

United States District Court  
Northern District of California

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UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
San Francisco Division

DJENEBA SIDIBE, et al.,  
Plaintiffs,  
v.  
SUTTER HEALTH,  
Defendant.

Case No. 12-cv-04854-LB

**(REDACTED) ORDER GRANTING  
MOTION TO CERTIFY CLASS  
UNDER RULE 23(B)(2) AND DENYING  
WITHOUT PREJUDICE MOTION TO  
CERTIFY CLASS UNDER RULE  
23(B)(3)**

Re: ECF Nos. 348 (under seal) and 379  
(redacted version)

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1 **INTRODUCTION**

2 In this putative class action, six plaintiffs (four individuals who enrolled in health-insurance  
3 policies from the health plans Aetna, Anthem Blue Cross, and Blue Shield and two small  
4 companies that paid for health insurance for their employees) are suing Sutter Health, which owns  
5 and operates a network of hospitals and medical-service providers in Northern California, for  
6 violations of the federal Sherman Antitrust Act, the California Cartwright Act, and the California  
7 Unfair Competition Law.

8 The plaintiffs allege that Sutter has “market power” in seven specific “geographic markets”  
9 (the “Tying Markets”) in Northern California, where Sutter’s hospitals are either the only hospital  
10 (i.e., a monopoly) or the dominant hospital in the market.<sup>1</sup> Health plans like Anthem and Blue  
11 Shield must include those Sutter hospitals in their provider networks to be able to assemble health-  
12 insurance products that are commercially marketable.<sup>2</sup> Sutter allegedly uses that leverage to  
13 require that health plans enter into “systemwide contracts” that include “all-or-nothing” and “anti-  
14 steering” provisions. Those provisions (1) require health plans to accept as in-network providers  
15 all of Sutter’s hospitals, at the prices Sutter dictates, and (2) prevent health plans from  
16 incentivizing their enrollees to go to lower-cost hospitals instead of Sutter’s higher-cost hospitals.<sup>3</sup>

17 In particular, the plaintiffs allege that Sutter (1) requires health plans to include its hospitals in  
18 four other geographic markets (the “Tied Markets”), at the prices Sutter dictates, and (2) prevents  
19 health plans from incentivizing their enrollees to go to non-Sutter hospitals in the Tied Markets.<sup>4</sup>  
20 Unlike in the Tying Markets, where Sutter has market power, in the Tied Markets, there are more  
21 hospitals and more hospital competition. This competition normally would drive Sutter’s prices  
22

23 \_\_\_\_\_  
24 <sup>1</sup> Fourth Amend. Compl. (“4AC”) – ECF No. 204 at 4 (¶ 4), 10 (¶¶ 30–31), 29 (¶¶ 86–87). The  
25 plaintiffs originally alleged eight Tying Markets but stipulated that summary judgment should be  
26 granted with respect to one of them. Citations refer to material in the Electronic Case File (“ECF”);  
27 pinpoint citations are to the ECF-generated page numbers at the top of documents.

28 <sup>2</sup> *Id.* at 4 (¶ 6), 11–12 (¶ 35).

<sup>3</sup> *Id.* at 4–5 (¶¶ 5–7), 11–12 (¶¶ 33–36), 13–15 (¶¶ 40–45).

<sup>4</sup> *Id.*

1 down.<sup>5</sup> But by tying its hospitals in the Tied Markets to its “must have” hospitals in the Tying  
2 Markets, Sutter forecloses competition by other hospitals in the Tied Markets and thus is able to  
3 charge and maintain supra-competitive prices at its hospitals.<sup>6</sup> The plaintiffs allege that the health  
4 plans have to pay Sutter supra-competitive prices and then, in turn, pass on those costs through to  
5 their customers in the form of higher premiums.<sup>7</sup> Consequently, it is the health plans’ customers  
6 — individuals and employers that buy health insurance — that ultimately bear the burden of  
7 paying Sutter’s supra-competitive prices.<sup>8</sup>

8 The plaintiffs seek (1) treble damages and restitution from Sutter to compensate them for the  
9 overcharges they incurred from Sutter’s alleged anticompetitive behavior and (2) a declaration that  
10 Sutter’s practices are anticompetitive and an injunction barring Sutter from continuing to engage  
11 in anticompetitive behavior, including its “tying,” “all-or-nothing,” and “anti-steering”  
12 arrangements.<sup>9</sup> They move to certify a class under Federal Rule of Civil Procedure 23(b)(2) and  
13 (b)(3) of all individuals and entities located in nine specific California Rating Areas (“RAs”)<sup>10</sup> that  
14 paid premiums for fully insured health-insurance policies from the health plans Blue Shield,  
15 Anthem, Aetna, Health Net, or UnitedHealthcare from September 28, 2008 to the present.<sup>11</sup>

16 Sutter opposes the plaintiffs’ motion. Sutter’s main arguments are that (1) there are intraclass  
17 differences and conflicts that render the plaintiffs atypical and inadequate to represent the class  
18 and (2) individual issues about whether class members suffered antitrust injury, and how class  
19 members’ damages would be calculated, predominate over common issues.

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21  
22 \_\_\_\_\_  
<sup>5</sup> *See id.* at 6 (¶ 9), 30 (¶ 94).

23 <sup>6</sup> *Id.* at 4–5 (¶¶ 5–8), 11–12 (¶¶ 35–36), 30 (¶ 94), 33 (¶¶ 103–05).

24 <sup>7</sup> *Id.* at 3 (¶ 2), 5 (¶ 8), 10 (¶ 28), 34–35 (¶¶ 109–12).

25 <sup>8</sup> *Id.*

26 <sup>9</sup> *Id.* at 43.

27 <sup>10</sup> Under the Affordable Care Act, states are required to define geographic “rating areas” to be used by  
health plans in setting premium prices for individual and small-group health-insurance policies. 42  
U.S.C. § 300gg(a)(2).

28 <sup>11</sup> Pls. Mot. for Class Certification (“MCC”) – ECF No. 379 at 3.

1 The court held a hearing and now rules as follows. The court finds that the plaintiffs have not  
 2 made a showing that issues of antitrust injury and damages are subject to common proof such that  
 3 certification of a damages class under Rule 23(b)(3) is appropriate. But the court also finds that the  
 4 plaintiffs have met the requirements for certification of an injunctive- and declaratory-relief class  
 5 under Rule 23(b)(2). The court thus grants the plaintiffs’ motion to certify their proposed class  
 6 under Rule 23(b)(2) and denies without prejudice their motion to certify their proposed class under  
 7 Rule 23(b)(3).

## 8 9 STATEMENT

### 10 1. The Proposed Class

11 The plaintiffs seek to certify a proposed class of:

12 All entities in California Rating area 1, 2, 3, 4, 5, 6, 8, 9 or 10 (the “Nine RAs”),  
 13 and all individuals that either live or work in one of the Nine RAs, that paid  
 14 premiums for a fully-insured health insurance policy from Blue Shield, Anthem  
 15 Blue Cross, Aetna, Health Net or United Healthcare from September 28, 2008 to  
 16 the present. This class definition includes Class Members that paid premiums for  
 17 individual health insurance policies that they purchased from these health plans and  
 18 Class Members that paid premiums, in whole or in part, for health insurance  
 19 policies provided to them as a benefit from an employer or other group purchaser  
 20 located in one of the Nine RAs.<sup>12</sup>

### 21 2. Background

22 “The market for hospital services and medical care is complex.” *Sidibe v. Sutter Health*, No.  
 23 12-cv-04854-LB, 2019 WL 2078788, at \*4 (N.D. Cal. Apr. 12, 2019) (quoting *Cascade Health*  
 24 *Sols. v. PeaceHealth*, 515 F.3d 883, 891 (9th Cir. 2008)). “There are at least three transactions  
 25 involved in providing hospital services and health care in connection with health insurance.” *Id.*

26 “First, hospitals [such as Sutter] sell hospital services to health-insurance plans [such as Blue  
 27 Shield, Anthem, Aetna, Health Net, or UnitedHealthcare]. Hospitals and health plans negotiate  
 28 whether a given hospital will be included in the health plan’s network and negotiate the rates that

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<sup>12</sup> Pls. MCC – ECF No. 379 at 13.

1 the health plan will pay the hospital for its hospital services.” *Id.* (citing *Saint Alphonsus Med.*  
2 *Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 784 & n.10 (9th Cir. 2015) (citing  
3 Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L.J. 671, 672, 674  
4 (2000))). “These negotiations are highly price-sensitive.” *Id.* (citing *FTC v. Advocate Health Care*  
5 *Network*, 841 F.3d 460, 465 (7th Cir. 2016) (citing Vistnes, 67 Antitrust L.J. at 674–75)). “All else  
6 being equal, hospitals prefer higher rates and health plans prefer lower rates.” *Id.* (citing *Cascade*  
7 *Health*, 515 F.3d at 892).<sup>13</sup>

8 “Second, health plans sell health insurance to consumers. The consumers are individuals (who  
9 directly purchase health insurance for themselves or their families) and employers (which  
10 purchase health insurance for their employees).” *Id.* at \*5 (citing *Cascade Health*, 515 F.3d at 892;  
11 *St. Luke’s*, 778 F.3d at 784). “An important way that health plans compete for consumers is their  
12 provider networks: the hospitals, physicians, and ancillary providers that the health plan offers ‘in  
13 network’ and that enrollees are encouraged to use.” *Id.* (citing Gregory S. Vistnes & Yianis  
14 Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 Antitrust L.J. 253, 267  
15 (2013)). “All else being equal, a health plan with a more comprehensive provider network will be  
16 more attractive to consumers.” *Id.* (citing Vistnes & Sarafidis, 79 Antitrust L.J. at 267). “At the  
17 same time, health plans that have high-priced providers in their networks have higher costs.” *Id.*  
18 (citing Vistnes & Sarafidis, 79 Antitrust L.J. at 267). “Thus, in choosing how inclusive their  
19 provider network is, health plans balance the benefit of more comprehensive networks with the  
20 costs of paying more to providers in their networks.” *Id.* (citing Vistnes & Sarafidis, 79 Antitrust  
21 L.J. at 267).<sup>14</sup>

22 “Third, hospitals seek to attract health-plan enrollees who need hospital services to come to  
23 them (as opposed to other hospitals).” *Id.* (citing *St. Luke’s*, 778 F.3d at 784 n.10 (citing Vistnes,  
24 67 Antitrust L.J. at 681–82); *Advocate Health*, 841 F.3d at 471 (citing Vistnes, 67 Antitrust L.J. at  
25 672); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016) (citing Vistnes,

26 \_\_\_\_\_  
27 <sup>13</sup> *Accord* Chipty Decl. – ECF No. 379-1 at 17 (¶ 14); Chipty Dep. – ECF No. 415-1 (under seal) at  
122 (p. 425).

28 <sup>14</sup> *Accord* Chipty Dep. – ECF No. 415-1 (under seal) at 123–24 (pp. 426–31).

1 Antitrust L.J. at 672)). “Unlike health plans, which are sensitive to the prices that hospitals charge  
 2 for their services, enrollees are ‘largely insensitive’ to price because the prices that hospitals  
 3 charge are largely borne by the enrollees’ health plans, not by the enrollees.” *Id.* (some internal  
 4 quotation marks omitted) (quoting *St. Luke’s*, 778 F.3d at 784 n.10 (citing *Vistnes*, 67 Antitrust  
 5 L.J. at 682) and citing *Advocate Health*, 841 F.3d at 471 (citing *Vistnes*, 67 Antitrust L.J. at 677,  
 6 680); *Penn State Hershey*, 838 F.3d at 342). “Instead of taking price into account, enrollees choose  
 7 hospitals based mostly on non-price factors, such as location or quality of services.” *Id.* (internal  
 8 quotation marks omitted) (quoting *Penn State Hershey*, 838 F.3d at 341 and citing *St. Luke’s*, 778  
 9 F.3d at 784 n.10 (citing *Vistnes*, 67 Antitrust L.J. at 682); *Advocate Health*, 841 F.3d at 465  
 10 (citing *Vistnes*, 67 Antitrust L.J. at 677, 682)).<sup>15</sup>

### 12 **3. The Plaintiffs’ Antitrust Allegations Regarding Sutter’s Anticompetitive Practices**

#### 13 **3.1 Sutter’s Systemwide Contracting and Its “All-or-Nothing,” “Anti-Steering,” and 14 “Penalty Rate” Provisions**

15 As of 2015, Sutter was the largest health system (other than Kaiser Permanente) in Northern  
 16 California, with 22 hospitals and approximately 4,000 patient beds.<sup>16</sup> Currently, Sutter has 24  
 17 hospitals and approximately 5,200 patient beds.<sup>17</sup>

18 Before the early 2000s, health plans were able to negotiate with Sutter’s various hospitals  
 19 individually. Health plans could include some Sutter hospitals in their provider network while  
 20 excluding (or threatening to exclude) others. Under that structure, if a health plan determined that  
 21 a particular Sutter hospital was too expensive, it had the option to exclude that hospital from its  
 22 provider networks. Consequently, each Sutter hospital had an incentive to offer competitive prices

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25 <sup>15</sup> *Accord* Chipty Decl. – ECF No. 379-1 at 17 (¶ 14); Chipty Dep. – ECF No. 415-1 (under seal) at  
 26 122 (p. 425). Some enrollees may be more directly sensitive to price, e.g., enrollees in high-deductible  
 plans. *Sidibe*, 2019 WL 2078788, at \*5 n.13 (citing *Penn State Hershey*, 838 F.3d at 342 n.6).

27 <sup>16</sup> Chipty Decl. – ECF No. 379-1 at 20–22 (¶ 20).

28 <sup>17</sup> *Id.* at 22–23 (¶¶ 21–22).

1 to incentivize health plans to include the hospital in their provider networks (which in turn would  
2 result in the hospital getting more patient volume).<sup>18</sup>

3 The plaintiffs maintain that beginning in the early 2000s, Sutter began requiring health plans to  
4 enter into “systemwide” contracts that included “all-or-nothing” requirements. Sutter’s  
5 systemwide contracts require, or effectively require, a health plan that wants to include one Sutter  
6 hospital in its provider network to include all Sutter hospitals. Additionally, Sutter’s systemwide  
7 contracts contain “anti-steering” provisions that effectively bar health plans from creating “tiered”  
8 insurance products to incentivize their enrollees to use lower-cost non-Sutter hospitals rather than  
9 more expensive Sutter hospitals (i.e., products where enrollees pay lower co-pays to use providers  
10 in higher tiers and higher co-pays to use providers in lower tiers where Sutter hospitals are in a  
11 lower tier).<sup>19</sup>

12 More specifically, Sutter’s systemwide contracts include provisions under which health plans  
13 must pay Sutter what they have characterized as “penalty rates”<sup>20</sup> for any Sutter hospital that they

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14  
15  
16 <sup>18</sup> Joyner Decl. – ECF No. 497 at 4–5 (¶ 7) (“Prior to 2002, Blue Shield negotiated with Sutter’s  
17 various hospitals, physician groups, and other providers individually to assemble provider networks.  
18 Blue Shield had the ability to decide whether and under what conditions each Sutter provider could  
19 participate in Blue Shield’s provider networks. During that time, if Blue Shield found that a particular  
20 Sutter provider was too expensive, it had the option to exclude that provider from its networks.  
21 Therefore, each Sutter provider had an incentive to offer competitive prices if it wanted to be included  
22 in Blue Shield’s networks.”); Melody Decl. – ECF No. 313-1 (under seal) at 5 (¶ 9); Lacroix-Milani  
23 Decl. – ECF No. 314 (under seal) at 6 (¶ 12); Welsh Decl. – ECF No. 335 (under seal) at 5 (¶ 11).

24 <sup>19</sup> Joyner Decl. – ECF No. 497 at 5 (¶ 8) (“This dynamic changed dramatically when Sutter announced  
25 that all of its providers would be negotiating as a bloc on a ‘systemwide’ basis. Beginning with the  
26 negotiations leading to the 2002 Systemwide Amendment between Sutter and Blue Shield, it became  
27 clear that selecting anything less than all Sutter hospitals and physician groups would have resulted in  
28 a requirement that Blue Shield and its self-funded health plan customers pay unsustainably high prices  
for the healthcare services of Sutter’s providers. Thus, as a practical matter, inclusion of one Sutter  
hospital suddenly required inclusion of all Sutter hospitals and physician groups, and one systemwide  
agreement would govern all of the relationships between Blue Shield and each Sutter provider. This  
was Sutter’s ‘systemwide’ negotiation strategy. It required Blue Shield to include ‘all’ of Sutter’s  
hospitals and physician groups in any new networks for the health plans to be competitive.”), 6 (¶¶ 15–  
16), 10 (¶ 30); Melody Decl. – ECF No. 313-1 (under seal) at 5–6 (¶¶ 9–13), 7 (¶ 18), 9 (¶ 26); de la  
Torre Decl. – ECF No. 312-4 (under seal) at 5 (¶ 12); Lacroix-Milani Decl. – ECF No. 314 (under  
seal) at 5–6 (¶¶ 9, 12–14); Lundbye Decl. – ECF No. 321 (under seal) at 4 (¶ 8), 8 (¶ 16); Welsh Decl.  
– ECF No. 335 (under seal) at 4 (¶¶ 9–10), 5 (¶¶ 12–14).

<sup>20</sup> Joyner Decl. – ECF No. 497 at 11–12 (¶¶ 34–35); Melody Decl. – ECF No. 313-1 (under seal) at 8  
(¶ 23); de la Torre Decl. – ECF No. 312-4 (under seal) at 6 (¶ 14), 7 (¶¶ 17–18).



