UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

UFCW LOCAL 1500 WELFARE FUND, on behalf of itself and all others similarly situated,

Plaintiff,

v.

THE NEW YORK AND PRESBYTERIAN HOSPITAL,

Defendant.

Case No. CV 25-5023

CEMENT AND CONCRETE WORKERS DC BENEFIT FUND, on its own behalf and on behalf of others similarly situated,

Plaintiff,

v.

THE NEW YORK AND PRESBYTERIAN HOSPITAL,

Defendant.

Case No. CV 25-5571

CEMENT AND CONCRETE WORKERS & POINTERS, CLEANERS, AND CAULKERS' OPPOSITION TO NYP'S MOTION TO DISMISS

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INTRODUCTION

Defendant The New York and Presbyterian Hospital ("NYP") imposes contractual restraints that impede price and quality competition among hospitals, raising the prices Plaintiffs and the Proposed Class pay NYP for healthcare.

As alleged in Plaintiffs' Consolidated Class Action Complaint, ECF 32 ("Complaint" or "CAC"), NYP has leveraged its size and importance in New York City to impose what it calls the "All Products Clause" on every insurance company it contracts with. This anti-steering restraint forbids insurance companies from creating networks, which Plaintiffs otherwise would have access to, that exclude or disfavor NYP. This also eliminates the competitive pressure that would otherwise force NYP to bring its prices in line with the world-renowned systems it competes with, such as NYU-Langone and Mt. Sinai.

The results have been astounding: NYP's average prices for an inpatient stay are *74% higher* than its competitors in New York. CAC ¶ 16. Plaintiffs and the Proposed Class—businesses, unions, and local governments that pay for their employees' and members' healthcare—pay NYP the inflated prices the All Products Clause enables. They bring this action to end NYP's anticompetitive conduct and recover their overcharges.

In its Motion to Dismiss, ECF 41 ("MTD" or "Motion"), NYP doesn't challenge the Complaint's allegations about NYP's sky-high prices compared to the market; that NYP imposes the All Products Clause on every major insurer; or that the All Products Clause operates as an anti-steering provision that prevents Plaintiffs and the Proposed Class from excluding NYP or steering their members away from NYP. Instead, NYP asks the Court to determine, at the pleading stage, that its anti-steering provisions aren't anticompetitive, or, if they are, that Plaintiffs aren't the right parties to sue. *See* MTD 2-3. These arguments are wrong and, at minimum, no basis for dismissal.

Each of NYP's arguments has been raised before by hospital systems in antitrust cases, and each time courts have rejected them. *See, e.g.*, *Uriel Pharmacy Health & Welfare Plan v. Advoc. Aurora Health, Inc.*, 2023 WL 12284689 (E.D. Wis. Apr. 28, 2023) (anti-steering clause plausibly anticompetitive and self-funded plans have standing); *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720 (W.D.N.C. 2017); *Brown v. Hartford Healthcare Corp.*, 2023 WL 7150051 (Conn. Super. Ct. Oct. 26, 2023); *Davis v. HCA Healthcare, Inc.*, 2022 WL 4354142 (N.C. Super. Sep. 19, 2022). Consistent with these authorities and the widespread condemnation of anti-steering provisions as anticompetitive, NYP cannot obtain dismissal based on the naked assertion that its conduct is "simply a volume discount" that supposedly results in no anticompetitive effects and causes Plaintiffs no harm, MTD at 3, especially given the Complaint's well-pled allegations that NYP's prices are more than 50% higher than competitors with equal or higher quality. CAC ¶¶ 105-29.

The Complaint's theory of harm is made more plausible because the U.S. Department of Justice ("DOJ") has filed a complaint against NYP alleging that the same conduct is anticompetitive. NYP didn't even move to dismiss the DOJ action, even though every merits argument it makes here would apply equally there. *See* Answer, *United States v. New York and Presbyterian Hosp.*, No. 26-cv-02480 (S.D.N.Y. May 26, 2026), ECF 22. For instance, NYP argues that Plaintiffs' failure to package their challenge as either "tying, bundling, [or] exclusive dealing …. kills their claim." MTD at 3. Yet DOJ also alleges none of those theories. The Court should not dismiss this case based on arguments NYP hardly appears to believe in, and that have been rejected by every court that's seen them.

NYP's standing arguments fare no better. NYP says Plaintiffs are "too remote" from the anticompetitive conduct but ignores that Plaintiffs pay the elevated prices created by NYP's anticompetitive conduct. That gives them standing. *United States v. Live Nation Ent., Inc.*, 2025

WL 835961, at *5 (S.D.N.Y. Mar. 14, 2025) ("[P]utting antitrust legalese to the side … where a defendant unlawfully maintains its monopoly over a product through a course of exclusionary conduct focusing on that product, consumers of that product alleging that they were overcharged suffer a cognizable injury.").[1] And NYP's argument that Plaintiffs aren't "direct purchasers" because a financial intermediary facilitates their payments to NYP impermissibly "attempt[s] to transform the *Illinois Brick* direct purchaser rule into a direct payor or 'who pays' rule." *In re Payment Card Interchange Fee & Merch. Disc. Antitrust Litig.*, 2024 WL 1014159, at *12 (E.D.N.Y. Mar. 8, 2024) ("*Payment Card II*").

Throughout its Motion, NYP insists that its contractual restraints are actually good because they "prevent discrimination" and ensure "an open network that … does not exclude anyone from any plan." MTD at 1. What NYP calls "discrimination" is just selective contracting, *i.e.*, the procompetitive ability of health plans to choose among providers based on price and quality—and, yes, to "exclude" or "discriminate" against providers who charge exorbitant prices. *See* CAC ¶¶ 4-9. As NYP itself has admitted, removing its restraints would "encourage competition among hospitals and providers on the basis of price, payment terms and quality." *Id.* ¶ 102. Plaintiffs agree: NYP's restraints block competition.

The Court should deny NYP's Motion.

FACTUAL BACKGROUND

I. Hospital and Insurance Market Overview

Many businesses and unions provide health plans to their employees and members. CAC ¶ 40. Some offer "fully-insured" health plans, in which the employer or union pays monthly premiums to an insurance company, which in turn pays the hospital bills and bears the insurance

[1] All emphasis in this brief is added, unless otherwise noted. Internal citations and quotations are omitted.

risk. *Id.* ¶ 41. For fully-insured plans, the insurance company is financially responsible for members' healthcare costs. *Id.*

Other union- or employer-sponsored health plans—including Plaintiffs'—are "self-funded." *Id.* ¶ 42. In a self-funded plan, the union or employer pays hospital bills for its employees or members and bears the insurance risk itself. *Id.* Employers or unions offering self-funded plans do not use insurance companies to insure anything—instead, they alone are financially responsible for the cost of their members' care. *Id.* ¶ 44.

