UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

UFCW LOCAL 1500 WELFARE FUND, *on its own behalf and on behalf of all others similarly situated*, Plaintiffs, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	Case No. 2:25-cv-05023-BMC
CEMENT AND CONCRETE WORKERS DC BENEFIT FUND, *on its own behalf and on behalf of all others similarly situated*, Plaintiffs, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	Case No. 1:25-cv-5571-BMC

PLAINTIFF UFCW LOCAL 1500 WELFARE FUND'S RESPONSE TO DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' CONSOLIDATED CLASS ACTION COMPLAINT

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INTRODUCTION

This case challenges New York Presbyterian's ("NYP" or "Defendant") scheme to insulate itself from competition, preserve its market power, and force Plaintiffs[1] and the Class to pay hundreds of millions of dollars more for inpatient hospital services than they would pay in a competitive market. NYP imposes contract provisions that prevent direct purchasers of healthcare, including Plaintiffs and the Class, from accessing health insurance plans that would give individuals greater choice and reduce their healthcare costs.

One way healthcare insurers reduce costs for themselves and the employers and individuals they serve is through "selective contracting"—using provider networks and plan designs that encourage providers to lower their prices and encourage health plan members to choose lower-cost, high-quality providers. These competitive tools put downward pressure on hospital prices to the benefit of payors and individuals and promote competition, but NYP's contractual restraints prevent insurers from using them.

NYP thwarts selective contracting in several ways. *First*, NYP forces insurers to accept "all-or-nothing" contract provisions, which require an insurer that wants to include *any* NYP facility in its network to include *every* NYP facility in that network. *Second*, NYP requires insurers to place all NYP facilities in the highest tier regardless of cost or quality, which restricts insurers from incentivizing—or "steering"—insured patients to use providers that offer lower costs or higher quality. *Third*, NYP imposes a "single negotiated rate," forcing payors to pay the same rate at NYP's expensive flagship hospitals as at its lower-rated hospitals, regardless of location, quality, or competition. *Fourth*, NYP requires "gag clauses," which forbid insurers from telling plan

[1] UFCW Local 1500 Welfare Fund ("UFCW Local 1500")—the Plaintiff filing this brief—is one of three Plaintiffs in the consolidated complaint filed on June 5, 2026. ECF No. 41 ("Compl.").

members about pricing and other terms. These provisions frustrate competition and force Plaintiffs and the Class to overpay for inpatient hospital services.

The plausibility of Plaintiffs' allegations is reinforced by the fact that, roughly six months after Plaintiffs filed their cases against NYP, the United States Department of Justice's ("DOJ") Antitrust Division brought its own suit, challenging the very same conduct alleged here. Declaration of Gregory Asciolla ("Asciolla Decl."), Ex. 1 (Complaint, *United States v. New York & Presbyterian Hosp.*, No. 26-cv-2480 (S.D.N.Y. Mar. 26, 2026), ECF No. 1) ("DOJ Compl.").[2]

NYP's motion to dismiss asks the Court to disregard the Complaint's well-pleaded allegations, ignore controlling law, and prematurely resolve issues that are unavoidably questions of fact. ECF No. 43 ("MTD"). NYP advances three unpersuasive arguments. First, NYP contends that Plaintiffs are not the right party to bring this suit, either because they are "too remote" from the conduct (and thus lack standing under *Associated General Contractors of California, Inc. v. California State Council of Carpenters* ("*AGC*"), 459 U.S. 519 (1983)) or because they are "indirect purchasers" (and thus lack standing under *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977)). MTD at 2–3. Both arguments misconstrue the law and disregard the Complaint's allegations, which show that Plaintiffs are direct purchasers and well-situated to bring this case against NYP. Even if Defendant's *Illinois Brick* argument had some merit—it does not—it would

[2] Plaintiff UFCW Local 1500 respectfully requests that the Court take judicial notice of the exhibits appended to the Asciolla Declaration: Asciolla, Exs. 1; 2 (Complaint, *United States v. OhioHealth Corp.*, No. 2:26-cv-00207 (S.D. Ohio Feb. 20, 2026), ECF No. 1); 3 (Proposed Final J., *United States v. OhioHealth Corp.*, No. 2:26-cv-00207 (S.D. Ohio June 16, 2026), ECF No. 29-2); 4 (Answer, *United States v. New York & Presbyterian Hosp.*, No. 26-cv-2480 (S.D.N.Y. May 26, 2026), ECF No. 22). The Court may take judicial notice of pleadings and settlement agreements filed in other cases in deciding a motion to dismiss without converting that motion into one for summary judgment. *Rothman v. Gregor*, 220 F.3d 81, 92 (2d Cir. 2000). Judicial notice is sought only to "establish the fact of such litigation and related filings." *Johnson v. Levy*, 812 F. Supp. 2d 167, 177 (E.D.N.Y. 2011) (internal quotation omitted).

not dispose of the case, since indirect purchasers may seek damages under the Donnelly Act and injunctive relief under the Clayton Act.

Second, NYP suggests that a hospital cannot possess market power unless it controls more than 50% of the relevant market. *Id*. at 3. That is not the law and disregards Plaintiffs' allegations of high barriers to entry and NYP's substantial share. In addition to this indirect evidence, Plaintiffs allege *direct* evidence of NYP's market power—NYP's status as a "must-have" provider and its exercise of that power to impose supracompetitive prices and extract onerous contract terms from payors.

Third, NYP casts the allegations as insufficient by offering a competing explanation for its conduct. *Id.* NYP also suggests the Complaint falls short because it does not meet the standard for pleading an exclusive dealing claim, but Plaintiffs do not allege exclusive dealing. *Id.* These sleights-of-hand are no basis for dismissal.

None of NYP's arguments undermines Plaintiffs' well-pled Complaint. Plaintiffs allege that NYP's anti-steering restrictions restrain trade, reduce competition, increase prices, and harm New York employers, unions, insurers, and patients. Because NYP's provisions frustrate competition, they cause antitrust injury to Plaintiffs and the Class in the form of supracompetitive pricing. As set forth below, Plaintiffs exceed the plausibility standard for alleging violations of the Sherman Act and Donnelly Act and respectfully ask the Court to deny Defendant's motion to dismiss.[3]

[3] Counsel for UFCW Local 1500 proposed that Plaintiffs file a single opposition brief in response to Defendant's motion to dismiss, but counsel for Cement and Concrete Workers DC Benefit Fund and Pointers, Cleaners & Caulkers Local 1 Welfare Fund declined.

FACTUAL BACKGROUND

NYP is one of the nation's largest hospital systems and the largest in New York City by net revenue, inpatient days, and certified beds. Compl. ¶ 1. Commercial insurers cannot market competitive health plans in New York City without including at least some NYP facilities in their provider networks. *Id.* ¶ 2. That provides NYP with significant leverage in contract negotiations with insurers, which NYP wields to demand that provider networks and network tiers include *all* NYP facilities, insulating NYP from price competition. *Id.* ¶¶ 153–154.

Absent these restrictions, health insurers can promote competition through "selective contracting," a common strategy that encourages hospital providers to compete on price to obtain inclusion and favorable placement within insurance networks. *Id.* ¶¶ 4–9, 56. The most straightforward form of selective contracting allows insurers to exclude higher-cost providers from certain networks unless the providers lower their prices to competitive levels. *Id.* ¶¶ 5, 58.

Another common form of selective contracting involves "steering," through which insurers encourage members to obtain care from more efficient providers by offering lower copayments or coinsurance. Such mechanisms may include: (1) tiering—placing lower-cost, higher-quality providers in a higher benefit tier, which incentivizes plan members to choose providers in the tier (*id.* ¶¶ 7, 61); (2) "site-of-service" and "centers of excellence" provisions, which encourage patients to have procedures done at lower-cost, high-quality facilities (*id.* ¶¶ 7, 62–63); and (3) price transparency tools that allow members to see the cost of a procedure at various facilities (*id.* ¶¶ 7, 64). These strategies lower healthcare costs by directing patients to more efficient providers and by increasing competitive pressure on hospitals to lower their prices and improve quality. *Id.* ¶¶ 57, 60, 65–66. Interference with this competitive process results in higher healthcare costs—a fact widely recognized by courts, enforcers, legislatures, and industry experts. *Id.* ¶¶ 20, 70–76.

Rather than competing through lower prices, higher quality, or greater efficiency, NYP uses its market power to engage in flagrantly anticompetitive contracting and negotiating tactics: it conditions its participation in insurers' healthcare provider networks on insurers' acceptance of anticompetitive anti-steering and gag provisions, preventing insurers from offering lower-cost plans. *Id.* ¶¶ 77–85.

The principal contractual restraint imposed by NYP is its "All Products" clause. Under this provision, any insurer wishing to include a single NYP hospital in its provider network must include all NYP facilities and providers in every network offered by the insurer and place those providers in the highest benefit tier regardless of their price or quality. *Id.* ¶¶ 12, 78–81. This prevents insurers from selectively excluding higher-cost NYP facilities or steering patients toward competing providers that provide comparable or superior care at lower prices. *Id.*

NYP also requires insurers to accept "single negotiated rate" provisions. Those provisions require insurers to apply the high rates charged at NYP's expensive flagship hospitals across *all* NYP hospitals, regardless of any differences in location, quality, efficiency, or operating costs. *Id.* ¶¶ 13, 90–92, 108. Such provisions prevent insurers from negotiating lower reimbursement rates for inpatient care provided by NYP's lower-rated or lower-cost hospitals. *Id.* ¶¶ 13, 90.

NYP also imposes "gag" clauses that prohibit insurers and payors (self-insured employers, union health and welfare funds, and other healthcare purchasers) from disclosing NYP's pricing or contractual terms to health plan members, blocking them from seeing a hospital's prices in advance of receiving care, thus limiting price transparency and comparison. *Id.* ¶¶ 14, 93, 95. NYP's gag clauses also prevent insurers from telling payors—their health plan clients—about NYP's anti-steering and other provisions, forcing insurers to conceal these provisions from the entities that are harmed by them: the self-funded payors that bear NYP's high prices. *Id.* ¶ 96.

These restraints insulate NYP from competitive pressure, enabling it to charge supracompetitive prices that are not explained by the quality of care NYP offers. *Id.* ¶¶ 125–126, 152. The effects of these restraints are laid bare by NYP's pricing. While NYP argues that it offers a "volume discount" to insurers to "avoid being excluded" from provider networks (MTD at 2), NYP is by far the most expensive hospital system in New York, charging 74% more for an average inpatient stay than any other health system in the Relevant Market. Compl. ¶¶ 1, 16, 106, 109. Common procedures cost tens of thousands of dollars more at NYP than at competing institutions, even if those institutions have higher quality and safety ratings. *Id.* ¶¶ 105–129. These pricing disparities persist because NYP's contractual restrictions prevent insurers from using selective contracting and plan designs that would otherwise discipline NYP's prices. NYP has profited handsomely from its restraints, vastly increasing its revenue while richly compensating its executives. *Id.* ¶¶ 22–24. NYP itself has recognized that its contract restrictions protect its high prices. *Id.* ¶¶ 101–104.

Federal and state antitrust authorities have recognized that anti-steering provisions imposed by dominant hospital systems like NYP suppress competition. In March 2026, DOJ filed an antitrust action challenging NYP's contractual restrictions, asserting that they reduce competition among hospitals, increase healthcare costs, and deny consumers access to lower-cost insurance products. *Id.* ¶ 19; Asciolla Decl., Ex. 1. DOJ and the State of Ohio recently challenged similar contractual restrictions imposed by OhioHealth Corporation. Compl. ¶ 20; Asciolla Decl., Ex. 2. That case is settling, with OhioHealth agreeing to void its restrictions. *Id.*, Ex. 3 at 5–7. Similarly, DOJ sued and settled with Atrium Health, which also agreed to stop imposing its restrictions on selective contracting. Compl. ¶ 71; *see United States v. Charlotte-Mecklenburg Hosp. Auth.*, 2019 WL 2767005, at *3 (W.D.N.C. Apr. 24, 2019). States such as Texas, Indiana, Massachusetts,

Nevada, and Connecticut have enacted legislation prohibiting comparable anti-steering restrictions. Compl. ¶¶ 20, 76.

Despite widespread recognition that such restrictions harm competition, NYP continues to impose them. As a direct consequence, Plaintiffs and members of the Class—self-funded employers, unions, insurers, and other entities that bear the financial risk and responsibility for their members' healthcare—have paid hundreds of millions of dollars in inflated healthcare costs to NYP while being denied access to lower-cost, higher-value health plans that would otherwise exist in a competitive market. *Id.* ¶¶ 25, 41–42, 98. Unlike "fully-insured" plans, where employers and entities pay premiums to an insurer and the insurer bears the risk, self-funded or "self-insured" employers and unions—Plaintiffs and members of the Class here—pay the vast majority of their members' healthcare expenses charged by the provider. *Id.* ¶¶ 41–42. Thus, they are directly harmed by NYP's conduct. *Id.* ¶¶ 26, 28, 31.

LEGAL STANDARD

To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), a complaint need only provide a "short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). Although it must provide more than "a formulaic recitation of the elements of a cause of action," it need not contain detailed factual allegations. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). But it must allege sufficient facts to state a plausible claim and give the defendant fair notice of the grounds upon which it rests. *Id.*; *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009). In evaluating a motion to dismiss, the Court accepts all well-pleaded facts as true and draws all reasonable inferences in the plaintiff's favor. *Faber v. Metro Life Ins. Co.*, 648 F.3d 98, 104 (2d Cir. 2011). This standard is one of *plausibility*, not probability; a complaint need only "raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555–56.

ARGUMENT

I. PLAINTIFFS HAVE ANTITRUST STANDING

At the outset, NYP attacks Plaintiffs' standing to sue, but this attack does not justify dismissal. First, Plaintiffs are efficient enforcers under *AGC* because they "take[] on the risks of the medical costs" themselves and "pay[] the healthcare costs directly." *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 188 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017). Second, Plaintiffs have standing under *Illinois Brick* because their injury is direct: Plaintiffs pay overcharges to NYP, they do not buy resold products through a "distribution chain," and no other entity has a claim for the overcharges they paid. In any event, both *AGC* and the Second Circuit make clear that standing cannot be resolved on a motion to dismiss.

A. Self-Funded Plans Are Direct Purchasers

Plaintiffs are self-funded employee welfare funds. Compl. ¶¶ 26, 28, 31. They offer healthcare plans and benefits to members and dependents of a union. This includes hospital benefits, including at NYP, an in-network provider. *Id.* Plaintiffs have "purchase[d] inpatient services directly from NYP at NYP's inflated prices[.]" *Id.* ¶ 26.

Employers and unions that offer healthcare benefits to their members have two options: purchase a "fully insured" product from a health insurer or self-fund their plan. In the case of a fully insured product, an insurer, such as Cigna or UnitedHealthcare, pools the risk of all members and covers their healthcare expenses in exchange for premiums. *Id.* ¶ 41. "In a 'self-funded' health plan, by contrast, the employer or union bears the financial risk for the healthcare costs of the plan's members, and directly pays the vast majority of the healthcare expenses those members . . . incur." *Id.* ¶ 42. The self-funded plan contracts with a third-party administrator

("TPA"), usually an insurance company, for access to a network of providers assembled by the TPA; the TPA also typically provides claims processing and adjudication services. *Id.* ¶ 45.

Anthem acts as the TPA for Plaintiffs. *Id.* ¶ 201. Thus, Plaintiffs' members have the right to access Anthem's provider network, which includes NYP. When they do, Plaintiffs pay NYP at the reimbursement rates Anthem negotiated for its fully insured products. *Id.* ¶¶ 48, 51–52. Typically, TPAs' provider contracts and their contracts with self-funded clients disclaim any ultimate financial responsibility for their clients' claims. *Id.* ¶ 52. Thus, if a self-funded client fails to pay a claim, the provider has ultimate recourse against that client and its members, not against the TPA. *Id.* Here, NYP's ultimate recourse is against Plaintiffs—the direct purchasers—not Anthem. *Id.* ¶ 201.

B. Plaintiffs Have Antitrust Standing Under *Associated General Contractors*

NYP contends that Plaintiffs are "too remote" from the challenged negotiations for purposes of standing. MTD at 2. That argument fails because the overcharges paid by Plaintiffs are direct injuries: nobody else paid or suffered them first.

Section 4 of the Clayton Act provides a broad right of action for redress of antitrust injuries such as Plaintiffs': "[A]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor[.]" 15 U.S.C. § 15(a). As the Supreme Court explained in *Reiter v. Sonotone Corp.*, "where petitioner alleges a wrongful deprivation of her money because the price of the [product] she bought was artificially inflated by reason of respondents' anticompetitive conduct, she has alleged an injury in her 'property' under § 4." 442 U.S. 330, 342 (1979). That makes payment of supracompetitive prices the classic antitrust injury—injury of the kind the antitrust laws exist to prevent, and which flows from the anticompetitive

conduct. *DirecTV, LLC v. Nexstar Media Grp., Inc.*, 162 F.4th 295, 309 (2d Cir. 2025), *cert. pet. pending*, No. 25-1243 (2026).