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Northern District of California

1 place out-of-network or in a lower tier. Typically, when health-plan enrollees use a hospital that is  
 2 not in-network, the hospital can charge the health plan only the “reasonable and customary value”  
 3 of the hospital services provided, as mandated by state law. Sutter, however, requires health plans  
 4 to sign contracts that supersede the “reasonable and customary value” limit on charges and instead  
 5 require health plans to pay 95 percent of Sutter’s “full billed charges” — a substantially higher  
 6 amount — if their enrollees use Sutter hospitals that they have placed out-of-network or in a lower  
 7 tier. No matter how a health plan might structure its health-insurance products, it is inevitable that  
 8 some enrollees will have to use Sutter hospitals (e.g., if they need emergency care and a Sutter  
 9 hospital is the nearest hospital), in which case Sutter’s “penalty rates” would apply. These higher  
 10 “penalty rates” reduce or eliminate any savings the health plans could achieve by excluding or  
 11 tiering Sutter hospitals in the first place. Consequently, even where health plans technically are  
 12 permitted under their contracts to exclude or tier Sutter hospitals, they are effectively prevented  
 13 from doing so in a way that would give Sutter any incentive to lower its prices.<sup>21</sup>

14 \_\_\_\_\_  
 15 <sup>21</sup> As a former Senior Vice President from Blue Shield explained:

16 Sutter’s unique out-of-network pricing terms worked as follows: In California, health  
 17 plans must pay the appropriate charges for emergency room services even when their  
 18 members seek emergency room treatment at out-of-network hospitals. Typically, when a  
 19 Blue Shield member uses a hospital outside of Blue Shield’s provider network (e.g., in an  
 20 emergency situation), the amount that Blue Shield (or its self-funded customers) must pay  
 21 may be limited to the “reasonable and customary value for the health care services  
 22 rendered,” as mandated by state law for out-of-network providers. (Cal. Code Regs., title  
 23 28 §1300.71(a)(3)(B).) The “reasonable and customary” rates that Blue Shield pays for  
 24 services at an out-of-network hospital are often somewhat higher than the rates it would  
 25 pay to an in-network hospital but they typically are substantially less than the “full billed  
 26 charges” that hospitals often list on their hospital “chargemasters” for their services.

27 A substantial percentage of hospital healthcare is provided through hospital emergency  
 28 rooms and large numbers of CalPERS [California Public Employees’ Retirement System]  
 health plan enrollees inevitably would end up in the emergency rooms of Sutter’s 26 acute  
 care hospitals in Northern California. Accordingly, Sutter demanded that CalPERS agree  
 in advance to pay 95% of full billed charges for any services provided at an out-of-network  
 (“non-participating”) Sutter hospital. As a result, CalPERS had to agree in advance to pay  
 “non-par” rates that substantially exceeded the “reasonable and customary” out-of-network  
 rates otherwise mandated by state law.

....

In 2005, Sutter introduced the concept of the Non-Par rate, or 95% of billed charges,  
 into its Systemwide Amendment with Blue Shield. . . .

....

1 The plaintiffs maintain that Sutter can impose these systemwide contracts on health plans  
 2 because it has “market power” in seven specific geographic markets — the Tying Markets — in  
 3 Northern California. Sutter hospitals are either the only hospital or the predominant hospital in  
 4

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5 The power of the Non-Par (95% of billed charges) rate cannot be overstated. Blue  
 6 Shield has performed financial analyses that have concluded that payment of 95% of  
 7 Sutter’s full billed charges erases any possible benefit of excluding some higher-priced  
 8 Sutter providers from a network. This is because it is impossible to prevent health plan  
 9 enrollees from using Sutter hospitals in all instances. If a member needs emergency care  
 and uses a Sutter hospital outside of his plan (a common scenario we refer to as “leakage”),  
 then Blue Shield (and its self-funded payor customers) would have to pay 95% of billed  
 charges to Sutter. These prices are so high that having to pay them would defeat any  
 significant benefit of a narrow network.

10 . . . .

11 For many years Blue Shield has attempted to create tiered networks to foster price and  
 12 quality competition among the health care providers in its networks. In 2001, for example,  
 Blue Shield created a tiered network called Network Choice that included Sutter hospitals,  
 but Sutter required that all of its facilities be included as “Tier 1 (Choice) providers.”  
 13 Sutter threatened that Blue Shield and its self-funded health plan customers would have to  
 14 pay Non-Par rates equal to 95% of full-billed charges if all its facilities were not placed in  
 the preferred tier. By requiring that all of its facilities be included in the first tier, Sutter  
 prevented Blue Shield from offering customers financial incentives to utilize more cost-  
 15 effective hospitals. Thus, although Sutter technically was participating in a tiered product,  
 its hospitals were not placed in the lower tier that actually corresponded with its  
 16 significantly higher prices.

17 . . . .

18 Sutter’s threat to charge Non-Par rates in response to Blue Shield’s proposals for tiered  
 products was typically the death knell for these products. If Blue Shield and its self-funded  
 health plan customers had to pay this exorbitant 95% of billed charges rate, an amount  
 19 much higher than Blue Shield had to pay any other out-of-network provider, these products  
 would be economically unfeasible. Any benefit to be gained by excluding high-priced  
 Sutter hospitals from Tier 1 would be erased once the inevitable emergency room  
 20 “leakage” to Non-Par Sutter hospitals occurred.

21 . . . .

22 Sutter’s anti-tiering contractual restraints affected Blue Shield and each of Blue  
 Shield’s self-funded health plan customers in precisely the same manner. Because Sutter  
 23 contractually prohibited health plans from giving their members financial incentives to  
 select lower-priced alternatives, insisted upon 1st Tier status for Sutter providers that did  
 not qualify and imposed charges for non-participating Sutter providers at non-par rates of  
 24 95% of full billed charges, Sutter was able to destroy the ability of any “tiered” health plan  
 to moderate Sutter’s above-market pricing.

25  
 26 Joyner Decl. – ECF No. 497 at 10–18 (¶¶ 31–55); *accord* Melody Decl. – ECF No. 313-1 (under seal)  
 at 6–10 (¶¶ 14–31); de la Torre Decl. – ECF No. 312-4 (under seal) at 6–9 (¶¶ 13–28); Lacroix-Milani  
 Decl. – ECF No. 314 (under seal) at 6–15 (¶¶ 12–36); Lundbye Decl. – ECF No. 321 (under seal) at 4–  
 27 7 (¶¶ 9–13), 8–10 (¶¶ 18–21); Welsh Decl. – ECF No. 335 (under seal) at 5–11 (¶¶ 11–36), 12–13  
 (¶¶ 45–46).  
 28

1 those markets. Because health plans are required to offer their enrollees at least one nearby in-  
2 network hospital, they have no choice but to contract with Sutter so that they can include those  
3 Tying Market hospitals in their provider networks. Sutter then uses the fact that health plans have  
4 no choice but to contract with it to force health plans to accept its systemwide-contract terms,  
5 including its all-or-nothing, anti-steering, and penalty-rate provisions.<sup>22</sup>

6 The plaintiffs maintain that Sutter’s systemwide contracts allow it to charge higher prices at its  
7 hospitals in certain other geographic markets — the Tied Markets. Unlike in the Tying Markets, in  
8 the Tied Markets, there are more hospitals and more competition among hospitals. Those other  
9 hospitals normally would act as price constraints on Sutter hospitals. Health plans could threaten  
10 to exclude Sutter hospitals in favor of those other hospitals or place Sutter hospitals in lower tiers  
11 — thereby reducing Sutter hospitals’ patient volume (and, thus, their revenues) — to negotiate  
12 with Sutter to get it to lower its prices. But the systemwide contracts that Sutter imposes on health  
13 plans effectively bar health plans from using these negotiating tactics. Health plans thus are  
14 prevented from exposing Sutter to price competition. As a result, Sutter is free to charge supra-  
15 competitive prices at its hospitals in the Tied Markets.<sup>23</sup>

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17 <sup>22</sup> Joyner Decl. – ECF No. 497 at 7 (¶ 20) (“Sutter’s new ‘systemwide’ approach was very effective in  
18 promoting all-or-nothing contracting in the context of California’s healthcare laws regulating the  
19 assembly of provider networks. For example, in assembling a provider network to be marketed to self-  
20 funded payors and insured clients, California law requires Blue Shield to create a network with access  
21 to health care providers such that ‘all enrollees have a residence or workplace within 30 minutes or 15  
22 miles of a contracting or plan-operated hospital . . . .’ (Cal. Code Regs. title 28, § 1300.51(d)(H)(ii)).  
23 For example, if one of Blue Shield’s self-funded customers has an employee living in a rural area of  
24 Northern California, and the only hospital within 30 minutes or 15 miles of his residence or workplace  
25 was a Sutter Hospital, the law mandates that Sutter’s hospital be included in the network. Beginning  
26 with Sutter’s 2002 Systemwide Amendment, Blue Shield could not feasibly contract with that one  
27 Sutter hospital alone. It had to include all Sutter providers on a ‘systemwide’ basis.”) (ellipsis in  
28 original), 9 (¶ 27); Melody Decl. – ECF No. 313-1 (under seal) at 5 (¶¶ 7–8), 6 (¶ 11); de la Torre  
Decl. – ECF No. 312-4 (under seal) at 4 (¶¶ 8–9); Lacroix-Milani Decl. – ECF No. 314 (under seal) at  
5–6 (¶ 9), 11 (¶ 28); Lundbye Decl. – ECF No. 321 (under seal) at 3–4 (¶¶ 5–6); Welsh Decl. – ECF  
No. 335 (under seal) at 4 (¶ 8).

<sup>23</sup> Joyner Decl. – ECF No. 497 at 8–9 (¶¶ 23–25) (“It would have been desirable for Blue Shield to  
foster price competition by excluding selected Sutter hospitals in locations where there were  
competing hospitals that had higher or comparable quality but charged significantly lower prices.  
However, for all of the reasons described above, it was not economically feasible to assemble a  
provider network in Northern California that excluded all of Sutter’s hospitals and medical practices  
from Blue Shield’s provider networks. Therefore, Sutter’s ‘all or none’ contracting policy substantially  
impaired Blue Shield’s ability to foster price competition. As a result, Sutter was able to quickly raise

1 The plaintiffs maintain that Sutter engages in systemwide contracting with its all-or-nothing,  
2 anti-steering, and penalty-rate provisions with each of the health plans Blue Shield, Anthem,  
3 Aetna, Health Net, or UnitedHealthcare in the same general way. Sutter also charges these health  
4 plans the same allegedly supra-competitive prices, across different insurance products offered by  
5 any one health plan, and across different health plans.<sup>24</sup>

### 6 3.2 The “But For” World

7 The plaintiffs maintain that in the “but for” world — the counterfactual world where Sutter did  
8 not tie its hospitals or engage in anticompetitive practices<sup>25</sup> — health plans would be able to  
9 negotiate lower rates from Sutter. While health plans might still have no choice but to contract  
10 with Sutter hospitals in the Tying Markets, in the but-for world, health plans could threaten to  
11 exclude Sutter hospitals in the Tied Markets from their provider networks or place those Sutter  
12 hospitals in a lower tier in lieu of other competitor hospitals. In the face of this competition, Sutter  
13 would no longer be able to charge supra-competitive prices at its Tied Market hospitals and  
14 instead would have to lower its prices to stay competitive. The plaintiffs maintain that this would  
15 benefit all healthcare consumers and class members.<sup>26</sup>

16 For example, suppose a health plan currently offers a health-insurance policy that costs \$100 a  
17 month and includes Tied Market Sutter hospitals in the top tier of its in-network providers. Under

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18  
19 its reimbursement rates significantly above the rates that competing providers charged. . . . At or  
20 around the time that Blue Shield entered into its ‘systemwide’ agreement with Sutter in 2002, Blue  
21 Shield determined that Sutter’s pricing for acute care hospital services began increasing at a  
22 dramatically faster pace than the prices of all or nearly all of its competitors.”) (emphasis in original),  
23 9 (¶ 27), 12 (¶ 36), 18–20 (¶¶ 54–61); Melody Decl. – ECF No. 313-1 (under seal) at 8–9 (¶ 24), 10  
(¶ 30); de la Torre Decl. – ECF No. 312-4 (under seal) at 3–4 (¶¶ 4–7); de la Torre Decl. – ECF No.  
312-4 (under seal) at 5 (¶ 10), 7 (¶ 16); Lacroix-Milani Decl. – ECF No. 314 (under seal) at 4–5 (¶¶ 5–  
7), 6 (¶ 10); Lundbye Decl. – ECF No. 321 (under seal) at 9–10 (¶ 20).

24 <sup>24</sup> Joyner Decl. – ECF No. 497 at 5–6 (¶ 13), 20 (¶ 61); Melody Decl. – ECF No. 313-1 (under seal) at  
4 (¶¶ 4, 6); de la Torre Decl. – ECF No. 312-4 (under seal) at 5 (¶ 11); Lacroix-Milani Decl. – ECF  
No. 314 (under seal) at 15 (¶¶ 37–39); Welsh Decl. – ECF No. 335 (under seal) at 5 (¶ 12), 13 (¶¶ 47–  
48).

25  
26 <sup>25</sup> See Chipty Dep. – ECF No. 415-1 (under seal) at 125 (p. 436) (“Q. And in this case — taking the  
27 general to the specific, in this case, the but-for world would be Sutter negotiating contracts that did not  
have the challenge[d] contract terms? A. That’s correct.”).

28 <sup>26</sup> Pls. MCC Reply – ECF No. 559 at 14.

1 Sutter’s systemwide contracts, the health plan effectively is barred from offering an alternative  
 2 health-insurance policy for, say, \$80 a month,<sup>27</sup> that excludes those Sutter hospitals or places them  
 3 in a lower tier.<sup>28</sup> In the but-for world, however, the health plan could offer such a policy. Some  
 4 health-insurance buyers who prioritize having in-network access to Sutter hospitals might continue  
 5 to enroll in the first policy. But others who place less importance on access to Sutter hospitals or  
 6 more importance on lowering their insurance premiums might enroll in the new second policy  
 7 instead. Under the second policy, those latter buyers would use Sutter hospitals less often to avoid  
 8 the higher co-pays associated with using out-of-network or lower-tiered providers. This would  
 9 reduce Sutter’s patient volume and, consequently, its revenues. In response, the plaintiffs argue,  
 10 Sutter would reduce the prices it charges the health plan, so that, in turn, the health plan could  
 11 reduce the premiums it has to charge for the first policy (perhaps down to, say, \$90 a month  
 12 instead of \$100), which in turn would entice more customers to sign up for the first policy again  
 13 instead of the second and use more Sutter hospitals, which in turn would restore some of Sutter’s  
 14 lost patient volume. As a result, even Sutter loyalists who would not enroll in a tiered health-  
 15 insurance policy (even if one were offered) nonetheless would be better off in the but-for world  
 16 because they would be able to enroll in the first non-tiered policy at a cheaper rate.<sup>29</sup>

#### 18 **4. The Plaintiffs’ Calculations of Antitrust Injury and Damages to Class Members**

19 One of the central issues in the litigation and in the plaintiffs’ motion for class certification  
 20 (and Sutter’s opposition thereto) is how to assess the antitrust injury that class members allegedly  
 21 have sustained and how to calculate class members’ purported damages.

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23 <sup>27</sup> These numbers are arbitrary and are used solely for illustrative purposes.

24 <sup>28</sup> According to the plaintiffs, under Sutter’s systemwide contracts, the health plan either is actually  
 25 barred from offering such a policy or is effectively barred from doing so because Sutter would then  
 26 charge the health plan a “penalty rate” if any enrollee who held that policy used a Sutter hospital (e.g.,  
 27 in an emergency situation), a rate so onerous as to make the policy unsustainable. *See supra* notes 19,  
 28 21.

<sup>29</sup> *See* Chipty Decl. – ECF No. 379-1 at 44–45 (¶¶ 61–62); Chipty Reply Decl. – ECF No. 559-1 at 20–  
 22 (¶¶ 19, 22).

1 The plaintiffs offer the following formula, developed by their expert Dr. Tasneem Chipty, to  
2 assess the purported antitrust injury and calculate damages for each class member. Broadly  
3 speaking, the plaintiffs' formula is as follows:

- 4 1. For each year between 2006 and 2015, calculate as a percentage how much of the  
5 amount that each relevant Sutter hospital charged each health plan and its patients was  
6 an overcharge (i.e., was beyond what the Sutter hospital would have charged in the but-  
7 for world).<sup>30</sup>
- 8 2. Disaggregate the total amount each health plan paid to each Sutter hospital into  
9 "cohorts" based on (1) the geographic Rating Area where health-plan enrollees live or  
10 work, (2) the "group type" of the insurance buyer (individual buyers versus "small-  
11 group"<sup>31</sup> employer buyers versus "large-group"<sup>32</sup> employer buyers) and (3) year, and,  
12 using the overcharge percentage from step one, calculate as a dollar figure each  
13 cohort's per-member-per-month ("PMPM") share of the overcharge.<sup>33</sup>
- 14 3. Assume that (1) health plans pass on 100 percent of any Sutter overcharge they have to  
15 pay through to the premiums they charge their customers and (2) there is a lag between  
16 when a health plan is overcharged and when it passes that overcharge on to its  
17 customers in the form of higher premiums, and, based on those assumptions, divide  
18 each cohort's PMPM overcharge for each year between 2006 and 2015 from step two

19  
20  
21 <sup>30</sup> Chipty Decl. – ECF Nos. 379-1 at 89 (¶ 137); Chipty Decl. – ECF Nos. 348-3 (under seal), 379-1  
(redacted version) at 90–91 (¶ 138).

22 <sup>31</sup> Until 2016, small-group employers were employers with 50 or fewer employees. From 2016  
23 onward, small-group employers are employers with 100 or fewer employees. Chipty Decl. – ECF No.  
24 348-3 at 25 n.53 (¶ 23 n.53); Axene Decl. – ECF No. 379-2 at 5 n.3 (¶ 5 n.3).

25 <sup>32</sup> Until 2016, large-group employers were employers with over 50 employees. From 2016 onward,  
26 large-group employers are employers over 100 employees. Axene Decl. – ECF No. 379-2 at 5 n.3 (¶ 5  
27 n.3).