Self-funded plans do, however, typically use an insurance company (like Anthem BCBS) to obtain two separate, non-insurance services. *Id.* ¶ 45. First, self-funded plans access networks of healthcare providers and negotiated rates through insurance companies. *Id.* ¶¶ 45-50. For example, Plaintiffs pay fixed per-member, per-month fees (regardless of how much their members use the network) to Anthem BCBS for access to its networks, while always retaining the responsibility to pay their members' bills. *Id.* ¶ 48. When acting in this capacity, Anthem BCBS is Plaintiffs' "Network Vendor." *Id.*

Second, self-funded plans often hire insurance companies (or other entities) to assist with administrative tasks, including calculating allowed amounts, adjudicating claims disputes, and processing payments. *Id.* ¶¶ 45, 51-52. Companies acting in this capacity are called "Third Party Administrators" or "TPAs." *Id.* ¶ 45. When processing payments, TPAs act like a wire-transfer or credit-card service, facilitating the self-funded plan's purchase of healthcare services. *Id.* ¶ 51. In exchange, the self-funded plan typically pays the TPA a per-member, per-month administrative services fee. *Id.*

In either scenario, the Network Vendor builds networks of providers who agree to provide medical services to plan members at pre-determined prices. *Id.* ¶¶ 40, 46. This leads to a provider being "in-network" for a health plan. *Id.* ¶ 46. In-network rates (also known as "allowed amounts")

are prices negotiated between Network Vendors and providers for each type of service offered, *id.*, and then paid by the self-funded plan or, for fully-insured plans, by the insurer, *id.* ¶¶ 41-43.

II. Provider Competition and Selective Contracting

Selective contracting refers to various tools Network Vendors use to spur price and quality competition among providers. *Id.* ¶¶ 4, 56-67. One tool is the threat of exclusion from the network: in competitive healthcare markets, hospitals know that if their prices are too high or their quality too low, Network Vendors may decline to contract with them in favor of higher-value providers. *Id.* ¶ 57. Providers don't want to be excluded from insurance networks because patients are less likely to use out-of-network providers. *Id*.

These competitive dynamics allow Network Vendors to assemble cost-effective products like "narrow networks," *i.e.*, networks with a smaller set of healthcare providers, typically excluding the most expensive providers. *Id.* ¶ 58. Narrow networks, or the threat of them, create downward pressure on providers' prices, as providers will offer lower prices to be included. *Id.* This, in turn, lowers overall spending on hospital care even for health plans that choose not to offer narrow-network options. *Id.*

Another tool is "steering" within a network. *Id.* ¶ 59. Network Vendors may include both higher-cost and lower-cost providers in the same broad network but incentivize (or "steer") members to use lower-cost providers offering equal or better-quality care. *Id.* In one form of steering, called "tiering," low-cost, high-quality providers are placed in a higher "tier" than more expensive and/or lower-quality competitors; the members are then incentivized (*e.g.*, through lower co-pays) to choose higher-tier providers. *Id.* ¶ 61. The Complaint describes several other forms of steering. *See id.* ¶¶ 62-64.

These selective contracting strategies, whether implemented or merely threatened, reduce healthcare costs. *Id.* ¶¶ 8-9, 65-67, 70-76. If providers know they could lose patient volume if their prices are too high, they are less likely to demand unjustifiably high prices. *Id.* ¶ 60.

III. NYP's Contractual Restrictions Unlawfully Restrain Competition

NYP imposes anticompetitive restraints that block or restrict these selective contracting tools. *Id.* ¶¶ 77-97. A principal restraint is the All Products Clause, which NYP forces onto all or nearly all networks a Network Vendor creates. *Id.* ¶¶ 11, 77-82. NYP requires Network Vendors that want to include *any* NYP provider or facility in *any* of its networks to include *all* NYP providers and facilities in *all* of its networks, and to include them at the highest tier or benefit level. *Id.* ¶¶ 12, 78-79. The restraint restricts steering away from NYP and toward more cost-effective competitors. The restraint thus insulates NYP from price competition—or, as NYP calls it, "erosion of rates of payment"—and allows it to maintain high prices. *Id.* ¶ 17.

NYP imposes its restraints through express contract provisions, negotiating tactics, and threats. *Id.* ¶ 82. Network Vendors and health plans do not want to accept NYP's restraints but, with rare exception, have no practical alternative because of NYP's size and market power: it would not be feasible for them to exclude *all* of NYP's facilities from *all* of their networks, so they have no choice but to accede to the All Products restraint. *Id.* ¶¶ 2, 82, 88, 148-86. In short, rather than compete on price and quality to *earn* inclusion and favorable placement in networks, NYP uses its market power and anticompetitive restraints to *force* its way in. *Id.*

These restraints lead to significantly—often staggeringly—higher prices. *Id.* ¶¶ 70-76, 98-129. The Complaint's detailed data analysis quantifies those effects at NYP, *see id.* ¶¶ 105-29, demonstrating that "NYP is by far the most expensive hospital system in New York, with the average inpatient stay at NYP costing 74% more than the average of other major New York City

hospitals," *id.* ¶ 16. These prices "are substantially higher than NYP would be able to charge absent the All Products restraint" and NYP's other, similar restrictions. *Id.*; *see id.* ¶¶ 98-129.

In fact, "[t]here is a widespread, bipartisan consensus that anti-steering restrictions like the All Products provision harm competition and result in higher prices for insurers, employers, unions, and consumers." *Id.* ¶ 70; *see id.* ¶¶ 71-76. This month, for example, the White House's Council of Economic Advisers reported that anti-steering and all-or-nothing provisions are "mechanisms by which dominant hospital systems insulate themselves from price competition" and raise prices by an average of 18%, specifically singling out NYP's contracts as an example.[2]

ARGUMENT

NYP's motion to dismiss must be denied because the complaint "state[s] a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). In reviewing a motion to dismiss, the "court must accept as true all [factual] allegations contained in a complaint." *Id.*

I. *Illinois Brick* Does Not Bar Plaintiffs' Claims

Plaintiffs are "direct purchasers" under *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977). Under *Illinois Brick*, only the entity that "directly" purchases from the antitrust violator may seek damages, not downstream purchasers who buy a good after it passes through the hands of several middlemen. *Id.* at 726-29. Plaintiffs are direct purchasers: they buy and receive medical services from NYP itself, not from a middleman. *Contra* MTD at 2-3.

A. Plaintiffs Are Direct Purchasers

As "self-funded" payors, Plaintiffs pay their members' hospital bills directly. They do not pay premiums to an insurer who then pays for members' care, as employers with "fully-insured" health plans do. *See* CAC ¶¶ 42, 201. Indeed, as NYP acknowledges, "self-funded payors do not

[2] *Effects of Banning Hospitals' Anti-Steering, Anti-Tiering, and All-or-Nothing Contracts* at 1, Council of Econ. Advisers (June 2026), *available at* t.ly/gyaSh.

purchase 'insurance' from the insurers." Joint Initial Letter (ECF 23) at 20. Instead, Plaintiffs "purchase inpatient services directly from NYP," CAC ¶¶ 26, 31, and "bear all financial risk related to healthcare services that NYP provides" to their members, *id.* ¶ 205. That makes them direct purchasers.

