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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE CITY AND COUNTY OF SAN FRANCISCO

CGC-18-565398

PEOPLE OF THE STATE OF CALIFORNIA EX REL. XAVIER BECERRA, **Plaintiff,** **v.** **SUTTER HEALTH,** **Defendant.**	**COMPLAINT FOR VIOLATIONS OF THE CARTWRIGHT ACT (BUS. & PROF. CODE § 16720 *et seq.*)**

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

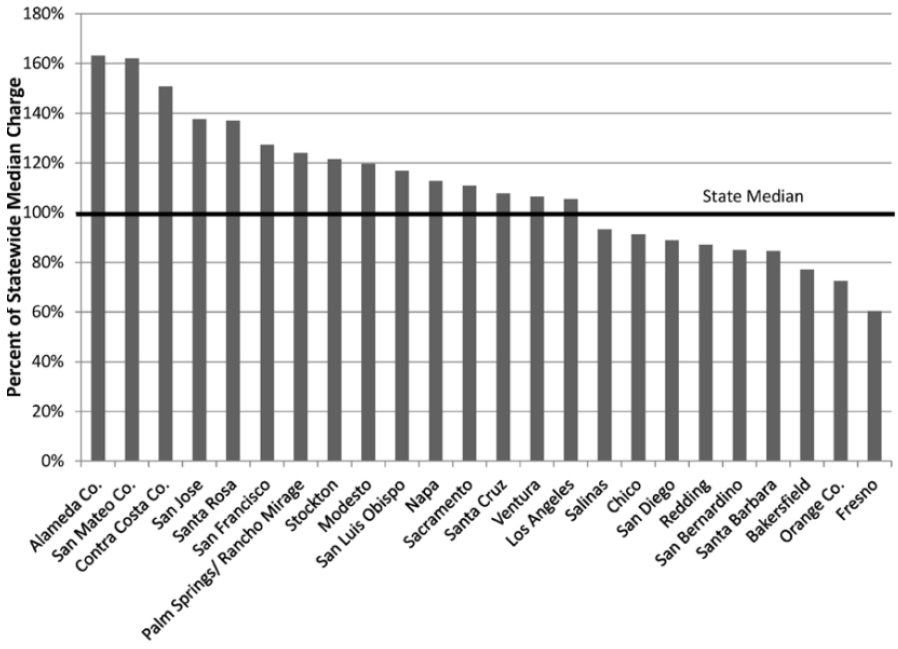
I. INTRODUCTION

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,

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

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

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

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

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

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

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

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

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

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

> When faced with price increases, there are numerous mechanisms through which health plans can discipline hospitals. (Defs.' Ex. 1021; Defs.' Ex. 1012, Decl. of Jay M. Gellert at 14–15; Hr'g Tr. at 716:18–718:17.) The simplest, but rarely used, is to exclude hospitals from the plans' provider networks. (Defs.' Ex. 1026, Dep. of John Sweeney at 17–21.) The primary mechanism by which MCOs and IPAs keep prices low is through the "steering" of patients. In managing their patients' illnesses, physicians are often responsible for deciding the components to be used in providing treatment, including the hospitals to 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-

> effective environment. When faced with rising prices, MCOs can attempt to steer patients to lower cost health care providers and away from the hospital imposing a price increase, thereby pressuring the hospital to eliminate the price increase. (Defs.' Ex. 1013, Pugh Report ¶ 57.) As one witness who has been on both sides of the table explained, "there is a discipline going both ways" because "we need them, but simultaneously they need us." (Defs.' Ex. 1012, Gellert Decl. at 18, 40.)
>
> Hospitals, in general, have high fixed costs, both in terms of the physical plant and equipment as well as the high cost of maintaining a highly skilled staff. At the same time, their profit margins are thin. (Hr'g Tr. at 508:3–12; 706:21 – 707:17; Defs.' Ex. 1013, Pugh Report ¶ 59; Defs.' Ex. 1001, Guerin–Calvert Report ¶ 63.) Steering has been quite effective in disciplining prices because hospitals are sensitive to declines in volume. (Defs.' Ex. 1001, Guerin–Calvert Report ¶¶ 63–64; Defs.' Ex. 1013, Pugh Report ¶¶ 59–61; Defs.' Ex. 1012, Gellert Decl. at 14.)

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

13. But through its anticompetitive conduct, Sutter leveraged and maximized its market power in certain local healthcare markets across all markets and prevented insurers from using steering and tiering to counter its excessive pricing. And it cloaked its conduct to prevent awareness by employers, enrollees, and the public. Sutter is not merely a provider with a few hospitals or one whose dominance is limited to a county or part of a county with geographical impediments preventing easy access to alternatives. Rather, Sutter became a large multi-market healthcare system with at least 24 state-licensed hospitals throughout Northern California. Sutter reports that within its network are 24 separately-licensed 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.