Under *AGC*, an antitrust plaintiff must suffer antitrust injury and be an efficient enforcer of the antitrust laws. *AGC*, 459 U.S. at 543–44. The Second Circuit distilled the *AGC* efficient-enforcer analysis into a four-factor test in *IQ Dental Supply, Inc. v. Henry Schein, Inc.*, which Defendant acknowledges is the governing authority (MTD at 2): (1) "the directness or indirectness of the asserted injury," (2) "the existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement," (3) "the speculativeness of the alleged injury," and (4) "the difficulty of identifying damages and apportioning them among direct and indirect victims so as to avoid duplicative recoveries." 924 F.3d 57, 62 (2d Cir. 2019) (quoting *Daniel v. Am. Bd. of Emergency Med.*, 428 F.3d 408, 443 (2d Cir. 2005)).

NYP does not dispute that Plaintiffs allege antitrust injury; rather, it challenges only the first factor in the efficient enforcer test—the directness of the injury. MTD at 2. "Directness in the antitrust context means close in the chain of causation." *IQ Dental Supply*, 924 F.3d at 65 (quoting *Gatt Commc'ns, Inc. v. PMC Assocs., L.L.C.*, 711 F.3d 68, 78 (2d Cir. 2013)). The Second Circuit has also described it as injury suffered at the "first step" of the causal chain, "requir[ing] 'some direct relation between the injury asserted and the injurious conduct alleged.'" *In re Am. Express Anti-Steering Rules Antitrust Litig.* ("*Amex Anti-Steering*"), 19 F.4th 127, 139–40 (2d Cir. 2021) (quoting *Bank of Am. Corp. v. City of Miami*, 581 U.S. 189, 203–04 (2017)). *IQ Dental Supply* distinguished direct from "indirect" injury, which is "*derivative*" of another—it "'flow[s] from the injuries' suffered by other parties." 924 F.3d at 65 (quoting *Paycom Billing Servs., Inc. v. Mastercard Int'l, Inc.*, 467 F.3d 283, 293 (2d Cir. 2006)) (emphasis added). This definition of

"direct" accords with the Supreme Court's definition in *Lexmark International, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014). In *Lexmark*, the plaintiff sold inputs to a remanufacturer of printer cartridges, which competed with the brand, Lexmark. *Id.* at 121. The plaintiff alleged under the Lanham Act that Lexmark's false advertising had damaged the remanufacturer and, by extension, itself, as a supplier to the remanufacturer. *Id.* at 123–24. Referencing the Clayton Act and the *AGC* analysis, the Court identified this "causal chain" as "not direct" because it included the "intervening link of injury to the remanufacturers." *Id.* at 139. Thus, a complaint "might not support standing under a strict application of the general tendency not to stretch proximate causation beyond the first step." *Id.* (quoting *Holmes v. Sec. Inv'r Prot. Corp.*, 503 U.S. 258, 271 (1992) (cleaned up)). The *Lexmark* Court nonetheless held that the plaintiff had stated a Lanham Act claim, as damages that flowed to it were "more or less automatic[]" and there were no "more immediate victims." *Lexmark,* 572 U.S. at 140 (internal quotation omitted). Thus, both *Lexmark* and *IQ Dental* recognize that, under the right circumstances, even indirect injuries can sometimes be actionable. *See Lexmark*, 572 U.S. at 139–40; *IQ Dental*, 924 F.3d at 65 ("[I]nfliction of a derivative injury does not always render an antitrust plaintiff's injury too indirect under the efficient-enforcer test.").

Plaintiffs here more than meet the direct injury standard. Unlike the plaintiffs in *Lexmark*, Plaintiffs do not allege a derivative injury. Only Plaintiffs paid overcharges on the claims of their members; nobody else paid them and passed them on to Plaintiffs. Compl. ¶ 205. Anthem, Plaintiffs' TPA, may have negotiated the prices that Plaintiffs paid, and it may have processed the claims. But payment for those claims came from Plaintiffs' funds. Or, as the court put it in *Anthem*:

> In self-insured plans, the employer takes on the risk of the medical costs itself. [] It pays the insurer an ASO fee in return for both access to the provider network and claims administration and adjudication

> services. But the employer ***pays the healthcare costs directly***, usually by funding a bank account from which the insurer pays the claims as they are submitted by the providers.

236 F. Supp. 3d at 188 (emphasis added).

Recent Second Circuit cases do not alter the result in this case. NYP cites *Amex Anti-Steering* in its motion to dismiss (MTD at 2) and may raise *Schwab Short-Term Bond Market Fund v. Lloyds Banking Group PLC* in its reply. 22 F.4th 103 (2d Cir. 2021). Both cases involved "umbrella"-like claims for overcharges paid to entities other than the defendant. In *Amex Anti-Steering*, merchants sued for overcharges they allegedly paid to other credit card networks (Visa, Mastercard, Discover) as the result of the suppression of competition caused by Amex's anti-steering rules. 19 F.4th at 134, 139. The court found the plaintiffs to be too remote from the conduct because "Amex did not raise the . . . fees" that plaintiffs paid to *other* credit card networks. *Id.* at 140–41. Similarly, in *Schwab*, the plaintiffs sued the LIBOR panel banks for suppressed interest payments on bonds issued and sold by *non-defendants*; the defendant LIBOR panel banks had nothing to do with third parties' use of a LIBOR-based index, nor did the defendant banks profit from plaintiffs' losses. 22 F.4th at 109. Again, the court ruled that plaintiffs were too remote. *Id.* at 118.

Neither case has any bearing on this one. In both cases, the plaintiffs sought to extend liability well beyond any benefit reaped by the LIBOR panel banks or Amex. In this case, however, NYP provided healthcare to Plaintiffs' members and reaped supracompetitive profits from the high prices Plaintiffs paid for that healthcare. Plaintiffs are not suing some other hospital, they are suing NYP. The connection is direct and Plaintiffs are efficient enforcers.

C. Because Plaintiffs Suffered Direct Injury, *Illinois Brick* Does Not Apply

Similarly, Plaintiffs are not barred from bringing federal antitrust claims by *Illinois Brick*, because they purchased healthcare directly and suffered direct injuries. *Illinois Brick* itself offers the classic counterexample of a true indirect injury. In that case, a cartel of concrete block manufacturers inflated the price of blocks sold to masonry contractors, who then sold the blocks to general contractors, who then sold the blocks as parts of building contracts. 431 U.S. at 726. The plaintiff, the State of Illinois, claimed it paid inflated prices for buildings due to the overcharges imposed by the concrete block manufacturers. *Id*. at 727. The Supreme Court rejected standing for such an "indirect purchaser," citing difficulties of proof and risk of duplicative recovery under what has come to be known as the *Illinois Brick* rule. *Id.* at 737.

The facts of *Illinois Brick* are far removed from the allegations here. Here, Plaintiffs do not buy healthcare services purchased in the first instance by Anthem, its TPA, and resold to Plaintiffs. The fact that Anthem negotiates the rates paid by Plaintiffs, or processes payments for some class members, does not affect the direct, non-derivative nature of Plaintiffs' injuries. If Plaintiffs do not have a claim arising from overcharges for these services, nobody does. As Judge Brodie recently explained in *In re Payment Card Interchange Fee & Merchant Discount Antitrust Litigation*, the key considerations when analyzing the "indirect purchaser" question are who purchases the services from the defendant and who bears the risk in the event of default. 2024 WL 1014159, at *12 (E.D.N.Y. Mar. 8, 2024). The court offered the example of a credit card holder who uses a Chase card to buy something on Amazon. *Id.* In that scenario, the credit card holder is the purchaser, not the credit card issuer. Crucially, in the event of default, Chase would have to pursue the cardholder for any shortfall; Amazon does not care because it has already been paid. *Id.* This logic applies *a fortiori* here because in this case, NYP *does* have recourse against

Plaintiffs, *not* against the TPA. Compl. ¶ 52. If NYP can go after Plaintiffs for billing discrepancies, it would be nonsensical to argue—as Defendant does—that only the TPA has standing to sue.

NYP may cite *In re NorthShore University HealthSystem Antitrust Litigation* in its reply, which found a self-funded plan to be an indirect purchaser. 2018 WL 2383098, at *8 (N.D. Ill. Mar. 31, 2018). But *NorthShore* is an out-of-circuit class decertification decision applying a different standard than the Rule 12(b)(6) pleading standard. *Id.* at *3. And in any event, it incorrectly held that the only "relevant consideration in the *Illinois Brick* analysis [] is which entity negotiated and maintained the contract with the healthcare provider." *Id.* at *8. Under this thinking, regardless of who suffers the injury and how it is suffered, the absence of a contractual relationship between a plaintiff and defendant negates standing. This incorrect definition of "indirect" conflicts with *IQ Dental*, 924 F.3d at 65; *Lexmark*, 572 U.S. at 138–40; and *Apple Inc. v. Pepper*, 587 U.S. 273, 286–87 (2019)—all of which confirmed that who negotiates the price does not matter. In fact, *Pepper* expressly *rejected* defendant Apple's proposed "who sets the price" rule, which would have barred consumer plaintiffs' claims against Apple for app overcharges at prices set by developers. *Id.* at 281–84. Moreover, a requirement of contractual privity with the violator would flatly contradict the Supreme Court's seminal decision in *Blue Shield of Virginia v. McCready*, which held that an employee had antitrust standing to bring claims against her health insurance company even though her employer, not she, contracted with the insurer. 457 U.S. 465, 472, 476–81 (1982). As in *McCready*, Plaintiffs' "injury is 'clearly foreseeable,' 'inextricably intertwined' with the anticompetitive conduct, and 'flows from that which makes [the] defendants' acts unlawful." *United States v. Live Nation Ent., Inc.*, 2025 WL 835961, at *5 (S.D.N.Y. Mar. 14, 2025) (quoting *McCready*, 457 U.S. at 479, 484).

Finally, Defendant's *Illinois Brick* argument has no bearing on Plaintiffs' state law claim or their claim for injunctive relief. *Illinois Brick* "does not pertain to [Plaintiffs'] claims under New York's antitrust statute, the Donnelly Act, as this statute expressly provides that an indirect purchaser has standing to sue for antitrust violations." *Leider v. Ralfe*, 2003 WL 22339305, at *3 (S.D.N.Y. Oct. 10, 2003). Nor does this argument have any bearing on Plaintiffs' claims for injunctive relief, because "*Illinois Brick* did not address injunctive relief." *Pepper*, 587 U.S. at 279 n.1.

In sum, because Plaintiffs bought and paid for the healthcare NYP provided, Plaintiffs are not "indirect purchasers" under *Illinois Brick*. At minimum, the *Illinois Brick* issue raises questions of fact not appropriate for resolution on a motion to dismiss. *Coal. for a Level Playing Field L.L.C. v. Autozone, Inc.*, 2001 WL 1763440, at *8 n.8 (E.D.N.Y. Oct. 18, 2001) ("discovery will aid in identifying which, if any, of the plaintiffs qualify as 'indirect purchasers'"). *See also Interchange*, 2024 WL 1014159, at *13.

II. THE COMPLAINT PLAUSIBLY ALLEGES A VIOLATION OF SECTION I OF THE SHERMAN ACT

Section 1 "was enacted 'to assure customers the benefits of price competition and with the 'central interest' of 'protecting economic freedom of participants in the relevant market.'" *Yankees Ent. & Sports Network LLC v. Cablevision Sys. Corp.*, 224 F. Supp. 2d 657, 665–66 (S.D.N.Y. 2002) (quoting *AGC*, 459 U.S. at 538). To that end, Section 1 prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade." 15 U.S.C. § 1. Because the Supreme Court has interpreted Section 1 to prohibit only "unreasonable" restraints of trade, restraints that "are not unreasonable *per se*" are analyzed under the "rule of reason." *Ohio v. Am. Express Co.*, 585 U.S. 529, 541 (2018). A restraint is unreasonable if it produces anticompetitive effects in a relevant

market, such as reduced output, increased prices, or decreased quality. *Id.* at 542. NYP imposes contractual restraints that unreasonably restrain trade in violation of Section 1.

A. The Complaint Plausibly Alleges NYP Has Market Power in a Relevant Market

NYP contends that Plaintiffs have not plausibly alleged market power. MTD at 3. But that ignores Plaintiffs' detailed allegations defining the relevant product market, relevant geographic markets, and NYP's market power within those markets. Further, Defendant misstates the law by arguing that only a defendant with more than a 50% market share can possess market power sufficient to violate the Sherman Act. NYP's arguments should be rejected.

1. Plaintiffs Plausibly Allege a Relevant Product Market

At this stage, a plaintiff need only allege a product market that "'bear[s] a rational relation to the methodology courts prescribe to define a market' and [] a 'plausible explanation as to why a market should be limited' to exclude possible substitutes." *Regeneron Pharm., Inc. v. Novartis Pharma AG*, 96 F.4th 327, 338-39 (2d Cir. 2024) (quoting *Todd v. Exxon Corp.*, 275 F.3d 191, 200 (2d Cir. 2001)). "Because market definition is a deeply fact-intensive inquiry, courts hesitate to grant motions to dismiss for failure to plead a relevant product market." *Todd*, 275 F.3d at 199–200.

Here, Plaintiffs allege the relevant product market is the sale of "inpatient general acute care ('inpatient GAC') hospital services" to payors, consisting "of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital." Compl. ¶¶ 132–133. The Complaint clearly explains why the market excludes non-hospital facilities (*id.* ¶ 134), and sales of inpatient GAC hospital services to government payors (*id.* ¶ 136), and why this group of services is a cluster market (*id.* ¶ 133). Accordingly, a hypothetical monopolist of inpatient GAC

hospital services could impose a "small but significant and non-transitory price increase" ("SSNIP") on such services. *Id.* ¶ 137. *United States v. Visa, Inc.*, 788 F. Supp. 3d 585, 607 (S.D.N.Y. 2025). Taken together, these allegations plausibly allege a relevant product market. *Regeneron*, 96 F.4th at 339.

In addition, Plaintiffs' relevant product market is firmly supported by precedent. *See, e.g.*, *Saint Francis Hosp. & Med. Ctr., Inc. v. Hartford Healthcare Corp*., 655 F. Supp. 3d 52, 65, 83–86 (D. Conn. 2023) (adult acute inpatient healthcare services plausible in anti-tiering case); *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 2015 WL 1399229, at *5–7 (C.D. Ill. Mar. 25, 2015) (finding market of "general acute-care inpatient hospital services" plausible). Indeed, hospital defendants in antitrust cases ordinarily concede that inpatient GAC hospital services is the relevant product market. *See F.T.C. v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 338 (3d Cir. 2016); *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720, 728 (W.D.N.C. 2017); *F.T.C. v. Advocate Health Care*, 2017 WL 1022015, at *3 (N.D. Ill. Mar. 16, 2017); *Sidibe v. Sutter Health*, 4 F. Supp. 3d 1160, 1174 (N.D. Cal. 2013).

NYP may argue, as it did in its Answer to the DOJ complaint, that the relevant market is two-sided. Asciolla Decl. Ex. 4, at 20–21. NYP's argument is mistaken and provides no basis for dismissal.

Amex expressly limited its holding to a narrow ambit of business conduct, "two-sided transaction platforms," which exist when: (1) each side of the platform engages in a "simultaneous transaction"; (2) the two sides of the market "jointly consume a single product . . . transactions"; and (3) the platform exhibits "pronounced indirect network effects and interconnected pricing and demand." 585 U.S. at 545. "[O]nly a relatively small subset of two-sided platforms fall within [*Amex*'s] requirements for treating the two sides as a single market." Herbert Hovenkamp,

Platforms and the Rule of Reason: The American Express Case, COLUM. BUS. L. REV. 35, 88 (2019). These characteristics are not present in healthcare markets. As the court explained in *In re Delta Dental Antitrust Litigation*, "[health] insurance lacks the 'key feature' of a transaction platform: simultaneity of the exchange." 484 F. Supp. 3d 627, 637 (N.D. Ill. 2020). In healthcare, health plan members obtain insurance and medical care; insurers obtain participation from providers and premiums from employers (or TPA fees from self-funded plans), and providers obtain reimbursements. These are not simultaneous transactions or joint consumption of a single transaction. Nor does the market for inpatient GAC hospital services exhibit indirect network effects such that "two-sided platforms cannot raise prices on one side without risking a feedback loop of declining demand." *Amex*, 585 U.S. at 544. That is because NYP *can*—and does—raise prices without health plans fleeing, because it knows it is a "must-have" provider in health plan networks. Moreover, NYP's *Amex* argument is fact-based, requires expert discovery, and precludes dismissal. *Delta Dental*, 484 F. Supp. 3d at 638–39.