Courts have repeatedly held at the pleading stage that self-funded payors are direct purchasers of medical services. *See Elec. Med. Tr. v. U.S. Anesthesia Partners, Inc.*, 2024 WL 5274650, at *6-7, *22 (S.D. Tex. Sep. 27, 2024) (rejecting *Illinois Brick* argument because self-funded plaintiffs "do not allege that commercial insurers purchase services from [the medical provider defendant] and then re-sell those services to [p]laintiffs."); *Uriel*, 2023 WL 12284689, at *3; *City of Pontiac v. BCBS of Michigan*, 2012 WL 1079885, at *7 (E.D. Mich. Mar. 30, 2012); *Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp.*, 1994 WL 619288, at *2 (N.D. Cal. Oct. 26, 1994).

While Plaintiffs, like most self-funded payors, pay an insurance company a fee for network access and/or claims administration, an insurance company acting in those capacities (*i.e.*, as a Network Vendor or TPA) does not purchase anything from NYP—it facilitates Plaintiffs' purchase of medical services by performing "solely administrative tasks." CAC ¶ 201. Put differently, Plaintiffs do not pay insurance companies for medical care/coverage, they purchase a different product from them entirely. The insurance company "has no financial responsibility or liability for charges for Plaintiffs' members," and Plaintiffs "contractually retain all financial risk for their health benefit plans." *Id.* ¶¶ 52, 205; *see United States v. Anthem, Inc.*, 855 F.3d 345, 351 (D.C. Cir. 2017) (self-insured employers pay for "network access" but retain all "risk of its employees' medical costs"); *Daniels v. United Healthcare Servs., Inc.*, 74 F.4th 803, 804-05 (7th Cir. 2023) (self-funded payor, not insurance company, is "financially liable for paying benefits").

Recognizing Plaintiffs as direct purchasers serves the purpose of the *Illinois Brick* rule—to prevent duplicative recovery and spare courts from apportioning overcharges among multiple claimants in a distribution chain. *Illinois Brick*, 431 U.S. at 730-32. For self-funded payors, the insurance companies serving as Network Vendors or TPAs purchase nothing and bear none of NYP's overcharge. As between insurance companies and Plaintiffs, there is no overcharge to divide and no risk of double recovery: Plaintiffs alone are injured, *see* CAC ¶ 205, and Plaintiffs alone may sue.

B. Hiring a TPA to Process Payments Does Not Make Plaintiffs Indirect Purchasers

NYP argues that the TPA is the direct purchaser because it facilitates the payments Plaintiffs make to NYP. *See* MTD at 2. That is wrong: Plaintiffs are not rendered indirect purchasers merely because a financial intermediary helps facilitate their payment. Courts recognize and enforce the distinction between (a) buying and re-selling a product in an *Illinois Brick*-like supply chain, and (b) facilitating other parties' transactions as a financial intermediary. A direct purchaser's use of a financial intermediary's services does not turn it into an indirect purchaser.

Two recent cases from this District rejected an identical "attempt to transform the *Illinois Brick* direct purchaser rule into a direct payor or 'who pays' rule." *Payment Card II*, 2024 WL 1014159, at *12. In *Payment Card*, Visa argued that merchants are not direct purchasers of credit-card-acceptance services because financial intermediaries called "acquirers" transmit the merchants' payments to Visa. *Id.* at *4. The court rejected Visa's argument, including its contention that a financial intermediary *ipso facto* makes the plaintiff an indirect purchaser: "The presence of an intermediary does not necessarily mean that the party receiving the benefit of the service is an indirect purchaser of that service." *Id.* at *11. The focus, the court explained, must be on "what precisely is being purchased" and who is purchasing it—not who is transmitting the

funds. *Id.* at *11-12. Accordingly, when the party transmitting payment is someone different from the purchaser, "the Court is bound by the Supreme Court's decision to confer standing on the *purchasers*." *Id.* at *12; *accord B&R Supermarket, Inc. v. Visa Inc.*, 2024 WL 4334075, at *6 (E.D.N.Y. Sep. 27, 2024) ("relevant inquiry" is who is actually purchasing the services at issue, not who is moving the money around).

The correctness of this rule becomes obvious when one considers credit cards: When a consumer uses a credit card to buy a product, the ***credit-card issuer*** pays the retailer, not the cardholder; the cardholder reimburses the issuer later when he gets his monthly bill. "There is no question, however, that the ***cardholder*** is the direct purchaser …, notwithstanding the fact that [the issuer] paid for the product on the cardholder's behalf." *Payment Card II*, 2024 WL 1014159, at *12. Likewise, regardless of whether the TPA transfers money to NYP from the self-funded plan's account or (as in the credit card example) fronts it and collects it later, the self-funded plan is the direct purchaser. *Id.*

The converse is true too: when TPAs try to sue for harm inflicted on their clients—the ones who actually bear payment responsibility—TPAs lack standing because they are not direct purchasers. *See In re Xyrem (sodium oxybate) Antitrust Litig.*, 2024 WL 4023561, at *16 (N.D. Cal. Aug. 26, 2024) (TPA "ASO Providers" lacked antitrust standing because they did not "pa[y] overcharges" or "bear any risk" on drug purchases by self-funded plans). Courts have reached the same conclusion in myriad other contexts: payment through a financial intermediary does not make the intermediary the direct purchaser. *See, e.g.*, *Leeder v. Nat'l Ass'n of Realtors*, 601 F. Supp. 3d 301, 310 (N.D. Ill. 2022) (home sellers are direct purchasers of broker services even though escrow company transmits payments); *In re Mercedes-Benz Anti-Trust Litig.*, 157 F. Supp. 2d 355, 366 (D.N.J. 2001) ("The Court does not believe that obtaining financing renders a purchaser an indirect purchaser for the purposes of *Illinois Brick*."); *In re NASDAQ Mkt.-Makers Antitrust Litig.*, 169

F.R.D. 493, 506 (S.D.N.Y. 1996) (stockbrokers are not direct purchasers of securities purchased for their clients).

NYP quotes from *Apple Inc. v. Pepper*, 587 U.S. 273, 281 (2019), to claim that purchasers may sue "*only* 'when there is no intermediary.'" MTD at 2. In fact, *Apple* held that iPhone owners are direct purchasers of apps from the Apple Store, even though they all bought the apps using credit cards or a third-party payment service like PayPal. In full context, the Court's comment—that "[t]here is no intermediary *in the distribution chain* between Apple and the consumer," *Apple*, 587 U.S. at 281—confirms that payment-facilitating financial intermediaries are not the sort of "middlemen" in the "distribution chain" that render a purchaser indirect.