28 <sup>33</sup> Chipty Decl. – ECF Nos. 379-1 at 89 (¶ 137); Chipty Decl. – ECF Nos. 348-3 (under seal), 379-1  
(redacted version) at 91–94 (¶¶ 139–41). "Member-months" are a measure of how many people were  
enrolled in the health-insurance product and for how long. For example, if one enrollee was enrolled in  
a health-insurance product from January 1 to June 30 of a given year and another was enrolled from  
January 1 to December 31 of the same year, the two of them together would represent 18 member-  
months. Chipty Decl. – ECF No. 379-1 at 93 n.276 (¶ 141 n.276).

1 by the cohort's total PMPM premium for each year between 2008 and 2017,  
 2 respectively (i.e., the PMPM premium two years later), to calculate as a percentage  
 3 how much of the premium was part of the Sutter overcharge.<sup>34</sup>

- 4 4. Multiply the individual premiums each class member paid by the premium-overcharge  
 5 percentage from step three to calculate that class member's share of damages.<sup>35</sup> Where  
 6 an employer and an employee both paid a portion of the employee's health-insurance  
 7 premium, split the damages proportionately based on the amount that the employer and  
 8 employee respectively contributed toward the total premium.<sup>36</sup>

9 For the purposes of this order, the court focuses on two aspects of the plaintiffs' formula:

10 (1) calculating Sutter's overcharges and (2) the assumption that health plans pass on 100 percent  
 11 of any Sutter overcharges through to the premiums they charge their customers.<sup>37</sup>

#### 12 **4.1 Calculating Sutter's Overcharges**

13 To calculate the amount that Sutter allegedly has overcharged health plans, Dr. Chifty  
 14 developed a regression-analysis model.<sup>38</sup>

15 Regression analysis is a statistical methodology for determining the relationship between a  
 16 dependent variable and a set of explanatory variables that can influence or drive the dependent  
 17 variable.<sup>39</sup> In Dr. Chifty's model, the dependent variable is hospital prices, or, more specifically,  
 18 "case-mixed adjusted hospital prices."<sup>40</sup> The explanatory variables are factors that Dr. Chifty

19 \_\_\_\_\_  
 20 <sup>34</sup> *Id.* at 89 (¶ 137); Chifty Decl. – ECF Nos. 348-3 (under seal), 379-1 (redacted version) at 94–96  
 (¶¶ 142–44).

21 <sup>35</sup> Chifty Decl. – ECF Nos. 379-1 at 89 (¶ 137); Chifty Decl. – ECF Nos. 348-3 (under seal), 379-1  
 (redacted version) at 97–98 (¶ 146).

22 <sup>36</sup> Chifty Reply Decl. – ECF No. 559-1 at 44 (¶ 60).

23 <sup>37</sup> The parties additionally raise disputes about other aspects of the plaintiffs' formula, including how  
 24 health plans distribute higher premiums caused by alleged Sutter overcharges across their customer  
 25 base and how higher premiums are apportioned between employers and employees when both pay a  
 portion of the premium for an employee's health insurance. The court focuses in this order on the two  
 aspects of the plaintiffs' formula listed above.

26 <sup>38</sup> Chifty Decl. – ECF No. 379-1 at 56–76 (¶¶ 80–111).

27 <sup>39</sup> *Id.* at 59–60 (¶ 88).

28 <sup>40</sup> *Id.* at 59 (¶ 88). The "case-mixed adjusted hospital price" for a given hospital for a given year is the  
 total amount of money paid to the hospital (by either the health plan or the end patient) for all

1 identified as being likely to drive hospital prices, such as the hospital’s operating costs, its  
2 perceived quality, the size of its system, and how many competitors it has (or variables that are  
3 measures or proxies of those factors).<sup>41</sup> Dr. Chipty states that her regression model measures how  
4 much Sutter hospital prices are driven by her explanatory variables (costs, perceived quality, size,  
5 or number of competitors) versus how much they are driven by the hospital’s being in the Sutter  
6 system — with the latter being a measure of how much the hospital is overcharging health plans  
7 by virtue of being Sutter and benefiting from Sutter’s anticompetitive practices.<sup>42</sup>

8 Dr. Chipty examined Sutter hospitals in the Tied Markets and in one Tying Market (Berkeley-  
9 Oakland) and group of “benchmark” hospitals that purportedly resemble Sutter hospitals except  
10 that (unlike Sutter) they do not impose tying or other similar anticompetitive restrictions on health  
11 plans.<sup>43</sup> Dr. Chipty initially used claims data from the health plan Anthem to calculate the case-  
12 mix adjusted hospital prices charged to Anthem enrollees for each of these hospitals from 2006 to

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13  
14  
15 individual claims divided by the “diagnosis related group” weights associated with those claims. *Id.* at  
16 63–64 (¶ 97). Dr. Chipty explains that “[d]iagnosis-related groups (‘DRGs’) categorize inpatient stays  
17 into groups based on the diagnosis and resources necessary to treat the condition. Each DRG is  
18 assigned a weight based on the average resources used to treat the patient. Therefore, dividing the  
19 allowed amount, or total eligible expenses including insurance payment and patient liability, by the  
20 DRG weight is a method of adjusting for the acuity/complexity of the inpatient stay.” *Id.* at 54 n.161  
(¶ 77 n.161).

21 <sup>41</sup> *Id.* at 64 (¶¶ 98–99). Specifically, Dr. Chipty selected as explanatory variables (1) the hospital’s  
22 wage index, as a measure of the cost of paying salary to its employees, (2) whether the hospital is a  
23 major teaching hospital, (3) whether the hospital has trauma facilities, (4) how many competitors the  
24 hospital has, (5) the hospital’s patient ratings, as a proxy for aspects of its quality, (6) the number of  
25 inpatient beds the hospital has, as a measure of the size of its system, and (7) the year, to reflect the  
26 general inflation in hospital prices over time. *Id.* at 64–67 (¶ 99).

27 <sup>42</sup> *Id.* at 70–71 & n.215 (¶ 104 & n.215) (“The estimated coefficients on these indicator variables  
28 capture the differences between the actual price at each Sutter Damage Hospital in each year and the  
29 predicted but-for price that the Sutter Damage Hospital would have negotiated for that year had it not  
30 been in the Sutter system, but otherwise maintained all of its other attributes (e.g. wage index, teaching  
31 status, trauma status, system size, and competitive landscape). Thus, under the model assumptions, the  
32 estimated coefficients on the *Sutter Damage Hospital x Year* indicators capture the overcharges  
33 resulting from Sutter’s challenged conduct. If, for example, the coefficient on a *Sutter Damage  
34 Hospital x Year* indicator takes the value of 0.35, one would say that the Sutter hospital price in that  
35 year is 42 percent higher as a result of the challenged conduct, accounting for the log transformation  
36 [ $100 \times (e^{0.35} - 1)$ , where  $e$  is the base of the natural logarithm, or approximately 2.71828].”), 72 (¶ 107)  
37 (same).

38 <sup>43</sup> *Id.* at 56 (¶ 80).



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2015.<sup>44</sup> Dr. Chipty ran her regression model twice on the Anthem-based case-mixed adjusted hospital prices, (1) once on only the benchmark hospitals to calculate an “out-of-sample prediction” and (2) once on a sample of both Sutter and benchmark hospitals to calculate an “in-sample prediction.”<sup>45</sup> (Dr. Chipty explained that, among other things, the out-of-sample regression generates year-by-year estimates of Sutter hospital overcharges, whereas the in-sample regression generates only a single average estimate of Sutter hospital overcharges.<sup>46</sup>) Based on her regression model, Dr. Chipty estimated Sutter’s overcharges of Anthem by year and hospital as set forth in the chart below.

[Opening Declaration] Exhibit 14A<sup>47</sup>  
Hospital Case-Mix Adjusted Price Overcharge Percentages, Anthem  
Baseline Regression 2006-2015

Hospital	Out-of-Sample										In-Sample 2006-2015	
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015		
Alta Bates-Main	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
Alta Bates-Summit	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
Sutter Sacramento	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
CPMC-Main	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
CPMC-St. Luke’s	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
Sutter Santa Rosa	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████
Sutter Modesto	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████	██████

In response to criticisms by Sutter’s expert Dr. Robert Willig that Dr. Chipty’s overcharge estimates were based on data only from Anthem,<sup>48</sup> Dr. Chipty applied her regression model to claims data from the health plan Blue Shield.<sup>49</sup> After processing the data, Dr. Chipty ran her

<sup>44</sup> The claims data contained information, at the claim level, on the inpatient hospital services received by each of Anthem’s health-plan enrollees, including the allowed amount (the amount paid to the hospital) for that claim. Chipty Decl. – ECF Nos. 348-3 (under seal), 379-1 (redacted version) at 11–14 (¶ 10), 58 (¶¶ 84–85); Chipty Decl. App’x C – ECF No. 348-3 (under seal), 379-1 (redacted version) at 129–37.

<sup>45</sup> Chipty Decl. – ECF No. 379-1 at 70–72 (¶¶ 102–07).

<sup>46</sup> *Id.* at 70 (¶ 103), 71–72 (¶ 106).

<sup>47</sup> Chipty Decl. – ECF Nos. 348-3 (under seal), 379-1 (redacted version) at 75 (¶ 110).

<sup>48</sup> Willig Decl. – ECF Nos. 446-2 (under seal), 557 (redacted version) at 124–25 (¶¶ 216–17).

<sup>49</sup> Chipty Reply Decl. – ECF No. 559-1 at 94 (¶ 148). Because the Blue Shield claims data did not report the total amount of money paid to hospitals in the same way as the Anthem data did and did not contain DRG codes at all — the two components that go into Dr. Chipty’s calculation of case-mix

1 regression model twice on the Blue Shield-based case-mixed adjusted hospital prices to calculate  
 2 an “out-of-sample” and an “in-sample” prediction.<sup>50</sup> Based on the Blue Shield claims data and her  
 3 regression model, Dr. Chipty estimated Sutter’s overcharges at its hospitals by year and hospital,  
 4 as set forth in the chart below.

5  
 6 **[Reply Declaration] Exhibit 17<sup>51</sup>**  
 7 **Hospital Case-Mix Adjusted Price Overcharge Percentages, Blue Shield**  
 8 **Baseline Regression 2006-2015**

Hospital	Out-of-Sample										In-Sample
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-2015
Alta Bates-Main	53% **	44% *	58% **	42% *	40% *	21%	42% *	17%	144% ***	88% *	50% **
Alta Bates-Summit	135% **	127% **	158% ***	165% ***	172% ***	142% ***	140% ***	126% **	22% **	3%	96% ***
Sutter Sacramento	95% ***	37%	95% ***	114% ***	83% ***	99% ***	84% ***	65% **	39% *	50% **	75% ***
CPMC-Main	25% **	11%	60% ***	44% ***	76% ***	78% ***	69% ***	57% ***	53% **	40% **	50% ***
CPMC-St. Luke’s	33%	16%	70% ***	40% **	45% **	109% ***	31%	30%	44% **	39% *	41% **
Sutter Santa Rosa	1%	-22% **	21% *	7%	-6%	-15%	-8%	6%	-4% **	-6%	-3%
Sutter Modesto	38% ***	57% ***	50% ***	29% **	24% *	26% **	28% **	31% **	19% **	34% **	33% ***

12  
 13 Dr. Chipty has not conducted similar regression analyses on claims data from the health plans  
 14 Aetna, Health Net, or UnitedHealthcare. She testified at her deposition that she has not offered an  
 15 overcharge model for class members who bought insurance through those health plans.<sup>52</sup> She  
 16 stated that she had two approaches for addressing those three health plans: (1) if she had access to  
 17 the same types of data for each health plan, she could run her regression models on each health  
 18 plan separately, or (2) she could try to extrapolate her findings from some health plans to other  
 19 health plans.<sup>53</sup> She testified, “I have not reached an opinion as to whether I have a preferred

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 21 \_\_\_\_\_  
 22 adjusted hospital prices — Dr. Chipty had to process the Blue Shield data somewhat differently than  
 23 she processed the Anthem data. Chipty Reply Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted  
 24 version) at 94 (¶ 149).

25 <sup>50</sup> Chipty Reply Decl. – ECF No. 559-1 at 95 (¶ 150).

26 <sup>51</sup> Chipty Reply Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted version) at 96 (¶ 151).

27 <sup>52</sup> Chipty Dep. – ECF No. 531-4 (under seal) at 64–65 (pp. 666–67) (“Q. Have you offered an  
 28 overcharge model for class members who access through Aetna? A. No, I have not. Q. Have you  
 offered an overcharge model for class members who access through United? A. No, I have not.  
 Q. Have you offered an overcharge model for class members who accessed through Health Net?  
 A. No, I have not.”).

<sup>53</sup> *Id.* at 70–71 (pp. 672–73).

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1 method between those two as yet.”<sup>54</sup> With respect to the first approach, she stated that she did not  
 2 fully know whether she had sufficient data from Aetna, Health Net, or UnitedHealthcare to run her  
 3 regression analyses and would not know until she tried to run the analyses.<sup>55</sup> With respect to the  
 4 second approach, she stated that she has not reached an opinion as to whether it would be  
 5 reasonable to use extrapolation as an overcharge-damages model.<sup>56</sup>

6 Sutter noted that Dr. Chipty’s regression model, when applied to Blue Shield claims data,  
 7 shows an undercharge (as opposed to an overcharge) at one of Sutter’s hospitals in a Tied Market,  
 8 Sutter Santa Rosa. When asked about it during her deposition, Dr. Chipty stated that this reflects  
 9 that her regression model has “an inability to measure the overcharge for Sutter-Santa Rosa.”<sup>57</sup> Dr.

10  
 11  
 12  
 13 <sup>54</sup> *Id.* at 71 (p. 673). She began by saying that she would apply her regression-analysis model to Aetna,  
 14 Health Net, and UnitedHealthcare but then shifted to saying that she might use extrapolation instead.  
 15 *Id.* at 69 (p. 671) (“Q. So is it your opinion, Dr. Chipty, that the methodology for estimating aggregate  
 16 overcharge amounts that you use for Anthem and Blue Shield, that’s the methodology that you’re  
 17 proposing to estimate aggregate damages amounts for Aetna, United and Health Net? A. I would — I  
 18 would imagine using the same model to estimate those damages. Except to the point if I were to do —  
 19 do my continued work on their claims data and their specific circumstances, it’s possible that I reached  
 20 the conclusion that it’s reasonable to extrapolate from the experiences of Anthem and Blue Shield, but  
 21 I haven’t completed my work on that front yet.”).

22 <sup>55</sup> *Id.* at 71–74 (pp. 673–76) (“Q. And have you reached an opinion on whether you have sufficient  
 23 data from Aetna, United and Health Net to apply the overcharge methodology that you use for Anthem  
 24 and Blue Shield for those health plans? A. Okay. So I may mess this up, in which case I’ll come back  
 25 and tell you. But I believe for United, we have the data that we need to move forward. By that I mean  
 26 we have adequate claims data and adequate premium data. I believe that’s true, but I would have to  
 27 talk to the team to make sure I’ve got that right. And for Aetna, I believe we’re still waiting on some of  
 28 the data. I believe we’re waiting on their premium data. On Health Net, there’s been a large production  
 of data from Health Net. It takes a different form, and I don’t think my team has completed its  
 assessment of the adequacy as yet of the Health Net data, but we’re working on that. . . . Q. . . . Your  
 understanding, subject to verification from your staff, is that you and your staff have sufficient data  
 from United to apply the same overcharge methodology that you used for Anthem and Blue Shield; is  
 that correct? A. That’s correct. That’s my understanding. But I should also add that until we undertake  
 the exercise, we won’t know fully whether we do or we don’t. We actually — one never knows until  
 one gets deep into a problem. But, yes, my expectation is that we do and that we will look at that.  
 Q. And then subject to verification with respect to Aetna and Health Net, you and your staff are still  
 examining the data that has been received to determine whether there is sufficient data to use the same  
 methodology, and you noted that Aetna may not have the premium data to date? A. That’s correct. I  
 think that’s correct.”).

<sup>56</sup> *Id.* at 71 (p. 673).

<sup>57</sup> *Id.* at 111 (p. 713).

1 Chipty did not propose an alternative model for estimating the overcharge percentage for Sutter  
2 Santa Rosa for Blue Shield class members.<sup>58</sup>

3 **4.2 Assuming Health Plans “Pass On” 100 Percent of Any Sutter Overcharges They**  
4 **Have to Pay Through to the Premiums That They Charge Their Customers**

5 Dr. Chipty’s formula for converting the amount that Sutter allegedly overcharged health plans  
6 to the amount that class members were overcharged for their insurance premiums relies on an  
7 assumption that health plans “pass on” 100 percent of any Sutter overcharges they have to pay  
8 through to the premiums that they charge their customers.<sup>59</sup> In other words, her formula assumes  
9 that if Sutter charged, say, Anthem \$100,000 more than it would have been able to charge in the  
10 but-for world, Anthem charged its customers (i.e., class members) \$100,000 more in premiums  
11 than it would have charged in the but-for world as well.

12 Dr. Chipty stated in her report that health plans may actually pass on less than 100 percent of  
13 hospital overcharges through to increased premiums to their customers. She explained in her  
14 report:

15 Basic economic principles indicate that health plans will pass through at least some  
16 portion of medical cost increases on to their consumers in the form of higher  
17 premiums. How much is passed through depends on market conditions. Given  
18 competitive conditions, a health plan may decide to absorb some portion of a  
19 medical cost increase, by cutting into [its] margins, to remain price competitive  
20 with other health plans who do not experience similar cost increases.<sup>60</sup>

21 As she testified in her deposition, “the different health plans may have different administrative  
22 costs, the different health plans may have different medical loss ratios or profit margins that  
23 they’re targeting.”<sup>61</sup>

24 Among other things, Dr. Chipty acknowledges that health plans like Anthem and Blue Shield  
25 might decide not to pass on 100 percent of hospital overcharges because of the competitive

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26 <sup>58</sup> *Id.*

27 <sup>59</sup> *See* Chipty Decl. – ECF No. 379-1 at 96 (¶ 144) (assuming for the purposes of her formula that the  
28 pass-through ratio is equal to one, i.e., 100 percent).