2. Plaintiffs Plausibly Allege Relevant Geographic Markets

In evaluating the relevant geographic market, courts "generally measure a market's geographic scope, the area of effective competition, by determining the areas in which the seller operates and where consumers can turn, as a practical matter, for supply of the relevant product." *Saint Francis Hosp.*, 655 F. Supp. 3d at 82. In cases involving hospitals, the geographic market may include a single county or metropolitan area. *Id.* Here, Plaintiffs plausibly allege that NYP has market power in two geographic markets: the borough of Manhattan and Four-Borough Market of Manhattan, Queens, the Bronx and Brooklyn, and in all events in a geographic market no larger than New York City. Compl. ¶¶ 138–144. Plaintiffs allege that a hypothetical monopolist controlling all the hospitals in either market could profitably impose a small but significant non-

transitory increase in price because commercial insurers cannot profitably market health plans without access to hospitals located within those areas. *Id.* ¶¶ 143–147. Both the Manhattan Market and Four-Borough Market reflect the commercial realities insurers face when marketing health plans in New York City. *Id.* ¶¶ 139–146.

These allegations more than suffice at the pleading stage. To the extent NYP argues that patients travel in and out of New York City for hospital care, that contention misses the relevant inquiry. The question is not whether some patients cross geographic boundaries for inpatient treatment, but whether "enough *insurers*, in the face of a small but significant non-transitory increase in price (SSNIP), would avoid the price increase by looking to hospitals outside the proposed geographic market" to include in their networks. *Hershey Med. Ctr.*, 838 F.3d at 342 (emphasis added). Plaintiffs plausibly allege that insurers cannot do so.

Moreover, at the pleading stage, Plaintiffs may allege alternative and multiple relevant markets. *See Borozny v. Raytheon Techs. Corp.*, 2023 WL 348323, at *11 (D. Conn. Jan. 20, 2023) (allowing pleading of both a United States geographic market and "local geographic markets" in and around certain geographic areas); *Daniel v. Am. Bd. of Emergency Med.*, 802 F. Supp. 912, 925–26 (W.D.N.Y. 1992) (finding two alleged market definitions were "adequate" as "a pleading may present alternative statements of the facts").

3. Plaintiffs Plausibly Allege Market Power

NYP's contention that Plaintiffs fail to allege NYP's market power (MTD at 3) ignores the Complaint's extensive allegations. Plaintiffs may establish market power through direct evidence, such as supracompetitive prices and the ability to impose onerous terms, or through indirect evidence, such as market shares, concentration, and barriers to entry. *See In re Payment Card Interchange Fee & Merchant Discount Antitrust Litig.*, 714 F. Supp. 3d 65, 96–97 (E.D.N.Y. 2024)

(market power can be demonstrated through "evidence of specific conduct indicating the defendant's power to control prices or exclude competition" or through market share as a "proxy") (internal quotation omitted); *Tops Mkts., Inc. v. Quality Mkts., Inc.*, 142 F.3d 90, 97–98 (2d Cir. 1998) (market power "may be proven directly by evidence of the control of prices or the exclusion of competition, or it may be inferred from one firm's large percentage share of the relevant market"). Plaintiffs allege both.

First, Plaintiffs allege that NYP leverages its market power to charge supracompetitive prices. NYP is the most expensive hospital system in New York City across a broad range of inpatient procedures. For instance, a 2025 review by the New York City Department of Health and Mental Hygiene found NYP had the highest costs per inpatient admission for 11 of the 12 inpatient procedures analyzed. Compl. ¶ 158. The Complaint alleges that NYP is demonstrably more expensive for a range of GAC services, including joint replacements, spinal fusion, and Caesarean sections. *Id.* ¶¶ 117–119. These allegations are direct evidence of NYP's market power. *Virgin Atl. Airways Ltd. v. British Airways PLC*, 257 F.3d 256, 265 (2d Cir. 2001) (market power is the "ability of a single seller to raise price[s] and restrict output") (quoting *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 464 (1992)); *In re Aggrenox Antitrust Litig.*, 94 F. Supp. 3d 224, 246–47 (D. Conn. 2015) (plaintiffs established direct evidence of market power where they alleged that defendant could charge supracompetitive prices without losing sales); *LyricFind, Inc. v. Musixmatch, S.p.A.*, 798 F. Supp. 3d 1040, 1070 (N.D. Cal. 2025) (allegations of supracompetitive pricing served as direct evidence of market power).

Second, Plaintiffs allege that NYP's size, reputation, breadth of services, and strength in critical service lines make it a "must-have" provider. Compl. ¶¶ 149–186. That explains why more than 95 percent of commercial networks include NYP; without it, commercial health plans would

not be viable. *Id.* ¶¶ 153–154, 156. But insurers do not need *every* NYP facility in every network, at *identical* prices. Nonetheless, NYP forces insurers and payors to accept its "All Products," single negotiated rate, and gag clauses—all of which prevent payors from steering patients toward lower-cost alternatives. *Id.* ¶¶ 11–12, 90–91, 93. The ability to compel such onerous terms is direct evidence of market power. *Charlotte-Mecklenburg*, 248 F. Supp. 3d at 731 (hospital's ability to impose anticompetitive anti-steering provisions "clearly demonstrates" market power).

Third, Plaintiffs allege indirect evidence of NYP's market power within the relevant markets, including its substantial market shares and facts related to market structure. *Id.* at 730–31. Plaintiffs allege that NYP accounts for more than 30% of inpatient GAC discharges in Manhattan and more than 25% in the Four-Borough Market, citing DOJ as its source. Compl. ¶ 165. Counter to NYP's contention (MTD at 3), courts do not require a minimum market share of 50 percent to plead market power. *See Interchange*, 714 F. Supp. 3d at 99–100 (denying summary judgment where defendant had 25% market share "in a market defined by high barriers to entry"); *United States v. Visa U.S.A., Inc.*, 344 F.3d 229, 240 (2d Cir. 2003) (determined at trial that 47% and 26% market shares were sufficient); *Toys "R" Us, Inc. v. F.T.C.*, 221 F.3d 928, 930, 937 (7th Cir. 2000) (20% national market share sufficient). In addition, Plaintiffs allege additional structural evidence including that NYP has over 4,000 beds across New York City, owns facilities in medically underserved areas with limited hospital capacity, and operates in a market characterized by high barriers to entry. Compl. ¶¶ 135, 161–174. DOJ likewise concluded, after investigating, that NYP possesses market power, a conclusion widely recognized throughout the industry. *Id.* ¶¶ 175–186. Together, these allegations satisfy Plaintiffs' pleading burden.

NYP's mischaracterization of *Amex* improperly raises the bar that Plaintiffs must clear. *Amex* does not require plaintiffs relying on direct evidence of market power to plead that

defendants control a certain percentage of the market. It says only that direct evidence of market power does not relieve plaintiffs of the duty to "define the relevant market." 585 U.S. at 543 n.7. Plaintiffs have done so. Accordingly, this argument fails. In any event, NYP's market power is "a fact-intensive inquiry" unsuitable for resolution on a motion to dismiss. *Aggrenox*, 94 F. Supp. 3d at 246; *see also Allen v. Dairy Farmers of Am., Inc.*, 748 F. Supp. 2d 323, 340 (D. Vt. 2010) ("Dismissals for insufficient pleading of market power are rare pre-discovery.").

B. The Complaint Plausibly Alleges That NYP's Contractual Restrictions Violate Section 1 of the Sherman Act

At this stage, Plaintiffs need only plausibly allege that NYP's anti-steering restrictions unreasonably restrain trade by harming competition in the relevant market. Plaintiffs easily clear this bar.

1. Plaintiffs Sufficiently Allege Anticompetitive Conduct

A restraint is unreasonable when "its anticompetitive effects outweigh its procompetitive effects." *Atl. Richfield Co. v. USA Petrol. Co.*, 495 U.S. 328, 342 (1990). Plaintiffs may satisfy this element by alleging NYP's conduct produced anticompetitive effects in the relevant markets. *See P & L Dev., LLC v. Gerber Prods. Co.*, 715 F. Supp. 3d 435, 462 (E.D.N.Y. 2024). Anticompetitive effects include "reduced output, increased prices, or decreased quality in the relevant market." *Amex*, 585 U.S. at 542. The question is whether Plaintiffs plausibly alleged a violation of law, such that discovery will likely uncover evidence corroborating their allegations. *See Mosaic Health, Inc. v. Sanofi-Aventis U.S., LLC*, 156 F.4th 68, 76 (2d Cir. 2025) (citing *Twombly*, 550 U.S. at 556), *cert. pet. pending*, No. 25-1070 (2026).

Courts consistently uphold Section 1 claims challenging all-or-nothing, anti-steering, anti-tiering, and gag provisions imposed by hospital systems. In February 2026, DOJ brought an

antitrust case based on similar conduct against a hospital system in Ohio. Asciolla Decl., Ex. 2. Within 116 days, the defendant settled, agreeing that "[a]ny and all of Defendant's contract provisions that prohibit, deter, prevent, or Penalize Steering, Steered Plans, or Transparency are void and unenforceable." *Id.*, Ex. 3 at 5. In *In re Mission Health Antitrust Litigation*, 2024 WL 759308 (W.D.N.C. Feb. 21, 2024), the court denied motions to dismiss Section 1 claims based on all-or-nothing provisions, anti-steering clauses, and gag provisions. *Id.* at *8. In *Davis v. HCA Healthcare*, 2022 WL 4354142 (N.C. Sup. Ct. Sept. 19, 2022), the court denied a motion to dismiss, holding that similar restrictions deprived insurers of the power "to decide which facilities should and should not be included" in-network. *Id.* at *4, *13. And in *Charlotte-Mecklenburg*, the court held that anti-steering allegations "are specifically the type of allegation that states a direct anticompetitive effect and a plausible claim for relief under Section 1." 248 F. Supp. 3d at 729. *See also Uriel Pharm. Health & Welfare Plan v. Advocate Aurora Health, Inc.*, 2023 WL 12284689, at *1, *3 (E.D. Wis. Apr. 28, 2023) (denying motion to dismiss where plaintiff alleged that defendant exploited its "must-have" status to implement all-or-nothing, anti-steering, anti-tiering, and gag clauses); *UFCW & Emps. Benefit Trust v. Sutter Health*, 2016 WL 3459451, at *1, *3-4 (Cal. Super. Ct. Apr. 1, 2016) (similar). Crucially, these allegations sufficed at the pleading stage, because "[r]esolution of these fact-intensive inquiries requires discovery, and perhaps ultimate decision by a fact-finder." *Charlotte-Mecklenburg*, 248 F. Supp. 3d at 730.

As in the cases above, Plaintiffs plausibly allege that NYP leverages its "must-have" status to impose the All Products, single negotiated rate, and gag clauses, all of which suppress the use of selective contracting to foster competition. While competitors ordinarily lower prices to compete for privileged positions in networks or tiers, NYP forecloses that critical form of competition. Compl. ¶¶ 8, 66, 82, 151, 213, 224. As Plaintiffs allege, "NYP leverages its market

power to, through contractual restrictions and otherwise, inhibit the creation of provider networks and health plans that are designed to lead to lower healthcare costs while providing members with equal- or higher-quality care." *Id.* ¶ 3. The Complaint contains specific allegations of how NYP uses its provisions to deny health plans the ability to design narrow networks (*id.* ¶ 86); forces health plans to include NYP in its highest tiers (*id.* ¶¶ 87–89); and overcharges Plaintiffs and the Class (*id.* ¶¶ 105–129). And because NYP's flagship academic medical centers are "must-haves," NYP is able to impose its All Products clause—giving insurers no choice but to include NYP's entire system in-network at high prices. *Id.* ¶¶ 153–154. Thus, plans are not permitted to steer patients toward more efficient providers. *Id.* ¶¶ 10, 15.

Like the restraints challenged in the cases discussed *supra* at 23, Plaintiffs' allegations more than plausibly state a claim of anticompetitive conduct that restrains trade.

2. The DOJ Case Underscores the Plausibility of Plaintiffs' Allegations

Under controlling Second Circuit law, DOJ's case—alleging antitrust violations based on the same conduct by the same defendant—strongly supports the plausibility of Plaintiffs' claims. In *Starr v. Sony BMG Music Entertainment*, the fact that "defendants' price-fixing is the subject of a pending investigation by the New York state attorney general and two separate investigations by the Department of Justice" contributed to the plausibility of plaintiffs' claims. 592 F.3d 314, 324 (2d Cir. 2010). *See also City of Philadelphia v. Bank of Am. Corp.*, 498 F. Supp. 3d 516, 531 (S.D.N.Y. 2020) (investigation by DOJ was probative of an antitrust conspiracy); *In re GSE Bonds Antitrust Litig.*, 396 F. Supp. 3d 354, 363 (S.D.N.Y. 2019) (similar). "[W]here a [government] investigation turns up inculpatory material or is necessarily predicated upon evidence of a conspiracy, such investigation can provide support for the existence of an antitrust [violation]." *In re Concrete & Cement Additives Antitrust Litig.*, 2025 WL 1755193, at *19 (S.D.N.Y. June 25,

2025). And when DOJ has not just opened an investigation but actually brought a case, that is even more compelling, because "[t]he initiation of an enforcement action . . . must be predicated upon the agency's evidentiary support." *Id.*

Here, DOJ's investigation uncovered inculpatory material that ripened into active litigation. NYP did not even try to dismiss DOJ's complaint, but instead promptly answered it. Asciolla Decl., Ex. 4. The government complaint indicates that DOJ uncovered damning evidence confirming Plaintiffs' allegations. For instance, a NYP executive acknowledged that NYP is one of the few hospitals in the country that continues to enforce anti-steering provisions: "Notwithstanding national and local trends to the contrary, [NYP] retained the . . . [] terms and conditions that protect against administrative erosion of rates of payment or steerage away from the Hospitals." Compl. ¶ 43.

The DOJ complaint also cites an internal analysis concluding that if NYP were forced to abandon its anticompetitive anti-steering provisions and compete on the merits, it "could impact margins, particularly for standardized procedures," costing NYP hundreds of millions of dollars in ill-gotten profits. *Id.* ¶ 44. Another DOJ allegation cites testimony from NYP's most senior contracting executive that its rivals' offering of lower prices to payors "has no relevance to me." *Id.* ¶ 38. In a competitive market, a competitor's lower prices would force NYP to consider lowering its prices too. But because NYP has insulated itself from competition, that competitive mechanism is broken.

In sum, the DOJ complaint strongly reinforces the plausibility of Plaintiffs' allegations.

C. NYP's Attempts to Justify Its Conduct Are Deficient

NYP offers three arguments to justify its conduct. None succeeds.

First, NYP's primary argument rests on the statement in *Amex* that "there is nothing inherently anticompetitive about . . . anti-steering provisions." MTD at 1 (citing 585 U.S. at 551). But *Amex* says anti-steering provisions are not "***inherently*** anticompetitive," not that they are ***never*** anticompetitive. 585 U.S. at 551 (emphasis added). *Amex*'s conclusion turned on a trial record; other courts have reached different conclusions on different facts, including *Interchange*, where Judge Brodie denied summary judgment and found triable issues of fact over whether defendants' anti-steering provisions caused supracompetitive prices or reduced output. 714 F. Supp. 3d at 115. Whether NYP's restraints fail the rule of reason analysis is a fact-intensive inquiry and not a basis for dismissal. *Charlotte-Mecklenburg*, 248 F. Supp. 3d at 729–33.

Second, NYP argues that the conduct Plaintiffs describe is not "exclusionary" and perhaps not a restraint at all, but "simply a volume discount." MTD at 3. According to Defendant, NYP merely negotiated for inclusion in health plan networks in exchange for "rate concessions." *Id.* This argument is not supported by law nor by the Complaint's allegations, which likely explains why Defendant cites no authority. *Id.*

NYP's attempt to mischaracterize the Complaint should be rejected. Plaintiffs do not allege any "discounts" or "rate concessions." To the contrary, Plaintiffs allege that NYP imposes a "single negotiated rate," which requires Plaintiffs and the Class to pay the same rate across all of NYP's facilities, resulting in substantial *overpayments*. Compl. ¶ 90. It is not even clear to what "volume discount" NYP is referring in light of NYP's exorbitant costs compared to other New York hospitals. But if the idea is that Plaintiffs somehow benefitted from the inclusion of all NYP facilities as "in-network" providers, that directly contradicts Plaintiffs' allegations that absent the restraints, class members could access plans that excluded some of those facilities. *Id.* ¶¶ 156, 163. As *Davis* held, the "contractual restrictions at issue" forced insurers to include facilities "that they

do not want" in-network, and such forcing deprived insurers of "the power they would normally be able to exercise in a competitive market to decide which facilities should and should not be included" in-network. 2022 WL 4354142, at *13. This is classic exclusionary conduct.