If NYP's "no-intermediaries" argument were correct, it would be able to cite consumer class actions dismissed under *Illinois Brick* because the plaintiffs used credit cards, or with their class definitions trimmed to include only consumers who paid cash. No such cases exist. The opposite is true. *E.g.*, *De Coster v. Amazon.com, Inc.*, 350 F.R.D. 293, 325 (W.D. Wash. 2025) (certifying class of purchasers asserting antitrust claims against Amazon, even though nearly all Amazon purchases are made with credit cards).

Against all this, NYP cited one unpublished, out-of-circuit decision: *In re Northshore Univ. HealthSystem Antitrust Litig.*, 2018 WL 2383098 (N.D. Ill. 2018). *See* ECF 23 at 19. While *Northshore* held that a self-funded plan's TPA was the direct purchaser, it was decided on a post-discovery factual record, is an outlier, and was recently rejected when cited for the same proposition. *See Elec. Med. Tr.*, 2024 WL 5274650, at *7 (declining to follow *Northshore* on motion to dismiss). And *Northshore* is distinguishable too: the hospital system there had no contractual right to seek payment from the self-funded payor for any "shortfall in payment." 2018 WL 2383098, at *7. Here, in contrast, NYP has the contractual right to seek payment directly from Plaintiffs. *See* CAC ¶ 52.

C. The Network Vendor's Contract With NYP Does Not Make It the Direct Purchaser

NYP's asserted contractual privity requirement for direct purchaser status, *see* MTD at 2 ("The unions concede they have no contract with NYP."); ECF 23 at 19 (arguing relevant question is whether plaintiffs "contracted with NYP"), contradicts decades of antitrust jurisprudence. The Supreme Court has never required contractual privity for someone to be a direct purchaser; instead, courts in antitrust cases "must look at the economic reality of the relevant transactions" rather than being "bound by formal conceptions of contract law." *United States v. Concentrated Phosphate Exp. Ass'n*, 393 U.S. 199, 208 (1968); *see, e.g.*, *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 469, 475 (1982) (purchaser had antitrust standing even though she was not party to contract containing exclusion); *Loeb Indus., Inc. v. Sumitomo Corp.*, 306 F.3d 469, 482 (7th Cir. 2002) ("[T]he Supreme Court has been willing to entertain suits between plaintiffs and defendants not in privity with each other."). Here, the economic reality is that Plaintiffs pay NYP for medical services provided to their members.

Apple v. Pepper is again instructive. iPhone users sued Apple based on a theory that the contracts between Apple and app developers—not between Apple and the plaintiffs—caused the plaintiffs to pay higher prices. 587 U.S. at 277. The Court held that the consumers were direct purchasers, even though they were not parties to the allegedly anticompetitive contract in which the prices were set. *Id.* at 281. The Court expressly rejected Apple's proposed "who sets the price" theory of antitrust standing. *Id.* There is no reason to credit the same debunked theory here.

D. NYP's Other Arguments Are Strawmen

NYP asserts that Plaintiffs "cannot satisfy the 'fixed-quantity, cost-plus' exception to *Illinois Brick*." MTD at 2; *see also* ECF 23 at 20. But Plaintiffs do not need any such exception.

Equally inaccurate is NYP's claim that Plaintiffs "seek an exception to *Illinois Brick* for *indirect* claims by asserting 100% pass-through." MTD at 2 (emphasis in original). Plaintiffs need

no such exception. The overcharges Plaintiffs pay are not "passed through" to them. Insurance companies do not buy medical services from NYP and then re-package and re-sell them to self-funded plans, "passing through" the overcharge. *See Payment Card II*, 2024 WL 1014159, at *12 ("A service, unlike a tangible (*e.g.*, concrete block) or intangible good (*e.g.*, an app), is not generally susceptible to being resold."). For self-funded plans, insurance companies do not buy *anything* from NYP and are not within any chain of distribution; they provide ancillary services that facilitate Plaintiffs' purchase of medical services, nothing more. CAC ¶¶ 42-45.

Finally, this case will not "strip[] insurers of their cause of action." *Contra* MTD at 2. For fully-insured plans, insurance companies are the direct purchasers, are within the class definition, and their claims are preserved. When working with self-funded payors like Plaintiffs, however, an insurance company has no cause of action to "strip"—acting as TPA or Network Vendor, an insurance company "has no financial responsibility … for charges for Plaintiffs' members," *id.* ¶ 205, and thus is not harmed by NYP's overcharges, *see In re Xyrem*, 2024 WL 4023561, at *16. Plaintiffs are the direct purchasers.[3]

II. Plaintiffs Have Antitrust Standing to Recover the NYP Overcharges They Paid

"To satisfy the antitrust standing requirement, a private antitrust plaintiff must demonstrate that (1) it has suffered 'a special kind of antitrust injury,' and (2) it is an 'efficient enforcer' of the antitrust laws." *Eastman Kodak Co. v. Henry Bath LLC*, 936 F.3d 86, 94 (2d Cir. 2019). Plaintiffs pass this test easily.

NYP does not—and could not—argue that Plaintiffs failed to plead antitrust injury. Purchasers "who allege being forced to pay supracompetitive prices as a result of the defendants'

[3] NYP's *Illinois Brick* argument applies only to Plaintiffs' damages claims under the Sherman Act. *Illinois Brick* did not address claims for injunctive relief, and New York has an "*Illinois Brick* repealer" for state-law claims under the Donnelly Act, *see* N.Y. Gen. Bus. Law § 340(6).

anticompetitive conduct" suffer injury that "plainly is of the type the antitrust laws were intended to prevent." *In re DDAVP Direct Purchaser Antitrust Litig.*, 585 F.3d 677, 688 (2d Cir. 2009).

Plaintiffs also are "efficient enforcers" under the well-settled four-factor test in *Associated General Contractors of California, Inc. v. California State Council of Carpenters* ("*AGC*"): (1) "the directness or indirectness of the asserted injury"; (2) "the existence of more direct victims" or "[t]he existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement"; (3) the extent to which the claim is "highly speculative"; and (4) "the importance of avoiding either the risk of duplicate recoveries on the one hand, or the danger of complex apportionment of damages on the other." 459 U.S. 519, 540-45 (1983). Every factor supports Plaintiffs' antitrust standing.

Direct Injury. The first factor strongly favors Plaintiffs, for the same reasons they are direct purchasers under *Illinois Brick*. Purchasers who pay overcharges resulting from anticompetitive conduct, like Plaintiffs, suffer sufficiently direct injury to plead antitrust standing. *See Live Nation*, 2025 WL 835961, at *4 ("Consumers who directly purchased a product at allegedly supracompetitive prices from a defendant [] usually have antitrust standing.").

