals based upon the competing provider's lower prices. Sutter
11 thereby gains the power to illegally insulate itself from the price competition that otherwise
12 would be present in an unfettered free market. As a result, Sutter's competitors cannot
13 effectively compete based on price or quality, allowing Sutter to charge and maintain system-
14 wide prices at levels that are significantly higher than the prices currently charged by its
15 Northern California healthcare competitors and substantially higher than those that could be
16 charged in a competitive market that is unconstrained by Sutter's illegal conduct.
17 Collectively, Sutter's anticompetitive contract terms unreasonably restrain price competition
18 among general acute care hospitals, between hospitals and ambulatory surgery centers for
19 outpatient surgery services, and between hospital and non-hospital ancillary service
20 providers, in Northern California and enable Sutter to price its general acute care services
21 (including inpatient and outpatient services), and ancillary and other provider services at
22 artificially inflated levels.

23 38. Sutter's illegally inflated pricing has had a direct negative economic impact on
24 the Self-Funded Payors and Healthcare Benefits Trusts that directly pay for Sutter's
25 healthcare services, and an indirect negative economic impact on other Employers. This has
26 caused substantial damage to each of them and to the general economy of the state.

27 39. This lawsuit seeks to obtain equitable nonmonetary and monetary relief from
28 Sutter's anticompetitive agreements and practices, as herein alleged.

1 **III. JURISDICTION AND VENUE**

2 40. This action is brought under the Cartwright Act, Cal. Bus. & Prof. Code § 16720,
3 *et seq.* for equitable non-monetary and monetary relief due to Sutter’s unlawful conduct.

4 41. This Court has personal jurisdiction over Sutter because Sutter and its affiliates
5 do business in the state of California, the claims asserted herein arise from conduct occurring
6 in California, and the Court has before it the related case *UFCW & Employers Benefit Trust*
7 *v. Sutter Health, et al.* (“UEBT” case), Case No. CGC 14-53841.

8 42. Venue is proper in the City and County of San Francisco because Sutter does
9 business in San Francisco.

10 43. Venue is further proper in the City and County of San Francisco because acts
11 giving rise to the claims asserted herein were committed in San Francisco.

12 **IV. THE PARTIES**

13 **A. The Plaintiff – The People of the State of California ex rel. Xavier**
14 **Becerra**

15 44. Xavier Becerra is the Attorney General of the State of California (“the Attorney
16 General”) and is the chief law enforcement officer of the State under the California
17 Constitution, Article V, Section 13. The Attorney General is authorized to bring an action for
18 equitable nonmonetary and monetary relief under the Cartwright Act on behalf of the People
19 under Business & Professions Code sections 16750, 16754, and 16754.5. This authorization
20 includes securing mandatory injunctions to restore and preserve fair competition under
21 Business & Professions Code section 16754.5 in addition to prohibitory injunctions. The
22 Attorney General has a unique role in representing the People and the State of California in
23 antitrust cases in carrying out the public interest in this state, particularly where equitable
24 actions are concerned. (See Bus. & Prof. Code, §§ 16750, subds. (b), (c), 16754.5; *see also*
25 *D’Amico v. Bd. of Medical Examiners* (1974) 11 Cal.3d 1, 20; Bus. & Prof. Code, § 16760,
26 subd. (f).)

1 **B. The Defendant**

2 45. Sutter Health is a non-profit corporation, organized and existing under the laws of
3 the State of California, with its principal place of business located in Sacramento, California.
4 Sutter was incorporated in California in September 1981.

5 46. Sutter is the largest and most dominant healthcare provider in Northern
6 California. According to its own current report on its website, it has as of today a chain of at
7 least 24 separately licensed hospitals; physicians' organizations with more than 5,000
8 members; medical research facilities; region-wide home health, hospice, and occupational
9 health networks; and long-term care centers. In 2016, Sutter had 53,000 network and affiliate
10 employees and controlled 4,311 acute beds.

11 47. Beginning in the 1990s, Sutter implemented a deliberate strategy to achieve
12 market power in particular geographic areas through a campaign of mergers and acquisitions.

13 48. In 1996, Sutter acquired the California Healthcare System, an affiliated hospital
14 group including California Pacific Medical Center in San Francisco, Mills-Peninsula
15 Hospital in San Mateo, and Alta-Bates Hospital in Berkeley.

16 49. In 2000, Sutter acquired Summit Medical Center as part of this intentional
17 strategy to acquire market power. Together with Sutter's Alta Bates Hospital this acquisition
18 created a geographic market concentration that proved to have significant pricing impacts
19 that remaining competition was rendered too weak to constrain. As set out in Paragraph 10
20 above, a 2008 Federal Trade Commission retrospective study of the merger found that the
21 contracted price increases for Summit following the merger ranged from 29 to 72 percent and
22 that the Summit post-merger price increases were among the highest in California.

23 50. In its 2011 Annual Report, Sutter reported over \$6.5 billion in net assets,
24 including over \$4.3 billion in cash and marketable securities. In 2015 and 2016, Sutter's net
25 assets, including cash and marketable securities, were \$7.243 and \$7.67 billion respectively.

26 51. In its 2012 Financial Results, Sutter reported operating revenues exceeding \$9.5
27 billion—up nearly \$500 million in just one year. In 2015, total operating revenues were
28

1 reported at more than \$10.9 billion, and in 2016 the non-profit reported its revenues had
2 jumped again to more than \$11.8 billion.

3 52. Sutter has grown from \$6.4 billion in total assets in 2005 to \$15.6 billion in total
4 assets at the end of 2016.

5 53. Sutter is the largest provider of general acute care hospital services and ancillary
6 services in Northern California. In 2016, Sutter had 193,161 hospital discharges, 873,992
7 emergency room visits, and 8,763,470 outpatient visits.

8 54. Sutter provides healthcare services to individuals in more than 100 Northern
9 California cities within the following counties: Yolo, Sutter, Yuba, Nevada, Placer, El
10 Dorado, Amador, Sacramento, Solano, San Joaquin, Stanislaus, Merced, Contra Costa,
11 Alameda, Santa Clara, Santa Cruz, San Francisco, San Mateo, Lake, Napa, Sonoma, Del
12 Norte, and Marin.

13 **V. HOSPITAL HEALTHCARE IN NORTHERN CALIFORNIA**

14 55. There are at least two contractual arrangements that must be in place before any
15 prospective patient is able to use a particular hospital or other Healthcare Provider as an in-
16 network, healthcare employment benefit:

- 17 • A Network Vendor must agree to include the hospital or other Healthcare
18 Provider in its Health Plan Provider Network at pricing levels established
19 through contract negotiations between the hospital or other Healthcare Provider
20 and the Network Vendor.
- 21 • The patient's Employer or Healthcare Benefits Trust must contract for access
22 by its Health Plan Enrollees to the Network Vendor's previously assembled
23 Provider Network.

24 56. Thereafter, as medical needs arise, Health Plan Enrollees must select the hospital
25 or other Healthcare Provider from which they want to obtain the needed healthcare services.

26 57. A hospital can be a "must have" hospital. A "must have" hospital is a hospital
27 that Network Vendors have to include in their provider network for that network to be
28 commercially viable. A hospital can be a "must have" because of physician referrals,

1 reputation, or the lack of alternatives in a geographic location. Likewise, other healthcare
2 providers such as an ambulatory surgery center or physicians' group could be a "must have"
3 provider because of physician referrals, reputation, or the lack of alternatives in a
4 geographical location. Ownership of a "must have" hospital or other healthcare provider can
5 give a Healthcare Provider market power.

6 58. A **Hospital System** is created when "two or more hospitals are owned, leased, or
7 contract managed by a central organization." A hospital system can include affiliations with
8 physician groups and other facilities. The unique mechanics of the healthcare market
9 provide an opportunity for Hospital Systems owning or controlling "must-have" hospitals
10 with market power to illegally restrain trade for all of their providers in their systems through
11 unduly restrictive agreements with Network Vendors. By requiring Network Vendors to sign
12 contracts that are designed to interfere with the formation of competitive Provider Networks
13 and restrict the incentives that Health Plans can offer their enrollees and restrain price
14 competition, a hospital system like Sutter can improperly limit the ability of rival hospitals,
15 rival Healthcare Providers, as well as rival Hospital Systems as a whole to compete
16 effectively. In this way, Sutter can exert control over the prices for general acute care
17 (including inpatient and outpatient services), ancillary, and other provider services paid by
18 Employers and Healthcare Benefits Trusts.

19 **A. The Formation of Health Plans and Provider Networks**

20 59. Employers and Healthcare Benefits Trusts lack the expertise, personnel, and
21 resources necessary to assemble Provider Networks that are sufficiently broad and
22 geographically dispersed to address all of the expected medical needs of their Health Plan
23 Enrollees. The vast majority of Employers and Healthcare Benefits Trusts also lack the
24 expertise, experience, personnel, and resources necessary to effectively negotiate pricing for
25 all of the healthcare services and products that are likely to be needed by their Health Plan
26 Enrollees. Moreover, it would be economically inefficient and financially unfeasible for each
27 Employer and Healthcare Benefits Trust to separately obtain the expertise, personnel, and
28 resources necessary, to independently assemble their own Healthcare Provider Networks, and

1 to individually negotiate pricing. Hence, Employers and Healthcare Benefits Trusts do not
2 negotiate prices and terms with the Healthcare Providers directly. Instead, they must rely
3 upon Network Vendors that have developed expertise in creating comprehensive Provider
4 Networks and negotiating pricing for all of the services and products sold by the Healthcare
5 Providers included in those networks.