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

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

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

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

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

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

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

II. SUMMARY OF FACTUAL ALLEGATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. A de facto anticompetitive agreement requiring that all Sutter Hospitals and Healthcare Providers throughout Northern California be included in the Provider Network. Sutter thereby abuses its market power derived from its "must have" hospitals, or other "must have" providers in some geographic areas, to force Health Plans to include all Sutter hospitals and Healthcare Providers in their Healthcare Provider Networks—even those Sutter hospitals and providers that are located in areas where it would be far less costly to assemble a Provider Network using Sutter's lower-priced and/or higher-quality competitors instead of Sutter;

b. An anticompetitive agreement that prohibits anyone offering access to a Provider Network from giving incentives to patients that encourage them to use the healthcare facilities of Sutter's competitors—even when those competitors could offer higher quality healthcare and/or lower pricing; and

c. An anticompetitive agreement requiring that Sutter's inflated prices for its general acute care hospital services (including inpatient and outpatient services) and ancillary and other provider services may not be disclosed to anyone before the service is utilized and billed. The inflated pricing in Sutter's agreements with the Network Vendors is thereby concealed from everyone else—including historically from the Self-Funded Payors and Healthcare Benefits Trusts that ultimately would have to pay those prices.

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

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

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

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

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

III. JURISDICTION AND VENUE

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

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

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

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

IV. THE PARTIES

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

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

B. The Defendant

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

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

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

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

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

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

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

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

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

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

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

V. HOSPITAL HEALTHCARE IN NORTHERN CALIFORNIA

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

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

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

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

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

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

A. The Formation of Health Plans and Provider Networks

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

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

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

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

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

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

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

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

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

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

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

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

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

C. The Selection of Hospitals by Health Plan Enrollees

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

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

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

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

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

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

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

VI. THE RELEVANT MARKETS

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

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

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

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

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

A. The Relevant Service/Product Market

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

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

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

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

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

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

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

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

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

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

and Healthcare Benefits Trusts covering more than 100 employees ("Large Employers") that purchase Commercial Insurance Products.

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

B. The Relevant Geographic Markets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. SUTTER'S MARKET POWER

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

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

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

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

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

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

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

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

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

107. This market power is enhanced as well by the extension of the conduct set out herein to include Sutter's affiliated physician groups providing physician services even if those physician groups refer patients to hospitals that compete with Sutter. Sutter's conduct has also been extended to include Sutter's providers of ancillary services that are located outside of hospitals as well as other healthcare services. As a result of this conduct, Sutter 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Sutter's Anti-Incentive Contract Terms

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

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

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

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

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

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

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

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

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

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

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

C. Sutter's Price Secrecy Contract Terms

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

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

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

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

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

IX. THE ANTICOMPETITIVE EFFECTS OF SUTTER'S ILLEGAL CONDUCT

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

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

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

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

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

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

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

X. CAUSES OF ACTION

First Cause of Action

Price Tampering and Fixing in Violation of the Cartwright Act

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

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

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

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

a. Force Self-Funded Payors to accept Provider Networks that include all Sutter hospitals and all other Sutter providers or no Sutter hospitals and Sutter providers, preventing them from selecting only those Sutter providers that offer pricing that is competitive with other providers in the area.

b. Prevent Self-Funded Payors from promoting price competition for the sale of general acute care hospital services, including inpatient and outpatient services, and ancillary services, by offering more favorable price terms to their Health Plan Enrollees that select more cost-effective competing hospitals, competing ambulatory surgery centers, and competing non-hospital ancillary providers, instead of higher-priced Sutter hospitals.

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

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

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

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

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

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

Second Cause of Action

Unreasonable Restraint of Trade in Violation of the Cartwright Act

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

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

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

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

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

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

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

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

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

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

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

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

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Third Cause of Action

Combination to Monopolize in Violation of the Cartwright Act

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

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

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

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

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

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

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

XI. PRAYER FOR RELIEF

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

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

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

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

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

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

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

D. Sutter be precluded from continuing to implement the All-or-Nothing, Anti-Incentive, and Price Secrecy Terms that are used to facilitate the anticompetitive conduct alleged herein. These proposed terms should apply to contracts with Network Vendors (whether those contracts are negotiated on behalf of Self-Funded Payors, Commercial Insurance Plans, or both) as the effects of Sutter's anticompetitive conduct are the same as to Self-Funded Payors as well as Commercial Insurance Plans and as any equitable relief imposed should not penalize the victims of Sutter's anticompetitive conduct by forcing them to become Self-Funded Payors to avail themselves of the benefits of these proposed terms.

E. Sutter be required to do the following affirmative acts so as to restore competition under Section 16754.5 of the Cartwright Act: (1) stagger its negotiations between its providers of inpatient services, outpatient services, ancillary services, and affiliated physician groups that refer patients to non-Sutter hospitals on the one hand and Network Vendors on the other hand so that Network Vendors are not faced with the prospect of *en masse* termination of all of Sutter's providers, but rather would negotiate with different groups of these Sutter providers at different times, with a trustee at Sutter's expense to be appointed to oversee that process and resolve any disputes; (2) require that different negotiating teams handle the negotiations of these different groups of Sutter providers with Network Vendors, and be forbidden from communicating with each other directly or indirectly, with a trustee to be appointed at Sutter's expense to oversee the creation of these teams and the creation of a wall to avoid such direct or indirect communications; (3) agree to mandatory, binding arbitration within 90 days of contract termination as to these group of Sutter providers in a neutral forum experienced in health care matters and according to neutral procedural rules with the existing contract provisions remaining in place pending the results of the arbitration, (4) agree to arbitration of out-of-network charges with Network Vendors in a neutral forum experienced in health care matters and according to neutral procedural rules; (5) allow Network

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

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

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

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

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

Dated: March 29, 2018

XAVIER BECERRA
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