<sup>60</sup> *Id.* at 77 (¶ 112).

<sup>61</sup> Chipty Dep. – ECF No. 415-1 (under seal) at 113 (p. 386).

1 pressures they face from Kaiser Permanente.<sup>62</sup> Kaiser is the largest health system in Northern  
 2 California (and California generally).<sup>63</sup> Kaiser is a “closed” health system consisting of a Kaiser  
 3 health plan and Kaiser hospitals and other medical providers, where Kaiser health-plan enrollees  
 4 can receive healthcare only from Kaiser hospitals and medical providers (other than in  
 5 emergencies).<sup>64</sup> Because Kaiser is a closed system that maintains its own network of hospitals,  
 6 Kaiser’s health plan does not contract with Sutter to include Sutter hospitals within its network  
 7 and thus is not subject to Sutter’s alleged systemwide contracting with its all-or-nothing, anti-  
 8 steering, and penalty-rate provisions.<sup>65</sup> Kaiser’s health plan competes with health plans like  
 9 Anthem and Blue Shield in the sale of commercial health insurance to individuals and  
 10 employers.<sup>66</sup> Dr. Chipty stated in her report that “[t]o the extent health plans like Anthem and Blue  
 11 Shield would absorb cost increases to compete with Kaiser, pass-through may be less than 100  
 12 percent.”<sup>67</sup> She explained in her deposition:

13 A. . . . So the way I understand the premiums work is, at least actuarially, they’re  
 14 built to cover health care expenses. And actuarially, if health care expenses go u[p],  
 15 premiums will go up, but there’s also some room to adjust profit margin. So [my  
 16 report] is recognizing that a health plan might decide to absorb a cost increase to  
 17 better compete with Kaiser. . . .

18 Q. Okay. And one way that you’ve described is to — rather than passing through  
 19 100 percent, is pass through a portion of it and then either lower the profit margin  
 20 or perhaps cut expenses and maintain their profit margin?

21 A. Perhaps.<sup>68</sup>

22 \_\_\_\_\_  
 23 <sup>62</sup> Chipty Decl. – ECF No. 379-1 at 77 (¶ 112).

24 <sup>63</sup> *Id.* at 5 (¶ 4), 18 (¶ 16).

25 <sup>64</sup> *Id.* at 18 (¶ 16).

26 <sup>65</sup> *See id.* (¶ 17) (“[N]o patient would have both Kaiser and Sutter hospitals in his or her provider  
 27 network.”).

28 <sup>66</sup> *Id.* at 19 (¶ 17); Chipty Dep. – ECF No. 415-1 (under seal) at 129 (p. 450).

<sup>67</sup> Chipty Decl. – ECF No. 379-1 at 77 (¶ 112).

<sup>68</sup> Chipty Dep. – ECF No. 415-1 (under seal) at 134 (pp. 472–73).

1 Sutter agrees and submits evidence (unrebutted by the plaintiffs) that supports Dr. Chipty’s  
 2 assessment that health plans might decide to not pass on their costs (including hospital costs)  
 3 through to the premiums they charge their customers, in order to remain competitive vis-à-vis rival  
 4 health plans. To take one example, in 2011, ██████ was discussing insurance rates for 2012 for  
 5 one of its customers, Woodruff Sayer, and originally proposed ██████  
 6 ██████.<sup>69</sup> Woodruff Sayer responded that ██████  
 7 ██████.<sup>70</sup> In response, ██████  
 8 ██████  
 9 ██████.<sup>71</sup> To take  
 10 another example, in 2014, Blue Shield was discussing insurance rates for 2015 for one of its  
 11 customers, the City and County of San Francisco.<sup>72</sup> Blue Shield acknowledged that it was in a  
 12 “difficult position” given that competitor health plans Kaiser and UnitedHealthcare had both  
 13 proposed rate decreases.<sup>73</sup> In response, Blue Shield offered the City a “rate pass” (a 0 percent  
 14 increase in premium rates) for 2015.<sup>74</sup>

15 Dr. Chipty’s damages-calculation formula nonetheless assumes that the rate at which health  
 16 plans pass on Sutter’s alleged overcharges through to their customers’ premiums will be 100  
 17 percent.<sup>75</sup> Dr. Chipty stated that one of the things she relies on to assume that (1) health plans pass  
 18 on 100 percent of any Sutter overcharges and (2) the passthrough rate is the same across all health  
 19 plans and class members, is a slide from a PowerPoint presentation drafted by Sutter’s former  
 20  
 21

22 \_\_\_\_\_  
 23 <sup>69</sup> ██████ email chain – ECF Nos. 415-3 (under seal), 445-6 (redacted version) at 10  
 (WSAW003956).

24 <sup>70</sup> *Id.* at 6 (WSAW003952).

25 <sup>71</sup> *Id.* at 5 (WSAW003951).

26 <sup>72</sup> Blue Shield email chain – ECF No. 445-10 at 274–75 (AON0009800–01).

27 <sup>73</sup> *Id.* at 274 (AON0009800).

28 <sup>74</sup> *Id.*

<sup>75</sup> Chipty Decl. – ECF No. 379-1 at 96 (¶ 144).

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CFO Bob Reed.<sup>76</sup> [REDACTED]  
[REDACTED]  
[REDACTED]<sup>77</sup> The  
presentation discussed a hypothetical scenario where Sutter reduced its prices by [REDACTED] and  
then examined how that might cause health plans to reduce their premiums [REDACTED]  
[REDACTED], assuming the health plans passed on 100 percent of Sutter’s price reductions to their  
customers.<sup>78</sup> [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]<sup>79</sup> Dr. Chifty also cited other documents and analyses that she  
said indicates that health plans try to set premiums at a level that covers all their expenses and that  
when their costs increase, their premiums do as well.<sup>80</sup>

Dr. Chifty also conducted a regression analysis that she claims supports her formula’s  
assumption that health plans pass on 100 percent of alleged overcharges through to their  
customers. For her regression, Dr. Chifty used health plans’ PMPM health-care costs and  
premiums between 2012 and 2015 for small-group-employer insurance buyers, as disclosed by the  
plans in their annual Uniform Rate Review Template filings.<sup>81</sup> (She did not include data from

<sup>76</sup> Chifty Decl. – ECF Nos. 348-3 (under seal), 379-1 (redacted) at 79–81 (¶¶ 118–19); Chifty Reply  
Decl. – ECF No. 559-1 at 55 (¶ 80); Chifty Dep. – ECF No. 415-1 (under seal) at 115 (pp. 395–97),  
131 (p. 459).

<sup>77</sup> Sutter Strategy Session PowerPoint Presentation – ECF Nos. 349 at 130 (under seal), 379-4 at 131  
(redacted version) (DEF001993774).

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* [REDACTED]  
[REDACTED]  
[REDACTED]

<sup>80</sup> Chifty Decl. – ECF Nos. 348-3 (under seal), 379-1 (redacted version) at 77–82 (¶¶ 114–22).

<sup>81</sup> Chifty Decl. – ECF No. 379-1 at 83 (¶ 123).

1 individual or large-group-employer buyers.<sup>82</sup>) In her analysis, her dependent variable was the  
 2 natural logarithm of PMPM premium in a given year, and her sole explanatory variable was the  
 3 natural logarithm of PMPM cost in that year.<sup>83</sup> She acknowledged that this was “a very simple  
 4 regression model.”<sup>84</sup> Her regression analysis calculated an estimated passthrough coefficient for  
 5 small-group-employer insurance of approximately 0.9 (where a coefficient of 1 indicates 100-  
 6 percent passthrough<sup>85</sup>), as set forth in the chart below.

7  
 8 **[Opening Declaration] Exhibit 17<sup>86</sup>**  
 9 **Pass-Through Analysis for Small Groups**  
 10 **Dependent Variable = Log (\$ Premium)**

Explanatory Variable	Estimates
Log(Cost)	0.914*** (0.0874)
Includes Health Plan Fixed Effects	Yes
Observations	41
R-squared	0.965

11  
 12  
 13  
 14  
 15 *Notes:*

1. Standard errors shown in parentheses below coefficient estimate.  
 The estimate is statistically significant at 1 percent significance level.  
 2. Coefficient estimated using ordinary least squares.

16  
 17 In response to criticisms by Sutter’s expert Dr. Willig that Dr. Chipty’s analysis did not  
 18 examine whether passthrough rates vary across different health plans, across health-plan business  
 19 lines (individual buyers versus small-group employer buyers versus large-group employer buyers),  
 20 or across different health-insurance products, or whether passthrough rates vary based on how  
 21 much competition a health plan faces (including competition from Kaiser),<sup>87</sup> Dr. Chipty ran  
 22 additional regression analyses, as set forth in the charts below.

23  
 24 <sup>82</sup> *Id.*; Chipty Dep. – ECF No. 415-1 at 116 (p. 399) (“[R]emember this is just for small group. It’s  
 exactly how Exhibit 17 is laid out.”).

25 <sup>83</sup> Chipty Decl. – ECF No. 379-1 at 83 (¶ 125).

26 <sup>84</sup> Chipty Dep. – ECF No. 415-1 at 114 (p. 391).

27 <sup>85</sup> Chipty Decl. – ECF No. 379-1 at 83 (¶ 125).

28 <sup>86</sup> *Id.* at 84 (¶ 125).

<sup>87</sup> Willig Decl. – ECF No. 557 at 46 (¶ 67), 59–60 (¶ 98).



**[Reply Declaration] Exhibit 7<sup>88</sup>**  
**Dr. Willig’s Table 1, Showing More Information**

Descriptions	Aetna	Blue Cross	Blue Shield	Health Net	UHC
Coefficient	0.302	████████***	1.042***	1.054***	████████***
Standard Error	(0.228)	(0.233)	(0.091)	(0.164)	(0.216)
95% CI	-0.164, 0.768	████████	0.857, 1.227	0.719, 1.389	████████
R-squared	0.976				
Plan/Year Observation	9	8	7	8	9

Notes:

1. Asterisks \*\*\* indicates statistical significance at the one percent level.
2. The data upon which the model relies are aggregated at the year-level for each health plan.

**[Reply Declaration] Exhibit 8<sup>89</sup>**  
**Summary of Evidence Indicating Pass-Through Is at or Near 100 Percent**

Health Plan [1]	Source [2]	Costs Included [3]	Product Included [4]	Line-of-Business Included [5]	Kaiser Non-Kaiser [6]	Coefficient [7]	95 Percent Confidence Interval [8]	Observations [9]
Aetna Blue Cross Blue Shield Health Net UHC	[1]	All Medical Costs	All	Small Group	Combined	0.914***	0.748, 1.079	41
Aetna Blue Cross Blue Shield Health Net UHC	[1]	All Medical Costs	All	Small Group	Combined	0.302 ████████*** 1.042*** 1.054*** ████████***	-0.164, 0.768 ████████ 0.857, 1.227 0.719, 1.389 ████████	9 8 7 8 9
Blue Shield	[2]	All Medical Costs	All	Large Group	Combined	0.954***	0.800, 1.109	9
Blue Shield	[2]	All Medical Costs	All	Large Group: 101 ≤ Insured Employees	Combined	0.993***	0.816, 1.171	9
Blue Shield	[2]	All Medical Costs	All	Large Group: 100 - 500 Insured Employees	Combined	0.898***	0.723, 1.073	9
Blue Shield	[2]	All Medical Costs	All	Large Group: 501 ≤ Insured Employees	Combined	0.988***	0.810, 1.165	9
Blue Shield	[2]	All Medical Costs	All	Large Group: 2,000+ Insured Employees	Combined	1.002***	0.771, 1.233	9
Anthem	[3]	Inpatient Spend	All	Individual	Combined	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Large Group	Combined	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Large Group	Non-Kaiser	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Large Group	Kaiser	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Large Group	Non-Kaiser Kaiser	████████*** ████████***	████████ ████████	20
Anthem	[3]	Inpatient Spend	All	Individual	Non-Kaiser	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Individual	Kaiser	████████***	████████	10
Anthem	[3]	Inpatient Spend	All	Individual	Non-Kaiser Kaiser	████████*** ████████***	████████ ████████	20
Anthem	[3]	Inpatient Spend	PPO	Large Group	Combined	████████***	████████	10
Anthem	[3]	Inpatient Spend	HMO	Large Group	Combined	████████***	████████	10

Note: Asterisks \*\*\* indicates statistical significance at the one percent level.

<sup>88</sup> Chipty Reply Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted version) at 49 (¶ 69).

<sup>89</sup> *Id.* at 51–52 (¶ 76) (“Exhibit 8 summarizes pass-through analyses separately for Anthem and Blue Shield data, by health plan, by line-of-business, by Kaiser’s presence, and by product. Column [1] identifies the health plan whose data was analyzed. Column [4] identifies the product (e.g., all, HMO,

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1 Dr. Chifty maintains that these analyses support her decision to assume a uniform 100-  
2 percent-passthrough rate across all health plans, health products, and class members in her  
3 damages calculations. She stated that the health-plan-by-health-plan analysis (Exhibit 7, above),  
4 which calculated passthrough coefficients of 0.32, [REDACTED], 1.042, 1.054, and [REDACTED] for the five  
5 health plans at issue in this case, “supports the view, using Dr. Willig’s own results, that pass-  
6 through rates for four of the five health plans are similar to each other and equal to 100 percent”<sup>90</sup>  
7 and that the fifth health plan’s coefficient rate — “0.3 (or a 30 percent pass-through rate)” — is  
8 “not statistically different from a pass-through rate as high as 77 percent.”<sup>91</sup> She similarly said that  
9 her analyses disaggregating health plans, business lines, and products (Exhibit 8, above), which  
10 generated coefficients ranging from 0.302 to [REDACTED], support her using a uniform 100-percent-  
11 passthrough rate in her damages calculations.<sup>92</sup> She acknowledged that for many of her analyses,  
12 the upper bound of the 95-percent confidence interval around the passthrough-rate estimate<sup>93</sup> fell  
13 below 1 (i.e., below a 100-percent-passthrough rate) interval.<sup>94</sup> She nonetheless maintains that

14  
15 \_\_\_\_\_  
16 PPO) considered. Column [5] identifies the line-of-business (e.g., individual, small group, and large  
17 group). Column [6] identifies whether pass-through rates in Kaiser and non-Kaiser areas were  
18 estimated separately or jointly. Column [7] shows the estimated pass-through coefficient. Column [8]  
19 describes the 95 percent confidence interval of the estimated passthrough rates, and Column [9] shows  
20 the regression observations, where each observation reflects the premium and claims experience of  
21 many. The first row shows results of the model presented in my Class Declaration. The second row  
22 shows the results of Dr. Willig’s model. Statistically, the estimated pass-through rates are at or near  
23 100 percent, for virtually all models. The lowest estimated pass-through rate comes from Dr. Willig’s  
24 small group analysis, for Aetna.”).

25 <sup>90</sup> Chifty Reply Decl. – ECF No. 559-1 at 48 (¶ 69).

26 <sup>91</sup> *Id.* at 46 (¶ 66).

27 <sup>92</sup> Chifty Reply Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted) at 50–54 (¶¶ 72–78).

28 <sup>93</sup> Dr. Chifty explains that “a ‘confidence interval’ provides a range of values within which the true  
population value is likely to lie.” Chifty Decl. – ECF No. 379-1 at 62 (¶ 94). “A 95 percent two-sided  
confidence interval is an interval around the sample estimate, constructed based on the standard error,  
that would contain the true population value 95 percent of the time if the sampling procedure were to  
be repeated infinitely.” *Id.* at 62 n.191 (¶ 94 n.191).

<sup>94</sup> Chifty Reply Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted version) at 50–51 nn.167–69  
(¶¶ 72 n.167, 74 n.168–69) (noting that in row 8 of Exhibit 8, the upper bound of the 95-percent  
confidence interval around the passthrough estimate is 0.9; in row 10, the upper bound of the 95-  
percent confidence interval around the passthrough estimate is 0.87; in row 13, the upper bound of the  
95-percent confidence interval around the passthrough estimate is 0.95; and in row 14, the upper  
bound of the 95-percent confidence interval around the passthrough estimate is 0.92).

1 these results are “near one [100 percent]” or “close to one [100 percent].”<sup>95</sup> She does not cite any  
 2 sources to explain what being “near” or “close to” 1 means or how that supports her decision to  
 3 assume a passthrough rate of 100 percent.<sup>96</sup>

4 Dr. Chipty acknowledged in her deposition that she has never conducted in any other contexts  
 5 the passthrough regression analyses she is running here.<sup>97</sup> She has not studied passthrough rates in  
 6 the context of medical premiums and has never offered an expert opinion on passthrough rates  
 7 outside of the context of this case.<sup>98</sup>

### 8 ANALYSIS

9  
 10 Class actions are governed by Federal Rule of Civil Procedure 23. A party seeking to certify a  
 11 class must prove that all the prerequisites of Rule 23(a) are met, as well as those of at least one  
 12 subsection of Rule 23(b) (the relevant subsections here are (b)(2) and (b)(3)).

13 The following are the prerequisites of Rule 23(a):

- 14 1. the class is so numerous that joinder of all members is impracticable;
- 15 2. there are questions of law or fact common to the class;
- 16 3. the claims or defenses of the representative parties are typical of the claims or defenses  
 17 of the class; and
- 18 4. the representative parties will fairly and adequately protect the interests of the class.

19 A court may certify a class under Rule 23(b)(3) if “the court finds that the questions of law or  
 20 fact common to class members predominate over any questions affecting only individual

21 \_\_\_\_\_  
 22 <sup>95</sup> *Id.* at 50–51 (¶¶ 72, 74).

23 <sup>96</sup> Dr. Chipty describes some of her results as being “not statistically different from one.” Chipty Reply  
 24 Decl. – ECF No. 559-1 at 50 (¶¶ 72, 74). She explains what she means when she says results are “not  
 25 statistically different from one”: that a value of 1 (a 100-percent-passthrough rate) is within the 95-  
 26 percent confidence interval. *See* Chipty Decl. – ECF No. 379-1 at 62 (¶ 94). She does not explain what  
 a result’s being “near one” or “close to one” means. It necessarily must mean that it is “statistically  
 different” from 1 (a 100-percent-passthrough rate), given that 1 falls above the 95-percent confidence  
 interval.