6 60. A Network Vendor's Provider Network will not be useful to Health Plan
7 Enrollees, and therefore will not be commercially viable, unless it covers all of the
8 geographic areas where the Health Plan's Enrollees are likely to need healthcare services. At
9 a minimum, this includes all of the local areas close to where the Health Plan Enrollees live
10 and work, e.g., within a 15-mile /30-minutes travel time from their home or work in an urban
11 area.

12 61. If there are geographic areas where a Network Vendor's Provider Network does
13 not provide access to needed medical services, the network will not be attractive to
14 Employers and Healthcare Benefits Trusts whose Health Plan Enrollees live or work in those
15 geographic areas. A network without such access raises regulatory concerns and can lead to
16 higher expenses for out-of-network emergency medical services.

17 62. In areas where there are multiple hospitals with sufficient existing or potential
18 capacity, a Network Vendor should be able to assemble a viable Provider Network that
19 includes some, but not all, of those hospitals. In those locations, a Network Vendor would
20 have the ability to assemble a more attractive, cost-efficient Provider Network by excluding a
21 particularly expensive hospital to reduce the total cost of healthcare offered through its
22 Provider Network. Under those circumstances, the particularly expensive hospital would
23 have an incentive to respond to the price competition by lowering its prices.

24 63. Conversely, in local areas where one hospital or provider has an overwhelming
25 share of the market as a "must have" due to reputation, referrals, or geographic location,
26 every Network Vendor would need that hospital or provider in its Provider Network in order
27 to offer Employers and Healthcare Benefits Trusts a commercially viable Health Plan.
28

1 64. Where a Network Vendor demands a rate from a provider that is too low for that
2 provider, the provider can refuse to contract with the Network Vendor. Similarly, if a
3 provider demands a rate that is too high, the Network Vendor can refuse to contract with that
4 provider. However, if a provider has acquired “must have” status, it can demand a higher
5 price from the Network Vendor since the Network Vendor must include that provider in its
6 network to be deemed attractive to Employers and Healthcare Benefits Trusts.

7 **B. The Selection of Provider Networks by Employers and Healthcare**
8 **Benefits Trusts**

9 65. Employers and Healthcare Benefits Trusts are able to obtain access to a Provider
10 Network for their workers in one of two ways:

11 **a. Commercial Healthcare Insurance:** Some Employers and Healthcare
12 Benefits Trusts prefer to purchase a risk avoidance product and therefore,
13 obtain a Commercial Healthcare Insurance policy that provides access to a
14 Provider Network but allows them to avoid all responsibility for the risk that
15 healthcare costs for their Health Plan Enrollees will exceed their projections.
16 Employers and Healthcare Benefits Trusts that prefer to purchase a
17 Commercial Healthcare Insurance product, choose among the insurance
18 policies offered through competing Commercial Insurance Companies by
19 comparing the insurance premiums charged by different competitors. The
20 Commercial Insurance Company profits (often substantially) if healthcare
21 expenses are less than the premiums that are paid for the purchase of the
22 Commercial Healthcare Insurance policy. However, the Commercial
23 Insurance Company also bears the risk that healthcare costs will exceed the
24 Commercial Healthcare Insurance premiums paid. Either way, when
25 Employers or Healthcare Benefits Trusts purchase a healthcare insurance
26 product from a Commercial Insurance Company, they do not buy healthcare
27 services and products from the Healthcare Providers.
28

1 **b. Self-Funded Payors:** Some Employers and Healthcare Benefits Trusts prefer
2 to avoid the extra cost of purchasing an insurance policy and therefore choose
3 to purchase healthcare services and products directly from Healthcare
4 Providers and pay for them out of their own funds. Those Employers and
5 Healthcare Benefits Trusts proceed as Self-Funded Payors because they are
6 willing to bear the financial risk that healthcare costs for their Health Plan
7 Enrollees will exceed their expectations. They contract with a Network
8 Vendor for access to the Healthcare Providers in the vendor's Provider
9 Network as well as the associated pricing that was previously negotiated by
10 the Network Vendor. The healthcare costs that Self-Funded Payors will incur
11 for the upcoming year cannot be determined until their Health Plan Enrollees
12 actually use the healthcare they require. Hence, Self-Funded Payors select
13 among the various Provider Networks available to them by comparing cost
14 projections made by competing Network Vendors.

15 66. Self-Funded Payors do not shop for Provider Networks offered through
16 competing Network Vendors by comparing the prices charged by participating Healthcare
17 Providers for individual healthcare services. Instead, they evaluate the projected total cost of
18 providing their Health Plan Enrollees with access to the entire cluster of covered healthcare
19 services such as general acute care services (including inpatient and outpatient services) and
20 ancillary services that are available from each competing Provider Network.

21 67. Self-Funded Payors employ approximately 50% of the workforce in California.
22 Because Self-Funded Payors generally fall outside of state and federal regulatory structures,
23 the People and the State of California as represented by the Attorney General have a special
24 role to play to ensure that Self-Funded Payors (and through them their employees) are not the
25 victims of anticompetitive conduct from Hospital Systems such as Sutter.

26 **C. The Selection of Hospitals by Health Plan Enrollees**

27 68. When Health Plan Enrollees obtain healthcare from a hospital that is included in
28 their Health Plan's Provider Network (an "**In-Network Hospital**"), most or all of the

1 hospital's charges are paid by the Self-Funded Payor (or Commercial Insurance Company)
2 that provides the Health Plan. When Health Plan Enrollees obtain healthcare from a hospital
3 that is not included in their Health Plan's Provider Network (an “**Out-Of-Network**
4 **Hospital**”), a relatively small amount of the hospital charges is paid by the Self-Funded
5 Payor (or Commercial Insurance Company) that provides the Health Plan, and the Health
6 Plan Enrollees are obligated to pay the uncovered portion of the charges. In addition, when
7 healthcare is obtained from an Out-Of-Network Hospital, the hospital's charges are generally
8 billed at rates that are significantly above the discounted in-network prices. As a result,
9 Health Plan Enrollees have a considerable financial incentive to seek healthcare from an In-
10 Network Hospital.

11 69. However, when choosing among the different hospitals that are included within
12 their Health Plan’s Provider Network, Health Plan Enrollees are largely ignorant of and
13 insensitive to price differences between competing hospitals. The same is true for outpatient
14 surgery services provided by hospitals and ambulatory surgery centers or for ancillary
15 services provided by hospitals and other providers of ancillary services. This is because
16 Health Plan Enrollees often pay little or none of the cost of receiving care at In-Network
17 Hospitals, and even large price differences between In-Network Hospitals often have little
18 effect upon any amount the Health Plan Enrollees must pay. For example, a Health Plan
19 Enrollee will generally pay the same out-of-pocket amount regardless of whether the total
20 hospital bill is \$20,000 or \$30,000 or \$100,000 or more.

21 70. Unless they are given significant incentives to consider price differences in
22 making their selections of hospitals and other healthcare providers, Health Plan Enrollees
23 will choose among competing In-Network Hospitals and other providers largely on the basis
24 of geographic proximity and other non-price factors.

25 71. Despite the initial apparent insensitivity of Health Plan Enrollees to differences in
26 the prices charged for in-network healthcare, Self-Funded Payors and Commercial Insurance
27 Companies have options they could employ to stimulate price competition in healthcare
28 markets were they not constrained by Sutter's illegal contracts. In geographic markets

1 containing alternative hospitals with sufficient existing or potential capacity, Self-Funded
2 Payors and Commercial Insurance Companies could encourage price competition by simply
3 utilizing Provider Networks that exclude any hospitals that charge supra-competitive prices.
4 Alternatively, they could use a Provider Network that includes a wider variety of hospitals
5 and providers but financially incentivize their Health Plan Enrollees to choose hospitals or
6 providers offering the best economic value. For example, they could use a tiered network
7 Health Plan to give Health Plan Enrollees a choice between a broader Provider Network that
8 includes higher-priced hospitals at a greater out-of-pocket cost to the enrollee and a narrower
9 Provider Network that excludes higher-priced hospitals but results in a lower out-of-pocket
10 cost to the enrollee. Self-Funded Payors, Commercial Insurance Companies, and Network
11 Vendors in Northern California want to implement each of those options to create price
12 competition.

13 72. Unfortunately, in Northern California, Sutter has found a way to illegally control
14 price and severely limit competition by compelling Network Vendors to enter into contracts
15 that improperly block any and all practical efforts to foster or encourage price competition
16 between Sutter and any rival Healthcare Providers or Hospital Systems.

17 **VI. THE RELEVANT MARKETS**

18 73. Judgment may be entered against Sutter for the illegal conduct described in this
19 Complaint without defining the particular economic markets that Sutter's conduct has
20 harmed based on the direct negative effects of that conduct, including supracompetitive
21 pricing. Sutter's anticompetitive conduct has caused Network Vendors and Self-Funded
22 Payors to pay substantial overcharges compared to what they would pay in a competitive
23 market for the array of healthcare services provided by Sutter. These increased costs in the
24 consumption of health care services in Northern California negatively affect Employers,
25 depressing profits and wages and increasing premiums and deductibles.