NYP's counter-narrative is also irrelevant at this stage. As the Second Circuit recently reiterated, "a court ruling on a Rule 12(b)(6) motion may not properly dismiss a complaint that states a plausible version of the events merely because the court finds a different version more plausible." *Mosaic Health,* 156 F.4th at 83 (cleaned up) (quoting *Anderson News, L.L.C. v. Am. Media, Inc.*, 680 F.3d 162, 184 (2d Cir. 2012)). And if Defendant's position is that its conduct is procompetitive rather than anticompetitive—for instance, because the result of NYP's contracting is supposedly "an open network that maximizes patient choice" (MTD at 3)—that argument is premature. Defendant may attempt to prove this later, but balancing anticompetitive and procompetitive effects under the rule of reason is a fact-intensive inquiry that cannot be properly resolved on a motion to dismiss. *Charlotte-Mecklenburg*, 248 F. Supp. 3d at 729–33.

Third, Defendant argues the Complaint does not allege that NYP's restraints foreclosed rivals from the market. MTD at 3. That is an improper attempt to shoehorn Plaintiffs' anti-steering case into an exclusive dealing claim, which Plaintiffs do not assert. Exclusive dealing is a wholly different variety of anticompetitive conduct requiring a different rule of reason analysis. *McWane, Inc. v. F.T.C.*, 783 F.3d 814, 835 (11th Cir. 2015) (citing *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 328–29 (1961)). Section 1 is not limited to exclusive dealing; it prohibits agreements that unreasonably restrain trade. Conduct is anticompetitive where its overall effect is "to coerce [market actors] rather than persuade them on the merits." *New York ex rel. Schneiderman v. Actavis PLC*, 787 F.3d 638, 653–54 (2d Cir. 2015). In determining what constitutes such conduct,

"antitrust jurisprudence is neither [] rigid, nor [] formulaic." *Sitts v. Dairy Farmers of Am., Inc.*, 417 F. Supp. 3d 433, 468 (D. Vt. 2019).

In any event, the Complaint alleges NYP's restrictions diminish the incentives of NYP's rivals to lower prices because doing so would not drive patient volume away from NYP. Compl. ¶ 97. That effectively forecloses competition. In short, the Complaint plausibly alleges that NYP's restrictions undermine selective contracting, lessen price competition, and increase healthcare costs for Plaintiffs and the Class.

CONCLUSION

For the foregoing reasons, Defendant's motion to dismiss should be denied.

Dated: June 30, 2026

Respectfully submitted,

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Word Count Certification

Pursuant to Local Rule 7.1(c), I hereby certify that the total number of words in this motion, excluding the caption, table of contents, table of authorities, signature block, and word count certification is 8,673 words.

s/ *Gregory Asciolla*
Gregory Asciolla

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/ Gregory Asciolla
Gregory Asciolla

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

UFCW LOCAL 1500 WELFARE FUND, *on its own behalf and on behalf of all others similarly situated*, Plaintiffs, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	Case No. 2:25-cv-05023-BMC
CEMENT AND CONCRETE WORKERS DC BENEFIT FUND, *on its own behalf and on behalf of all others similarly situated*, Plaintiffs, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	Case No. 1:25-cv-5571-BMC

DECLARATION OF GREGORY ASCIOLLA IN SUPPORT OF UFCW LOCAL 1500 WELFARE FUND'S RESPONSE TO DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' CONSOLIDATED CLASS ACTION COMPLAINT

I, Gregory Asciolla, hereby declare and state as follows:

1. I am a partner of the law firm DiCello Levitt LLP and am counsel for Plaintiff UFCW Local 1500 Welfare Fund in the above-referenced litigation. I am licensed to practice law in the state of New York and am admitted to practice before this Court. I make this declaration in support of Plaintiff UFCW Local 1500 Welfare Fund's Response to Defendant's Motion to Dismiss Plaintiffs' Consolidated Class Action Complaint. I have personal knowledge of the facts stated in this Declaration and, if called upon, could and would testify competently thereto.

2. Attached hereto as **Exhibit 1** is a true and correct copy of the following pleading: Complaint, *United States v. New York & Presbyterian Hospital*, No. 26-cv-2480 (S.D.N.Y. Mar. 26, 2026), ECF No. 1.

3. Attached hereto as **Exhibit 2** is a true and correct copy of the following pleading: Complaint, *United States v. OhioHealth Corp.*, No. 2:26-cv-00207 (S.D. Ohio Feb. 20, 2026), ECF No. 1.

4. Attached hereto as **Exhibit 3** is a true and correct copy of the following proposed settlement: Proposed Final J., *United States v. OhioHealth Corp.*, No. 2:26-cv-00207 (S.D. Ohio June 16, 2026), ECF No. 29-2.

5. Attached hereto as **Exhibit 4** is a true and correct copy of the following Answer: Answer, *United States v. New York & Presbyterian Hosp.*, No. 26-cv-2480 (S.D.N.Y. May 26, 2026), ECF No. 22.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 30th day of June 2026, in New York, New York.

/s/ *Gregory Asciolla*
Gregory Asciolla

EXHIBIT 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, - against - THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	No. 26 Civ. 2480 **COMPLAINT**

The United States brings this action pursuant to Section 1 of the Sherman Act, 15 U.S.C. § 1, to stop The New York and Presbyterian Hospital ("New York-Presbyterian" or "NYP") from continuing to stifle competition among New York City healthcare providers. NYP's contracts with health insurance companies unlawfully deny patients the choice of insurance plans that prioritize NYP's lower-cost competitors. The United States seeks an order prohibiting NYP from entering into or enforcing these illegal contractual plan design restrictions, which reduce competition among hospitals, raise healthcare costs, and deny consumers seeking healthcare in New York City access to budget-conscious health insurance plans.

INTRODUCTION

1. Healthcare costs weigh heavily on the minds and budgets of American families and businesses. The cost of health insurance is too high, often because many large hospital systems charge high prices. Hospital-driven restraints on the availability of innovative, budget-conscious health insurance plans contribute to these high prices. For years, many price-conscious consumers have sought, and some insurance companies in New York City have tried to offer,

health insurance plans that are designed to give individuals choices that can reduce their healthcare costs.

2. Americans deserve the benefits of vigorous competition between healthcare providers. Robust competition that is unrestrained by NYP's plan design restrictions would be a powerful mechanism to lower healthcare costs for consumers. But rather than compete on price to serve patients who seek healthcare in New York City, NYP has chosen to prevent competition from rival providers.

3. NYP is the largest and most powerful hospital system in Manhattan and throughout New York City. For decades, NYP has used its market power to protect its position—as well as its high prices—by using its leverage over commercial health insurers ("payors") to block them from selling health insurance plans that feature hospitals and other providers that offer lower prices.

4. Consumers benefit when payors negotiate competitive prices with healthcare providers and pass those savings along. Payors can create a budget-conscious insurance plan by designing a network (a group of participating providers) or a benefit structure (*e.g.*, copays and coinsurance) that encourages patients to select providers that offer more competitive prices. For providers, the promise of being featured in this kind of plan is an opportunity to attract more patients by reducing their prices. Providers that elect to keep their prices significantly higher than their rivals' prices risk not being featured in budget-conscious plans and thus losing patient volume.

5. NYP is one of these high-priced providers. It protects its high prices by imposing contractual plan design restrictions ("plan restrictions") that prevent payors from offering budget-conscious insurance plans. NYP's plan restrictions generally forbid payors from offering

plans that either exclude NYP or offer more generous benefits (*e.g.*, lower copays) when patients choose a rival provider. As a result, these restrictions deprive patients of a choice among a full spectrum of competitive health insurance plans, where patients could decide for themselves whether going to NYP for care is worth NYP's high prices.

6. NYP's anticompetitive conduct insulates it from price competition—or, as NYP calls it, "erosion of rates of payment"—and helps it to maintain its high prices. Without its unlawful contracts, NYP would need to compete more vigorously against other providers, and its rivals could compete to attract additional patients by lowering their own prices or investing in quality improvements. All employers and patients who purchase healthcare in New York City would benefit from lower prices and higher quality as the healthcare marketplace becomes more competitive.

7. The United States of America brings this civil antitrust action to stop NYP from using unlawful plan restrictions that lessen healthcare competition in New York City in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. NYP's restrictions deter the emergence and development of money-saving health insurance plans and reduce competition among hospitals and other providers on both price and quality. The result is reduced choice of insurance plans, higher healthcare costs, and less competition for high-quality healthcare for employers and patients who purchase healthcare in New York City.

NEW YORK-PRESBYTERIAN

8. NYP is a not-for-profit healthcare system with its principal place of business in New York City. NYP owns or manages hospitals, outpatient facilities, and physician groups throughout New York City. Its two flagship facilities are New York-Presbyterian/Columbia University Irving Medical Center and New York-Presbyterian/Weill Cornell Medical Center. It

operates a total of eight general acute care hospitals in the New York area, which includes six hospitals in New York City and four hospitals in Manhattan.

9. Although larger and more powerful than its rivals, NYP competes with other hospitals and hospital systems in Manhattan and New York City, including Mount Sinai, NYU Langone, and Northwell, all of which are academic medical centers that offer hospital services. Mount Sinai operates six hospitals in New York City, including four in Manhattan; NYU Langone operates three hospitals in New York City, including two in Manhattan; and Northwell operates six hospitals in New York City, including two in Manhattan.

10. NYP has substantially higher prices than its competitors, even though its major competitors offer similarly high-quality healthcare. For example, NYP's prices are significantly higher than its two largest rivals, NYU Langone and Mount Sinai, which are both academic medical centers with prestigious medical schools, significant research programs, and strong reputations for quality.

11. NYP has market power over payors, which it uses to extract high reimbursement rates for treating commercially insured patients across a range of services. NYP's market power is built on the scale, breadth, and configuration of its providers, including, among other things, its large size, many locations, and strong brand and reputation. NYP leverages its market power to effectively force the major payors that offer commercial insurance to patients in New York City to contract with it on an all-or-nothing basis, which means that the payor must include *all* of NYP's hospitals (including associated outpatient facilities and other healthcare services) in its networks if it wants to have *any* NYP facilities or services in its network. Payors cannot resist this exercise of market power because they cannot viably do business in New York City without at least one plan that includes access to NYP's hospitals. NYP's market power is further

evidenced by its ability to impose on payors the anticompetitive plan restrictions that are the focus of this Complaint.

12. NYP knows the implications of its plan restrictions. In a recent strategic planning document, NYP acknowledged that there is "consumer price sensitivity" among patients. If consumers could act on this sensitivity through budget-conscious plans, NYP may experience "pricing pressure" because of its high prices, which may "impact [NYP's] margins"—that is, the profits it garners from treating patients.

JURISDICTION AND VENUE

13. The Court has subject-matter jurisdiction over this action under 28 U.S.C. §§ 1331, 1337(a), and 1345. Plaintiff brings this action pursuant to Section 4 of the Sherman Act, 15 U.S.C. § 4, to prevent and restrain violations of Section 1 of the Sherman Act, 15 U.S.C. § 1. The Court has personal jurisdiction over NYP under Section 12 of the Clayton Act, 15 U.S.C. § 22. NYP maintains its principal place of business and transacts business in this District.

14. Venue is proper under 28 U.S.C. § 1391 and Section 12 of the Clayton Act, 15 U.S.C. § 22. NYP transacts business and resides in this District and the events giving rise to this action occurred in this District.

15. NYP engages in interstate commerce and in activities substantially affecting interstate commerce. NYP provides healthcare services for which employers, payors, and individual patients remit payments across state lines. NYP also purchases supplies and equipment that are shipped across state lines and otherwise participates in interstate commerce.

HOSPITAL COMPETITION BENEFITS PATIENTS AND EMPLOYERS

16. Hospitals and hospital systems (all called "hospitals" here for convenience) participate in commercial insurance plans that payors sell directly to individuals and, more often,

to employers or other plan sponsors such as unions. Payors individually negotiate reimbursement rates and contract terms with each hospital so that their members can use the hospital's services. Payors design the commercial features, such as premiums, co-payments, and deductibles, for each plan they sell. Two important plan features that payors negotiate with hospitals are the hospitals and other providers to include in each specific plan and how much members will pay for various healthcare services.

17. Many employers and other plan sponsors offer their employees or members a choice among insurance plans that differ in their benefit features because consumers value these features differently. Payors generally offer broad network plans that appeal to consumers who are willing to pay higher premiums for the benefit of access to a broad panel of providers in their area. Payors in competitive markets across the United States also generally offer plans that either allow their members to save money by using a more limited network of cost-effective providers or require members to pay more for choosing more expensive providers. These plan designs create incentives for patients to use certain providers and are sometimes called "steered plans" because they may influence patients' decisions about where to receive treatment. These "steering" features reward competition by allowing hospitals or other providers to compete to be included or featured in the plans.

18. Although not all patients or employers choose to save money by using plans with cost-saving plan designs, patients and their employers deserve the opportunity to make these choices. Health plans that allow patients to save money by choosing not to use high-cost providers may particularly appeal to budget-conscious employers and patients.

19. Budget-conscious plans can take a variety of forms. But they all emphasize competition, either by creating price competition among hospitals and other providers to be

included in a network or by creating competition among hospitals and other providers to attract patients once the provider is included in a health network. The tools that payors can use to create budget-conscious plans can be used either in combination with each other or on their own. Some of these tools are described below.

20. **Narrow network plans** include a relatively limited set of cost-effective providers. When a payor creates a narrow network, it gives providers an incentive to offer competitive prices to participate in the plan in exchange for the added patient volume from being included in the network. Payors recruit cost-effective providers to participate in narrow networks because they are willing to provide services at lower prices. Providers are also sometimes willing to discount their prices to participate in narrow network products in exchange for the incremental flow of patients that may result from being included in a narrow network. Narrow network plans can charge lower premiums to employers and patients than broad network plans because the payors are not paying as much to providers. Some employers will offer employees a choice between narrow and broad network plans, allowing the employee to pay the additional cost for the broad network plan if the employee values the additional provider options.

21. **Tiered network plans** use broad networks but reward members with lower out-of-pocket expenses if they choose cost-effective providers in the preferred tier within the network. For example, a plan may charge members different co-insurance payments for hospitals in different benefit tiers. Payors may assign a lower co-insurance payment to lower-cost hospitals to give members an incentive to use hospitals that offer better value. Members of tiered network plans can choose to receive care from the lower-priced preferred tier of providers or to pay more for care from the more expensive tier of providers.

22. **Centers of excellence** give patients with broad network plans an incentive to seek specific healthcare services from designated groups of providers that offer better value within a broad network. When creating a center of excellence, payors identify specific cost-effective programs of excellent quality—such as orthopedic surgery or oncology programs—and encourage their members to choose care at those facilities by reducing or waiving the fees that the patient must pay. Members can then choose whether to seek care from the "center of excellence" providers that their plan has designated or to seek care from costlier providers at a higher price.

23. **Site of service steering** is a plan feature that saves patients money by incentivizing them to have procedures done in a lower-cost location (site of service)—such as an ambulatory surgery center—instead of a higher-cost site of service, such as a hospital.

24. Because these plan design tools allow members to save money by choosing cost-effective hospitals and other providers while still obtaining high-quality care, they create price and quality competition among providers. Not all patients choose plans with these money-saving features, just as not all consumers choose lower-cost products in other areas of their lives. But the ability to make that choice as a consumer is the very essence of competition. NYP impedes this competition by restricting payors from offering budget-conscious plans that would result in more patients choosing rival hospitals and other providers instead of high-priced NYP providers. NYP's restrictions do not allow the essential features of competition to take hold in New York City.

NEW YORK-PRESBYTERIAN VIOLATES THE SHERMAN ACT

A. New York-Presbyterian's Contractual Restrictions Unlawfully Restrain Competition

25. NYP restricts payors from designing and offering budget-conscious plans that promote competition among healthcare providers. Instead, NYP effectively forces payors to include NYP in almost all networks for commercial insurance products and requires that NYP be featured at the most favored level of benefits in each plan, regardless of how NYP's prices compare to its competitors. Illustrating how NYP insists upon this treatment, NYP told a payor that had attempted to exclude it from a network that NYP "expect[s] to be in every network offered." Rather than compete to earn the opportunity to be in payors' networks through lower prices or better value, NYP relies on its market power to impose contractual restrictions to ensure its participation.

26. NYP's plan restrictions deter the payors that account for a dominant majority of commercial health insurance business in New York City from introducing budget-conscious plans that exclude or charge more for access to NYP's hospitals. Payors that serve New York City already design and offer budget-conscious plans in other parts of the United States. These payors want to provide budget-conscious plans in New York City too but are restrained from doing so by NYP's plan restrictions. For example, a commercial payor repeatedly reported to NYP that it needed "to offer a low-cost insurance option in the NY market," but NYP's unlawful plan restrictions prohibited it from creating a viable product. Similarly, payors have frequently sought to change their plan designs to favor less expensive providers, only to be told by NYP that they are violating their contract with NYP.