27 <sup>97</sup> Chipty Dep. – ECF No. 415-1 (under seal) at 110 (pp. 376–77).

28 <sup>98</sup> *Id.* at 110–11 (pp. 377–80). In addition to Dr. Chipty, the plaintiffs proffered another expert, David  
 Axene, but Mr. Axene did not conduct any analysis to calculate passthrough rates of hospital charges  
 to health-plan premiums. Axene Dep. – ECF No. 415-1 (under seal) at 20 (pp. 68–69), 29 (p. 105).

1 members, and that a class action is superior to other available methods for fairly and efficiently  
2 adjudicating the controversy.” Fed. R. Civ. P. 23(b)(3). A court may certify a class under Rule  
3 23(b)(2) for injunctive or declaratory relief (i.e., not for money damages) if “the party opposing  
4 the class has acted or refused to act on grounds that apply generally to the class, so that final  
5 injunctive relief or corresponding declaratory relief is appropriate respecting the class as a  
6 whole[.]” Fed. R. Civ. P. 23(b)(2).

7 “[P]laintiffs wishing to proceed through a class action must actually *prove* — not simply plead  
8 — that their proposed class satisfies each requirement of Rule 23, including (if applicable) the  
9 predominance requirement of Rule 23(b)(3).” *Halliburton Co. v. Erica P. John Fund, Inc.*, 573  
10 U.S. 258, 275 (2014) (emphasis in original) (citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338,  
11 350–51 (2011); *Comcast Corp. v. Behrend*, 569 U.S. 27, 32–33 (2013)). “[C]ertification is proper  
12 only if ‘the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23[] have  
13 been satisfied.’” *Comcast*, 569 U.S. at 33 (quoting *Wal-Mart*, 564 U.S. at 350–51). “Such an  
14 analysis will frequently entail ‘overlap with the merits of the plaintiff’s underlying claim.’” *Id.* at  
15 33–34 (quoting *Wal-Mart*, 564 U.S. at 351). “That is so because the ‘class determination generally  
16 involves considerations that are enmeshed in the factual and legal issues comprising the plaintiff’s  
17 cause of action.’” *Id.* at 34 (quoting *Wal-Mart*, 564 U.S. at 351). Still, “Rule 23 grants courts no  
18 license to engage in free-ranging merits inquiries at the certification stage.” *Amgen Inc. v. Conn.*  
19 *Ret. Plans and Tr. Funds*, 568 U.S. 455, 466 (2013). “Merits questions may be considered to the  
20 extent — but only to the extent — that they are relevant to determining whether the Rule 23  
21 prerequisites for class certification are satisfied.” *Id.* (citing *Wal-Mart*, 564 U.S. at 351 n.6).

## 22

### 23 **1. Rule 23(a) Prerequisites**

#### 24 **1.1 Numerosity — Rule 23(a)(1)**

25 Rule 23(a)(1) requires that “the class [be] so numerous that joinder of all members is  
26 impracticable.” There is no absolute minimum class size for establishing numerosity, but courts  
27 have held that classes as small as 40 satisfy the numerosity requirement. *See, e.g., In re Qualcomm*  
28 *Antitrust Litig.*, 328 F.R.D. 280, 294 (N.D. Cal. 2018) (citing *Twegbe v. Pharmaca Integrative*

1 *Pharmacy, Inc.*, No. CV 12-5080 CRB, 2013 WL 3802807, at \*3 (N.D. Cal. July 17, 2013)),  
 2 *appeal docketed sub nom. Stromberg v. Qualcomm Inc.*, No. 18-80135 (9th Cir. filed Oct. 11,  
 3 2018); *In re Lidoderm Antitrust Litig.*, No. 14-md-02521-WHO, 2017 WL 679367, at \*13 (N.D.  
 4 Cal. Feb. 21, 2017) (citing Daniel R. Coquillette et al., 5 Moore’s Federal Practice – Civil § 23.22  
 5 (2016)). The plaintiffs reasonably estimate that the proposed class contains at least hundreds of  
 6 thousands of members.<sup>99</sup> Sutter does not dispute numerosity.<sup>100</sup> The court finds that the plaintiffs  
 7 have satisfied Rule 23(a)(1)’s numerosity requirement.

### 8 **1.2 Commonality — Rule 23(a)(2)**

9 Rule 23(a)(2) requires that “there [be] questions of law or fact common to the class.” “What  
 10 matters to class certification is not the raising of common ‘questions’ — even in droves — but,  
 11 rather the capacity of a classwide proceeding to generate common answers apt to drive the  
 12 resolution of the litigation.” *Torres v. Mercer Canyons Inc.*, 835 F.3d 1125, 1133 (9th Cir. 2016)  
 13 (internal ellipsis and some internal quotation marks omitted) (quoting *Wal-Mart*, 564 U.S. at 350).  
 14 “To satisfy Rule 23(a)(2) commonality, ‘even a single common question will do.’” *Id.* (some  
 15 internal quotation marks omitted) (quoting *Wal-Mart*, 564 U.S. at 359). Courts have held that  
 16 “‘antitrust liability alone constitutes a common question.’” *In re Qualcomm*, 328 F.R.D. at 294  
 17 (internal brackets omitted) (quoting *In re High-Tech Emp. Antitrust Litig.*, 985 F. Supp. 2d 1167,  
 18 1180 (N.D. Cal. 2013)); *accord, e.g., In re Lithium Ion Batteries Antitrust Litig.*, No. 13-MD-2420  
 19 YGR, 2017 WL 1391491, at \*3 (N.D. Cal. Apr. 12, 2017) (*In re Lithium Ion Batteries I*) (“[T]he  
 20 very nature of a conspiracy antitrust action compels a finding that common questions of law and  
 21 fact exist.”) (quoting *In re Dynamic Random Access Memory (DRAM) Antitrust Litig.*, No. M 02-  
 22 1486 PJH, 2006 WL 1530166, at \*3 (N.D. Cal. June 5, 2006)). The plaintiffs have raised common  
 23 questions about whether Sutter’s systemwide contracting with its all-or-nothing, anti-steering, and  
 24 penalty-rate provisions is anticompetitive that would generate common answers apt to drive

25 \_\_\_\_\_  
 26 <sup>99</sup> Chipty Decl. – ECF No. 379-1 at 31 (¶ 30) (“[T]here could be between 430,000 and 680,000 Class  
 Members in any given year.”).

27 <sup>100</sup> *See* Def. MCC Opp’n – ECF No. 445 at 9, 30–31 (disputing whether the plaintiffs have satisfied  
 28 Rule 23(a)’s typicality and adequacy requirements but not numerosity or commonality).

1 resolution of the litigation. Sutter does not dispute commonality.<sup>101</sup> The court finds that the  
2 plaintiffs have satisfied Rule 23(a)(2)'s commonality requirement.

### 3 **1.3 Typicality — Rule 23(a)(3)**

4 Rule 23(a)(3) requires that “the claims or defenses of the representative parties [be] typical of  
5 the claims or defenses of the class.” “The test of typicality serves to ensure that ‘the interest of the  
6 named representative aligns with the interests of the class.’” *Torres*, 835 F.3d at 1141 (quoting  
7 *Hanon v. Dataproducts Corp.*, 976 F.2d 497, 508 (9th Cir. 1992)). “‘Under the Rule’s permissive  
8 standards, representative claims are ‘typical’ if they are reasonably coextensive with those of  
9 absent class members; they need not be substantially identical.’” *Id.* (quoting *Parsons v. Ryan*, 754  
10 F.3d 657, 685 (9th Cir. 2014)). “In this context, ‘typicality refers to the nature of the claim or  
11 defense and not to the specific facts from which it arose or the relief sought.’” *Id.* (internal ellipsis  
12 omitted) (quoting *Parsons*, 754 F.3d at 685). “Measures of typicality include ‘whether other  
13 members have the same or similar injury, whether the action is based on conduct which is not  
14 unique to the named plaintiffs, and whether other class members have been injured by the same  
15 course of conduct.’” *Id.* (quoting *Hanon*, 976 F.2d at 508). Put another way, “[t]ypicality is  
16 present ‘when each class member’s claim arises from the same course of events, and each class  
17 member makes similar legal arguments to prove the defendants’ liability.’” *In re Qualcomm*, 328  
18 F.R.D. at 295 (quoting *Rodriguez v. Hayes*, 591 F.3d 1105, 1122 (9th Cir. 2010)). “Thus, ‘in  
19 antitrust cases, typicality usually will be established by plaintiffs and all class members alleging  
20 the same antitrust violations by defendants.’” *Id.* (internal brackets and some internal quotation  
21 marks omitted) (quoting *In re High-Tech Emp.*, 985 F. Supp. 2d at 1181).

22 The named plaintiffs’ claims are typical of the class’s claims. The conduct they challenge —  
23 Sutter’s systemwide contracting with its all-or-nothing, anti-steering, and penalty-rate provisions  
24 — is not unique to any plaintiff. Rather, Sutter engaged in this same conduct with the five health  
25 plans at issue and allegedly charged all five health plans supra-competitive rates as a result, which  
26

27 \_\_\_\_\_  
28 <sup>101</sup> See Def. MCC Opp’n – ECF No. 445 at 9, 30–31 (disputing whether the plaintiffs have satisfied Rule 23(a)’s typicality and adequacy requirements but not numerosity or commonality).

1 the health plans then allegedly passed on to their customers (the class members). The alleged  
2 injuries to the named plaintiffs and to the class arise from the same course of conduct.

3 Sutter argues that the named plaintiffs' claims are not typical because the named plaintiffs are  
4 two small employers and four individuals (two of whom worked for the same employer) and do  
5 not include any large-group employers or any persons who bought an individual health-insurance  
6 policy.<sup>102</sup> Sutter argues that the plaintiffs do not have any personal stake or interest in establishing  
7 that health plans passed on supra-competitive hospital costs through to large-group employers  
8 despite the presence of individually negotiated premiums.<sup>103</sup> But under Rule 23's permissive  
9 standards, the plaintiffs' claims need only be "reasonably coextensive" with absent class  
10 members' claims; they need not be substantively identical. *Torres*, 835 F.3d at 1141. The  
11 overarching gravamen of the plaintiffs' claims is Sutter's alleged anticompetitive tying activity.  
12 While differences in how health plans may have passed on Sutter's alleged overcharges through to  
13 their customers may go to Rule 23(b)(3)'s predominance requirement, it is not sufficient to defeat  
14 typicality. *Cf. In re Lithium Ion Batteries I*, 2017 WL 1391491, at \*7–8 (rejecting argument that  
15 claims of individuals who bought battery products at non-negotiable prices were atypical of claims  
16 of large institutional buyers who bought products in bulk and could negotiate prices because "the  
17 overarching [antitrust] price-fixing scheme is the gravamen of the claim, regardless of the type of  
18 product purchased, the quantity, the purchasing procedures, or the price paid") (citing *In re Static  
19 Random Access Memory (SRAM) Antitrust Litig.*, 264 F.R.D. 603, 609 (N.D. Cal. 2009)); *In re  
20 Online DVD Antitrust Litig.*, No. M 09-2029 PJH, 2010 WL 5396064, at \*4 (N.D. Cal. Dec. 23,  
21 2010) (*In re Online DVD I*) ("The named plaintiffs' claims are typical of the class because for all  
22 claims, proof of the alleged violations in question will depend on proof of violation *by defendants*,  
23 and not on the individual positioning of each plaintiff.") (emphasis in original).<sup>104</sup>

24  
25 <sup>102</sup> Def. MCC Opp'n – ECF No. 445 at 31. Sutter also argues that the plaintiffs and class members  
26 have conflicts of interest, *id.* at 30–31, which the court will address in the next section in connection  
27 with Rule 23's adequacy requirement.

28 <sup>103</sup> *Id.* at 31.

<sup>104</sup> It is worth noting that the "individually negotiated premiums" that Sutter discusses in its opposition  
refers to large-group employers' negotiations with *health plans*, not with Sutter. Sutter does not

1 The court finds that the plaintiffs have satisfied Rule 23(a)(3)'s typicality requirement.<sup>105</sup>

2 **1.4 Adequacy — Rule 23(a)(4)**

3 Rule 23(a)(4) requires that “the representative parties [] fairly and adequately protect the  
4 interests of the class.” “This adequacy requirement . . . ‘serves to uncover conflicts of interest  
5 between named parties and the class they seek to represent’ as well as the ‘competency and  
6 conflicts of class counsel.’” *Espinosa v. Ahearn (In re Hyundai and Kia Fuel Econ. Litig.)*, 926  
7 F.3d 539, 566 (9th Cir. 2019) (en banc) (quoting *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591,  
8 625, 626 n.20 (1997)). “To determine legal adequacy, [courts] resolve two questions: ‘(1) do the  
9 named plaintiffs and their counsel have any conflicts of interest with other class members and

10  
11  
12 contend that large-group employers had any more ability to negotiate with *Sutter* over prices or  
13 premiums than individuals or small-group employers did. The fact that large-group employers might  
14 have engaged in negotiations with health plans does not render plaintiffs’ claims — which are against  
15 *Sutter*, not the health plans — atypical of the claims of the class as a whole. *Cf. In re Optical Disk*  
16 *Drive Antitrust Litig.*, 303 F.R.D. 311, 317–18 (N.D. Cal. 2014) (in price-fixing antitrust case, finding  
17 that typicality was not satisfied based on differences between large institutional class members and  
18 small class members where the large institutional class members engaged in direct price negotiations  
19 with the defendants — i.e., the parties that were actually doing the price-fixing — and small class  
20 members did not) (citing *In re Graphics Processing Units Antitrust Litig.*, 253 F.R.D. 478, 489–90  
21 (N.D. Cal. 2008)).

22 <sup>105</sup> *Sutter* cites *Burkhead v. Louisville Gas & Electric Co.*, 250 F.R.D. 287 (W.D. Ky. 2008), and  
23 *Major v. Ocean Spray Cranberries, Inc.*, No. 5:12-CV-03067 EJD, 2013 WL 2558125 (N.D. Cal. June  
24 10, 2013), to argue that the named plaintiffs’ claims are not typical of the class’s. Def. MCC Opp’n –  
25 ECF No. 445 at 31. Neither case is apposite here. *Burkhead* was a class action brought against an  
26 allegedly polluting power plant where the named plaintiffs were a “geographically concentrated group  
27 living relatively close to Defendant’s plant.” *Burkhead*, 250 F.R.D. at 300. The plaintiffs sought to  
28 represent a class of residents in a two-mile radius of the plant but offered no evidence that the plant  
spread any pollution elsewhere within that radius. *Id.* at 292–93 & n.3. In light of the plaintiffs’  
geographic concentration and their lack of evidence that other areas were affected, the court held that  
their claims were not typical. *Id.* at 295–96. The court contrasted that situation from a situation where  
“the harm suffered by the named plaintiffs may differ in *degree* from that suffered by other members  
of the class so long as the harm suffered is of the same *type*,” which would support a finding of  
typicality. *Id.* at 295 (emphasis in original, citation omitted). *Major* was a class action brought against  
a food manufacturer where the named plaintiff alleged misleading product labeling. *Major*, 2013 WL  
2558125, at \*1. The plaintiff bought allegedly mislabeled fruit drinks but sought to represent classes of  
persons who bought the defendant’s products more broadly. *Id.* at \*2. The court held that the plaintiff  
“fail[ed] to link any of those products to any alleged misbranding issue[.]” *Id.* at \*4. For example, the  
plaintiff alleged that a blueberry drink she purchased made misleading claims specifically about  
blueberries, which the court held was not typical of claims related to other products that did not  
contain blueberries. *Id.* (“[T]he content that purportedly gives rise to Plaintiffs claims is unique to the  
specific and particular product she purchased and has no applicability to other products within the  
same line.”). Neither of those cases is analogous to the case here.



1 (2) will the named plaintiffs and their counsel prosecute the action vigorously on behalf of the  
2 class?” *Id.* (quoting *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1020 (9th Cir. 1998)).

### 3 **1.4.1 Prosecuting the action vigorously on behalf of the class**

4 Taking the second issue first, the plaintiffs and their counsel maintain that they will prosecute  
5 this case vigorously on behalf of the class. The named plaintiffs have actively participated in this  
6 case, cooperated in discovery, made themselves available for and sat for depositions, and followed  
7 case developments.<sup>106</sup> All are willing to prosecute the action vigorously and to sit for trial.<sup>107</sup> They  
8 have retained class counsel with experience in litigating antitrust class actions.<sup>108</sup> Sutter does not  
9 dispute that the named plaintiffs and their counsel will prosecute this case vigorously on behalf of  
10 the class.<sup>109</sup>

11 The court finds that the plaintiffs have satisfied this component of Rule 23(a)(4)’s adequacy  
12 requirement.

### 13 **1.4.2 Conflicts of interest**

14 The Ninth Circuit has cautioned that “we do not ‘favor denial of class certification on the basis  
15 of speculative conflicts.’” *Resnick v. Frank (In re Online DVD-Rental Antitrust Litig.)*, 779 F.3d  
16 934, 942 (9th Cir. 2015) (*In re Online DVD II*) (quoting *Cummings v. Connell*, 316 F.3d 886, 896  
17 (9th Cir. 2003)). “Nor does a district court abuse its discretion [in certifying a class] when  
18 conflicts are trivial.” *Id.* (citing *Abbott v. Lockheed Martin Corp.*, 725 F.3d 803, 813 (7th Cir.  
19 2013)). ““Only conflicts that are fundamental to the suit and that go to the heart of the litigation  
20 prevent a plaintiff from meeting the Rule 23(a)(4) adequacy requirement.”” *Id.* (quoting William  
21

22 <sup>106</sup> MacAusland Decl. – ECF No. 356-16; Feeney Decl. – ECF No. 356-17; Hansen Decl. – ECF No.  
23 356-18; Herman Decl. – ECF No. 356-19; Stewart Decl. – ECF No. 356-20; Jankowski Decl. – ECF  
24 No. 356-21; Sidibe Decl. – ECF No. 356-22; *see, e.g.*, Feeney Dep. – ECF No. 558 at 3–33 (co-owner  
of named employer plaintiff sitting for deposition); Herman Dep. – ECF No. 445-6 at 195–221 (named  
individual plaintiff sitting for deposition).