26 74. It also has caused umbrella effects in terms of rival Hospital Systems also raising
27 prices. These umbrella effects have further increased costs in the consumption of healthcare
28

1 services in Northern California and thus amplified the negative effects of these costs on
2 Employers and on the general economy of this state.

3 75. Sutter's ability to impose anticompetitive contract terms in all of its agreements
4 with the Network Vendors and its ability to persistently and directly charge supra-
5 competitive prices to Network Vendors and Self-Funded Payors on a system-wide basis are
6 direct evidence of Sutter's market power that obviates any need for further analysis of
7 competitive effects in particular defined markets. In any event, market definitions are
8 unnecessary because Sutter's anticompetitive behavior is a per se violation of the Cartwright
9 Act.

10 76. If the People must define specific markets, the markets that are relevant to the
11 illegal conduct described in this complaint are properly defined as follows:

12 **A. The Relevant Service/Product Market**

13 77. The relevant market in this action is the cluster of general acute care hospital
14 services (including inpatient and outpatient services), as well as ancillary services, that are
15 made available for purchase, in whole or in part, through Network Vendors out of the funds
16 of Self-Funded Payors. The cluster of general acute care services and ancillary services
17 offered by each hospital is a broad array of individual healthcare services connected to a
18 variety of medical specialties. They are properly analyzed as a cluster of services because
19 hospitals only offer group Health Plans access to them as a cluster, and Network Vendors,
20 Self-Funded Payors, and Commercial Insurance Companies are required to contract for them
21 as a cluster. Sutter and its competitors generally do not offer separate contracts for each
22 individual medical specialty, hospital service, or ancillary service.

23 78. From the standpoint of an individual Health Plan Enrollee with a specific medical
24 need, the different medical specialties generally are not substitutes for one another. However,
25 those same individual Health Plan Enrollees require the Health Plans offered through their
26 employment to provide access to the entire range of healthcare services they might need in
27 the future. The Health Plans created in response to that demand must accommodate the
28 potential healthcare needs of all enrollees.

1 79. The location of a hospital is an important factor to the vast majority of patients
2 and Network Vendors in differentiating the service cluster offered by a local hospital from
3 the service cluster offered by another hospital at a more distant location. For the same reason,
4 Self-Funded Payors seeking to satisfy the demand from their Health Plan Enrollees for local
5 hospital care do not view the service cluster offered by hospitals operating at distant
6 locations to be substitutes for the service cluster offered by a local hospital. Therefore, the
7 service cluster offered by each Sutter hospital is different than the cluster offered by more
8 distant Sutter hospitals merely by virtue of their differing geographic locations.

9 80. The cluster of general acute care services and of ancillary services that hospitals
10 provide is significantly broader than the services provided by a facility that does not address
11 acute medical problems as a substantial part of its business—such as nursing homes and
12 facilities focused primarily upon transitional care, long term psychiatric care, substance
13 abuse treatment, or rehabilitation services. Such specialty facilities are not viable substitutes
14 for a hospital that offers general acute care hospital services and ancillary products. Hence,
15 facilities that do not provide general acute care hospital services among their primary
16 services are not part of the relevant general acute care market or inpatient submarket. If
17 facilities do not provide outpatient surgery services, they are also not part of the outpatient
18 submarket.

19 81. All general acute care hospitals have the ability to provide healthcare services to
20 patients who need to be admitted overnight for inpatient care. A Network Vendor's Provider
21 Network will not be commercially viable if it does not include access to a sufficient number
22 of hospitals that provide general acute care inpatient services and ancillary products. Self-
23 Funded Payers and Commercial Insurance Companies could not practically offer such a
24 network to their Health Plan Enrollees. A facility that only offers out-patient care is not a
25 viable substitute for a hospital that provides in-patient care when a medical problem requires
26 an overnight stay. Therefore, general acute care hospitals do not view facilities with no
27 significant ability to provide in-patient hospital healthcare as meaningful competitors. Such
28

1 facilities are properly excluded from the relevant market in this action as far as the general
2 acute care market, or the submarket of inpatient care, is concerned.

3 82. All competitors in the relevant market sell general acute care hospital services
4 (including inpatient and outpatient services) and ancillary services through group Health
5 Plans funded by Self-Funded Payers using Provider Networks developed by independent
6 Network Vendors. Commercial Healthcare Insurance products sold to Employers or
7 Healthcare Benefits Trusts do not compete in the same relevant market although the effects
8 of Sutter's anticompetitive conduct are the same as they are for Self-Funded Payors.

9 83. Hospitals that serve only military personnel and veterans also are excluded from
10 the relevant market. These hospitals do not sell their healthcare services and products to the
11 general public and do not permit independent Network Vendors to include them in their
12 Provider Networks. They also will not allow independent Commercial Insurance Companies
13 or Self-Funded Payors to include them in the Provider Networks they offer to their Health
14 Plan Enrollees. In addition, the rates at which such hospitals are reimbursed for their
15 services are established by government agencies. Those rates are not determined through
16 competition with other hospitals. Thus, hospitals that serve only military personnel and
17 veterans do not compete with Sutter and are not in the same market as Sutter.

18 84. Another system that is excluded from the relevant market is the sale of general
19 acute care hospital services and products through government payors, which set the prices
20 that Healthcare Providers may charge. Government programs such as Medicaid, Medicare
21 and TRICARE do not allow prices to be established by negotiation in a competitive market
22 and therefore do not participate in the market that is relevant to this action.

23 85. Kaiser Permanente ("**Kaiser**"), a closed large integrated health-care system that
24 provides its own insurance for access to its own system and does not accept Commercial
25 Insurance Products from Network Vendors nor make its own network accessible to Network
26 Vendors for Self-Funded Payors, is also excluded from the relevant market. Kaiser is not a
27 substitute for Sutter for Self-Funded Payors and Healthcare Benefits Trusts, or for Employers
28

1 and Healthcare Benefits Trusts covering more than 100 employees (“Large Employers”) that
2 purchase Commercial Insurance Products.

3 86. While acute care inpatient hospital services are provided only by hospitals,
4 outpatient surgery services can be provided by hospitals and ambulatory service centers.
5 Sutter’s anticompetitive conduct has increased prices for all these services. The People
6 reserve the right to prove separate direct effects as to each of these cluster of services—acute
7 care inpatient hospital services, on the one hand, and outpatient surgery services, on the other
8 hand—as submarkets within the general acute care hospital services market.

9 **B. The Relevant Geographic Markets**

10 87. Patients generally seek general acute care hospital services and ancillary services
11 in the local areas where they live and work and where their local physicians have admitting
12 privileges. Generally, patients do not regard hospitals located many miles away from them
13 as substitutes for local hospitals—particularly when they have little financial incentive to
14 travel greater distances.

15 88. Recognizing the importance of consumer preferences for convenient hospital
16 healthcare, regulations promulgated by California’s Department of Managed Health Care
17 under California’s Knox-Keene Health Care Service Plan Act of 1975, codified at California
18 Health & Safety Code section 1340, *et seq.* (the Knox-Keene Act) require, among other
19 things, that Health Maintenance Organization Health Plans offered by Commercial Insurance
20 Companies must provide their enrollees with access to at least one hospital that is no more
21 than 15 miles or 30 minutes of travel time from the enrollee’s residence or workplace.
22 California Code of Regulations, Title 28, § 1300.51, subd. (H)(ii). A hospital satisfies the
23 Knox-Keene requirements for the urban region surrounding the hospital when that facility is
24 no more than 15 miles away or within 30 minutes of travel time.

25 89. Moreover, regulations promulgated by California’s Department of Insurance
26 requires that non-Knox-Keene insurance plans within the jurisdiction of that department
27 under such provisions as California Insurance Code sections 740 and 10133, e.g., Preferred
28 Provider Organization Insurance or Exclusive Provider Organization Insurance, must provide

1 their enrollees with access to “a network hospital with sufficient capacity to accept covered
2 persons for covered services within a maximum travel time of 30 minutes or a maximum
3 travel distance of 15 miles of each covered person’s residence or workplace. Networks must
4 include hospitals with sufficient capacity to serve the entire population of covered persons
5 based on normal utilization patterns.” California Code of Regulations, Title 10, Section
6 2240.1, subdivision (c)(7), *available at* [https://www.insurance.ca.gov/0400-news/0100-press-](https://www.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/Network+AdequacyRegulation3-8-16.pdf)
7 [releases/2016/upload/Network AdequacyRegulation3-8-16.pdf](https://www.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/Network+AdequacyRegulation3-8-16.pdf). A hospital satisfies the
8 Department of Insurance requirements for the urban region surrounding the hospital that is
9 up to 15 miles away or within 30 minutes of travel time.

10 90. A Provider Network that does not satisfy patient demand for access to
11 conveniently located hospitals will not be a commercially viable Provider Network for
12 Network Vendors to offer to their Employer and Healthcare Benefits Trust customers.
13 Hence, Network Vendors take patient tolerances for travel and their preferences for access to
14 local hospitals into account when they decide whether or not to include a particular hospital
15 in their Provider Networks.