B. Inpatient General Acute Care Hospital Services Are a Relevant Product Market

27. Defining a relevant product market helps courts assess, among other things, the products or services for which the defendant wields market power and the anticompetitive impact of the challenged restraints. Although the contractual restrictions imposed by NYP affect both inpatient services and other NYP healthcare services, the sale of inpatient general acute care ("GAC") hospital services to commercial payors and their members is a relevant product market in which to assess the market power that NYP wields and the competitive effects of NYP's contractual restrictions. The market includes sales of such services to payors' individual and group, fully insured and self-funded health plans.

28. Inpatient GAC hospital services consist of a broad group of medical and surgical diagnostic and treatment services provided to adult and pediatric patients that include the patient's overnight stay in the hospital. Although individual inpatient GAC hospital services are not substitutes for each other (*e.g.*, obstetrics is not a substitute for cardiac services), payors typically contract for the various individual inpatient GAC hospital services as a bundle, the services are sold under similar competitive conditions, and NYP's contractual restrictions have an adverse impact on the sale of all inpatient GAC hospital services. Therefore, individual inpatient GAC hospital services can be analyzed together.

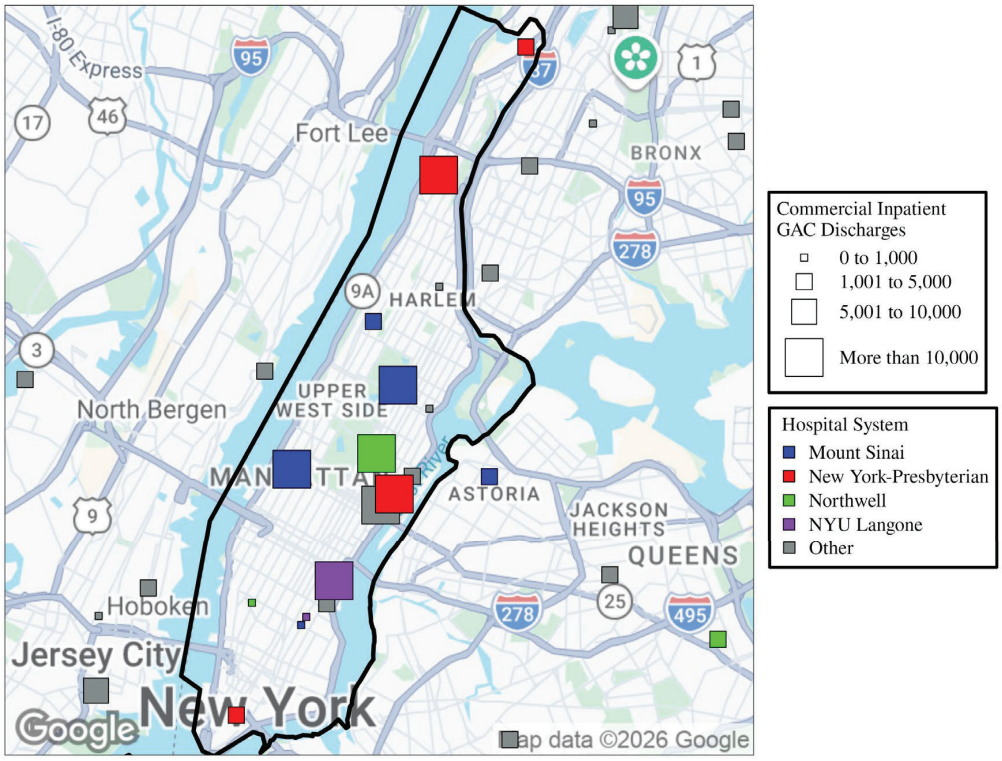
29. Inpatient GAC hospital services do not include psychiatric care, substance abuse, rehabilitation services, or outpatient services, as these services may be offered by a different set of competitors under different conditions from inpatient GAC hospital services and are not substitutes for inpatient GAC hospital services. The relevant market also does not include sales of inpatient GAC hospital services to government payors, *e.g.*, Medicare (covering people age 65 and up or people with certain disabilities or medical conditions), Medicaid (covering low-income

persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations for commercial insurance plans are separate from the process used to determine the rates paid to providers by government payors.

30. There are no reasonable substitutes or alternatives to inpatient GAC hospital services. Consequently, a hypothetical monopolist of inpatient GAC hospital services sold to payors would likely profitably impose a small but significant price increase or other worsening of terms for those services over a sustained period of time.

C. Manhattan, and the Four Boroughs of the Bronx, Brooklyn, Manhattan, and Queens, are Relevant Geographic Markets

31. Defining relevant geographic markets helps courts assess, among other things, the geographic area in which NYP wields market power and the anticompetitive impact of the challenged restraints. The borough of Manhattan is a relevant geographic market. The following map shows the GAC hospitals located in and around Manhattan.

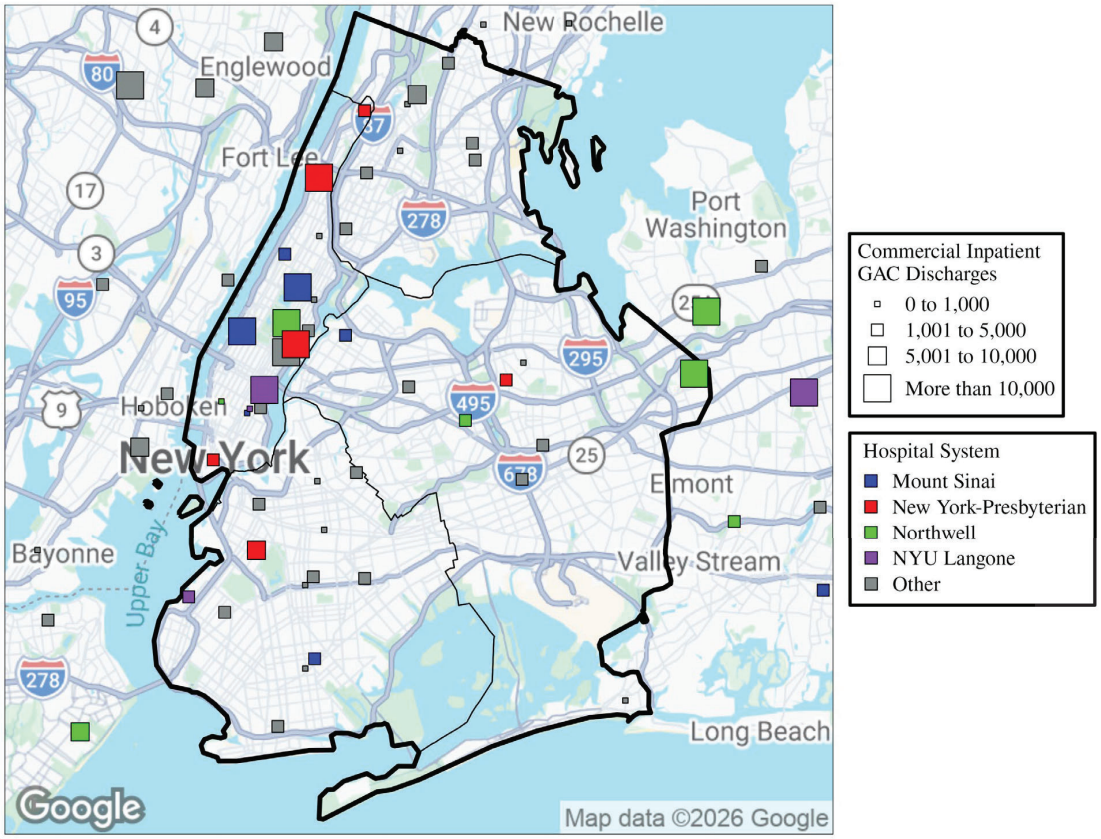


32. Manhattan is a geographic market in which market power in the sale of inpatient GAC hospital services can be exercised. It satisfies the hypothetical monopolist test. A hypothetical monopolist consisting of all hospitals in Manhattan likely would undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Many patients who seek healthcare in New York City prefer to receive inpatient GAC hospital services at the well-regarded hospitals in Manhattan. Because of this, a payor without any in-network hospitals located in Manhattan would not be competitive in selling commercial health plans to many employers and individuals in New York City, including those in Manhattan. To continue selling commercial health insurance to individuals and employers in New York City, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

33. The area comprising the boroughs of the Bronx, Brooklyn, Manhattan, and Queens is also a relevant geographic market (the "Four-Borough Market") in which market power in the sale of inpatient GAC hospital services can be exercised.

34. The Four-Borough Market excludes Staten Island. Few patients using hospitals in the Four-Borough Market consider hospitals located on Staten Island to be a close substitute to hospitals in the Four-Borough Market.

35. The following map shows the GAC hospitals in and around the Four-Borough Market.



36. The Four-Borough Market satisfies the hypothetical monopolist test. A hypothetical monopolist that consists of all hospitals in the Four-Borough Market likely would

undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Patients who seek healthcare in the Four-Borough Market prefer to receive inpatient GAC hospital services at the well-regarded hospitals in the Four-Borough Market and at hospitals that are close to where they live and work. Because of this, a payor without any in-network hospitals located in the Four-Borough Market would not be competitive selling commercial health plans to many employers and individuals in New York City. To continue selling health plans to individuals and to employers in New York City, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

D. New York-Presbyterian Wields Market Power to Harm Competition

37. NYP has market power in inpatient GAC hospital services in Manhattan and the Four-Borough Market. NYP is by far the largest hospital system in both markets. In 2024, NYP's share of inpatient GAC hospital discharges was more than 30 percent in Manhattan and more than 25 percent in the Four-Borough Market.

38. Market power confers the ability to raise prices above those that could be charged in a competitive market, and NYP's supracompetitive rates provide compelling evidence of its possession and exercise of market power. Unlike firms in a competitive market, NYP does not fear losing patients to its rivals if it charges higher prices than they do. NYP's most senior contracting executive testified that its rivals' offering of lower prices to payors "has no relevance to me." NYP can be unconcerned about its competitors' lower prices because NYP's market power allows it to impose plan restrictions that insulate it from price competition.

39. The fact that large payors cannot do business in Manhattan or the Four-Borough Market without contracting with NYP is also telling evidence of NYP's market power. Because of NYP's size, brand, and reputation, and the many hospitals and other providers it controls, a

payor selling health insurance plans to individuals and employers in Manhattan and in the Four-Borough Market must have NYP as a participant in at least some of its provider networks to have successful health insurance products. Without NYP—a large hospital system that is well-known by generations of New Yorkers—an insurance plan would not be attractive to the employers and residents who prefer a broad network plan that covers medical care from the full range of providers.

40. NYP understands that payors must contract with NYP to successfully sell health insurance and exerts this leverage in its negotiations with payors. Payors that sell commercial health insurance plans in the relevant geographic markets have tried to negotiate the removal of plan restrictions from their contracts with NYP, but NYP has summarily refused. The inability of large payors to overcome this costly refusal is further evidence of NYP's market power.

41. NYP's plan restrictions harm the process by which NYP and other Manhattan and Four-Borough Market hospitals would otherwise compete on the prices of the services they sell. Indeed, NYP recognizes the risk of increased competition that would occur without these restrictions in its disclosures to bond holders, noting that "[i]nsurers may further encourage competition among hospitals and providers on the basis of price, payment terms and quality" and that doing so "may lead to increased competition among hospitals based on price where insurance companies attempt to steer patients to the hospitals that have the most favorable contracts."

42. NYP uses its market power in inpatient GAC hospital services to impose both high prices and plan restrictions that obstruct the competitive process. These plan restrictions lessen competition between NYP and the other hospitals that provide inpatient GAC hospital services in Manhattan and the Four-Borough Market. Because of NYP's plan restrictions, NYP's

rivals cannot effectively win more commercially insured business by offering lower prices or better value. The restrictions thus help insulate NYP from price competition and make it difficult for other hospitals to win patients and market share from NYP.

43. NYP recognizes that its plan restrictions protect its high prices. NYP's most senior contracting executive took credit for protecting NYP's plan restrictions and prices. He acknowledged: "Notwithstanding national and local trends to the contrary, [NYP] retained the Hospitals' … terms and conditions that protect against administrative erosion of rates of payment or steerage away from the Hospitals."

44. NYP further recognizes that protecting its high prices through its plan restrictions benefits NYP's bottom line because payors, employers, and consumers would often seek care elsewhere if they had the option to choose budget-conscious plans. For example, during an internal planning process involving some of NYP's most senior executives, NYP calculated the financial impact to NYP if businesses and patients were able to implement budget-conscious plan designs. According to this analysis, the introduction of tiered plans alone would reduce profits by hundreds of millions of dollars, and other forms of steerage would also cause that same outcome for NYP. Similarly, NYP recognized that efforts by payors to incentivize patients to use providers who offer better value "could impact margins, particularly for standardized procedures."

45. NYP has admitted that the mere risk that payors might implement steering in the future could increase competition and reduce prices in its market. In a 2023 bond offering memorandum for the issuance of $300 million of bonds, NYP noted that steering would be a risk to NYP's financial standing: "Payors have used the threat of patient steerage [in other markets] . . . to drive provider prices lower."

46. NYP uses its market power in inpatient GAC hospital services to impose the same plan restrictions on outpatient services. Outpatient services comprise a wide range of diagnostic, treatment, and surgical services that do not require an overnight stay, including but not limited to imaging, infusions, lab services, and less-complex surgeries. Outpatient services can be provided at hospitals but also at freestanding facilities. Outpatient services are included in the same contracts with payors and covered by the same contract terms under which NYP provides inpatient GAC hospital services.

47. NYP's plan restrictions effectively prevent payors from providing incentives to patients to select outpatient services outside of NYP at facilities or other hospitals that charge less and would thus save money for patients and employers. This effectively prevents rival providers or potential new entrants from competing on price to attract patients. For instance, in 2022, NYP invoked its plan restrictions to stop a payor from charging patients lower copays for certain outpatient radiology services performed at less expensive hospitals or at other facilities rather than at NYP's hospitals.

48. NYP's plan restrictions protect its high prices in outpatient services. For example, in 2023, NYP stopped a payor from shifting outpatient colonoscopies away from NYP's hospitals. NYP observed that even stopping a single payor from moving outpatient colonoscopies out of NYP's hospitals was "worth ~250k [dollars] to [a physician group in NYP's system] and multiples more to [NYP]."

49. As a result of this reduced competition from NYP's plan restrictions, individuals and employers who seek healthcare in New York City pay higher prices for health insurance coverage and have fewer insurance plans from which to choose. In the absence of these plan restrictions, payors would be free to offer budget-conscious plans that allow patients to save

money by choosing high-quality and cost-effective hospitals and outpatient services that compete with NYP, such as those offered by NYU Langone or Mount Sinai. NYP might also lower the prices that it charges payors for participating in their broad-network plans if it were forced to compete with its rivals on price through payors' offering or threatening to offer budget-conscious plans.

50. Entry or expansion by other hospitals in the relevant geographic markets has not prevented NYP from exercising its market power by imposing plan restrictions, nor has it counteracted the resulting actual and likely competitive harms. And in the future, such entry or expansion is unlikely to counteract these harms to competition. Building a hospital anywhere in the Four-Borough Market would entail significant time and cost for construction and permitting. And building a hospital with a strong reputation that can attract physicians and patients is difficult, time-consuming, and expensive. In fact, NYP's plan restrictions raise barriers to entry or expansion for healthcare providers by making it significantly more difficult for them to attract more patients by offering lower prices or more value.

51. NYP's restrictions on budget-conscious plans do not have any procompetitive effects. Any arguable benefits of NYP's plan restrictions are outweighed by their actual and likely anticompetitive effects and/or could be achieved through less restrictive means. Without these restrictions, NYP can seek to maintain its patient volume and market share by competing to offer lower prices, higher-quality, and better value than its competitors.

CLAIM FOR RELIEF

52. Plaintiff incorporates paragraphs 1 through 51 of this Complaint.

53. NYP has market power in the sale of inpatient GAC hospital services in Manhattan and in the Four-Borough Market.

54. NYP has and likely will continue to negotiate and enforce contracts containing restrictions on budget-conscious plans with commercial payors in the relevant geographic markets. The contracts containing these plan restrictions are contracts, combinations, and conspiracies within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

55. NYP's contractual restrictions on budget-conscious plans have had, and will likely continue to have, the following substantial anticompetitive effects in the relevant markets, among others:

a. protecting NYP's market power and enabling NYP to maintain at supracompetitive levels the prices of inpatient GAC hospital services;

b. substantially lessening competition among hospitals in their sale of inpatient GAC hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and better value for inpatient GAC hospital services;

d. reducing patients' incentives to seek inpatient GAC hospital services from more cost-effective providers; and

e. depriving New York residents and their employers of the benefits of a competitive market for their purchase of inpatient GAC hospital services.

56. The challenged restrictions unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

RELIEF REQUESTED

WHEREFORE, Plaintiff requests that the Court enter judgment in its favor and provide the following relief:

a. adjudge that all of the restrictions on budget-conscious plans in the contracts between NYP and any commercial payors violate Section 1 of the Sherman Act, 15 U.S.C. § 1;

b. enjoin NYP, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts a payor from offering, or attempting to offer, plans that give or inform members about financial incentives to use any healthcare provider;

c. enjoin NYP from substituting other unlawful and anticompetitive means of restricting budget-conscious plans that would replicate the effects of its plan restrictions;

d. enjoin NYP from retaliating, or threatening to retaliate, against any insurer for offering, or attempting to offer, budget-conscious plans; and

e. award Plaintiff its costs in this action and such other relief as the Court may deem just and proper.