25 <sup>107</sup> MacAusland Decl. – ECF No. 356-16; Feeney Decl. – ECF No. 356-17; Hansen Decl. – ECF No.  
26 356-18; Herman Decl. – ECF No. 356-19; Stewart Decl. – ECF No. 356-20; Jankowski Decl. – ECF  
27 No. 356-21; Sidibe Decl. – ECF No. 356-22.

28 <sup>108</sup> *See* Counsel Biographies – ECF No. 362-3.

<sup>109</sup> *See* Def. MCC Opp’n – ECF No. 445 at 9, 30–31 (disputing whether the plaintiffs have satisfied  
Rule 23(a)(4)’s adequacy requirements in light of purported conflicts but not disputing the plaintiffs’  
or counsel’s prosecution of this case).

1 B. Rubenstein et al., 1 Newberg on Class Actions § 3.58 (5th ed. 2011)). “A conflict is  
2 fundamental when it goes to the specific issues in controversy.” *Id.* (quoting Newberg on Class  
3 Actions § 3.58).

4 Sutter argues that there are two conflicts of interest that prevent class certification. Neither  
5 purported conflict goes to the heart of the litigation so as to render the plaintiffs inadequate to  
6 pursue their class claims.

7 First, Sutter argues that employers and employees have conflicts, because employers have an  
8 incentive to argue that they bore the entire brunt of any premium increase and did not pass any of  
9 it along to their employees, while employees have an incentive to argue that the entire alleged  
10 increase was passed on to them.<sup>110</sup> This is not a conflict that goes to the heart of the litigation.  
11 Employers and employees do not have a conflict regarding the central issues at controversy in this  
12 case, namely, whether Sutter overcharged health plans for its hospital services, whether health  
13 plans passed on those overcharges through to the premiums that they charged their customers,  
14 whether they as the health plans’ customers paid more in premiums than they otherwise would  
15 have but for Sutter’s anticompetitive conduct, and whether Sutter should pay damages to make  
16 them whole. Only if the class collectively were to establish that Sutter is liable and should pay  
17 damages would any purported conflicts arise between employers and employees regarding how  
18 those damages should be allocated. This is not a conflict that is so fundamental to the suit or goes  
19 so much to the heart of the litigation as to render the plaintiffs inadequate to pursue their class  
20 claims. *Cf. In re Lidoderm*, 2017 WL 679367, at \*26 (finding plaintiffs adequate in antitrust class  
21 action alleging that defendants had inflated the price of lidocaine patches, rejecting arguments that  
22 end purchasers had insuperable conflicts with employers or insurers that bore some of the costs,  
23 and finding that “any theoretical disputes between, for example, an end payor consumer and her  
24 health insurance plan over how their overcharge damages should be split. . . . does not create a  
25 type of conflict that precludes certification”).

26  
27 \_\_\_\_\_  
28 <sup>110</sup> Def. MCC Opp’n – ECF No. 445 at 30.

1 Second, Sutter argues that class members have conflicts because some class members received  
 2 a net benefit from its allegedly anticompetitive practices “and would have been harmed in the  
 3 world plaintiffs[] hypothesize absent Sutter’s challenged conduct.”<sup>111</sup> Sutter and its expert Dr.  
 4 Willig maintain that some class members derive more benefit from having Sutter hospitals in their  
 5 health-insurance provider networks than any harm they suffer in increased health-insurance  
 6 premiums attributable to Sutter’s alleged overcharges.<sup>112</sup> Sutter argues that these class members  
 7 thus have a conflict with other class members who do not derive such benefit and want to  
 8 challenge Sutter’s practices.

9 Sutter’s argument necessarily relies on an assumption that, in the but-for world where Sutter is  
 10 barred from engaging in allegedly anticompetitive practices, health plans would no longer offer  
 11 health-insurance policies that have Sutter hospitals in-network. In other words, Sutter’s argument  
 12 assumes that in the but-for world, health plans would offer only narrow health-insurance policies  
 13 that exclude Sutter hospitals (or that place Sutter hospitals in a lower tier and increase the amount  
 14 enrollees had to pay to use those hospitals<sup>113</sup>), thereby harming class members who currently  
 15 benefit from having access to Sutter hospitals.

16 But that is not the plaintiffs’ case theory. The plaintiffs’ theory is that in the but-for world,  
 17 health plans would offer narrow policies that exclude some Sutter hospitals (e.g., the Sutter  
 18 hospital in the Tying Markets) in addition to — not to the exclusion of — the broader policies they  
 19 currently offer that include Sutter hospitals in-network.<sup>114</sup> Class members who derive benefit from  
 20

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21 <sup>111</sup> Def. MCC Opp’n – ECF No. 445 at 30.

22 <sup>112</sup> Def. MCC Sur-Reply – ECF No. 535 at 7–9; Willig Decl. – ECF Nos. 446-2 (under seal), 557  
 (redacted) at 27–35 (¶¶ 34–45).

23 <sup>113</sup> The fact that health plans might place Sutter hospitals in a lower tier does not, on its own,  
 24 necessarily harm any class member. For example, if a health plan currently requires enrollees to make  
 25 a co-payment of, say, \$40 for hospital services, and then were to create a new health-insurance policy  
 that placed Sutter hospitals in a lower tier and required enrollees to make a co-payment of \$20 for  
 services from hospitals in the highest tier and \$40 for services from hospitals in the lowest tier (with  
 all else being equal), no enrollee would be worse off.

26 <sup>114</sup> As the plaintiffs explain, “Sutter’s ‘net harm’ argument distorts plaintiffs’ antitrust theory. Dr.  
 27 Chipty posited that, in the but for world: (a) Sutter would have faced price competition due to the  
 threat of exclusion, the launching of additional narrow networks and/or steering; (b) Sutter would have  
 28 dropped its rates in order to retain critical patient volume; and (c) consumers would thus have

1 having Sutter hospitals in-network could remain in the original broader policies. Consequently,  
 2 class members would not be worse off. Class members would also have the additional option of  
 3 signing up for cheaper narrower policies that excluded Sutter hospitals (or placed them in a lower  
 4 tier). Not all class members would sign up for those cheaper narrower policies, but some would.  
 5 This would cause Sutter to lose patient volume. This loss in patient volume (and, thus, revenues)  
 6 would pressure Sutter to lower its supra-competitive prices, so that health plans could in turn  
 7 lower the premiums of the original Sutter-including broader policies to make them more appealing  
 8 to customers and more competitive vis-à-vis the narrower policies.<sup>115</sup> Those lower prices and  
 9 premiums would benefit all class members. To take the example discussed above, no matter how  
 10 much a class member might benefit from having a health-insurance policy that includes Sutter  
 11 hospitals in-network, that class member would benefit more (and not be harmed) if she were able  
 12 to enroll in that policy for, say, \$90 a month instead of \$100. That some class members benefit  
 13 from the inclusion of Sutter hospitals in-network does not mean that they benefit from Sutter’s  
 14 alleged overcharges and, consequently, does not present a conflict that is so fundamental to the  
 15 suit or goes so much to the heart of the litigation as to render the plaintiffs inadequate to pursue  
 16 their class claims.

17 Sutter’s expert Dr. Willig challenges the plaintiffs’ view and argues that in the but-for world  
 18 — where Sutter faces the prospect of losing patient volume due to increased competition from  
 19 cheaper narrower health-insurance policies that do not include Sutter hospitals in-network —  
 20 Sutter might respond by increasing its prices instead of reducing them.<sup>116</sup> Sutter argues that if

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21  
 22 continued access to the hospitals of their choice (including any in-demand Sutter hospitals) but at  
 23 lower prices. Consequently, in Dr. Chipty’s ‘but for’ world, all existing insurance products that include  
 24 Sutter hospitals in-network *would continue to exist*, but at substantially lower prices, making all Class  
 25 Members better off.” Pls. MCC Reply – ECF No. 559 at 14 (emphasis in original) (citing Chipty Reply  
 26 Decl. – ECF Nos. 462-3 (under seal), 559-1 (redacted) at 20–24 (¶¶ 19–27)); accord Def. MCC Sur-  
 27 Reply – ECF No. 535 at 6 (“Plaintiffs expressly allege that, in the but-for world, insurers ‘would have  
 28 launched a number of **additional** “tiered” or “limited” or “narrow” networks.”) (emphasis in original)  
 (quoting 4AC – ECF No. 204 at 31 (¶ 97)).

<sup>115</sup> Alternatively, health plans might be able simply to threaten to create new cheaper narrower policies  
 that excluded Sutter hospitals (without actually going through with it) because even the threat of  
 competing cheaper policies could exert pressure on Sutter to lower its prices. See *infra* note 117.

<sup>116</sup> See, e.g., Willig Decl. – ECF No. 557 at 22 (¶ 22).

1 health plans then passed those increased prices through to the premiums the health plans charged  
 2 their customers (i.e., class members), those class members who wanted to keep Sutter hospitals in-  
 3 network would be worse off. But whether, in the but-for world, Sutter would respond to increased  
 4 competition and the threatened loss of patient volume by reducing its prices or increasing them is  
 5 not for the court to resolve on this class-certification motion. *Cf. In re Lidoderm*, 2017 WL  
 6 679367, at \*18 (“[W]hat the but-for price should have been is not appropriately resolved on this  
 7 [class-certification] motion.”); *see also In re Aftermarket Automotive Lighting Prods. Antitrust*  
 8 *Litig.*, 276 F.R.D. 364, 373–74 (C.D. Cal. 2011) (“[I]n situations where a court is faced with two  
 9 opposing expert analyses or econometric models of what the ‘but for’ world would look like, the  
 10 Court is not supposed to decide at the certification stage which expert analysis or model is  
 11 better.”) (citing *In re TFT-LCD Antitrust Litig.*, 267 F.R.D. 291, 313 (N.D. Cal. 2010)). The  
 12 plaintiffs and Dr. Chipty sufficiently support their position that Sutter would respond to a  
 13 threatened loss of patient volume by lowering, not raising, its prices (and thus leaving no intraclass  
 14 conflict that goes to the heart of the litigation) to establish adequacy at this juncture.<sup>117</sup>

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16 <sup>117</sup> Among other things, the plaintiffs and Dr. Chipty point to Sutter’s own assertions before the court  
 17 in *California v. Sutter Health*, No. 3:99-cv-03803-MMC (N.D. Cal. filed Aug. 10, 1999), that health  
 18 plans’ ability to steer patients away from Sutter — and thereby threaten Sutter with a loss of patient  
 19 volume — would serve to “discipline” Sutter’s pricing.

19 The California Attorney General brought the *California v. Sutter* case in 1999, challenging as  
 20 anticompetitive a proposed merger between Sutter’s Alta Bates Medical Center in Berkeley, Alameda  
 21 County, and the then independently owned Summit Medical Center in Oakland, Alameda County. *See*  
 22 *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1059–60 (N.D. Cal. 2001). In defending why the  
 23 proposed merger would not be anticompetitive and would not result in higher prices for patients, Sutter  
 24 argued to the court that “hospitals are very sensitive to even small declines in [patient] volume” and  
 25 that “the loss of even a modest number of patients would be sufficient to discipline Alta Bates’ and  
 26 Summit’s prices. Defendants’ economist estimates that a shift of less than 8% (equal to about an  
 27 additional 1 patient per day in various competing East Bay hospitals) would be sufficient to prevent a  
 28 5% increase at Summit or Alta Bates.” *California v. Sutter* Defs. Proposed Findings of Fact and  
 Conclusions of Law – ECF No. 462-5 (under seal) at 15–17 (¶¶ 27, 30). Sutter argued that its  
 hospitals’ “viability depends on volume, and only a modest loss of patients would be sufficient to  
 discipline their pricing activity,” *id.* at 29 (¶ 55), that “the evidence establishes that relatively modest  
 redirection of patients would impose a critical loss sufficient to defeat a price increase” by Sutter, *id.* at  
 37 (¶ 70), that “[t]here are numerous mechanisms by which health plans can discipline the hospitals in  
 the event of an attempted price increase. The simplest, but rarely used, is to exclude hospitals from the  
 plans’ provider networks,” *id.* at 31 (¶¶ 58–59) (citations omitted), and thus that “if the combined Alta  
 Bates/Summit acted in an anticompetitive manner, the physician groups could, either on their own or  
 at the impetus of health plans, discipline the merged entity by admitting patients to other hospitals, by  
 threatening to do so, or by shifting referrals (particularly for high value specialty services) to physician

1 The court finds that the plaintiffs have satisfied this component of Rule 23(a)(4)'s adequacy  
2 requirement.

## 3 4 **2. Rule 23(b) Prerequisites**

### 5 **2.1 Predominance — Rule 23(b)(3)**

6 Among other things, Rule 23(b)(3) requires that “the questions of law or fact common to class  
7 members predominate over any questions affecting only individual members.” “Considering  
8 whether ‘questions of law or fact common to class members predominate’ begins . . . with the  
9 elements of the underlying cause of action.” *Erica P. John Fund, Inc. v. Halliburton Co.*, 563 U.S.  
10 804, 809 (2011). The plaintiffs here bring claims under Sections 1 and 2 of the federal Sherman  
11 Antitrust Act, the California Cartwright Act, and the California Unfair Competition Law

12  
13  
14 \_\_\_\_\_  
15 specialists at other hospitals,” *id.* at 36 (¶ 68). In 2001, the court denied the California Attorney  
16 General’s request for an injunction blocking the merger and allowed the merger to go forward,  
17 adopting Sutter’s arguments that “[w]hen faced with price increases, there are numerous mechanisms  
18 through which health plans can discipline hospitals. The simplest, but rarely used, is to exclude  
19 hospitals from the plans’ provider networks.” *California v. Sutter*, 84 F. Supp. 2d at 1078.

20 Sutter’s own assertions in the *California v. Sutter* case, together with the other analyses Dr. Chipty  
21 discusses, Chipty Decl. – ECF No. 379-1 at 42–46 (¶¶ 57–63); Chipty Reply. Decl. – ECF Nos. 462-3  
22 (under seal), 559-1 (redacted version) at 21–24 (¶¶ 22–27), provide support for the plaintiffs’ position  
23 that in the but-for world, Sutter would lower its prices, not raise them, thereby benefiting all class  
24 members and leaving no fundamental intraclass conflicts. *Cf. In re Online DVD II*, 779 F.3d at 942  
25 (courts “do not ‘favor denial of class certification on the basis of speculative conflicts’”) (quoting  
26 *Cummings*, 316 F.3d at 896). Sutter’s disagreement with the plaintiffs’ but-for world may be a merits  
27 issue, but it does not defeat class certification in the first instance.

28 It is worth noting that around the time that the merger was allowed or shortly thereafter, Sutter  
(according to the plaintiffs) began engaging in its systemwide-contracting practices, thereby allegedly  
preventing health plans from using the patient-steering mechanisms that Sutter argued in *California v.*  
*Sutter* would discipline it from imposing price increases. Following the merger, Sutter (according to  
the plaintiffs) increased its prices at Summit by 29.0 to 72.0 percent, significantly more than other  
hospitals. Chipty Reply Decl. – ECF No. 559-1 at 102–03 (¶ 164); *see also Advocate Health*, 841 F.3d  
at 472 (“For example, in 2001 the Northern District of California refused to enjoin a hospital merger,  
relying in part on patient movement data. In 2011, a follow-up study found that the cheaper of the two  
hospitals raised its prices by 29 to 72 percent, much more than a control group had.”) (citing  
*California v. Sutter*, 130 F. Supp. 2d at 1131–32, 1137; Steven Tenn, *The Price Effects of Hospital*  
*Mergers: A Case Study of the Sutter-Summit Transaction*, 18 Int’l J. of the Econ. of Bus. 65, 75–76  
(2011)). Whether Sutter in fact increased its prices to supra-competitive levels, and whether it was  
because of its systemwide-contracting practices that it was able to do so, are issues that can be  
addressed at the merits phase of the litigation.

1 (“UCL”).<sup>118</sup> “To establish a federal antitrust claim, ‘plaintiffs typically must prove (1) a violation  
2 of antitrust laws, (2) an injury they suffered as a result of that violation, and (3) an estimated  
3 measure of damages.’” *In re Qualcomm*, 328 F.R.D. at 296 (quoting *In re High-Tech Emp.*, 985 F.  
4 Supp. 2d at 1183). “With regard to Plaintiffs’ Cartwright Act claim, ‘the analysis mirrors the  
5 analysis under federal law because the Cartwright Act was modeled after the Sherman Act.’” *Cf.*  
6 *id.* (quoting *Cty. of Tuolumne v. Sonora Cmty. Hosp.*, 236 F.3d 1148, 1160 (9th Cir. 2001)). “Also,  
7 Plaintiffs’ UCL claim is premised at least in part upon the Sherman and Cartwright Act  
8 violations.” *Cf. id.* (citing *Cel-Tech Commc’ns, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180  
9 (1999)). “Neither party identifies any material difference between the federal and state claims  
10 warranting separate treatment.” *Cf. id.* “Thus, the Court may treat the state law claims together  
11 with the federal claims in this case.” *Cf. id.*

### 12 **2.1.1 Antitrust violations**

13 As discussed above, the plaintiffs have introduced evidence that Sutter engaged in common  
14 anticompetitive systemwide-contracting practices with respect to all five health plans at issue in  
15 this case and that its practices allow it to charge all five health plans supra-competitive rates in the  
16 same way.<sup>119</sup> Sutter does not meaningfully dispute that the plaintiffs’ claims — that it violated the  
17 antitrust laws — are subject to common proof.<sup>120</sup> The court finds that common questions will  
18 predominate with respect to the alleged antitrust violations.