16 91. The relevant geographic markets are those areas in which Health Plans must have
17 one or more general acute care hospitals with sufficient capacity to reasonably handle the
18 anticipated healthcare requirements of the Health Plan Enrollees located in the region. The
19 need for a Health Plan to have a general acute care hospital in a particular location is driven
20 primarily by the demand of Health Plan Enrollees living or working within the region.
21 Hence, when Network Vendors assemble Provider Networks they attempt to determine the
22 geographic regions within which Health Plan Enrollees can practically use alternative
23 sources of general acute care services (including inpatient and outpatient services) and
24 ancillary services.

25 92. Data showing patients’ historical hospital utilization reflect their choices of
26 competing hospitals based upon the options and incentives available to them. Patient choices
27 among competing hospitals have been distorted by Sutter’s insistence upon anticompetitive
28 agreements with Network Providers. These agreements foreclose consideration of Sutter’s

1 inflated pricing as a significant factor in the patients' hospital selection process. As a result,
2 utilization data may not fully capture the patient demand for particular hospital locations that
3 would exist in a market unaffected by Sutter's anticompetitive conduct. Nevertheless,
4 historical data concerning hospital utilization by patients are indicators of the geographic
5 areas in which Health Plans and their enrollees have been willing to seek alternative sources
6 of healthcare in response to changes in hospital prices and quality over time.

7 93. Northern California hospital utilization data clearly indicates that over a
8 significant period in which prices have changed, Health Plan Enrollees living or working in
9 specific areas have been willing to choose primarily among hospitals located within
10 identifiable geographic regions that each constitute a separate geographic market. The data
11 shows that Health Plan Enrollees living within the geographic vicinity of the hospital
12 groupings described below overwhelmingly choose from among the hospitals in the group
13 nearest to their residences or workplaces and rarely seek healthcare outside of the geographic
14 area where those local hospitals are found.

15 94. The Relevant Geographical Markets can alternatively be defined either as a 15-
16 mile/30- minute driving time from any Sutter hospital or on the basis of counties in which a
17 Sutter hospital is located. The Relevant Geographic Markets may also be defined based on
18 the regions set out in paragraph 84 of the Complaint in *UFCW & Employers Benefit Trust v.*
19 *Sutter Health, et al.*, Case No. 15-53841 in which one or more Sutter facilities are located.

20 95. Health Plan Enrollees living or working in the vicinity of any of the alternative
21 geographic areas described above as Relevant Geographic Markets are generally unwilling to
22 consider a hospital located outside of their Relevant Geographic Market as a viable substitute
23 for hospitals located within their Relevant Geographic Market.

24 96. Network Vendors assembling Provider Networks for use by those Health Plan
25 Enrollees are generally unwilling to consider a hospital outside of a particular Relevant
26 Geographic Market as a viable substitute for the hospitals located within that Relevant
27 Geographic Market.
28

1 97. Commercial Insurance Companies and Self-Funded Payors offering Health Plans
2 to their Health Plan Enrollees are generally unwilling to consider a hospital outside of a
3 particular Relevant Geographic Market as a viable substitute for the hospitals located within
4 that Relevant Geographic Market.

5 98. Hence, a hypothetical monopolist controlling all of the general acute care
6 hospitals within any of the Relevant Geographic Markets defined above, would be able to
7 profitably impose a small, but significant, non-transitory price increase above the
8 competitive level for its general acute care services (including inpatient and outpatient
9 services) and for ancillary services.

10 99. If the Network Vendors were not restrained by the anticompetitive terms in their
11 contracts with Sutter, they would be able to assemble more competitive, less costly, Provider
12 Networks by replacing Sutter hospitals with lower-priced competing hospitals, or competing
13 ambulatory surgery centers in the case of outpatient surgery services, or competing non-
14 hospital providers of ancillary services, in regions where patients do not require access to a
15 Sutter hospital because that Sutter hospital is not a “must have” hospital. Network Vendors
16 might even be able to assemble commercially viable Provider Networks despite their
17 exclusion of Sutter hospitals in rural areas. However, because of Sutter’s market shares in a
18 large number of zip code areas and the existence of certain “must have” Sutter hospitals, the
19 Network Vendors are unable to assemble commercially viable Provider Networks that
20 exclude all Sutter hospitals. However, as a direct result of Sutter's anticompetitive
21 contractual practices, nearly every Provider Network is forced to include **all** of Sutter’s
22 hospitals.

23 **VII. SUTTER’S MARKET POWER**

24 100. Because of the anticompetitive terms in its contracts with the Network Vendors,
25 Sutter has considerable market power within every market that is relevant to the claims
26 described in this complaint and is reflected in Sutter’s ability to charge prices on a system-
27 wide level that are in excess of the prices in a more competitive market. Each of Sutter’s
28 hospitals competes in a Relevant Geographic Market where it has been able, through Sutter’s

1 centralized contracting and negotiating conduct as well as its pricing, to profitably impose
2 and sustain at least a small but significant, non-transitory increase in price above the
3 competitive price level. In other words, Sutter's significant, non-transitory increases in price
4 above competitive price levels generally have not caused its hospitals to be excluded from
5 Health Plans and have not caused Sutter's hospitals to lose enough patients to make the price
6 increases unprofitable.

7 101. Sutter's ability to charge substantially higher prices than its competitors for the
8 same services and products cannot be explained by legitimate system-wide market factors
9 such as quality of care or costs.

10 102. There are significant barriers to entry into the hospital healthcare market.
11 Building and staffing hospitals is expensive and hospital healthcare is highly regulated.
12 However, it is Sutter's own illegal conduct that presents the most effective barrier to entry.
13 Because Sutter uses its market power to impose contractual restrictions that block efforts by
14 Network Vendors, Commercial Insurance Companies and Self-Funded Payors to stimulate
15 price competition, it has become virtually impossible for Sutter's more cost-effective rivals to
16 effectively compete by offering lower prices.

17 103. Sutter's anticompetitive long-term agreements with the Network Vendors make it
18 virtually impossible for rival hospitals to gain any significant market share by providing
19 customers with better value. Sutter's contractual restrictions hinder new entrants and existing
20 competitors from successfully opening or expanding competing hospitals, or ambulatory
21 surgery services in the case of outpatient surgery services, in geographic markets where
22 Sutter currently has a substantial market share and, thereby, facilitate Sutter's illegal
23 maintenance or enhancement of its economic power in those markets.

24 104. Sutter enhances the market power it possesses for its "must have" hospitals
25 through the substantial market shares it also has in many other Relevant Geographic Markets
26 in Northern California. The disruption caused by a Sutter threat to exclude all of its hospitals
27 throughout the region from a Provider Network would eliminate any such Provider Network
28

1 as a commercially viable option for the vast majority of Health Plans available in Northern
2 California.

3 105. Sutter has exploited its substantial market power to illegally tie or bundle each of
4 its individual hospitals to all of the other hospitals and providers in its Northern California
5 hospital network. Through its anticompetitive agreements with the Network Vendors, Sutter
6 makes it effectively impossible to substitute a higher quality or lower cost competing
7 hospital or ambulatory surgery center in a Health Plan's Provider Network for a higher-
8 priced Sutter hospital, in any geographic market served by a Health Plan without also losing
9 access to all of Sutter's other hospitals in Northern California. As a result of Sutter's
10 conduct, Self-Insured Payors are forced to offer access to Sutter's higher-priced hospitals
11 even in markets where there could be more cost-effective competing hospitals or ambulatory
12 surgery centers. Self-Insured Payors are thereby forced to pay for costlier services and
13 products they do not want to purchase.

14 106. Moreover, Sutter has obtained enormous market power to control price and
15 exclude competition by contractually insulating itself from price competition. Sutter's
16 contracts with the Network Vendors make it impossible to incentivize Health Plan Enrollees
17 to choose a more cost-effective hospital or ambulatory surgery center competitor over a
18 higher-priced Sutter hospital. Sutter thereby forecloses the ability of more cost-effective
19 hospital rivals to compete with Sutter with lower prices and preserves Sutter's ability to
20 charge supra-competitive prices to the detriment of this state.

21 107. This market power is enhanced as well by the extension of the conduct set out
22 herein to include Sutter's affiliated physician groups providing physician services even if
23 those physician groups refer patients to hospitals that compete with Sutter. Sutter's conduct
24 has also been extended to include Sutter's providers of ancillary services that are located
25 outside of hospitals as well as other healthcare services. As a result of this conduct, Sutter
26 can prevent any erosion of its market power from competing providers in related markets.

108. Sutter's persistent ability to charge supra-competitive prices, while simultaneously maintaining or growing its market share, provides direct evidence of Sutter's market power flowing from the conduct described in this Complaint.

VIII. SUTTER'S ANTICOMPETITIVE CONDUCT

109. Sutter has engaged in a number of acts and practices that have significant detrimental effects on competition in the sale and marketing of general acute care hospital healthcare services (including inpatient and outpatient services) and ancillary services in Northern California. Collectively, these practices ensure that Sutter is immune from the forces of price competition and, as a result, can charge Network Vendors and Self-Funded Payors and others significantly more than it could charge but for these practices. Because of Sutter's size and presence throughout Northern California, its supra-competitive prices cause a large regional reduction in price competition, resulting in system-wide hospital pricing above competitive levels across every Northern California geographic market.