Circuit caselaw forecloses NYP's argument that Plaintiffs' injuries are "too remote" and "too far removed" from the contract negotiations between NYP and Network Vendors that cause the higher prices Plaintiffs pay. MTD at 2. Direct purchasers who suffer overcharges resulting from anticompetitive conduct have standing, even where those injuries are "'downstream' of anticompetitive conduct perpetrated against other market actors," including anticompetitive contracts imposed on other market actors that cause plaintiffs' overcharges. *Live Nation*, 2025 WL 835961, at *4; *accord In re DDAVP*, 585 F.3d at 688 (plaintiff-purchasers' injury sufficiently direct where "harming competitors was simply a means for the defendants to charge the plaintiffs higher prices."); *Apple v. Pepper*, 587 U.S. at 277, 281; *see also Mbadiwe v. Amazon.com, Inc.*,

2025 WL 2675937, at *11-12 (S.D.N.Y. Sep. 18, 2025) (plaintiff-consumers satisfied first factor even where they alleged that Amazon's anticompetitive conduct caused them to pay higher prices on non-Amazon platforms).

NYP misapplies the "first-step rule"—which focuses on "injuries that happen at the first step following the harmful behavior," *In re Am. Express Anti-Steering Rules Antitrust Litig.*, 19 F.4th 127, 140 (2d Cir. 2021)—by attempting to recast Plaintiffs' injury as the "challenged negotiations." MTD at 2. The "challenged negotiations" are part of NYP's "harmful behavior"—they are not the injury Plaintiffs suffered. The *overcharges Plaintiffs paid* are the injuries that occur at the first step following NYP's harmful behavior. *See* CAC ¶ 202.

Similarly, NYP's attempt to minimize its anticompetitive conduct by arguing that it "merely affect[s] the types of plans insurers offer," MTD at 2, ignores Plaintiffs' allegations that NYP's contracting practices insulated it from competition, allowing it to charge supracompetitive prices and resulting in the overcharges that Plaintiffs paid. *See* CAC ¶¶ 15, 17, 67, 83, 85, 202, 216. NYP also is wrong that Plaintiffs are "not constrained by" NYP's anticompetitive conduct, MTD at 2; that conduct limited the types of provider networks available to Plaintiffs, "deprive[d]" them "of a choice among a full spectrum of competitive health insurance products[,]" and prevented them from implementing narrow networks or steering programs, CAC ¶¶ 15, 79, 81; *see also id*. ¶ 15 (NYP restricts Plaintiffs' ability "to select and offer cost-effective networks to their members to lower healthcare costs").

No "More Direct" Victims / No Duplicative Recoveries. Factors two and four likewise favor Plaintiffs. There are no "more direct" victims of NYP's overcharges, and no possibility of duplicative recoveries or difficult apportionments. As the entities that directly pay NYP's overcharges, CAC ¶¶ 26, 28, 31, 201, Plaintiffs are not only appropriate plaintiffs—they are the *only* plaintiffs who can sue to recover those overcharges they paid. NYP has argued that Plaintiffs'

"alleged injury is derivative of the purported injuries of those in privity with NYP—the patients and insurers." ECF 23 at 20. But NYP is factually wrong: the overcharges Plaintiffs pay do not depend on any injury to patients or insurers.

Plaintiffs directly purchase healthcare services from NYP on behalf of their members. The members' shares of payment are limited to out-of-pocket costs (*e.g.*, co-pays, co-insurance, and deductibles); Plaintiffs do not seek to recover those amounts, which they did not pay. *See* CAC ¶¶ 42, 55, 192. And insurance companies purchase nothing from NYP when acting as Network Vendors or TPAs for self-funded payors. *See id.* ¶¶ 45, 51, 201.[4] For self-funded payors like Plaintiffs, insurance companies are not responsible to NYP for the costs of care of Plaintiffs' members; Plaintiffs are. *See id*. ¶¶ 44, 52-53, 205.

There are no "more direct victims" than Plaintiffs and the Proposed Class of similarly situated direct purchasers, no "class of persons whose self-interest would normally motivate them" to bring this action other than Plaintiffs, and no "risk of duplicate recoveries" or "danger of complex apportionment of damages." *See In re DDAVP*, 585 F.3d at 689 (plaintiffs were "significantly motivated due to their natural economic self-interest in paying the lowest price possible.").

Plaintiffs' Damages Are Not "Speculative." The third factor likewise favors Plaintiffs. Plaintiffs have more than adequately alleged that NYP's anticompetitive conduct has resulted in their paying significant overcharges. CAC ¶¶ 15, 25, 98, 124, 127-79, 206. Independent sources confirm Plaintiffs' allegations that NYP's conduct results in overcharges. *See* CAC ¶¶ 70-76

[4] Insurance companies are payors too, but only when they act as insurers for fully-insured plans. In that context, they are financially responsible for paying for NYP's services, they suffer the same overcharge injury as Plaintiffs, and they are in the Proposed Class for that reason.

(documenting bipartisan and academic consensus that hospital anti-steering provisions harm price and quality competition). There is no speculation.

NYP's Cited Cases Are Inapposite. The three cases NYP cited have no bearing on Plaintiffs' antitrust standing. None involves a plaintiff who paid an overcharge resulting from a defendant's anticompetitive conduct.

In *AGC*, there was no purchaser at all: The plaintiff union alleging that defendants diverted business to non-union entities "was neither a consumer nor a competitor in the market in which trade was restrained" and didn't "even allege[] any marketwide restraint of trade" or that "prices [were] enhanced throughout an entire competitive market." 459 U.S. at 539 & n.40. By contrast, Plaintiffs are purchasers of NYP's healthcare services and complain about NYP's marketwide restraints that resulted in enhanced NYP prices throughout.

In re American Express is equally far afield. The plaintiff-merchants there found not to be efficient enforcers failed the "first step" rule because they did not even accept American Express and thus did not pay its inflated prices. 19 F.4th at 140-41 ("Amex did not raise the [plaintiffs'] fees. Nor could it have: the [plaintiffs] do not accept American Express cards."). Here, by contrast, Plaintiffs' members *did* use NYP and Plaintiffs *did* pay NYP's overcharges.

NYP's reliance on *IQ Dental Supply, Inc. v. Henry Schein, Inc*., also is misplaced. That case involved a competitor to the alleged co-conspirators, not a purchaser. 2017 WL 6557482 (E.D.N.Y. Dec. 21, 2017). And the plaintiff's injury was derivative of the alleged conspiracy's target (an online portal for distributors), because the plaintiff speculated that, had the portal not been targeted, it would have worked with the portal to develop new networks that would have generated more profits for the plaintiff. *Id.* at *9. By contrast, here, Plaintiffs *are* the target of NYP's conduct: NYP imposed the All Products Clause specifically to make payors like Plaintiffs pay more for its services, or, as NYP put it, prevent the "erosion of rates." CAC ¶ 17. *IQ Dental*'s

conclusion that a non-targeted competitor lacked standing is far afield from the context here: direct purchasers who paid inflated prices as a result of conduct directed at them by NYP.

The private right of action for violations of the federal antitrust laws was created for purchasers like Plaintiffs. *See AGC*, 459 U.S. at 530 ("Congress was primarily interested in creating an effective remedy for consumers who were forced to pay excessive prices by the giant trusts and combinations that dominated certain interstate markets."). Plaintiffs have antitrust standing to sue to recover the NYP overcharges they paid.