### 19 **2.1.2 Antitrust injury and calculating damages**

20 “Antitrust ‘impact’ — also referred to as antitrust injury — is the ‘fact of damage’ that results  
21 from a violation of the antitrust laws.” *In re Qualcomm*, 328 F.R.D. at 299 (some internal  
22 quotation marks omitted) (quoting *In re DRAM*, 2006 WL 1530166, at \*7). “‘It is the causal link  
23 between the antitrust violation and the damages sought by plaintiffs.’” *Id.* (quoting *Brown v. Am.*  
24

25 \_\_\_\_\_  
26 <sup>118</sup> 4AC – ECF No. 204 at 38–43 (¶¶ 124–70).

27 <sup>119</sup> See *supra* notes 18–24 and accompanying text.

28 <sup>120</sup> See Def. MCC Opp’n – ECF No. 445 at 16–29 (disputing whether antitrust injury or damages calculations are subject to common proof but not disputing whether antitrust violations are subject to common proof).

1 *Honda (In re New Motor Vehicles Canadian Antitrust Litig.)*, 522 F.3d 6, 19 n.18 (1st Cir. 2008)).  
 2 “Thus, Plaintiffs here ‘must be able to establish, predominantly with generalized evidence, that all  
 3 (or nearly all) members of the class suffered damage as a result of [defendant’s] alleged anti-  
 4 competitive conduct.’” *Id.* (quoting *In re High-Tech Emp.*, 289 F.R.D. at 567).

5 On a motion for class certification, “plaintiffs [must] be able to show that their damages  
 6 stemmed from the defendant’s actions that created the legal liability” and “must show that  
 7 ‘damages are capable of measurement on a classwide basis,’ in the sense that the whole class  
 8 suffered damages traceable to the same injurious course of conduct underlying the plaintiffs’ legal  
 9 theory.” *Nguyen v. Nissan N. Am., Inc.*, 932 F.3d 811, 817 (9th Cir. 2019) (some internal quotation  
 10 marks omitted) (quoting *Just Film, Inc. v. Buono*, 847 F.3d 1108, 1120 (9th Cir. 2017)).

11 “[U]ncertainty regarding class members’ damages does not prevent certification of a class as long  
 12 as a valid method has been proposed for calculating those damages.” *Id.* (quoting *Lambert v.*  
 13 *Nutraceutical Corp.*, 870 F.3d 1170, 1182 (9th Cir. 2017), *rev’d on other grounds*, 139 S. Ct. 710  
 14 (2019)). “Although uncertain damages calculations do not alone defeat certification, the Supreme  
 15 Court has emphasized that ‘at the class-certification stage (as at trial), any model supporting a  
 16 plaintiff’s damages case *must be consistent* with its liability case.’” *Id.* (emphasis in original, some  
 17 internal quotation marks omitted) (quoting *Comcast*, 569 U.S. at 35).

18 The plaintiffs’ liability theory is that Sutter charged the five health plans at issue in this case  
 19 — Blue Shield, Anthem, Aetna, Health Net, and UnitedHealthcare — supra-competitive rates. The  
 20 plaintiffs do not allege that Sutter directly charged class members supra-competitive rates. Instead,  
 21 the alleged antitrust injury is indirect: the class members’ harm comes only to the extent the health  
 22 plans passed on Sutter’s alleged overcharges through to class members in the form of higher  
 23 premiums than the health plans would have charged in the but-for world. As a result, the plaintiffs  
 24 have a two-fold burden: they must demonstrate that (1) the five health plans paid Sutter inflated  
 25  
 26  
 27  
 28



1 prices for inpatient hospital services, and then (2) those overcharges were passed on to class  
2 members in the form of inflated premiums. *Cf., e.g., In re Qualcomm*, 328 F.R.D. at 299.<sup>121</sup>

3 Courts have recognized that “‘antitrust plaintiffs have in recent years trended toward  
4 presenting an econometric formula or other statistical analysis to show class-wide impact’ and that  
5 such analysis has often been accepted at the certification stage.” *In re Optical Disk Drive Antitrust*  
6 *Litig.*, No. 3:10-md-2143 RS, 2016 WL 467444, at \*7 (N.D. Cal. Feb. 8, 2016) (*In re Optical Disk*  
7 *Drive II*) (quoting *In re Graphics Processing Units Antitrust Litig.*, 253 F.R.D. 478, 491 (N.D.  
8 Cal. 2008)). “[S]uch methods, where plausibly reliable, should be allowed as a means of common  
9 proof. To rule otherwise would allow antitrust violators a free pass in many industries.” *Id.*  
10 (quoting *In re Graphics Processing Units*, 253 F.R.D. at 491). “Accordingly, it is clear that  
11 statistical and economic methodologies . . . may be employed to establish class-wide impact.” *Id.*  
12 (emphasis in original). Courts are cautious about “engaging in a battle of expert testimony” at the  
13 certification stage. *Id.* at \*6 (citing *In re DRAM*, 2006 WL 1530166, at \*9); *accord, e.g., In re*  
14 *Lidoderm*, 2017 WL 679367, at \*18. At the same time, “[c]ertification should not be automatic  
15 every time counsel dazzle the courtroom with graphs and tables.” *In re Optical Disk Drive II*,  
16 2016 WL 467444, at \*6 (internal brackets omitted) (quoting *In re Graphics Processing Units*, 253  
17 F.R.D. at 491). “If the presumption were otherwise, ‘nearly all antitrust plaintiffs could survive  
18 certification without fully complying with Rule 23.’” *Id.* (quoting *In re Graphics Processing*  
19 *Units*, 253 F.R.D. at 492). “‘It is now clear that Rule 23 not only authorizes a hard look at the  
20 soundness of statistical models that purport to show predominance — the rule commands it.’” *Id.*  
21 (internal ellipsis omitted) (quoting *In re Rail Freight Fuel Surcharge Antitrust Litig.* 725 F.3d 244,  
22 255 (D.C. Cir. 2013)). “Put another way, the inquiry must be to determine if the proffered expert  
23 testimony has the requisite integrity to demonstrate class-wide impact.” *Id.*; *accord Nguyen*, 932  
24 F.3d at 817 (plaintiff’s method for calculating damages must be “valid”).

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25  
26 <sup>121</sup> This distinguishes this case from the *UFCW & Employers Benefit Trust v. Sutter Health* class  
27 action pending against Sutter in state court. In contrast to the putative class here, the class in that case  
28 consists of self-funded payors that paid Sutter directly for healthcare charges incurred by their  
employee-members instead of buying health insurance. *UFCW & Emps. Benefit Tr. v. Sutter Health*,  
No. CGC - 14-538451, 2017 WL 11405066, at \*5 (Cal. Super. Ct. S.F. Cty. Aug. 14, 2017).

1 The court has taken a “hard look” at the plaintiffs’ proposed methodology for assessing  
2 antitrust injury and calculating antitrust damages. The court finds the plaintiffs’ proposed  
3 methodology has at least two significant deficiencies that prevent the plaintiffs from relying on it  
4 to demonstrate that they can prove antitrust injury or calculate antitrust damages on a class-wide  
5 basis: (1) it does not include a reliable method for proving or calculating Sutter’s overcharges to  
6 the five health plans, and (2) it does not include a reliable method for proving or calculating how  
7 the overcharges were passed through to health-insurance premiums paid by class members.<sup>122</sup>

### 8 **2.1.2.1 Calculating Sutter’s overcharges**

9 As discussed above, the plaintiffs and Dr. Chipty used a regression-analysis model that  
10 purports to calculate what portion of Sutter’s charges to the health plans Anthem and Blue Shield  
11 are attributable to Sutter’s alleged anticompetitive practices. Dr. Chipty has not offered an  
12 overcharge model with respect to Aetna, Health Net, or UnitedHealthcare.<sup>123</sup> She stated that she  
13 had two approaches for addressing those three health plans — (1) trying to run her regression-  
14 analysis model on them or (2) extrapolating her findings from some health plans to other health  
15 plans — but she had not reached an opinion as to which approach she preferred, did not know if  
16 she could run regression analyses on those three health plans, and did not have an opinion about  
17 whether extrapolation would be reasonable.<sup>124</sup> She does not explain how one of her two  
18 alternatives — extrapolation — would actually work: despite the fact that her regression-analysis  
19 model returned significantly different overcharge rates as between Anthem and Blue Shield,<sup>125</sup> she  
20 does not explain how she would reconcile those differences to use them to extrapolate rates for  
21 Aetna, Health Net, or UnitedHealthcare. Assuming without deciding that Dr. Chipty’s regression-

22 \_\_\_\_\_  
23 <sup>122</sup> The court is not engaging in a “battle of the experts” here. The court does not find that the  
24 plaintiffs’ methodology is unreliable because Sutter’s experts or methodologies are more persuasive.  
25 Rather, it finds that the plaintiffs’ methodology is unreliable due to deficiencies within the  
26 methodology.

27 <sup>123</sup> See *supra* note 52.

28 <sup>124</sup> See *supra* notes 53–56.

<sup>125</sup> For example, her model calculated the overcharge rate by Sutter’s Alta Bates Main hospital in 2006  
as [REDACTED] for Anthem and 53 percent for Blue Shield, [REDACTED]. See *supra* notes 47,  
51.

1 analysis model for Anthem and Blue Shield is sound, the plaintiffs nonetheless have not  
2 demonstrated that they can prove or calculate Sutter’s overcharges on a class-wide basis given that  
3 they have not offered a method (or hedged between various methods) for calculating overcharges  
4 for the remaining three health plans, customers of which Dr. Chipty estimates comprise 30 percent  
5 of the class.<sup>126</sup>

6 The court in *In re Lithium Ion Batteries* was confronted with a similar situation. The plaintiffs  
7 there alleged that battery manufacturers engaged in a price-fixing conspiracy to inflate the price of  
8 batteries used in portable consumer electronics (e.g., laptops, smartphones, etc.). *In re Lithium Ion*  
9 *Batteries I*, 2017 WL 1391491, at \*1–2. The plaintiffs relied on an expert report and model to  
10 prove and calculate damages on a class-wide basis. *Id.* at \*16. The court found, however, that:

11 [The expert]’s analysis fails to provide a firm foundation for class certification  
12 because he was unable to complete an analysis based on the actual cost data for any  
13 products other than Toshiba laptops. Further, even in his analysis of the Toshiba  
14 products, the data was limited and required some extrapolation. The data for all  
15 other products was, by [the expert]’s own admission, insufficient to run an analysis  
16 as to any of the other products types covered by the class definition. While it is  
17 unclear where to lay the blame, the Court nevertheless cannot ignore the large gaps  
18 in the evidence supporting the ability to demonstrate impact and damages on a  
19 class-wide basis. . . . As it stands, the analysis of the Toshiba laptops alone does not  
20 satisfy the Court that a showing of antitrust impact for that product can be  
21 extrapolated as a measure of impact for the rest of the Cells, Batteries and Finished  
22 Products in the class definition.

19 *Id.* at \*17–18. The court reaches a similar conclusion here. Dr. Chipty offers an overcharge model  
20 only for Anthem and Blue Shield, which is insufficient to demonstrate a method for proving  
21 antitrust impact or calculating damages on a class-wide basis across the entire class.<sup>127</sup>

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23 <sup>126</sup> Chipty Reply Decl. – ECF No. 559-1 at 16–17 (¶ 13).

24 <sup>127</sup> The plaintiffs argue that “[c]lasses have . . . been certified where experts have proposed a damages  
25 model, *but have not yet actually calculated any damages* for any class members.” Pls. Sur-Sur-Reply –  
26 ECF No. 569 at 4 (emphasis in original). But it is not simply that the plaintiffs have not calculated  
27 damages for Aetna, Health Net, or UnitedHealthcare. They have not proposed a damages model (or try  
28 to hedge between two different models, in order to have it both ways). *See supra* notes 52, 54.

The court also has some questions about other aspects of Dr. Chipty’s overcharge model with respect  
to Anthem and Blue Shield. For example, her model shows an undercharge — rather than an  
overcharge — for Blue Shield by one of Sutter’s hospitals in a Tied Market, Sutter Santa Rosa. *See*  
*supra* note 51. Dr. Chipty testified that this reflects that her model has “an inability to measure the

1                   **2.1.2.2 Assuming health plans “pass on” 100 percent of any Sutter overcharges**  
 2                   **they have to pay through to the premiums that they charge their**  
 3                   **customers**

4                   “Where, as here, the class is composed of indirect purchasers, ‘proof of class-wide antitrust  
 5 impact is made more complex because plaintiffs must offer a model of impact and damages that  
 6 demonstrates the alleged overcharge was passed through to each successive link in the distribution  
 7 chain, and ultimately to the plaintiffs.’” *In re Qualcomm*, 328 F.R.D. at 301 (quoting *In re Lithium*  
 8 *Ion Batteries Antitrust Litig.*, No. 13-MD-2420 YGR, 2018 WL 1156797, at \*3 (N.D. Cal. Mar. 5,  
 9 2018) (*In re Lithium Ion Batteries II*)).

10                   Courts in indirect-purchaser antitrust cases have recognized the use of averaging in calculating  
 11 passthrough rates where experts have shown the sound methodological steps through which they  
 12 calculated their averages. *See, e.g., id.* at 315 (collecting cases). For example, *In re Qualcomm* —  
 13 an antitrust case against a manufacturer of “modem chips” used in cellphones brought by a class of  
 14 indirect purchasers who bought phones containing the chips — the plaintiffs’ expert calculated an  
 15 average passthrough rate from the chip manufacturer through cellphone manufacturers and  
 16 retailers to cellphone buyers through regression analyses based on sales data from (1) six major  
 17 cellphone manufacturers, including the five largest manufacturers in the U.S. market (Apple,  
 18 Samsung, Motorola, LG, and HTC), representing approximately 90 percent of total cellphone  
 19 sales, (2) six of the largest U.S. retailers (including Best Buy, Amazon, Wal-Mart, and Target),  
 20 representing approximately 84 percent of the retailer market, and (3) five wireless carriers,  
 21 including the four major U.S. carriers (AT&T, Sprint, T-Mobile, and Verizon) and one regional  
 22 carrier, representing approximately 97 percent of the wireless-carrier market. *Id.* at 302–03. The  
 23 expert used ten control variables in his regressions (the same ten control variables that the

24 \_\_\_\_\_  
 25 overcharge for Sutter-Santa Rosa.” *See supra* note 57. It is unclear if the plaintiffs are taking the  
 26 position that Sutter did not overcharge Blue Shield at its Sutter Santa Rosa hospital or if they are  
 27 taking the position that it did overcharge and that they need a new model to determine how much it  
 28 overcharged (because their current model cannot measure that overcharge). The latter raises the  
 prospect of the plaintiffs proposing additional individualized overcharge models for specific hospitals  
 or health plans. In light of the court’s decision on other grounds that the plaintiffs have not provided a  
 sufficient model, it need not fully resolve these questions now, but it raises them as issues that may  
 need to be addressed on any further class-certification motion.

1 defendant used in a submission to the FTC) and calculated separate passthrough rates for each of  
2 18 sales channels, which he then weighted to calculate an overall sales-channel-weighted average  
3 passthrough rate of 87.4 percent. *Id.* at 303–04. In finding that the expert’s average weighted  
4 passthrough rate was sufficient to support class certification, the court found that:

5 [The plaintiffs’ expert] does not simply assume a uniform pass-through rate for  
6 OEMs. Instead, he examines transactional data for six different OEMs — including  
7 the five largest OEMs in the U.S. market (Apple, Samsung, Motorola, LG, and  
8 HTC) — who “accounted for approximately 90% of total cell phone sales” during  
the relevant period. [He] calculates individual pass-through rates for these six  
OEMs in order to model a composite pass-through rate.

9 *Id.* at 308. By contrast, courts have rejected the use of averaging in calculating passthrough rates  
10 where experts have not shown the sound methodological steps through which they calculated their  
11 averages. For example, in *In re Lithium Ion Batteries* — an antitrust case against manufacturers of  
12 batteries used in consumer electronics — the plaintiffs’ expert assumed that the passthrough rate at  
13 each level in the distribution chain from the battery manufacturers to device manufacturers to  
14 retailers to the end consumers approached 100 percent without sufficiently supporting his analysis.  
15 *In re Lithium Ion Batteries I*, 2017 WL 1391491, at \*12. Among other things, “[the expert]  
16 acknowledged that bundling, rebates, and discounts would affect the accuracy of cost data, but  
17 apparently has offered no methodology to account for it in his analysis.” *Id.*<sup>128</sup> The court there  
18 “f[ound] the [expert’s] declarations insufficient to show that pass-through and damages can be  
19 established by expert analysis on a class-wide basis” and denied certification. *Id.* On a renewed  
20 motion a year later, the court found that the expert’s supplemental analysis still failed to account  
21 for a central issue affecting passthrough rates (focal-point pricing; meaning, the practice of  
22 retailers setting prices at certain “focal points,” such as prices ending with 9, and not adjusting  
23 such prices based on small differences in costs) and thus “left too much uncertainty as to whether  
24 pass-through can be estimated reliably at 100% as to retailers or distributors farther down the  
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27 <sup>128</sup> By way of contrast, the expert in *In re Qualcomm* “perform[ed] separate pass-through rate  
28 calculations for subsidized and unsubsidized phones and f[ound] statistically significant pass-through  
rates for each wireless carrier for subsidized and unsubsidized phones.” *In re Qualcomm*, 328 F.R.D.  
at 310.

1 supply chain, and ultimately to the consumers who make up the proposed class,” and once again  
2 denied certification. *In re Lithium Ion Batteries II*, 2018 WL 1156797, at \*4.