110. Beginning no later than 2003 and continuing through the present, Sutter has engaged in a single, continuous practice of repeatedly entering into anticompetitive agreements with the Network Vendors that offer Provider Networks through Self-Funded Payors or Commercial Insurance Companies to Health Plan Enrollees living or working in Northern California. As those agreements expired, Sutter entered into extension or renewal agreements containing the identical or substantially similar anticompetitive terms. These agreements contained non-disclosure provisions that concealed the anticompetitive terms of the agreements from those who were illegally harmed by them, including the Self-Funded Payors who bear the costs of the improperly inflated Sutter pricing that results from Sutter's agreements to unreasonably restrain trade.

111. Sutter utilizes punitively high Out-Of-Network Hospital pricing in combination with the anticompetitive provisions in its agreements with Network Vendors to make it economically unfeasible for Network Vendors to choose higher-quality and/or lower-cost hospital competitors for inclusion in their Provider Networks instead of particular Sutter hospitals. The agreements between Sutter and the Network Vendors also make it virtually

1 impossible to incentivize Health Plan Enrollees to choose lower-cost providers of general
2 acute care hospital services (including inpatient and outpatient services) and ancillary
3 products. The terms of Sutter's agreements with the Network Vendors in Northern California
4 illegally restrain trade by insulating Sutter's hospital services from competitive forces that
5 normally discipline pricing in a free market and by imposing unlawfully inflated prices on
6 Commercial Insurance Companies and Self-Funded Payors that have Health Plan Enrollees
7 in Northern California. Hence, Sutter illegally controls prices and precludes price
8 competition from high-quality, but lower-priced, hospital, non-hospital ancillary service
9 providers, and ambulatory surgery competitors through the agreements it makes with the
10 Network Vendors.

11 112. Beginning no later than 2003, and continuing unabated through the present, Sutter
12 has exploited its market power to compel Network Vendors operating in Northern California
13 to enter into agreements with Sutter that unreasonably restrain trade through a variety of
14 anticompetitive terms, including, but not limited to, the contract terms described in the
15 paragraphs below.

16 **A. Sutter's All-or-Nothing Contract Terms**

17 113. Shortly after its Alta Bates–Summit market expansion in 2000, Sutter began
18 bundling together and using the leverage of the market power of its various affiliated
19 hospitals, medical groups, and other providers, insisting that all contract negotiations for any
20 of its providers be conducted on a system-wide basis with a single termination date for all of
21 its providers.

22 114. Sutter's agreements with Network Vendors in Northern California include de
23 facto terms collectively and effectively requiring every Health Plan that offers its enrollees
24 the services and products available at a Sutter hospital or provider to also offer, through its
25 Provider Network, the services available at every other Sutter hospital or provider ("**All-or-
26 Nothing Terms**"). Sutter imposes this requirement even though the prices charged at
27 Sutter's hospitals are dramatically higher than the prices charged by general acute care
28 hospitals competing with Sutter in the same Relevant Geographic Markets. Through its de

1 facto All-or-Nothing Terms and practices and the other agreement provisions described
2 below, Sutter illegally ties or bundles the price-inflated services and products available at
3 Sutter hospitals located in potentially more price competitive markets to its entire network of
4 other hospitals and providers (including Sutter “must have” hospitals and providers) forcing
5 Self-Funded Payors and Commercial Insurance Companies to pay for services and products
6 they do not want to offer their Health Plan Enrollees at prices that dramatically exceed the
7 prices Sutter could charge absent the illegal tie or bundle.

8 115. In Relevant Geographic Markets where there are competing hospitals with
9 sufficient existing or potential capacity, it would be economically feasible to create lower-
10 cost Provider Networks assembled entirely from the high-quality and/or lower-priced
11 hospitals that compete with Sutter in those locations. Those cost-efficient Provider Networks
12 then could be made available to Self-Funded Payors that would like to offer their Health Plan
13 Enrollees high-quality and/or cost-effective healthcare. Thereafter, Sutter would have to
14 choose between lowering its prices to meet the competition of its more efficient rivals or
15 maintaining its inflated pricing at the risk of losing business to its competitors.

16 116. Unfortunately, the de facto All-or-Nothing Terms in Sutter’s agreements with the
17 Network Vendors make it impossible to assemble such lower-cost Provider Networks.
18 Instead, Network Vendors are required to enter into contracts that include access to Sutter’s
19 higher-priced hospitals in the Provider Networks assembled for every geographic market in
20 Northern California—even in markets where it otherwise would be feasible to assemble a
21 Provider Network consisting entirely of Sutter's lower-priced hospital competitors. This
22 prevents more cost-efficient Healthcare Providers from effectively competing with Sutter
23 based on price. Rather, it incentivizes Healthcare Providers to try to follow in Sutter’s
24 footsteps as to its anticompetitive conduct and to raise their own prices.

25 117. Sutter ensures that its de facto All-or-Nothing Terms are effectuated by specific
26 Excessive Out-of-Network Pricing Provisions in their contracts with Network Vendors
27 (**“Excessive Out-of-Network Pricing Provisions”**). If an enrollee requires services at a
28 Healthcare Provider that is not in his or her Health Plan (e.g., he or she gets into an accident

1 and is taken to the emergency room of a hospital outside of his or her plan), the contracts
2 between Network Vendors and the Healthcare Provider or Hospital System fix the rate at
3 which that non-participating provider shall be paid. In the absence of a specific contract rate,
4 services at a non-participating provider are to be charged at a “reasonable and customary”
5 rate, where under state law as well as federal law that rate is to be determined with reference
6 to such criteria as in-network rates of rivals or Medicare rates. The preference for
7 alternatives close to where patients live or work becomes even more acute as the need and
8 urgency increase, e.g., a patient has a heart attack or a stroke. However, the out-of-network
9 rates set by Sutter are excessive and render uneconomical any narrow networks that exclude
10 that Hospital System or any of its members from a Network Vendor’s provider networks
11 because of this need for emergency services.

12 118. Sutter is further able to insist on all-or-nothing terms by the imposition of
13 punitive pricing for those that balk at inclusion of high-priced Sutter providers. If for
14 instance, a Network Vendor balks at paying higher charges for a newly-acquired Sutter
15 facility, Sutter can simply increase substantially the rates charged for existing facilities and
16 thereby coerce the Network Vendor to accept the high charges for a newly acquired Sutter
17 facility. If a Network Vendor wants to exclude some of the Sutter’s facilities from a
18 proposed network, Sutter can respond with a very significant increase in the prices for its
19 other facilities, thereby forcing that Network Vendor to relent to the inclusion of the Sutter
20 provider because the alternative would be worse.

21 119. By using its de facto All-or-Nothing Terms in combination with the other
22 anticompetitive agreement conduct described below, Sutter has illegally tied or bundled the
23 sale of services and products at each of its individual hospitals to its entire network of
24 hospitals in Northern California and has thereby illegally immunized itself from the
25 discipline provided by price competition in a free market.

26 120. Sutter’s use of its de facto All-or-Nothing Terms to immunize itself from price
27 competition also has provided it with the ability to illegally maintain its dominant market
28 power and charge higher prices in the geographic markets such as the Relevant Geographic

1 Markets where there are significantly fewer rival hospitals. By contractually making it
2 impossible for a lower-priced competitor to be included in any commercially viable Provider
3 Network as a substitute for a higher-priced Sutter hospital, the Sutter All-or-Nothing Terms
4 make it futile for small hospital competitors in those geographic markets to compete by
5 expanding the capacity of their hospitals to a level where they could displace Sutter in
6 Provider Networks with facilities that offer lower-priced services and products. Likewise,
7 the All-or-Nothing Terms make it futile for competitors in adjoining geographic markets or
8 other new entrants to attempt to compete where Sutter has substantial market power. As a
9 result of its illegal All-or-Nothing Terms and the other anticompetitive agreement terms
10 described below, Sutter can improperly charge dramatically inflated prices across all of the
11 Relevant Geographic Markets without fear that its high prices will attract entry or expansion
12 by more cost-effective competitors.

13 **B. Sutter's Anti-Incentive Contract Terms**

14 121. In most other service or product markets in our economy, the person who makes
15 the purchasing decision and the person who ultimately pays for the service or product are one
16 and the same. In those markets, the differing prices charged by competing vendors are
17 important factors that are considered in making the ultimate purchasing decision. Healthcare
18 provider markets are different—and Sutter has illegally exploited those differences by
19 requiring restrictions in its agreements with the Network Vendors that insulate its hospitals
20 from the salutary price discipline and efficiencies that flow from vigorous competition.

21 122. Generally, in the healthcare market the person who makes the purchase decision
22 is not the person who pays the bulk of the purchase price. In the hospital healthcare market, it
23 is the patient who ultimately chooses the hospital, sometimes with the recommendation of a
24 medical professional. However, it is the Self-Funded Payor or the Commercial Insurance
25 Company that pays all or most of the price charged by the chosen hospital for the healthcare
26 provided to a Health Plan Enrollee.