Dated: March 26, 2026

Respectfully submitted,

FOR PLAINTIFF
UNITED STATES OF AMERICA

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EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA, U.S. Department of Justice Antitrust Division 450 Fifth Street, NW, Suite 4100 Washington, DC 20530 and STATE OF OHIO, 30 East Broad Street, 26th Floor Columbus, OH 43215 *Plaintiffs,* v. OHIOHEALTH CORPORATION, 3430 OhioHealth Parkway Columbus, OH 43202 *Defendant.*	)	Case No.: 2:26-cv-207 Judge: Magistrate Judge: **COMPLAINT**

The United States of America and the State of Ohio, for their Complaint against Defendant OhioHealth Corporation ("OhioHealth"), allege as follows:

INTRODUCTION

1. Healthcare costs weigh heavily on the minds and budgets of American families and businesses. The mechanism that ultimately lowers costs for all patients and healthcare consumers is robust and unrestrained competition. Americans deserve the benefits of vigorous competition between healthcare providers. Rather than compete to serve patients in Columbus, Ohio, OhioHealth has chosen to prevent competition from other providers. Through contractual restrictions, OhioHealth restricts commercial health insurers ("payors") from offering health

plans that allow patients to share in the savings that come from choosing to use OhioHealth's lower-cost rivals.

2. OhioHealth has thereby denied patients the ability to choose a health plan that may work better for them—a choice that patients would be free to make in a competitive market unburdened by OhioHealth's burdensome restrictions. OhioHealth's contractual restrictions insulate it from price competition and help to maintain its extremely high prices. The dynamic effect of these contractual restrictions is that OhioHealth is effectively preventing competitors from achieving scale with regard to patients as well as quality.

3. OhioHealth is the dominant hospital system in Columbus. Since at least 2003, it has used its market power to protect its dominance—and its high prices—by blocking payors from offering patients health insurance plans that feature lower-cost hospitals and other providers and even from informing patients that lower-cost options are available.

4. As a result, these restrictions deprive patients of a choice among a full spectrum of competitive health insurance plans, where patients could decide for themselves whether going to OhioHealth for care is worth the high prices it charges. If such plans were available, the employers and patients who choose them would benefit immediately from lower premiums and out-of-pocket costs.

5. Further, without its unlawful contracts, OhioHealth would need to compete more vigorously against other providers. Those other providers could compete for additional patients by lowering their own prices, gaining both business and incentive to make quality-improving investments that would enhance their attractiveness. All employers and patients in the Columbus area would benefit from higher quality and lower prices as the healthcare marketplace became more competitive. More competition means patients and employers would get lower premiums,

lower out-of-pocket healthcare costs, and more insurance plan choices. Yet, OhioHealth's conduct prevents patients from receiving the real, tangible benefits associated with competition.

6. The United States of America and the State of Ohio bring this civil antitrust action to stop OhioHealth from using unlawful contract restrictions that lessen healthcare competition in Columbus. OhioHealth's restrictions that deter the emergence and development of money-saving health insurance plans reduce competition among hospitals and other providers on both price and quality. The result is reduced choice of insurance plans, higher healthcare costs, and less competition for high quality healthcare for Columbus-area patients, employers, and payors, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and Ohio's Valentine Act, Ohio Revised Code §§ 1331.01 *et seq*.

OHIOHEALTH

7. OhioHealth is an Ohio not-for-profit healthcare services corporation, with its principal place of business in Columbus, Ohio. OhioHealth owns or manages hospitals, outpatient facilities, physician groups, and other healthcare services throughout Ohio. Its flagship facility, Riverside Methodist Hospital, is in Columbus, Ohio. OhioHealth owns or manages 16 hospitals in Ohio and is attempting to acquire Fairfield Medical Center in Fairfield County, Ohio.

8. OhioHealth is the dominant hospital system in the Columbus area. The Ohio State University Wexner Medical Center ("Ohio State") competes with OhioHealth in the Columbus area. Ohio State operates an academic medical center and research institution in Columbus that receives referrals for advanced care from throughout Ohio and the midwestern United States. OhioHealth also competes in the Columbus area with Mount Carmel Health System ("Mount Carmel"), which is owned by Trinity Health. Mount Carmel operates five hospitals in the Columbus area and holds a majority joint-venture interest in a sixth.

9. OhioHealth charges payors prices (in the form of "reimbursement rates") that are significantly higher than OhioHealth's competitors.

10. While higher priced, OhioHealth's services are not generally higher quality than those of its local rivals. Indeed, one widely used public measure of hospital safety, the Leapfrog Hospital Safety Grade, reports that OhioHealth's hospitals in the Columbus area often received lower grades than the hospitals of its primary competitors. Other publicly available quality metrics, like Centers for Medicare & Medicaid Services Five-Star Quality Rating System, similarly do not show OhioHealth to be of consistently higher quality than its primary Columbus-area competitors. OhioHealth nevertheless has extracted reimbursement rates from payors that are higher than those of Ohio State, a leading regional academic medical center that operates a top-tier medical school, conducts medical research, and trains physicians in advanced subspecialities through numerous fellowship programs. OhioHealth's prices are also higher than those of Mount Carmel.

11. OhioHealth can extract high reimbursement rates because it exerts market power over payors, as reflected in its high market share. OhioHealth's market power is built upon the scale, breadth, and configuration of its providers, including, among other things, its large size, its many locations, and its control of rural hospitals that payors need to include in at least some hospital networks to maintain network coverage. OhioHealth requires a payor that wants *any* of these providers in its network to include *all* of them in its network. To offer competitive insurance plans to Columbus-area patients, payors need to include access to OhioHealth's hospitals—as well as its many other facilities and providers—in at least some of their provider networks. OhioHealth's market power has enabled it to negotiate high reimbursement rates for

treating insured patients across a range of services. OhioHealth's market power is further evidenced by its ability to impose contractual restrictions on payors that reduce competition.

JURISDICTION

12. The Court has subject-matter jurisdiction over this action under 28 U.S.C. §§ 1331, 1337(a), and 1345. Plaintiff United States brings this action pursuant to Section 4 of the Sherman Act, 15 U.S.C. § 4, to prevent and restrain violations of Section 1 of the Sherman Act, 15 U.S.C. § 1.

13. Plaintiff State of Ohio, by and through its Attorney General, brings this action, pursuant to Section 109.81(A) of the Ohio Revised Code, in its sovereign capacity and as parens patriae on behalf of the citizens, general welfare, and economy of the State of Ohio (a), pursuant to Section 16 of the Clayton Act, to prevent OhioHealth from violating Section 1 of the Sherman Act, 15 U.S.C. § 1; and (b), pursuant to its equitable and/or common law powers and Section 1331.11 of the Ohio Revised Code, to prevent OhioHealth from violating Section 1331.04 of the Ohio Revised Code.

14. The Court has personal jurisdiction over OhioHealth under Section 12 of the Clayton Act, 15 U.S.C. § 22. OhioHealth maintains its principal place of business and transacts business in this District.

VENUE AND INTERSTATE COMMERCE

15. Venue is proper under 28 U.S.C. § 1391 and Section 12 of the Clayton Act, 15 U.S.C. § 22. OhioHealth transacts business and resides in this District and the events giving rise to this action occurred in this District.

16. OhioHealth engages in interstate commerce and in activities substantially affecting interstate commerce. OhioHealth provides healthcare services for which employers, payors, and individual patients remit payments across state lines. OhioHealth also purchases

supplies and equipment that are shipped across state lines, and it otherwise participates in interstate commerce.

HOSPITAL COMPETITION BENEFITS PATIENTS AND EMPLOYERS

17. Hospital systems and hospitals ("hospitals") participate in commercial insurance plans that payors sell directly to individuals and, more often, that payors contract with employers to offer to their employees. Payors individually negotiate reimbursement rates and contract terms with each hospital so that their members can use the hospital's services. Payors design the commercial features of each plan they sell, such as premiums, co-payments, and deductibles. Importantly, as part of their negotiations with hospitals, payors choose which hospitals and other providers will be included in each specific plan as well as how much members pay for various healthcare services.

18. Many employers, or other plan sponsors such as unions, offer their employees or members a choice among insurance plans, as plans differ in what benefits they offer and consumers value these benefits differently. Payors generally offer broad network plans that appeal to consumers willing to pay a premium to have access to virtually all providers in their area. Payors in competitive markets—in other parts of Ohio and across the United States—also generally offer plans that allow their members to save money by using a more limited panel of cost-effective providers or by asking members to pay more for choosing more expensive providers. These plans create incentives for patients to use certain providers and are sometimes called "steered plans" because they may influence patients' decisions about where to receive treatment. These "steering" features reward competition by allowing hospitals or other providers to compete to be included or otherwise featured in the plans.

19. Consumers deserve the benefit of a marketplace where they can pick from differently priced options. This is a common and basic feature of free and competitive markets.

Consumers see these options available to them in their everyday lives. For example, when consumers go to any Columbus grocery store, they can often choose from a range of options that could be considered "good/better/best." Consumers can choose a "best" brand item at a premium price. Consumers may instead choose the "better" or "good" brand at a lower price. The choice of a "better" or "good" brand at a lower price may be particularly attractive to a family looking to stay within a tight household budget.

20. Patients and their employers deserve the opportunity to make these choices when it comes to their healthcare. In other parts of Ohio and the United States, employers and patients choose from different health plans that vary in the size and composition of the provider network, the prices of health insurance premiums, and the cost to visit specific hospitals or other providers. Like the "better" or "good" brands in grocery stores, health plans that limit the availability of healthcare services from high-cost providers may particularly appeal to budget-conscious employers and patients.

21. Budget-conscious plans can take a variety of forms. But they all emphasize competition, either by creating competition among hospitals and other providers to be included in a network or among those hospitals and other providers to attract patients once the provider is included in a health network. The tools that can be used to create and offer these plans can be used either in combination with each other or on their own. Different features of many budget-conscious plans are described below.

22. **Narrow network plans** offer employers and individuals the ability to reduce the cost of health insurance. Narrow networks include a relatively limited set of cost-effective providers. When a payor creates a narrow network, it gives providers an incentive to offer competitive prices to participate in the plan in exchange for the added patient volume that being

included in the new network creates. Payors recruit cost-effective providers to participate in narrow networks precisely because they are willing to provide services at lower prices. Payors are sometimes also able to secure further discounts from providers in exchange for the incremental flow of patients that may result from being included in a narrow network. Narrow network plans can charge lower premiums to employers and patients than broad network plans because the payors are not paying as much to providers. Some employers will offer employees a choice between narrow and broad network plans, allowing the employee to pay the additional cost for the broad network plan if the employee values the additional provider options.

23. **Tiered network plans** use broad networks but reward members with lower out-of-pocket expenses if they choose cost-effective providers within the network when they seek care. For example, a plan may charge members different co-insurance payments for different hospitals. Payors may assign a lower co-insurance payment to lower-cost hospitals to give members an incentive to use hospitals that offer better value. Members of tiered network plans can choose to secure healthcare from the lower-priced favored tier of providers or to pay more for care from the more expensive tier of providers.

24. **Centers of excellence** give patients with broad network plans an incentive to seek specific healthcare services from designated groups of providers that offer better value within a broad network. When creating a center of excellence, payors identify specific high-quality, cost-effective programs—such as orthopedic surgery or oncology programs—at specific providers and encourage their members to choose care at those facilities by reducing or waiving the fees that the patient must pay. Members can then choose whether to seek care from the "center of excellence" providers that its plan has designated or to seek care from costlier providers at a higher price.

25. **Site of service steering** is a plan feature that saves money by incentivizing patients to have procedures done in a lower-cost site of service—such as an ambulatory surgery center—instead of a higher cost site of service, such as a hospital.

26. **Reference-based pricing** is a fixed reimbursement rate for a procedure (often pegged to some reference point like a market average price). The member has the option to seek care from any in-network provider, but the member will bear the additional costs associated with care that is obtained from a provider that charges more than this price.

27. **Active transparency** is payor outreach to members to share pricing information that informs the member's choice of healthcare provider. For example, a payor may call a patient who has scheduled a magnetic resonance imaging ("MRI") procedure at a hospital and explain that the patient could save money by rescheduling the procedure at an outpatient facility where the payor has negotiated a better rate for the procedure. The patient can then choose where to get the MRI with the benefit of additional information about the cost to the patient.

28. Not all patients may choose plans with these money-saving features, just as not all consumers choose lower-cost products at the grocery store. But the personal agency to make that choice as a consumer is the very essence of competition.

29. Because these plan designs allow members to save money and obtain high-quality care by choosing cost-effective hospitals and other providers, they create price and quality competition among providers. As rival providers gain patient volume from participating in these plans, and as these plans gain members when patients are given the agency to choose among plans, more efficient rival providers obtain revenues to invest in quality improvements. Patients also experience good outcomes as they benefit from competition for quality, enabling rival providers to mitigate the reputational and informational barriers that dominant providers erect in

the marketplace. In short, the ability of payors to offer a variety of network plans and configurations generates a virtuous cycle of competition among providers.

30. This, of course, is the essence of how competition benefits society. But OhioHealth impedes this competition by restricting payors from offering budget-conscious plan designs that would result in patients choosing rival hospitals and other providers instead of high-priced OhioHealth providers. OhioHealth's restrictions do not allow the essential features of competition to take hold in Columbus.

OHIOHEALTH VIOLATES THE SHERMAN ACT AND THE VALENTINE ACT

I. OhioHealth's Contractual Restrictions Unlawfully Restrain Competition

31. Payors must include OhioHealth in at least some of their plans to offer commercially viable health insurance in the Columbus area. OhioHealth has used its dominance to contractually restrict payors who want to include OhioHealth in any of their plans from offering budget-conscious plans, with the effect of protecting itself against price competition for healthcare services. These restrictions prevent rival hospitals or other providers from competing for more patient volume by lowering their rates. In so doing, the restrictions enable OhioHealth to continue to charge supracompetitive prices without the consequence of losing patient volume.

32. Except for limited carve outs, OhioHealth restricts payors from offering budget-conscious plan designs that promote competition among healthcare providers by effectively forcing them to include OhioHealth in all networks for all commercial insurance products, regardless of how OhioHealth's prices compare to its competitors, and requiring that OhioHealth be featured at the most favored level of benefits in each network.

33. OhioHealth's contractual restrictions effectively prevent the payors that account for at least 85% of commercial health insurance business in the Columbus area from introducing

budget-conscious plans. OhioHealth's restrictions inhibit the implementation of each and every one of the tools for creating budget-conscious plans described above.

34. OhioHealth's contractual provisions with payors also severely limit payors' efforts to increase transparency about the price of healthcare services in the Columbus area, thereby depriving patients of information they need to make good decisions. OhioHealth's contract provisions prevent payors from even providing patients with truthful information about the prices of healthcare services they may receive. These restrictions act effectively as gag rules. They prevent transparency by limiting the dissemination of price information or by setting other burdensome requirements on its disclosure. Patients, deprived of price information because of OhioHealth's restrictions, are deprived of their agency as purchasers of healthcare. They are unable to make price-conscious decisions, let alone shop around to consider obtaining healthcare services from OhioHealth's more cost-effective competitors.

35. These restrictions on budget-conscious plans and price transparency, in turn, deter OhioHealth's competitors from competing for patients by reducing prices or improving quality.

36. As a result of OhioHealth's anticompetitive conduct, patients and employers in the Columbus area likely pay more for healthcare and are less informed about the costs of healthcare than they would be if OhioHealth did not impose these contractual restrictions.

37. Payors that serve the Columbus area already offer budget-conscious plan designs in other parts of Ohio and in large parts of the United States. These payors want to provide these budget-conscious plans in the Columbus area but are restrained from doing so by OhioHealth's restrictions.

II. The Relevant Market and Anticompetitive Effects

A. Relevant Product Market

38. Defining a relevant product market helps courts assess, among other things, the products or services for which a contract restrains trade. Although the contractual restrictions imposed by OhioHealth affect both inpatient services and OhioHealth's other healthcare services, the sale of inpatient general acute care ("GAC") hospital services to commercial payors and their members is a relevant product market in which to assess the market power that OhioHealth wields and the competitive effects of OhioHealth's contractual restrictions.

39. Inpatient GAC hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual inpatient GAC hospital services are not substitutes for each other (*e.g.*, obstetrics is not a substitute for cardiac services), payors typically contract for the various individual inpatient GAC hospital services as a bundle, and the services are sold under similar competitive conditions, and OhioHealth's contractual restrictions have an adverse impact on the sale of all inpatient GAC hospital services. Therefore, inpatient GAC hospital services can be aggregated for analytical convenience.