III. Plaintiffs Have Adequately Alleged That NYP's Conduct Has A Substantial Anticompetitive Effect

Plaintiffs plausibly allege the anticompetitive effects of NYP's conduct. "[A]t the pleading stage, only the first step of [the rule of reason] framework is material"; consideration of any alleged pro-competitive justifications "is inappropriate on a motion addressed to the sufficiency of the complaint." *Davitashvili v. Grubhub Inc.*, 2022 WL 958051, at *6 (S.D.N.Y. Mar. 30, 2022).

A plaintiff may satisfy its pleading burden of demonstrating substantial anticompetitive effect through either: (1) direct evidence, *i.e.*, "proof of actual detrimental effects on competition"; or (2) indirect evidence, *i.e.*, "proof of market power plus some evidence that the challenged restraint harms competition." *Ohio v. Am. Express Co.* ("*Amex*"), 585 U.S. 529, 542 (2018); *accord SourceOne Dental, Inc. v. Patterson Cos., Inc.*, 310 F. Supp. 3d 346, 363 (E.D.N.Y. 2018) (Cogan, J.) ("A plaintiff can establish this actual adverse effect either directly by showing an actual adverse effect on competition as a whole within the relevant market or indirectly by showing that the defendant has sufficient market power to cause an adverse effect on competition.").

Either is sufficient. Plaintiffs plead both.

A. Plaintiffs Plausibly Plead Relevant Antitrust Markets

Courts often begin by "defining the relevant market because 'courts usually cannot properly apply the rule of reason without an accurate definition of the relevant market.'" *Payment Card I*, 714 F. Supp. 3d at 83.

The relevant product market Plaintiffs allege—"inpatient general acute care ('inpatient GAC') hospital services," CAC ¶¶ 132-37—is one courts have repeatedly blessed. *See FTC v. Hackensack Meridian Health, Inc.*, 2021 WL 4145062, at *15 n.19 (D.N.J. Aug. 4, 2021), *aff'd*, 30 F.4th 160 (3d Cir. 2022); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1210-11 (11th Cir. 1991). It is also the same product market defined by DOJ in its complaint. Complaint ("DOJ Compl.") ¶¶ 27-28, 30, 31-36, *United States v. New York and Presbyterian Hosp.*, No. 26-cv-02480 (S.D.N.Y. Mar. 26, 2026), ECF 1. NYP has not moved to dismiss DOJ's complaint, but it nevertheless alludes to unspecified "defects with [Plaintiffs'] alleged markets" here. MTD at 3. Whatever those supposed defects, they are no basis for dismissal. *Davitashvili*, 2022 WL 958051, at *5 ("[C]ourts hesitate to grant motions to dismiss for failure to plead a relevant product market" because inquiry is "deeply fact-intensive"); *Todd v. Exxon Corp.*, 275 F.3d 191, 199-200 (2d Cir. 2001) (Sotomayor, J.) (analysis of market definition "generally requires discovery").

Plaintiffs (and DOJ) also plausibly allege two relevant geographic markets—Manhattan and the Four-Borough Market. CAC ¶¶ 139-48. "[T]he determination of the area of effective competition poses a question of fact, not one of law," and provides no basis for dismissal. *Vasquez v. Ind. Univ. Health, Inc.*, 40 F.4th 582, 585-86 (7th Cir. 2022).

B. NYP's Supracompetitive Prices and Anticompetitive Restraints Are Direct Evidence of Anticompetitive Effect in the Relevant Market

Plaintiffs adequately allege direct evidence that NYP's conduct has anticompetitive effects in the market for inpatient GAC services. Direct evidence of anticompetitive effects includes

evidence of "output reductions, increased prices, or reduced quality in the relevant market." *1-800 Contacts, Inc. v. FTC*, 1 F.4th 102, 118 (2d Cir. 2021).

Increased Prices. NYP "persistently and profitably charge[s] prices above those that would be charged in a competitive market." CAC ¶ 150. It is "by far, the most expensive hospital system in New York City[,]" "charg[ing] substantially higher prices than its competitors across the board"—even for "'generally homogenous' procedures" where quality and cost vary little, and even where its competitors earn higher quality and safety ratings. *Id.* ¶ 152.

The Complaint supports these allegations with empirical evidence, well beyond anything required to state a plausible claim for relief. *Todd*, 275 F.3d at 198 ("No heightened pleading requirements apply in antitrust cases."). *See, e.g.*, CAC ¶ 158 ("NYP had the highest overall facility expenditure per inpatient admission" and "the highest prices for 11 of 12 inpatient procedures analyzed"); *id.* ¶ 109 ("the standardized price per inpatient stay at NYP is approximately 74% more expensive than the average standardized price per inpatient stay at major non-NYP New York City hospitals"); *id.* ¶¶ 113-15 (detailing other NYP services with significantly higher prices); *id.* ¶¶ 117-20 (NYP's prices for "generally homogenous" procedures are substantially higher than NYP's world-renowned competitors); *id.* ¶¶ 122-23 ("NYP charges, on average, 66% more than NYU Langone" and "commands a median rate premium of 59% over Mount Sinai," with its premium "exceed[ing] 92%" for a quarter of all comparable procedures). NYP's supracompetitive prices are direct evidence of anticompetitive effects. *Uriel*, 2023 WL 12284689, at *3 (anticompetitive effect plausible where defendant hospital's prices were "almost" and "more than double the price of the same procedure[s] at [] nearby competitors with [similar or] higher quality and safety ratings").

Reduced Quality. NYP's anticompetitive conduct also diminishes competition between hospitals on quality. *E.g.*, CAC ¶ 74. NYP's facilities received middling patient safety ratings in

2022 and 2023. *Id.* ¶¶ 125-26. Yet NYP's business only continued to grow. "NYP's continued growth in profitability during its periods of lower quality care indicates that the reason for its continued growth is not superior quality, but NYP's market power and anticompetitive conduct." *Id.* ¶ 126.

Direct Evidence Remains Sufficient to Plead Anticompetitive Effects. NYP incorrectly reads a footnote in *Amex* to quietly overrule decades of antitrust law holding that anticompetitive effects can be shown through direct evidence, including in rule of reason cases involving vertical restraints. MTD at 3. After *Amex*, courts in this Circuit continue to hold that "[d]irect evidence of anticompetitive effects establishes a prima facie case of a Sherman Act Section 1 violation and obviates the need for a … showing of market power." *In re Payment Card Interchange Fee & Merch. Disc. Antitrust Litig.*, 714 F. Supp. 3d 65, 93 (E.D.N.Y. 2024) ("*Payment Card I*"); *accord United States v. Live Nation Ent., Inc.*, 2026 WL 456804, at *4 (S.D.N.Y. Feb. 18, 2026); *1-800 Contacts*, 1 F.4th at 117. The cited footnote in *Amex* says only that antitrust plaintiffs usually must *define* a relevant market. In the footnote, the Court rejected the plaintiffs' argument that they "need not define the relevant market ... because they have offered actual evidence of adverse effects on competition[,]" noting that vertical restraints' effect on the market "cannot be evaluated unless the Court first defines the relevant market." 585 U.S. at 543 n.7; *see* Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law § 520e (5th ed. & Supp. 2026) ("In *AmEx*, the Supreme Court … held that antitrust assessment of a vertical practice required a *market definition*."). Plaintiffs have defined a market, so the footnote has no bearing here.