27 123. Sutter generally does not tell the patient what the expected hospital prices are
28 before its hospital is selected by the patient, so under the terms of Sutter's current agreements

1 with the Network Vendors there is little opportunity for patients to choose a hospital based
2 upon a price comparison. More importantly, because most (if not all) of the healthcare costs
3 will be paid by the Self-Funded Payor or Commercial Insurance Company, the patient has
4 little or no incentive to consider price differences when choosing between rival hospitals,
5 under the terms of Sutter's current agreements with the Network Vendors.

6 124. Absent Sutter's illegal restraint of trade, normal market forces would remedy this
7 market inefficiency. Health Plans that included Sutter's higher-priced hospitals in their
8 Provider Networks would provide incentives encouraging Health Plan Enrollees to choose a
9 higher-quality, and/or lower-priced, competing hospital over Sutter's higher-priced hospitals.
10 By placing some of the financial burden for choosing a higher-priced provider on the Health
11 Plan Enrollee, the Health Plan would, to some extent, normalize the competitive landscape
12 by bringing price considerations back into the purchase decision made by the Health Plan
13 Enrollee, thereby stimulating price competition.

14 125. One important strategy that Self-Funded Payors and Commercial Insurance
15 Companies in other markets have utilized to incentivize Health Plan Enrollees to choose
16 more cost-efficient Healthcare Providers is the creation of Health Plans that have tiered
17 Provider Networks. These arrangements include one network tier that includes the higher-
18 priced Healthcare Providers but also requires Health Plan Enrollees to incur a higher out-of-
19 pocket cost—and another network tier that includes only lower-priced Healthcare Providers
20 but requires little or no out-of-pocket cost to be incurred by the Health Plan Enrollees. After
21 weighing the financial incentives to choose the network tier requiring the lowest patient cost
22 contribution against the benefit of a more inclusive network, each Health Plan Enrollee has
23 the opportunity to select the tier that he or she prefers. Such tiered Provider Networks
24 provide an economic incentive for Health Plan Enrollees to consider healthcare pricing as
25 part of their purchase decision.

26 126. With the ability to offer tiered Provider Networks or other financial incentives,
27 Health Plans would be able to exert some influence over their enrollees to choose more cost-
28 efficient or better-quality Healthcare Providers—even if they were constrained by Sutter's

1 All-or-Nothing Terms. However, Sutter understood the potency of tiering to incentivize
2 Enrollees to avoid Sutter's overpriced providers, and to insulate itself from any possibility of
3 price or quality competition, Sutter required Network Vendors to enter written or oral
4 agreements that forbid or severely penalized Health Plans that use tiered Provider Networks
5 or any other incentive for the Health Plan Enrollee to choose a competing hospital or
6 provider over a higher-priced and/or inferior quality Sutter hospital or provider (**"Anti-
7 Incentive Terms"**). Such penalties can include elimination or near elimination of the Health
8 Plan's negotiated price discounts off of Sutter's pricing. These penalties are sufficiently
9 severe that they effectively eliminate the commercial viability of any Health Plan that tries to
10 incentivize more cost-effective or better- quality purchase choices.

11 127. Health Plan Enrollees would frequently choose a higher-quality and/or lower-cost
12 hospital if they have a financial incentive to do so. However, by including Anti-Incentive
13 Terms in its contracts, Sutter prevents Network Vendors (and thus Self-Funded Payors) from
14 offering Health Plans that incentivize their Health Plan Enrollees to select healthcare services
15 and products from Sutter's lower- priced or higher-quality competitors instead of selecting
16 higher-priced services and products from Sutter.

17 128. The Anti-Incentive Terms reinforce and exacerbate the pernicious effect of the
18 All-or- Nothing Terms in Sutter's agreements with the Network Vendors, effectively
19 preventing price competition in the sale of general acute care hospital services (including
20 inpatient and outpatient services) and ancillary services. The All-or-Nothing Terms force
21 Network Vendors to include all Sutter hospitals in their Provider Networks but they do not
22 prevent them from incentivizing Health Plan Enrollees to select more cost-effective and/or
23 higher-quality hospitals for their healthcare needs. By adding the Anti-Incentive Terms into
24 its contracts, Sutter eliminates most or all of the motivation that Health Plan Enrollees might
25 have to select their hospital Healthcare Provider based upon the value the hospital provides.
26 The addition of the Anti-Incentive Terms to Sutter's contracts guarantees that a much larger
27 percentage of Health Plan Enrollees will select Sutter's higher-priced and/or lower-quality
28 hospitals because those terms all but eliminate price or quality as a consideration in the

1 hospital selection process. The effects of Sutter's Anti-Incentive Terms are also exacerbated
2 by the Excessive Out-of-Network Pricing Provisions because it adds a further barrier to
3 Network Vendors marketing narrow or tiered networks. Such Anti-Incentive Terms in the
4 aggregate thus cause damage to consumers, Employers, and the state by forcing Network
5 Vendors and Self-Funded Payors to pay higher prices for such services and products than
6 they would pay but for this anticompetitive conduct.

7 **C. Sutter's Price Secrecy Contract Terms**

8 129. In properly functioning competitive markets pricing information is freely
9 available, allowing purchasers to determine the prices they will be obligated to pay their
10 suppliers if they purchase the suppliers' services and products. The ability to determine the
11 amount of the purchase price before the purchase decision is made allows the customer to
12 compare the prices offered by various competitors and allows the purchase decision to be
13 influenced by price competition. However, to prevent the Self-Funded Payors and enrollees
14 in Health Plans from searching out or demanding better pricing, Sutter had required terms in
15 its agreements with each Network Vendor that forbid them from disclosing the prices that
16 Sutter Health has negotiated for the healthcare services and products offered through the
17 Health Plans that are made available to Health Plan Enrollees ("**Price Secrecy Terms**").

18 130. As a result of the Price Secrecy Terms, Self-Funded Payors and enrollees in
19 Health Plans were unable to determine the prices they will later have to pay to Sutter for the
20 healthcare services included in their Health Plans at the time they select among the Provider
21 Network options offered by competing Network Vendors. Because the Price Secrecy Terms
22 prevented the Self-Funded Payors and enrollees in Health Plans from determining what they
23 will be obligated to pay Sutter for the healthcare services included in their Health Plans (and
24 how much those prices exceed the prices charged by Sutter's competitors), they were less
25 able to exert commercial pressure on Sutter to moderate its inflated pricing.

26 131. These Price Secrecy Terms reinforced the anticompetitive effects of Sutter's All-
27 or-Nothing Terms and Anti-Incentive Terms. Together, these terms effectively eliminated
28 price competition for Sutter's healthcare services throughout Northern California's Relevant

1 Geographic Markets. Sutter has unreasonably restrained trade in each of the Relevant
2 Geographic Markets by continuously entering into successive agreements with each of the
3 significant Network Vendors that make it impossible for rival hospitals to effectively
4 compete by offering lower prices for the hospital healthcare services and products they sell.
5 This conduct has damaged Self-Funded Payors, and by extension the general economy of
6 this state, by requiring them to pay higher prices for healthcare than they would have to pay
7 in the absence of Sutter's anticompetitive contract terms.

8 132. While Sutter may be recently changing course on allowing Self-Funded Payors
9 the opportunity to review confidentially contracts between Sutter and Network Vendors in
10 order to bind Self-Funded Payors to arbitration provisions,¹ nothing prevents Sutter from
11 reversing itself. Moreover, recently enacted statutes require Sutter to be more transparent as
12 to its pricing vis-à-vis Self-Funded Payors and enrollees in Health Plans, but Sutter can and
13 does still hinder price transparency on the part of its hospitals or other providers for general
14 acute care services (including inpatient or outpatient services) or for ancillary services to
15 enrollees in Health Plans.

16 **IX. THE ANTICOMPETITIVE EFFECTS OF SUTTER'S ILLEGAL CONDUCT**

17 133. Hospitals offer pricing below their Chargemaster prices only through access
18 negotiated by the Network Vendors that arrange for hospital participation in their Provider
19 Networks. Self-Funded Payors and Commercial Insurance Companies can obtain the access
20 necessary to offer a commercially viable Health Plan to their Health Plan Enrollees only by
21 utilizing those same Provider Networks through agreements with the Network Vendors that
22 assembled them. Hence, it is the agreements between Sutter and the Network Vendors for
23 Health Plan access to Sutter's hospitals that determines the amounts that will be paid by Self-
24 Funded Payors and Commercial Insurance Companies when their Health Plan Enrollees use
25 the Sutter hospitals included in their Health Plans.

27 ¹ Although the People are not challenging Sutter's arbitration provisions in this
28 Complaint, the People do not thereby concede that those arbitration provisions are legal
under antitrust laws.

1 134. While Sutter claims it is willing to negotiate agreements with Network Vendors
2 that do not require the inclusion of all Sutter providers, inflated prices for included providers,
3 in combination with the All-or-Nothing Terms, Anti-Incentive Terms, and Price Secrecy
4 Terms, effectively force Network Vendors to contract for all Sutter Vendors.

5 135. The All-or-Nothing Terms, Anti-Incentive Terms, and Price Secrecy Terms in the
6 agreements between Sutter and the Network Vendors are components of an overarching
7 restraint of trade that unreasonably prevents the salutary price competition that is the
8 hallmark of our free-market economic system. By contractually insulating itself from the
9 price discipline that flows from unconstrained price competition, Sutter is able to charge and
10 maintain prices for its general acute care hospital and other healthcare services that
11 dramatically exceed the prices it could charge in an unrestrained competitive market.