40. There are no reasonable substitutes or alternatives to inpatient GAC hospital services. Consequently, a hypothetical monopolist of inpatient GAC hospital services sold to payors would likely profitably impose a small but significant price increase or other worsening of terms for those services over a sustained period of time.

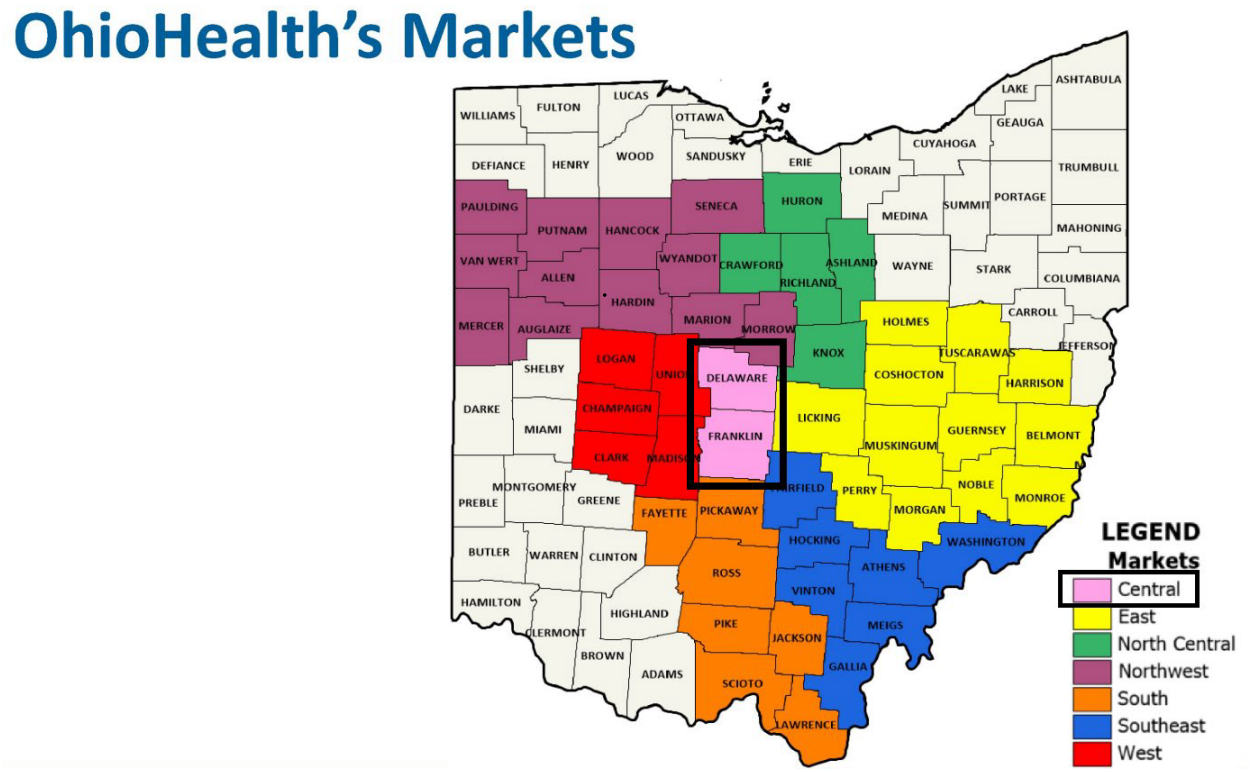
41. Inpatient GAC hospital services do not include psychiatric care, substance abuse, rehabilitation services, pediatrics services, or outpatient services, as these services may be offered by a different set of competitors under different conditions from inpatient GAC hospital services and are not substitutes for inpatient GAC hospital services. The relevant market also

does not include sales of inpatient GAC hospital services to government payors, *e.g.*, Medicare (covering people age 65 and up or people with certain disabilities or medical conditions), Medicaid (covering low-income persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations for commercial insurance plans are separate from the process used to determine the rates paid to providers by government payors. OhioHealth jointly negotiates inpatient GAC hospital services with all of the other services it offers in its contracts with payors, and its contract restrictions bind and impact competition for its full suite of service offerings.

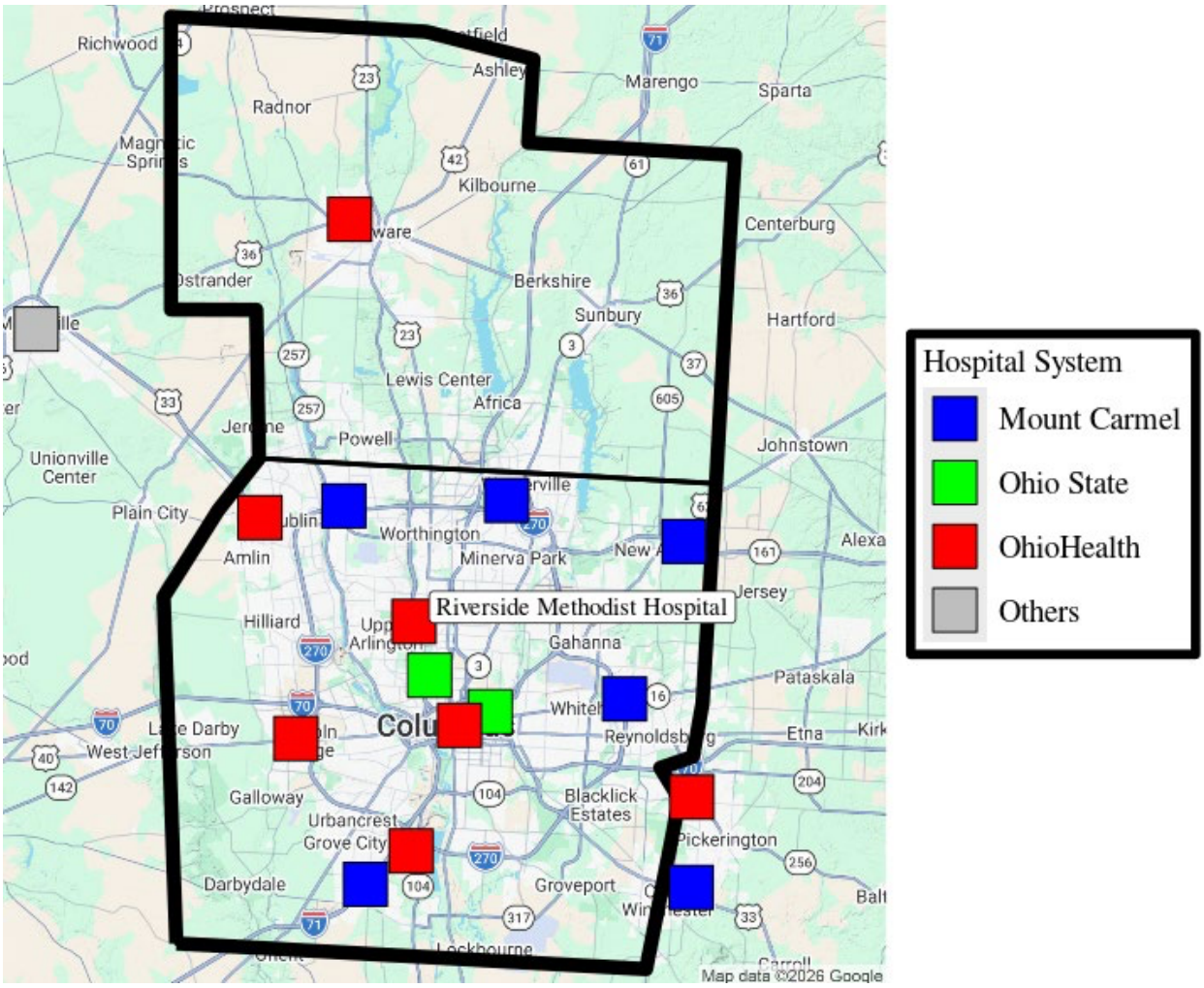
B. Relevant Geographic Market

42. Defining relevant geographic markets helps courts assess, among other things, the market power wielded by OhioHealth and the anticompetitive impact of the challenged restraints. The area comprising Franklin and Delaware counties in Ohio is a relevant geographic market.

43. OhioHealth, in the ordinary course of its business, identifies Central Columbus as a distinct region for the delivery of healthcare services, and defines it as Franklin and Delaware counties. For example, a November 2024 Market Share Update prepared by OhioHealth shows the following map:



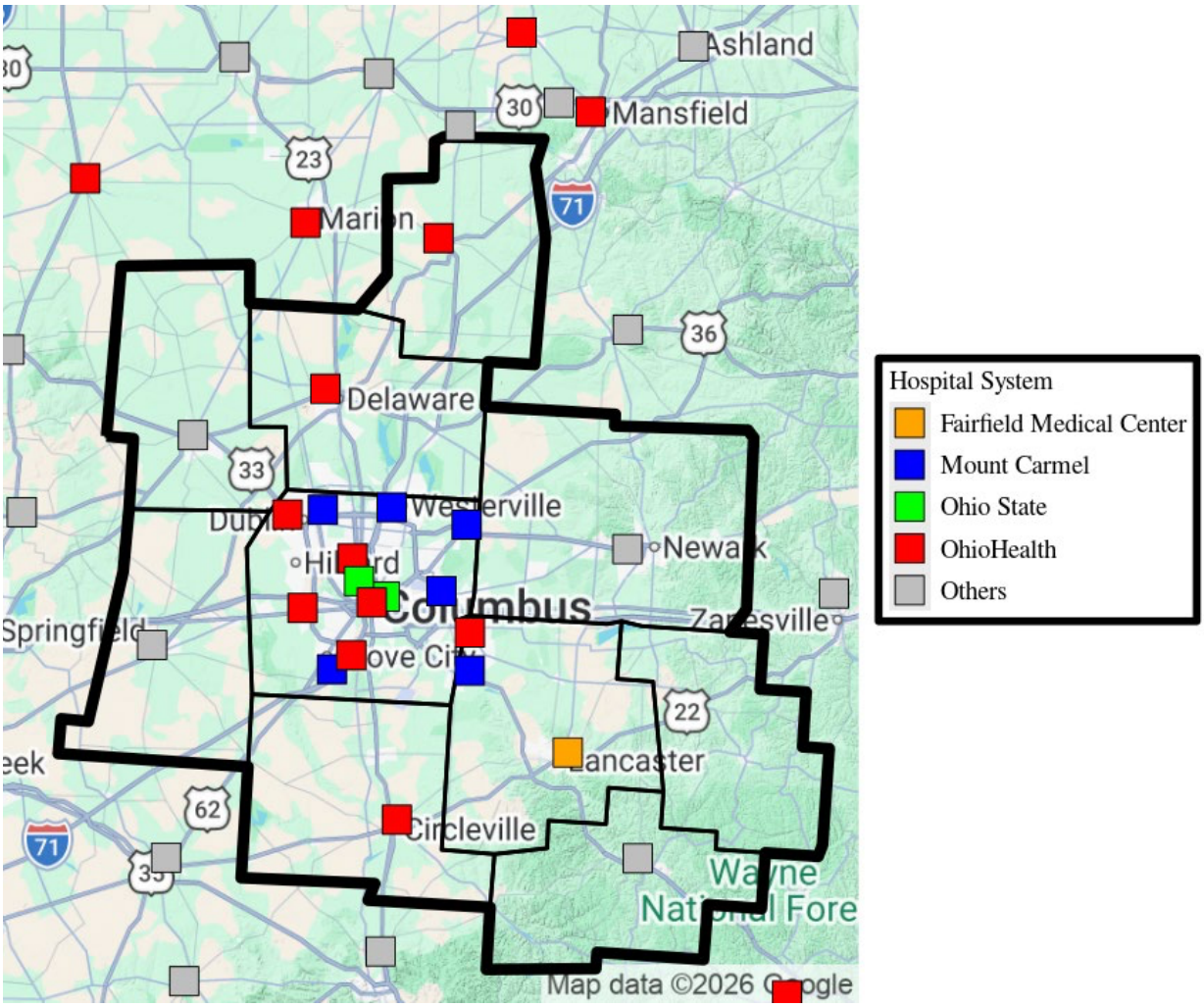
44. For purposes of this Complaint, the area comprising Franklin and Delaware counties is called Central Columbus. Central Columbus contains most of the city of Columbus, Ohio. OhioHealth's flagship hospital is in the Central Columbus market, as are five other OhioHealth hospitals. Central Columbus is home to more than 1.5 million Ohioans who prefer to obtain care from hospitals located in Central Columbus. The following map shows the GAC hospitals located in and around Central Columbus.



45. Central Columbus is a geographic market in which market power in the sale of inpatient GAC hospital services can be exercised. It satisfies the hypothetical monopolist test. A hypothetical monopolist consisting of all hospitals in Central Columbus likely would undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Patients in Central Columbus prefer to receive inpatient GAC hospital services at hospitals that are close to their homes. Because of this, a payor without any in-network hospitals located in Central Columbus would not be competitive selling commercial health plans in Central Columbus. To continue selling commercial health insurance

to individuals and to employers in Central Columbus, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

46. The area not larger than the Columbus Metropolitan Statistical Area ("MSA"), as defined by the U.S. Office of Management and Budget, is also a relevant geographic market in which market power in the sale of inpatient GAC hospital services can be exercised. This market includes the counties of Delaware, Fairfield, Franklin, Hocking, Licking, Madison, Morrow, Perry, Pickaway, and Union. This Complaint refers to these 10 counties as the Columbus MSA. The following map shows the GAC hospitals in and around the Columbus MSA.



47. A market of the Columbus MSA satisfies the hypothetical monopolist test. A hypothetical monopolist consisting of all hospitals in the Columbus MSA likely would undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Patients in the Columbus MSA prefer to receive inpatient GAC hospital services at hospitals that are close to their homes. Because of this, a payor without any in-network hospitals located in the Columbus MSA would not be competitive selling commercial health plans in the Columbus MSA. To continue selling health plans to individuals and to employers in the Columbus MSA, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

C. Market Power and Anticompetitive Effects

48. OhioHealth has market power in inpatient GAC hospital services in the relevant geographic markets. Other than OhioHealth, Ohio State and Mount Carmel are the only hospital systems that provide inpatient GAC services in Central Columbus. In the broader Columbus MSA, these three hospital systems control more than 85% of inpatient GAC discharges.

49. In 2023, OhioHealth's share of inpatient GAC discharges was more than 35% in both the Central Columbus and Columbus MSA markets. Similarly, OhioHealth controls more than 35% of inpatient GAC hospital beds in the Columbus MSA market and the Central Columbus market. OhioHealth's market shares have been growing, and in 2023, an internal OhioHealth document reported "OhioHealth maintains strong market position" and "strong profitability." Market power confers the ability to raise prices above those that could be charged

in a competitive market, and OhioHealth's supracompetitive rates provide compelling evidence of its possession and exercise of market power.

50. Because of OhioHealth's size and the many hospitals it controls, a payor selling health insurance plans to individuals and employers in the Columbus MSA and in Central Columbus must have OhioHealth as a participant in at least some of its provider networks to have viable health insurance products. OhioHealth also derives market power from its control of hospitals outside of the Columbus MSA, some of which are the only hospitals in their counties. Payors need those hospitals in their provider networks. This market power gives OhioHealth the ability to ward off competition by imposing restrictions in its contracts with payors that inhibit payors from offering budget-conscious plans.

51. Payors that sell commercial health insurance plans in the relevant geographic markets have tried to negotiate the removal of these restrictions from their contracts with OhioHealth, but OhioHealth has summarily refused. Because of OhioHealth's market power, payors have had to agree to those restrictions. In the absence of these contractual restrictions, payors would be free to offer budget-conscious plans that allow patients to save money by choosing high quality and cost-effective hospitals, such as Ohio State or Mount Carmel. OhioHealth's contractual restrictions short circuit the competitive process and thereby lessen competition between OhioHealth and the other hospitals that provide inpatient GAC hospital services in the Columbus area, including Ohio State and Mount Carmel. Because of OhioHealth's contractual restrictions, OhioHealth's rivals are impeded in their efforts to win more commercially insured business by offering lower prices or higher value. The restrictions thus help insulate OhioHealth from competition and make it difficult for other hospitals to win market share from dominant OhioHealth. This failure of market forces, induced by OhioHealth's

contractual restrictions, harms the process by which OhioHealth and other Columbus-area hospitals would otherwise compete on the prices of the services they sell.

52. OhioHealth's restrictions on budget-conscious plans further harm competition by hindering OhioHealth's rival hospitals from expanding and improving over time. Denied the ability to attract new patients via these plans, non-dominant rivals lose the opportunity to demonstrate what they offer to patients and to build their reputation and consumer loyalty. This in turn deprives them of the larger patient volume that could make new investments in services viable, further hurting patients and buttressing OhioHealth's ability to charge higher prices than it could if competition were not restricted.