3 The *In re Optical Disk Drive* antitrust litigation is instructive because the court there first  
4 denied class certification due in part to deficiencies in the plaintiffs’ passthrough assumptions and  
5 then, two years later, granted a renewed motion for class certification. The plaintiffs there alleged  
6 that optical-disc-drive (“ODD”) manufacturers engaged in bid-rigging to prop up the price of  
7 ODDs. *In re Optical Disk Drive Antitrust Litig.*, 303 F.R.D. 311, 314 (N.D. Cal. 2014) (*In re*  
8 *Optical Disk Drive I*).<sup>129</sup> The plaintiffs sought to certify a class of direct-purchaser plaintiffs  
9 (“DPPs”) that bought ODDs directly from the defendants, *id.* at 316, and a class of indirect-  
10 purchaser plaintiffs (“IPPs”) that bought products that contained ODDs manufactured by the  
11 defendants (but which the IPPs did not buy directly from the defendants), *id.* at 323. On the  
12 plaintiffs’ initial class-certification motion, the plaintiffs’ expert aggregated prices for all  
13 purchasers who bought ODDs of particular types in given years before running a regression  
14 analysis to calculate a passthrough rate. *Id.* at 324. The court found that this resulted in “class-  
15 wide impact . . . being *assumed* by the models, rather than demonstrated by the results.” *Id.*  
16 (emphasis in original). The expert “purport[ed] to test the validity of his models by looking to  
17 specific examples in the data,” but the court rejected this approach, holding that “[i]dentifying  
18 some instances where the empirical data appears to match the model does not transform the  
19 analysis from one that assumes class-wide impact into one that proves it.” *Id.* The court ultimately  
20 concluded that “the IPPs have not presented a persuasive explanation as to why it would be  
21 reasonable to assume a uniform pass through rate” and denied certification. *Id.*

22 Two years later, the plaintiffs moved for certification again, this time for a narrower IPP class.  
23 *In re Optical Disk Drive II*, 2016 WL 467444, at \*3. The plaintiffs’ expert offered a modified  
24 overcharge model that, among other things, “integrate[d] all ‘useable’ sales and costs data  
25 produced — from 86 percent of the market” and “provide[d] further detail on the multivariable  
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27 <sup>129</sup> “Optical discs” include CDs and DVDs. *In re Optical Disk Drive I*, 303 F.R.D. at 314. While the  
28 action was captioned “Optical Disk Drive Antitrust Litigation,” apparently “disc” (not “disk”) is the  
preferred spelling for optical media. *Id.* at 314 n.1.

1 regression analysis, which [the plaintiffs] contend shows that all factors other than [the antitrust]  
2 conspiracy are being adequately controlled for in the overcharge model.” *Id.* at \*6. The court  
3 found that this new analysis, which measured passthrough rates for over 273 million ODD  
4 products, *id.* at \*9, was sufficient to support certification.

5 Dr. Chipty’s passthrough analyses here have more in common with the deficient models in *In*  
6 *re Lithium Ion Batteries* and the first *In re Optical Disk Drive* decision than the models in *In re*  
7 *Qualcomm*, the second *In re Optical Disk Drive* decision, or other decisions where courts have  
8 accepted passthrough models. Dr. Chipty began by assuming what she needs to prove, namely,  
9 that each of the five health plans pass on 100 percent of any Sutter overcharges through to the  
10 premiums they charge their customers. Dr. Chipty based her 100-percent-passthrough assumption  
11 in large part on the Bob Reed PowerPoint presentation where Sutter supposedly assumed a 100-  
12 percent-passthrough rate for the purpose of running hypotheticals [REDACTED]

13 [REDACTED]  
14 [REDACTED].<sup>130</sup> Contrary to Dr. Chipty’s inference, the hypothetical in that presentation does not  
15 establish that Sutter actually concluded that health plans pass on 100 percent of Sutter’s price  
16 reductions (or increases) through to their customers’ premiums. Even if it did, the fact that Sutter  
17 (which is not a health plan) might have drawn this conclusion does not establish that health plans  
18 actually pass on 100 percent of price reductions (or increases) through to their customers’  
19 premiums. Dr. Chipty further based her 100-percent-passthrough assumption on documents and  
20 analyses that she said indicates that health plans try to set premiums at a level that covers all their  
21 expenses and that when their costs increase, their premiums do as well.<sup>131</sup> The fact that health  
22 plans try to set premiums at a level that covers all their expenses as a whole, or that their  
23 premiums generally increase when their costs increase, does not establish that health plans pass on  
24 100 percent of any given cost increase or overcharge through to their customers. To the contrary,  
25 Dr. Chipty herself acknowledged that “a health plan may decide to absorb some portion of a

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27 <sup>130</sup> See *supra* notes 77–79.

28 <sup>131</sup> See *supra* note 80.

1 medical cost increase, by cutting into [its] margins,” rather than passing on 100 percent of those  
2 increases to its customers.<sup>132</sup>

3 Dr. Chipty tries to bolster her 100-percent-passthrough-rate assumption with a regression  
4 analysis. Her original regression analysis is overly simplistic, using data only from small-group  
5 employers (not individuals or large-group employers) and measuring the relationship between  
6 PMPM premiums and only a single explanatory variable, PMPM costs. Dr. Chipty herself  
7 acknowledged that this was “a very simple regression model” and that this model might not be  
8 appropriate if the relationship between a health plan’s costs (including costs in paying hospitals  
9 like Sutter) and the health plan’s premiums were complex.<sup>133</sup> She said that she nonetheless elected  
10 to use this simple model because she assumed that the relationship between costs and premiums  
11 was “formulaic.”<sup>134</sup> In other words, Dr. Chipty assumed what she set out to prove — that the  
12 method by which health plans pass on their costs through to their customers’ premiums is in fact  
13 “formulaic” — and then developed a “simple” regression-analysis model to try to support that  
14 assumption. *Cf. In re Optical Disk Drive I*, 303 F.R.D. at 324 (finding unreliable models that  
15 assumed class-wide impact, rather than demonstrating class-wide impact).

16 Among the model’s other flaws is its failure to take into account how competition from rival  
17 health plans (including Kaiser Permanente) affects a health plan’s decision to pass its costs

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21 <sup>132</sup> See *supra* note 60.

22 <sup>133</sup> See Chipty Dep. – ECF No. 415-1 (under seal) at 114 (pp. 391–92) (“Q. Are you aware of any  
23 generally accepted method of determining the pass-through rates? A. Oh, I believe this is a generally  
24 accepted method. There are a range of methods ranging from simple to highly complicated that people  
25 use and can use. And it just depends, I think, on the context and the available evidence to study as well  
26 as the other corroborating evidence you have. So I view this as a component of the larger evidence that  
27 I use to reach my conclusion. Now, would I do exactly the same thing in a different setting? Probably  
28 not. I would have to adapt to the — to the circumstances and the facts of the case. Q. What would it  
depend on? A. It would depend in part on the complexity of the relationship between the price and the  
cost. Here are the reasons — clear reasons to believe, given the rate setting process, that there is a, if  
you will, formulaic relationship between costs and premiums. So that’s part of the underpinning that  
led me to believe that there would surely be a relationship, and the question was to what extent are  
those movements correlated.”).

<sup>134</sup> See *id.*



1 through to its premiums.<sup>135</sup> Dr. Chipty stated in her report that “[t]o the extent health plans like  
2 Anthem and Blue Shield would absorb cost increases to compete with Kaiser, pass-through may  
3 be less than 100 percent.”<sup>136</sup> But she offers no methodology for taking health-plan competition  
4 into account in her original regression-analysis model, undermining her model’s reliability. *Cf.*  
5 *Lithium Ion Batteries I*, 2017 WL 1391491, at \*12 (finding unreliable models where expert  
6 acknowledged that certain factors would affect the accuracy of cost data but had no methodology  
7 to account for those factors in his analysis).

8 Dr. Chipty’s additional analyses in her reply declaration fare no better. For one health plan,  
9 Aetna, Dr. Chipty does not dispute Dr. Willig’s analysis estimating a passthrough rate of 30  
10 percent, with a 95-percent confidence interval ranging from negative 16.4 percent and 76.8  
11 percent.<sup>137</sup> Dr. Chipty describes this 30-percent-passthrough rate as being “not statistically  
12 different from a pass-through rate as high as 77 percent”<sup>138</sup> — ignoring that, by that same logic, it  
13 also is not statistically different from a passthrough rate as low as negative 16.4 percent — and  
14 then offers no analysis for how she went from a passthrough rate “as high as 77 percent” to  
15 assuming a significantly higher 100-percent-passthrough rate for Aetna in her damages model.  
16 Similarly, of the 23 passthrough calculations that she listed in Exhibit 8 of her reply declaration,<sup>139</sup>  
17 █████ of them (i.e., more than █████ of her results) had 95-percent-confidence intervals whose  
18 upper bound fell below 1 — meaning that for those regressions, there was less than a five-percent  
19 chance that the actual passthrough rate was as high as 100 percent. Other than saying that these  
20 results nevertheless were “near” or “close to” 100 percent<sup>140</sup> — terms she does not define with any  
21 precision<sup>141</sup> — she does not explain how these results or her analyses support her decision to  
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23 <sup>135</sup> *Cf. supra* notes 69–74 and accompanying text (discussing examples where health plans did not pass  
24 on costs through to their customers’ premiums due to competition from rival health plans).

25 <sup>136</sup> *See supra* note 67; *see also supra* notes 62, 68.

26 <sup>137</sup> *See supra* note 88.

27 <sup>138</sup> *See supra* note 91.

28 <sup>139</sup> *See supra* note 89.

<sup>140</sup> *See supra* note 95.

<sup>141</sup> *See supra* note 96.

1 assume a uniform 100-percent-passthrough rate across all health plans, all business lines, all  
2 health-insurance products, in all competitive situations.

3 The court finds that Dr. Chipty’s analyses are insufficient to show that antitrust injury and  
4 damages can be established on a class-wide basis. And absent a sound methodology for proving  
5 on a class-wide basis what Sutter’s overcharges were and how those overcharges were passed  
6 through to the class, the plaintiffs have not met their burden of showing that common issues  
7 predominate. *Cf. In re Optical Disk Drive I*, 303 F.R.D. at 324 (absent a class-wide methodology  
8 for calculating overcharges and passthroughs, the case would result in ““thousands of mini-trials,  
9 rendering this case unmanageable and unsuitable for class action treatment””). The court therefore  
10 denies the plaintiffs’ motion to certify their proposed class under Rule 23(b)(3). *Cf. In re Lithium*  
11 *Ion Batteries II*, 2018 WL 1156797, at \*5 (denying certification due to lack of valid class-wide  
12 passthrough model); *In re Lithium Ion Batteries I*, 2017 WL 1391491, at \*19 (same); *In re Optical*  
13 *Disk Drive I*, 303 F.R.D. at 324–25 (same).

14 This denial is without prejudice to the plaintiffs moving to certify a Rule 23(b)(3) class if they  
15 are able to make a fuller showing that they can prove antitrust injury and calculate damages on a  
16 class-wide basis with a model that addresses the deficiencies the court identified here (and any  
17 other deficiencies that may be present elsewhere in their models). *Cf. In re Lithium Ion Batteries I*,  
18 2017 WL 1391491, at \*12. This denial also is without prejudice to the plaintiffs moving to certify  
19 a Rule 23(b)(3) class for settlement purposes, which does not raise the same manageability issues  
20 that certifying a litigation class does. *In re Hyundai and Kia*, 926 F.3d at 556–57 (“The criteria for  
21 class certification are applied differently in litigation classes and settlement classes. In deciding  
22 whether to certify a litigation class, a district court must be concerned with manageability at trial.  
23 However, such manageability is not a concern in certifying a settlement class where, by definition,  
24 there will be no trial.”).

## 25 **2.2 Acting on Grounds That Apply Generally to the Class — Rule 23(b)(2)**

26 A court may certify a class under Rule 23(b)(2) if “the party opposing the class has acted or  
27 refused to act on grounds that apply generally to the class, so that final injunctive relief or  
28 corresponding declaratory relief is appropriate respecting the class as a whole[.]”

1 “The key to the (b)(2) class is the ‘indivisible nature of the injunctive or declaratory remedy  
2 warranted — the notion that the conduct is such that it can be enjoined or declared unlawful only  
3 as to all of the class members or as to none of them.’” *B.K. ex rel. Tinsley v. Snyder*, 922 F.3d 957,  
4 971 (9th Cir. 2019) (quoting *Wal-Mart*, 564 U.S. at 360). “In other words, Rule 23(b)(2) applies  
5 only when a single injunction or declaratory judgment would provide relief to each member of the  
6 class. It does not authorize class certification when each individual class member would be  
7 entitled to a different injunction.” *Id.* (quoting *Wal-Mart*, 564 U.S. at 360).

8 Rule 23(b)(2) “does not require [courts] to examine the viability or bases of class members’  
9 claims for declaratory and injunctive relief, but only to look at whether class members seek  
10 uniform relief from a practice applicable to all of them.” *Rodriguez v. Hayes*, 591 F.3d 1105, 1125  
11 (9th Cir. 2010). “[I]t is sufficient’ to meet the requirements of Rule 23(b)(2) that ‘class members  
12 complain of a pattern or practice that is generally applicable to the class as a whole.’” *Id.* (quoting  
13 *Walters v. Reno*, 145 F.3d 1032, 1047 (9th Cir. 1998)). “The fact that some class members may  
14 have suffered no injury or different injuries from the challenged practice does not prevent the class  
15 from meeting the requirements of Rule 23(b)(2).” *Id.* (citing *Walters*, 145 F.3d at 1047).  
16 “Furthermore, unlike actions brought under one of the other 23(b) prongs, ‘questions of  
17 manageability and judicial economy are irrelevant to 23(b)(2) class actions.’” *Id.* (internal ellipsis  
18 omitted) (quoting *Forbush v. J.C. Penney Co., Inc.*, 994 F.2d 1101, 1105 (5th Cir. 1993)).

19 The Ninth Circuit has recently instructed that courts should not impose a “cohesiveness”  
20 requirement in assessing whether certification under Rule 23(b)(2) is appropriate. *Senne v. Kan.*  
21 *City Royals Baseball Corp.*, 934 F.3d 918, 937–38 (9th Cir. 2019) (internal brackets omitted)  
22 (quoting Fed. R. Civ. P. 23(b)(2)). “Although common issues must predominate for class  
23 certification under Rule 23(b)(3), no such requirement exists under 23(b)(2).” *Id.* at 938 (quoting  
24 *Walters*, 145 F.3d at 1047). Instead, “Rule 23(b)(2) . . . requires only that ‘the party opposing the  
25 class have acted or refused to act on grounds that apply generally to the class, so that final  
26 injunctive relief or corresponding declaratory relief is appropriate respecting the class as a  
27 whole.’” *Id.* at 928 (internal brackets omitted) (quoting Fed. R. Civ. P. 23(b)(2)). Due to Rule  
28 23(b)(2)’s and Rule 23(b)(3)’s differing requirements, courts have granted motions to certify

1 putative classes under Rule 23(b)(2) while denying motions to certify the classes under Rule  
2 23(b)(3). *See, e.g., Ang v. Bimbo Bakeries USA, Inc.*, No. 13-cv-01196-HSG, 2018 WL 4181896,  
3 at \*12, \*17 (N.D. Cal. Aug. 31, 2018) (denying certification under Rule 23(b)(3) “[b]ecause  
4 Plaintiffs have not shown that the economic harm they allegedly sustained . . . is capable of  
5 measurement on a classwide basis” but granting certification under Rule 23(b)(2) because “a  
6 single injunction would provide relief to each member of the class”) (internal ellipsis omitted);  
7 *Campbell v. Facebook Inc.*, 315 F.R.D. 250, 269–70 (N.D. Cal. 2016) (same).

8 The plaintiffs here seek a single injunction or declaratory judgment — namely, an injunction  
9 barring Sutter from engaging in anticompetitive behavior, including its systemwide-contracting  
10 practices with their “all-or-nothing,” “anti-steering,” and “penalty rate” provisions or a declaration  
11 that Sutter’s practices are anticompetitive and violate the antitrust laws — that would provide  
12 relief to each member of the class.<sup>142</sup> They therefore have satisfied the requirement for certifying a  
13 class under Rule 23(b)(2). *Cf. In re Qualcomm*, 328 F.R.D. at 318–19 (certifying Rule 23(b)(2)  
14 class in antitrust case); *In re TFT-LCD*, 267 F.R.D. at 595–97 (same).<sup>143</sup>

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21 <sup>142</sup> The plaintiffs do not need to specify at the class-certification stage the precise injunction they will ultimately seek on the merits. *B.K.*, 922 F.3d at 972.

22 <sup>143</sup> Sutter argues that the putative class is not sufficiently “cohesive” to be certified under Rule 23(b)(2) and argues that “[t]he need for cohesiveness under (b)(2) is similar to the requirements of ‘predominance’ and ‘superiority’ under Rule 23(b)(3),” citing cases from the Third Circuit. Def. MCC Opp’n – ECF No. 445 at 31–32. This argument fails in light of the Ninth Circuit’s decision in *Senne*, 934 F.3d at 937–38. Sutter also argues that certification under Rule 23(b)(2) is improper because (so it claims) many class members benefited from its practices. Def. MCC Opp’n – ECF No. 445 at 32. As the court discussed above in the context of Rule 23(a)(4)’s adequacy requirement, Sutter’s argument about ostensible “benefit” to some class members from its practices is misplaced. Additionally, arguments that some hypothetical members of the class allegedly benefit from the practices that the class seeks to enjoin and do not want those practices to end do not provide a basis for denying certification under Rule 23(b)(2). *Campbell*, 315 F.R.D. at 269–70 (citing *In re Yahoo Mail Litig.*, 308 F.R.D. 577, 601 (N.D. Cal. 2015)). “[C]lass certification is not a decision on the merits, and the plaintiffs will only be entitled to injunctive relief if such relief is necessary to redress the . . . violations they actually prove at trial.” *B.K.*, 922 F.3d at 971.

**CONCLUSION**

The court grants the plaintiffs’ motion to certify their proposed class under Rule 23(b)(2) and denies without prejudice their motion to certify their proposed class under Rule 23(b)(3).

**IT IS SO ORDERED.**

Dated: August 30, 2019



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LAUREL BEELER  
United States Magistrate Judge

United States District Court  
Northern District of California

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