12 136. Sutter has been able to charge higher system-wide prices, even when adjusted for
13 the severity of its patients, with its prices greatly exceeding that of its competitors in the
14 inpatient and outpatient markets in Northern California. Those prices do not reflect
15 differential system-wide costs or differential system-wide quality of care.

16 137. Sutter's illegal practices foreclose the sale of lower-priced and/or higher-quality
17 hospital healthcare services and ancillary products in the relevant markets. Because
18 approximately up to half of California workers obtain their healthcare through a Health Plan
19 offered by a Self-Funded Payor, the economic damage to the state is quite substantial.

20 138. So long as Sutter can compel Network Vendors to enter into anticompetitive
21 contracts that prevent price considerations from influencing the purchase decisions of their
22 Health Plan Enrollees, Sutter will be able to evade the competitive forces that make a free
23 market economy work properly for the benefit of employers that offer healthcare and
24 employees who need it, thereby damaging the economy of the state. Sutter's conduct also
25 thwarts the incentive of any competitors to challenge Sutter, and Self-Funded Payors will
26 continue to pay supra-competitive prices for general acute care services (including inpatient
27 and outpatient services) as well as ancillary services. These effects are the same for
28 Commercial Insurance Plans.

1 **X. CAUSES OF ACTION**

2 **First Cause of Action**

3 **Price Tampering and Fixing in Violation of the Cartwright Act**

4 **(Cal. Bus. & Prof. Code Section 16720, *et seq.*)**

5 139. The People incorporate by reference and reallege, as though fully set forth herein,
6 each and every allegation as set forth in the preceding paragraphs of this Complaint.

7 140. Sutter has entered into contracts with Network Vendors that unlawfully control
8 and tamper with the price terms that Self-Funded Payors may offer the enrollees in their
9 Health Plans. The purpose of Sutter's contractual restrictions is to eliminate price
10 competition and thereby stabilize and maintain prices for general acute care services
11 (including inpatient and outpatient services) as well as ancillary services at supra-competitive
12 levels in violation of California Bus. & Prof. Code §16720 *et seq.*

13 141. Sutter unlawfully controls, fixes, and tampers with prices through the Anti-
14 Incentive, Price Secrecy and All-or-Nothing Terms that it compels Network Vendors to
15 accept. The combined effect of these agreement terms is to:

- 16 a. Force Self-Funded Payors to accept Provider Networks that include all Sutter
17 hospitals and all other Sutter providers or no Sutter hospitals and Sutter providers,
18 preventing them from selecting only those Sutter providers that offer pricing that
19 is competitive with other providers in the area.
- 20 b. Prevent Self-Funded Payors from promoting price competition for the sale of
21 general acute care hospital services, including inpatient and outpatient services,
22 and ancillary services, by offering more favorable price terms to their Health Plan
23 Enrollees that select more cost-effective competing hospitals, competing
24 ambulatory surgery centers, and competing non-hospital ancillary providers,
25 instead of higher-priced Sutter hospitals.

26 142. The Anti-Incentive Terms guarantee that whenever Sutter is included in a
27 Provider Network, no other Healthcare Provider in that network will receive more
28 preferential treatment than Sutter with respect to the price terms offered by Self-Funded

1 Payors to their Health Plan Enrollees. Sutter thus interferes with the freedom of Self-Funded
2 Payors to set the prices they charge Health Plan Enrollees in accordance with their best
3 judgment and in response to competitive market conditions.

4 143. The purpose and combined effect of the All-or-Nothing, Anti-Incentive, and Price
5 Secrecy Terms is to insulate Sutter from and hinder price competition for the sale of general
6 acute care hospital services, including inpatient and outpatient services, and ancillary
7 services. These terms enable Sutter to charge, maintain, and collect supra- competitive prices
8 from Self-Funded Payors, and they unreasonably restrain the ability of Sutter's competitors to
9 compete with Sutter.

10 144. Sutter's anticompetitive conduct constitutes price tampering and fixing, which is
11 a per se violation of California's antitrust laws and in the alternative is, in any event, an
12 unreasonable and unlawful restraint of trade as the anticompetitive effects of Sutter's conduct
13 far outweigh any purported non-pretextual, pro-competitive justifications.

14 145. The alleged need to provide charity care or to compensate for alleged losses in
15 covering Medicare and Medicaid patients are not valid procompetitive defenses under the
16 law.

17 146. Under Cal. Bus. & Prof. Code § 16754 and 16754.5, the Attorney General seeks
18 injunctive, declaratory and other equitable relief to require Sutter to cease its anticompetitive
19 conduct, to restore fair competition, to deny Sutter the fruits of its illegal conduct—
20 specifically the disgorgement of overcharges, to prevent the resumption of that conduct or
21 conduct with the same effect, and to impose such other relief as may be just and appropriate
22 for Sutter's violations of the Cartwright Act.

23 **Second Cause of Action**

24 **Unreasonable Restraint of Trade in Violation of the Cartwright Act**

25 **(Cal. Bus. & Prof. Code Section 16720, *et seq.*)**

26 147. The People incorporate by reference and reallege, as though fully set forth herein,
27 each and every allegation as set forth in the preceding paragraphs of this Complaint.
28

1 148. Sutter has entered into contracts with Health Plan Vendors and engaged in
2 anticompetitive conduct that was and continues to be an unreasonable restraint of trade and
3 commerce in violation of California Bus. & Prof. Code §16720.

4 149. Some Sutter hospitals have market power in certain Relevant Geographic
5 Markets as “must have” hospitals. The market power that Sutter possesses in those markets is
6 greatly enhanced on a system-wide basis across all markets because Sutter allows Health
7 Plan access to its hospitals only on a bundled all-or-nothing basis. Sutter uses that collective
8 market power to compel the Network Vendors to include the anticompetitive All-or-Nothing,
9 Anti-Incentive, and Price Secrecy Terms in their written agreements with Sutter.

10 150. By compelling Network Vendors to agree to the All-or-Nothing, Anti-Incentive,
11 and Price Secrecy Terms, Sutter unlawfully restrains trade and restricts the ability of its
12 competitors to compete in the Relevant Geographic Markets for general acute care hospital
13 services (including inpatient and outpatient surgery services) and ancillary services.

14 151. The purpose and combined effect of the All-or-Nothing, Anti-Incentive, and Price
15 Secrecy Terms is to dramatically reduce or eliminate price considerations from the purchase
16 decisions made by Health Plan Enrollees when they select a hospital in Northern California
17 and thereby eliminate the ability of more cost-efficient rival hospitals, rival ambulatory
18 surgery centers, or rival non-hospital ancillary service providers, to compete with Sutter
19 hospitals. These same anticompetitive contract terms dramatically reduce or eliminate price
20 considerations from the decisions made by Network Vendors to either include or exclude
21 individual Sutter hospitals in their Provider Networks.

22 152. The purpose and combined effect of the All-or-Nothing, Anti-Incentive and Price
23 Secrecy Terms is to restrain competition for general acute care hospital services (including
24 inpatient and outpatient surgery services), and for ancillary services, in the Relevant
25 Geographic Markets, which in turn allows Sutter to command supra-competitive prices, as
26 described in detail above.

27 153. Through its All-or-Nothing, Anti-Incentive, and Price Secrecy Terms, Sutter
28 unlawfully conditions the sale of general acute care hospital services (including inpatient and

1 outpatient services) and of ancillary services on an In-Network price basis at any Sutter
2 hospital to an agreement to offer and pay for Sutter's price-inflated services and products at
3 all of Sutter's hospitals. These terms together ensure not only that all Sutter hospitals will be
4 included in nearly every Provider Network, but also that Health Plan Enrollees will actually
5 tend to use higher-priced Sutter hospitals because they have no economic incentive to choose
6 a more cost-effective competing hospital, ambulatory surgery center, or non-hospital
7 ancillary service provider instead. Sutter's use of these terms in its agreements with the
8 Network Vendors forecloses millions of dollars of commerce that would otherwise go to
9 lower-priced or higher-quality hospital or other competitors, thereby preventing substantial
10 savings to Self-Funded Payors.

11 154. Sutter's anticompetitive conduct unlawfully restrains competition in the relevant
12 markets. Sutter's anticompetitive conduct constitutes a per se violation of California's
13 antitrust law and is, in any event, an unreasonable and unlawful restraint of trade. The
14 anticompetitive effects of Sutter's conduct far outweigh any purported non-pretextual, pro-
15 competitive justifications.

16 155. The alleged need to provide charity care or to compensate for alleged losses in
17 covering Medicare and Medicaid patients are not valid procompetitive defenses under the
18 law

19 156. Under Cal. Bus. & Prof. Code §§ 16754 and 16754.5, the Attorney General seeks
20 injunctive, declaratory and other equitable relief to require Sutter to cease its anticompetitive
21 conduct, to restore fair competition, to deny Sutter the fruits of its illegal conduct—
22 specifically the disgorgement of overcharges, to prevent the resumption of that conduct or
23 conduct with the same effect, and to impose such other relief as may be just and appropriate
24 for Sutter's violations of the Cartwright Act.