Plaintiffs (and DOJ) have more than adequately stated a plausible Section 1 claim. *See Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d at 729 (allegations that anti-steering provisions resulted in employers paying "higher prices," having "fewer insurance plans from which to choose," and being denied access to "more efficient health plans" are "specifically the

type of allegation that states a direct anticompetitive effect and a plausible claim for relief"). And the mere existence of DOJ's complaint, "which must be predicated upon the agency's evidentiary support, *see* Fed. R. Civ. P. 11(b)(3)," supports plausibility as well. *In re Concrete & Cement Additives Antitrust Litig.*, 2025 WL 1755193, at *19 (S.D.N.Y. June 25, 2025) (observing that "the initiation of an enforcement action" suggests plausibility); s*ee also In re GSE Bonds Antitrust Litig.*, 396 F. Supp. 3d 354, 363 (S.D.N.Y. 2019) (citing *Starr v. Sony BMG Music Enter.*, 592 F.3d 314, 325 (2d Cir. 2010)) (existence of mere investigation by DOJ "bolstered" plausibility of allegations).

C. Alternatively, Plaintiffs Have Adequately Alleged NYP's Market Power and Likely Anticompetitive Effects

Plaintiffs also adequately allege indirect evidence of anticompetitive effects—*i.e.*, "proof of market power plus some evidence that the challenged restraint harms competition." *Amex*, 585 U.S. at 542. "Market power may be shown by evidence of specific conduct indicating the defendant's power to control prices or exclude competition." *Payment Card I*, 714 F. Supp. 3d at 96. While "market share may be used as a proxy for market power," no particular market share automatically establishes or negates it. *Id.* To assess market power, courts consider: "(i) the ability to price discriminate"; "(ii) the ability to set prices without regard to costs"; "(iii) excess or supracompetitive profits"; "(iv) structural barriers to entry"; and, "(v) the power to 'force a purchaser to do something that he would not do in a competitive market.'" *Id.* at 96-97. The CAC plausibly alleges NYP's market power under each factor. *See* CAC ¶¶ 149-86; *accord* DOJ Compl. ¶¶ 37-51.

Power to Control Prices. NYP has admitted—in words and actions—its power to control prices without regard for competition. NYP's most senior contracting executive testified that its rivals' offering of lower prices "has no relevance to me." CAC ¶ 151. NYP is unconcerned about its competitors' prices because NYP's market power allows it to impose plan restrictions that

insulate it from price competition. *Id.* So, unsurprisingly, "NYP is, by far, the most expensive hospital system in New York City." *Id.* ¶ 151; *see generally supra*.

NYP's power to control prices is especially stark in its ability to demand a "single negotiated rate" for services "across multiple hospitals—despite significant differences across the hospitals in terms of the services offered, geographic locations, and quality." CAC ¶ 160. For example, health plans pay the same supracompetitive price of $120,938 for a spinal fusion "at both an NYP hospital that is ranked above-average in safety and an NYP hospital that is ranked well below-average in safety." CAC ¶ 90. By comparison, a spinal fusion at the internationally renowned Hospital for Special Surgery, which is ranked higher in quality for orthopedic procedures than NYP, is 30% cheaper. *Id.*

These facts reflect that NYP is "dictating or setting prices rather than prices being determined as the outcome of a competitive process." CAC ¶ 160.

Power to Impose Restraints. NYP's ability to impose unwanted restrictions on Network Vendors and the Proposed Class is further evidence of its market power. *United States v. Visa U.S.A., Inc.*, 344 F.3d 229, 240 (2d Cir. 2003) (defendants had market power because "merchants testified that they could not refuse" to accept their terms); *Toys "R" Us, Inc. v. FTC*, 221 F.3d 928, 937 (7th Cir. 2000) (market power shown by defendant's success in forcing restraint on major toy manufacturers); *Davitashvili*, 2022 WL 958051, at *10 (plaintiffs plausibly alleged that defendant takeout/delivery platforms had market power because restaurants "cannot feasibly avoid doing business" with them). In a competitive market, payors would be able to "offer their members a choice between a broad network plan and a [lower-cost] narrow-network plan," CAC ¶ 58, and would be able to implement cost-saving steering programs. *Id.* ¶¶ 59-67. But NYP has successfully forced Network Vendors to include all of NYP's facilities in their networks despite their high prices, and—over Network Vendors' objections—to accept restraints that block procompetitive,

cost-saving plan designs. *Id.* ¶¶ 87-88, 153-59, 164; *see also id.* ¶ 182 (Cigna executive stating that NYP is "a must-have in the network, which gives them the power they want in negotiating contracts"). And courts have recognized that a hospital's importance to insurance networks supports a finding of market power. *See, e.g.*, *Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d at 730 (allegation that "an insurer selling health insurance plans to individuals and employers in the Charlotte area must have CHS as a participant in at least some of its provider networks, in order to have a viable health insurance business in the Charlotte area" plausibly supported market power).

Excess or Supracompetitive Profits. NYP's anticompetitive restraints have been enormously profitable. *See, e.g.*, *id.* ¶ 157 (detailing NYP's operating profit per discharge from 2011-2023). NYP's internal analysis confirms that the challenged restraints boost its profits, concluding that "the introduction of tiered plans alone would reduce profits by hundreds of millions of dollars, and other forms of steering would also cause that same outcome for NYP." *Id.* ¶ 104. The scale of NYP's revenue growth also reflects these supracompetitive profits. Despite its nominal nonprofit status, NYP's revenue reached $10.7 billion in 2022, $12.5 billion in 2023, and $13 billion in 2024. *Id.* ¶ 22. NYP funnels these outsized profits to pay "extraordinary amounts to the executives of this supposedly charitable institution[,]" including $26.3 million to its former CEO in 2024 and seven-figure compensation as high as $6.5 million to "over 30 other officers, directors, trustees, key employees, and highly compensated employees." *Id.* ¶ 23.

Structural Barriers to Entry. NYP's market power is amplified by extremely high barriers to entry in the market for inpatient GAC hospital services relative to other product markets. CAC ¶ 135. These barriers include: the need to build expensive facilities; the difficulty of hiring skilled staff (such as surgeons and anesthesiologists with specialized licenses); onerous regulatory

hurdles; limited real estate availability in New York City; and the many years required to build a new hospital. *Id.* ¶¶ 135, 161.

Market Share. Particularly given this market's uniquely high barriers to entry, NYP's 25-30% market share is entirely consistent with Plaintiffs' allegations of market power. *Contra* MTD at 3. While "market share *may* be used as a proxy for market power," *K.M.B. Warehouse Distribs., Inc. v. Walker Mfg. Co.*, 61 F.3d 123, 129 (2d Cir. 1995), "a threshold showing of market share is not a prerequisite for bringing a § 1 claim," *Todd*, 275 F.3d at 206; *see also Payment Card I*, 714 F. Supp. 3d at 98 (quickly disposing of market share argument similar to NYP's by observing that "[p]laintiffs do not use market share as a proxy for market power").

Many courts have found market power with market shares around, or even below, NYP's share of the inpatient GAC market. *See Visa*, 344 F.3d at 240 (Visa and Mastercard had market power with 47% and 26% shares); *Toys "R" Us*, 221 F.3d at 937 (Toys "R" Us had market power with 20% share); *Payment Card I*, 714 F. Supp. 3d at 99 (whether Mastercard exercised market power was "triable issue of fact" in part because, "[d]uring the relevant period, Mastercard has consistently had approximately 25% market share … in a market defined by high barriers to entry").

These precedents confirm the anachronism of NYP's assertion that 39% market share is "below that which has been deemed sufficient to confer market power in any previous decision." MTD at 3 (quoting *New York v. Anheuser-Busch, Inc.*, 811 F. Supp. 848, 873 (E.D.N.Y. 1993)). NYP's decades-old precedent has been superseded by the weight of subsequent authority. Moreover, the *Anheuser-Busch* court concluded the defendant lacked market power based on its market share *and* the "lack of entry barriers" *and* "the intense price competition" in the market. 811 F. Supp. at 873. By contrast, the market here has "enormous" barriers to entry, CAC ¶¶ 135, 161, and far less price competition, *id.* ¶¶ 151-2.

Taken together, the Complaint's detailed allegations more than satisfy Plaintiffs' burden of alleging plausible anticompetitive effects—whether measured by direct or indirect evidence.[5]

D. NYP's Arguments About Exclusionary Effects and Foreclosure Are Misguided

NYP's last two arguments—that the Complaint fails to allege "exclusionary contracts" and "rival foreclosure," MTD at 3—reflect category errors: NYP imports these requirements from other areas of antitrust law that have no application here, which is why courts in hospital antitrust cases have not applied them. *See, e.g.*, *Uriel*, 2023 WL 12284689, at *2-3, n.1 (concluding anti-steering clause had plausible anticompetitive effect and rejecting the requirement to "plead 'substantial foreclosure' of the relevant market"); *Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720.

For the reasons given above, the Complaint adequately states a claim because it plausibly alleges "that the challenged restraint has a substantial anticompetitive effect that harms consumers in the relevant market." *Amex*, 585 U.S. at 541 (describing plaintiff's initial burden in rule of reason cases); *see supra* Section III.C. In any event, the Complaint details how NYP has foreclosed *competition—i.e.*, NYP prevents selective contracting, which is the mechanism by which hospitals normally compete with each other on price, and this has caused Plaintiffs to pay higher prices. Alleging such interference with the competitive process is sufficient to state a claim. *See United States v. Microsoft Corp.*, 253 F.3d 34, 64 (D.C. Cir. 2001) (finding liability because, "although Microsoft did not bar its rivals from all means of distribution, it did bar them from the cost-efficient ones").

[5] Plaintiffs have met their pleading burden within the rule of reason framework. Given consensus that anti-steering provisions imposed by hospital systems are anticompetitive, NYP's conduct may be analyzed under the less demanding "quick look" framework, in which case Plaintiffs even more easily plead a plausible Section 1 claim.

NYP's "exclusionary contracts" argument—which it supports with zero citations—is an attempt to squeeze Plaintiffs' claims into a box they don't belong in: NYP argues Plaintiffs do not plead "tying, bundling, [or] exclusive dealing …. That kills their claim." MTD at 3. "But anticompetitive conduct comes in many different forms that cannot always be categorized." *Duke Energy Carolinas, LLC v. NTE Carolinas II, LLC*, 111 F.4th 337, 354 (4th Cir. 2024); *see also FTC v. Deere & Co.*, 2025 WL 1638474, at *7 (N.D. Ill. June 9, 2025) ("The Court rejects Deere's argument that the Governments must slot Deere's behavior into a certain antitrust category at this [pleading] stage."). As the many anti-steering cases already discussed demonstrate, a contractual restraint can be anticompetitive without fitting in one of these theoretical buckets.[6]

The same is true for NYP's final argument regarding the Complaint's purported failure to plead "rival foreclosure." MTD at 3. This simply is not a requirement outside the context of exclusive dealing claims, which Plaintiffs do not allege here. *See, e.g.*, *McWane, Inc. v. FTC*, 783 F.3d 814, 835 (11th Cir. 2015) ("The difference between the traditional rule of reason and the rule of reason for exclusive dealing is that in the exclusive dealing context, courts are bound … to consider substantial foreclosure."); *Uriel*, 2023 WL 12284689, at *2-3 & n.1 (rejecting hospital-defendants' attempt to impose a "foreclosure" requirement). Moreover, NYP is wrong that the All Products Clause "has not foreclosed anyone from anything," MTD at 3—it has foreclosed Network Vendors from designing and offering cost-saving networks to self-funded payors like Plaintiffs, thereby inhibiting the price competition between hospitals that would normally drive NYP's prices

[6] NYP has cited *Medical Center at Elizabeth Place, LLC v. Premier Health Partners* to suggest its conduct is just a procompetitive way for hospitals to get the "benefit of their bargain." 2017 WL 3433131 (S.D. Ohio 2017) (cited in ECF 23 at 14 n.9 & 22 n.22). NYP's supposed procompetitive justifications are irrelevant for purposes of a motion to dismiss but, regardless, *Premier Health* actually supports Plaintiffs' position that discovery is warranted. *Id.* at *16. The court, on *summary judgment*, held that the evidence *did* make out a rule-of-reason claim, but plaintiff had pled only a *per se* theory. *Id.* at *17 ("After reviewing all of the evidence in this case, a jury could ultimately conclude that the [restraints] are an unreasonable restraint of trade.").

(and therefore Plaintiffs' bills) down. *See New York v. Actavis PLC*, 787 F.3d 638, 656 (2d Cir. 2015) ("For there to be an antitrust violation, [competitors] need not be barred from all means of distribution if they are barred from the cost-efficient ones.").

CONCLUSION

For all these reasons, the Court should deny NYP's Motion.

Dated: June 30, 2026

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WORD COUNT CERTIFICATION

Pursuant to Local Rule 7.1, I hereby certify that the total number of words in this affirmation, excluding the caption, signature block, and word count certification is 8,750.

/s/ Mark Musico
Mark Musico

CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2026, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ Mark Musico
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