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1 **Third Cause of Action**

2 **Combination to Monopolize in Violation of the Cartwright Act**

3 **(Cal. Bus. & Prof. Code Section 16720, *et seq.*)**

4 157. The People incorporate by reference and reallege, as though fully set forth herein,
5 each and every allegation as set forth in the preceding paragraphs of this Complaint.

6 158. Sutter has entered into contracts with Health Plan Vendors and engaged in
7 anticompetitive conduct that constitutes a combination to monopolize, and/or maintain its
8 monopoly in, the markets for general acute care hospital services (including inpatient and
9 outpatient services) and for ancillary services in which it participates in violation of
10 California Bus. & Prof. Code §16720.

11 159. By compelling Health Plan Vendors to agree to the All-or-Nothing, Anti-
12 Incentive, and Price Secrecy Terms, Sutter unlawfully restrains trade with the purpose and
13 effect of obtaining or maintaining monopoly power. This in turn allows Sutter to demand and
14 obtain supra-competitive prices, as described in detail above.

15 160. Sutter's anticompetitive conduct constitutes a per se violation of California's
16 antitrust laws and in the alternative is, in any event, an unreasonable and unlawful restraint of
17 trade as the anticompetitive effects of Sutter's conduct far outweigh any purported non-
18 pretextual, pro-competitive justifications.

19 161. The alleged need to provide charity care or to compensate for alleged losses in
20 covering Medicare and Medicaid patients are not valid procompetitive defenses under the
21 law

22 162. Under Cal. Bus. & Prof. Code §§ 16754 and 16754.5, the Attorney General seeks
23 injunctive, declaratory, and other equitable relief to require Sutter to ease its anticompetitive
24 conduct, to restore fair competition and, to deny Sutter the fruits of its illegal conduct—
25 specifically the disgorgement of overcharges, to prevent the resumption of that conduct or
26 conduct with the same effect, and to impose such other relief as may be just and appropriate
27 for Sutter's violations of the Cartwright Act.
28

1 **XI. PRAYER FOR RELIEF**

2 WHEREFORE, the People pray that this Court enter judgment against Defendant,
3 adjudging, and decreeing that:

4 A. Defendant has engaged in a trust, contract, combination, or conspiracy in violation
5 of California Business and Professions Code §16750(a), and the People have been
6 injured as a result of this violation.

7 B. The unlawful conduct, contract or combination alleged herein be adjudged and
8 decreed to be:

9 a. An unlawful effort to maintain, control, or tamper with prices in violation
10 of the Cartwright Act;

11 b. An unreasonable restraint of trade in violation of the Cartwright Act; and

12 c. An unlawful conspiracy to attain or maintain monopoly power in
13 violation of the Cartwright Act.

14 C. Sutter, its affiliates, successors, transferees, assignees, and the officers, directors,
15 partners, agents, and employees thereof, and all other persons acting or claiming to
16 act on their behalf or in concert with them, be permanently enjoined and restrained
17 from continuing, maintaining, or renewing the conduct, contract, conspiracy, or
18 combination alleged herein, or from entering into any other illegal agreement,
19 conspiracy, or combination alleged herein, or from entering into any other contract,
20 conspiracy or combination having a similar purpose or effect, and from adopting or
21 following any practice, plan, program, or device having a similar purpose or effect.
22 These proposed terms should apply to contracts with Network Vendors (whether
23 those contracts are negotiated on behalf of Self-Funded Payors, Commercial
24 Insurance Plans, or both) as the effects of Sutter's anticompetitive conduct are the
25 same as to Self-Funded Payors as well as Commercial Insurance Plans and as any
26 equitable relief imposed should not penalize the victims of Sutter's anticompetitive
27 conduct by forcing them to become Self-Funded Payors to avail themselves of the
28 benefits of these proposed terms.

- 1 D. Sutter be precluded from continuing to implement the All-or-Nothing, Anti-
2 Incentive, and Price Secrecy Terms that are used to facilitate the anticompetitive
3 conduct alleged herein. These proposed terms should apply to contracts with
4 Network Vendors (whether those contracts are negotiated on behalf of Self-Funded
5 Payors, Commercial Insurance Plans, or both) as the effects of Sutter's
6 anticompetitive conduct are the same as to Self-Funded Payors as well as
7 Commercial Insurance Plans and as any equitable relief imposed should not
8 penalize the victims of Sutter's anticompetitive conduct by forcing them to become
9 Self-Funded Payors to avail themselves of the benefits of these proposed terms.
- 10 E. Sutter be required to do the following affirmative acts so as to restore competition
11 under Section 16754.5 of the Cartwright Act: (1) stagger its negotiations between
12 its providers of inpatient services, outpatient services, ancillary services, and
13 affiliated physician groups that refer patients to non-Sutter hospitals on the one
14 hand and Network Vendors on the other hand so that Network Vendors are not
15 faced with the prospect of *en masse* termination of all of Sutter's providers, but
16 rather would negotiate with different groups of these Sutter providers at different
17 times, with a trustee at Sutter's expense to be appointed to oversee that process and
18 resolve any disputes; (2) require that different negotiating teams handle the
19 negotiations of these different groups of Sutter providers with Network Vendors,
20 and be forbidden from communicating with each other directly or indirectly, with a
21 trustee to be appointed at Sutter's expense to oversee the creation of these teams
22 and the creation of a wall to avoid such direct or indirect communications; (3) agree
23 to mandatory, binding arbitration within 90 days of contract termination as to these
24 group of Sutter providers in a neutral forum experienced in health care matters and
25 according to neutral procedural rules with the existing contract provisions
26 remaining in place pending the results of the arbitration, (4) agree to arbitration of
27 out-of-network charges with Network Vendors in a neutral forum experienced in
28 health care matters and according to neutral procedural rules; (5) allow Network

1 Vendors to exclude individual Sutter hospitals from quality programs, such as
2 Centers of Excellence programs, where those hospitals do not meet generally
3 applicable criteria for gauging cost-effective delivery of quality services; (6) set out
4 an arbitration process by which Sutter, or individual Sutter providers of general
5 acute care services (including inpatient and outpatient services), ancillary products,
6 and affiliated physician groups that refer to non-Sutter hospitals, would participate
7 in a tiering plan or narrow network if agreement between Sutter (or individual
8 providers of the Sutter system) and Network Vendors cannot be reached in a neutral
9 forum experienced in health care matters and according to neutral procedural rules;
10 (7) forbear from imposing any additional prerequisites or requirements for
11 transparency beyond those required by SB 751 and 1340; (8) charge the pre-
12 acquisition or pre-affiliation contract rate for any newly acquired or affiliated
13 Healthcare Providers until the later of (a) the expiration of the pre-acquisition or
14 pre-affiliation contract or (b) one year from the date of any such acquisition or
15 affiliation; (9) cease transferring monies earned by its Healthcare Providers in its
16 various corporate regions outside of those regions for purposes of financing its
17 health plan; (10) agree not to retaliate directly or indirectly against Self-Funded
18 Payors, Healthcare Benefits Trusts, Network Vendors, or Commercial Insurance
19 Plans for any cooperation with the Attorney General or with the plaintiffs in the
20 UEBT case; (11) allow the Attorney General access as required to its business,
21 records, and personnel to enforce the provisions of paragraphs C, D, and E; and
22 (12) agree to a trustee, to be appointed by the Attorney General at Sutter's expense,
23 to ensure compliance with the provisions of paragraphs C, D, and E, with periodic
24 compliance audits (including if necessary the hiring of accountants at Sutter's
25 expense to aid him or her in conducting such audits) and periodic interviews of
26 Sutter's senior management and directors. These proposed affirmative acts should
27 apply to contracts with contracts with Network Vendors (whether those contracts
28 are negotiated on behalf of Self-Funded Payors, Commercial Insurance Plans, or

1 both) as the effects of Sutter's anticompetitive conduct are the same as to Self-
2 Funded Payors as well as Commercial Insurance Plans and as any equitable relief
3 imposed should not penalize the victims of Sutter's anticompetitive conduct by
4 forcing them to become Self-Funded Payors to avail themselves of the benefits of
5 these proposed affirmative acts.

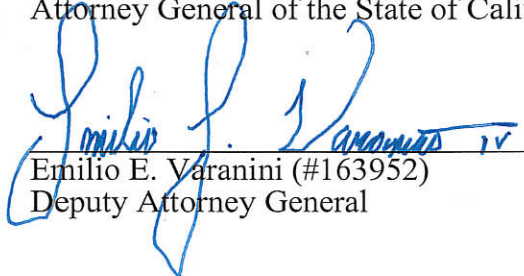
6 F. Sutter be ordered, under Section 16754.5 of the Cartwright Act so as to restore
7 competition, to disgorge overcharges to Self-Funded Payors arising from its
8 anticompetitive acts.

9 G. The People recover their costs of suit, including reasonable attorneys' fees, as
10 provided by law.

11 H. The People receive such other, further, and different relief as the case may require
12 and the Court may deem just and proper under the circumstances.

13 Dated: March 29, 2018

14 By: XAVIER BECERRA
Attorney General of the State of California

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17 Emilio E. Varanini (#163952)
18 Deputy Attorney General
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