53. Because OhioHealth's contractual restrictions apply to all of the services it sells to payors, including inpatient GAC hospital services, outpatient services, physician services, and ancillary services such as labs and imaging, they impact competition across these services. In addition to hindering expansion by its rivals and preventing payors from featuring lower-cost providers, they create a barrier to entry by new providers of these services. Prospective entrants cannot, as in competitive markets, hope to attract patients by offering quality services at lower prices than the incumbents. This further harms consumers in the Columbus area.

54. As a result of this reduced competition due to OhioHealth's contractual restrictions, individuals and employers in the Columbus area pay higher prices for health insurance coverage and have fewer insurance plans from which to choose. Deprived of price transparency and the ability to benefit from choosing more cost-effective providers, Columbus-area patients incur higher out-of-pocket costs for their healthcare.

55. OhioHealth's restrictions on budget-conscious plans do not have any procompetitive effects. Any arguable benefits of OhioHealth's contractual restrictions are

outweighed by their actual and likely anticompetitive effects and/or could be achieved through less restrictive means. Without these restrictions, OhioHealth can seek to maintain its patient volume and market share by competing to offer lower prices, higher-quality, and better value than its competitors.

56. Entry or expansion by other hospitals in the Columbus area has not counteracted the actual and likely competitive harms resulting from OhioHealth's restrictions on budget-conscious plans. And in the future, such entry or expansion is unlikely to counteract these harms to competition. Building a hospital with a strong reputation that can attract physicians and patients is difficult, time-consuming, and expensive. In fact, OhioHealth's restrictions raise barriers to entry for hospitals and other providers by making it virtually impossible for them to attract more patients by offering lower prices or more value.

CLAIMS FOR RELIEF

First Claim

(Sherman Act, 15 U.S.C. § 1)

57. Plaintiffs incorporate paragraphs 1 through 56 of this Complaint.

58. OhioHealth has market power in the sale of inpatient GAC hospital services in the Columbus MSA and in Central Columbus.

59. OhioHealth has and likely will continue to negotiate and enforce contracts containing restrictions on budget-conscious plans with commercial payors in the Columbus area. The contracts containing these restrictions are contracts, combinations, and conspiracies within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

60. OhioHealth's contractual restrictions on budget-conscious plans have had, and will likely continue to have, the following substantial anticompetitive effects in the relevant markets, among others:

a. protecting OhioHealth's market power and enabling OhioHealth to maintain at supracompetitive levels the prices of inpatient GAC hospital services;

b. substantially lessening competition among hospitals in their sale of inpatient GAC hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for inpatient GAC hospital services;

d. reducing patients' incentives to seek inpatient GAC hospital services from more cost-effective providers;

e. creating barriers to entry and expansion by rival providers of inpatient GAC hospital services; and

f. depriving payors and their members of the benefits of a competitive market for their purchase of inpatient GAC hospital services.

61. The challenged restrictions unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

Second Claim

(Valentine Act, Section 1331.04 of the Ohio Revised Code)

62. The State of Ohio incorporates paragraphs 1 through 61 of this Complaint.

63. Through the exercise of market power, OhioHealth has induced payors to agree to the contracts containing restrictions on budget-conscious plans, and it has exploited its market

dominance to maintain and preserve the restrictions and prevent payors from negotiating procompetitive contract terms.

64. OhioHealth has thereby entered into combinations with payors for the purpose of creating and carrying out restrictions in trade or commerce, creating trusts under Section 1331(C)(1)(a) of the Ohio Revised Code, and each such combination, contract, or agreement in the form of a trust constitutes an illegal conspiracy against trade in violation of Section 1331.04 of the Ohio Revised Code.

RELIEF REQUESTED

65. WHEREFORE, Plaintiffs request that the Court enter judgment in their favor and provide the following relief:

a. adjudge that all of the restrictions on budget-conscious plans in the contracts between OhioHealth and any commercial payors violate Section 1 of the Sherman Act, 15 U.S.C. § 1, and Sections 1331.01(C)(1)(a) and 1331.04 of the Valentine Act;

b. enjoin OhioHealth, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts a payor from offering, or attempting to offer, plans that give members information and financial incentives to use any healthcare provider;

c. enjoin OhioHealth from substituting other unlawful and anticompetitive means of restricting budget-conscious benefit designs that would replicate the effects of its contractual restrictions;

d. enjoin OhioHealth from retaliating, or threatening to retaliate, against any insurer for offering, or attempting to offer, budget-conscious plans; and

e. award Plaintiffs their costs in this action and such other relief as the Court may deem just and proper.

Dated: February 20, 2026

Respectfully submitted,

FOR PLAINTIFF
UNITED STATES OF AMERICA

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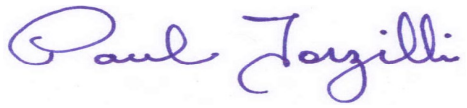
Assistant Chief, Healthcare and Consumer Products Section



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JS 44 (Rev. 03/24)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

United States Department of Justice, Antitrust Division
State of Ohio

(b) County of Residence of First Listed Plaintiff N/A
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

See attachment

DEFENDANTS

OhioHealth Corporation

County of Residence of First Listed Defendant Franklin
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

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II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- [x] 1 U.S. Government Plaintiff
- [ ] 2 U.S. Government Defendant
- [ ] 3 Federal Question *(U.S. Government Not a Party)*
- [ ] 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	[ ] 1	[ ] 1	Incorporated *or* Principal Place of Business In This State	[ ] 4	[ ] 4
Citizen of Another State	[ ] 2	[ ] 2	Incorporated *and* Principal Place of Business In Another State	[ ] 5	[ ] 5
Citizen or Subject of a Foreign Country	[ ] 3	[ ] 3	Foreign Nation	[ ] 6	[ ] 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- [ ] 110 Insurance
- [ ] 120 Marine
- [ ] 130 Miller Act
- [ ] 140 Negotiable Instrument
- [ ] 150 Recovery of Overpayment & Enforcement of Judgment
- [ ] 151 Medicare Act
- [ ] 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- [ ] 153 Recovery of Overpayment of Veteran's Benefits
- [ ] 160 Stockholders' Suits
- [ ] 190 Other Contract
- [ ] 195 Contract Product Liability
- [ ] 196 Franchise

REAL PROPERTY
- [ ] 210 Land Condemnation
- [ ] 220 Foreclosure
- [ ] 230 Rent Lease & Ejectment
- [ ] 240 Torts to Land
- [ ] 245 Tort Product Liability
- [ ] 290 All Other Real Property

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- [ ] 315 Airplane Product Liability
- [ ] 320 Assault, Libel & Slander
- [ ] 330 Federal Employers' Liability
- [ ] 340 Marine
- [ ] 345 Marine Product Liability
- [ ] 350 Motor Vehicle
- [ ] 355 Motor Vehicle Product Liability
- [ ] 360 Other Personal Injury
- [ ] 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- [ ] 365 Personal Injury - Product Liability
- [ ] 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- [ ] 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
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- [ ] 380 Other Personal Property Damage
- [ ] 385 Property Damage Product Liability

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- [ ] 442 Employment
- [ ] 443 Housing/ Accommodations
- [ ] 445 Amer. w/Disabilities - Employment
- [ ] 446 Amer. w/Disabilities - Other
- [ ] 448 Education

PRISONER PETITIONS

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- [ ] 463 Alien Detainee
- [ ] 510 Motions to Vacate Sentence
- [ ] 530 General
- [ ] 535 Death Penalty

Other:
- [ ] 540 Mandamus & Other
- [ ] 550 Civil Rights
- [ ] 555 Prison Condition
- [ ] 560 Civil Detainee - Conditions of Confinement

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- [ ] 625 Drug Related Seizure of Property 21 USC 881
- [ ] 690 Other

LABOR
- [ ] 710 Fair Labor Standards Act
- [ ] 720 Labor/Management Relations
- [ ] 740 Railway Labor Act
- [ ] 751 Family and Medical Leave Act
- [ ] 790 Other Labor Litigation
- [ ] 791 Employee Retirement Income Security Act

IMMIGRATION
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- [ ] 465 Other Immigration Actions

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- [ ] 423 Withdrawal 28 USC 157

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- [ ] 820 Copyrights
- [ ] 830 Patent
- [ ] 835 Patent - Abbreviated New Drug Application
- [ ] 840 Trademark
- [ ] 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- [ ] 861 HIA (1395ff)
- [ ] 862 Black Lung (923)
- [ ] 863 DIWC/DIWW (405(g))
- [ ] 864 SSID Title XVI
- [ ] 865 RSI (405(g))

FEDERAL TAX SUITS
- [ ] 870 Taxes (U.S. Plaintiff or Defendant)
- [ ] 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- [ ] 375 False Claims Act
- [ ] 376 Qui Tam (31 USC 3729(a))
- [ ] 400 State Reapportionment
- [x] 410 Antitrust
- [ ] 430 Banks and Banking
- [ ] 450 Commerce
- [ ] 460 Deportation
- [ ] 470 Racketeer Influenced and Corrupt Organizations
- [ ] 480 Consumer Credit (15 USC 1681 or 1692)
- [ ] 485 Telephone Consumer Protection Act
- [ ] 490 Cable/Sat TV
- [ ] 850 Securities/Commodities/ Exchange
- [ ] 890 Other Statutory Actions
- [ ] 891 Agricultural Acts
- [ ] 893 Environmental Matters
- [ ] 895 Freedom of Information Act
- [ ] 896 Arbitration
- [ ] 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- [ ] 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- [x] 1 Original Proceeding
- [ ] 2 Removed from State Court
- [ ] 3 Remanded from Appellate Court
- [ ] 4 Reinstated or Reopened
- [ ] 5 Transferred from Another District *(specify)*
- [ ] 6 Multidistrict Litigation - Transfer
- [ ] 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
15 U.S.C. § 1

Brief description of cause:
Unreasonable restraint of trade

VII. REQUESTED IN COMPLAINT:

[ ] CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: [ ] Yes [x] No

VIII. RELATED CASE(S) IF ANY *(See instructions)*:

JUDGE _____ DOCKET NUMBER _____

DATE
Feb 20, 2026

SIGNATURE OF ATTORNEY OF RECORD
/s/ Paul Torzilli

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related cases, if any. If there are related cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

Attachment to JS-44

Attorneys of Record for Plaintiff United States of America:

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Antitrust Division
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Washington, D.C. 20530
202-476-0547

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Attorney of Record for Plaintiff State of Ohio:

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Principal Assistant Attorney General
Antitrust Section
615 West Superior Avenue, 11th Floor
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216-787-4484

EXHIBIT 3

EXHIBIT B

[Proposed] Final Judgment

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA, and STATE OF OHIO Plaintiffs, v. OHIOHEALTH CORPORATION, Defendant.	Case No. 2:26-cv-207 Judge Algenon L. Marbley Magistrate Judge S. Courter M. Shimeall

[PROPOSED] FINAL JUDGMENT

WHEREAS, Plaintiffs, United States of America and the State of Ohio, filed their Complaint on February 20, 2026;

AND WHEREAS, the United States, State of Ohio, and Defendant, OhioHealth Corporation ("OhioHealth"), have consented to entry of this Final Judgment without the taking of testimony, without trial or adjudication of any issue of fact or law, and without this Final Judgment constituting any evidence against or admission by any party relating to any issue of fact or law;

AND WHEREAS, Defendant has signed a stipulation agreeing to be bound by the provisions of this Final Judgment pending its approval by this Court;

AND WHEREAS Defendant agrees to undertake certain actions and refrain from certain conduct for the purpose of remedying the anticompetitive effects alleged in the Complaint;

AND WHEREAS, Defendant represents that the relief required by this Final Judgment can and will be made and that Defendant will not later raise a claim of hardship or difficulty as grounds for asking the Court to modify any provision of this Final Judgment;

NOW THEREFORE, it is ORDERED, ADJUDGED, AND DECREED:

I. JURISDICTION

The Court has jurisdiction over the subject matter of, and each of the parties to, this action. The Complaint states a claim upon which relief may be granted against Defendant under Section 1 of the Sherman Act, as amended, 15 U.S.C. § 1, and Ohio's Valentine Act, Ohio Revised Code Sections 1331.01 *et seq*.

II. DEFINITIONS

As used in this Final Judgment:

A. "Benefit Plan" means a specific set of Healthcare Services that is made available to a Payor's members through a health plan underwritten by an insurer, a self-funded benefit plan, or a Medicare Part C plan. The term "Benefit Plan" does not include workers' compensation programs, Medicare (except Medicare Part C plans), Medicaid, or uninsured discount plans.

B. "Broad Network" means a network that offers a full range of Healthcare Services to a Payor's members and is not significantly limited in the number of Providers in the network.

C. "Broad Network Benefit Plan" means any Benefit Plan that is offered with a Broad Network.

D. "Center of Excellence" means a feature of a Benefit Plan that designates Providers of certain Healthcare Services based on objective quality or quality-and-price criteria in order to encourage patients to obtain such Healthcare Services from those designated Providers.

E. "Commercial Benefit Plan" means a "Benefit Plan" that does not include Medicare Part C plans.

F. "Defendant" means OhioHealth Corporation, an Ohio Healthcare Services corporation with its headquarters in Columbus, Ohio, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships, and joint ventures, and their directors, officers, managers, agents, and employees.

G. "Healthcare Services" mean any or all inpatient services, outpatient services, professional services, and ancillary services. "Healthcare Services" does not mean management of patient care, such as through population health programs or employee or group wellness programs.

H. "Including" means including, but not limited to.

I. "Narrow Network" means a network composed of a significantly limited number of Providers that offers a range of Healthcare Services to a Payor's members.

J. "Payor" means any Person providing commercial health insurance or access to Provider networks, including managed-care organizations, and rental networks (i.e., entities that lease, rent, or otherwise provide direct or indirect access to a proprietary network of Providers), regardless of whether that entity bears any risk or makes any payment relating to the provision of healthcare. The term "Payor" includes Persons that provide Medicare Part C plans but does not include Medicare (except Medicare Part C plans), Medicaid, or TRICARE, or entities that

otherwise contract on behalf of Medicare (except Medicare Part C plans), Medicaid, or TRICARE.

K. "Penalize" means using any contract term or taking any action that has the actual or likely effect of restraining, discouraging, or reducing Steering through the use of Steered Plans or Transparency. The term "Penalize" has a meaning that is broader than "prohibit" or "prevent." In determining whether any contract provision or action "Penalizes" Steering, factors that may be considered include: the facts and circumstances relating to the contract provision or action and its economic impact.

L. "Person" means any natural person, corporation, company, partnership, joint venture, firm, association, proprietorship, agency, board, authority, commission, office, or other business or legal entity.

M. "Provider" means all of any part of any Person delivering any Healthcare Service. For avoidance of doubt, two different hospitals owned by the same corporation or other business entity are each a Provider.

N. "Reference-Based Pricing" means a feature of a Benefit Plan pursuant to which a Payor pays up to a uniformly-applied defined contribution, based on an external price set by the Payor, with the Payor's member being required to pay the remainder of the full price charged for a Healthcare Service. However, a Benefit Plan with Reference-Based Pricing as a feature may permit a Payor to pay a portion of this remainder.

O. "Relevant Payors" means any Payor with which Defendant has a contractual relationship, or that contacts or communicates with the Defendant about contracting for Defendant's participation in a Benefit Plan or Provider network.

P. "Site-of-Service Steering" means a feature of a Benefit Plan pursuant to which a Payor requires or encourages, including by providing different levels of benefits, its members to obtain certain Healthcare Services at specific facilities or types of facilities.

Q. "Steered Plan" means any Benefit Plan with one or more forms of Steering. Steered Plans include, but are not limited to, Narrow Network Benefit Plans, Tiered Network Benefit Plans, or any Benefit Plans with Reference-Based Pricing, Site-of-Service Steering, or a Center of Excellence as a component.

R. "Steered" or "Steering" means a Payor providing any incentive to that Payor's members to seek care at specific Providers or types of Providers.

S. "Tiered Network" means a network of Providers (i) that a Payor divides into different sub-groups based on objective price, access, and/or quality criteria; and (ii) for which a Payor's members receive different levels of benefits when they use Healthcare Services from Providers in the different sub-groups.

T. "Transparency" means communication of any price, cost, quality, or patient experience information directly or indirectly by a Payor to its members or other Persons that contract with the Payor for access to a Benefit Plan or Plans.

III. APPLICABILITY

This Final Judgment applies to Defendant, as defined above, and all other Persons in active concert with, or participation with, Defendant who receive actual notice of this Final Judgment.

IV. PROHIBITED CONDUCT

A. Any and all of Defendant's contract provisions that prohibit, deter, prevent, or Penalize Steering, Steered Plans, or Transparency are void and unenforceable. For example, the

contract language reproduced in Exhibit A is void, and Defendant may not enforce or attempt to enforce it.

B. Defendant must not seek or obtain any contract provision that would prohibit, deter, prevent, or Penalize Steering, Steered Plans, or Transparency, including:

1. requirements of prior approval for the introduction of new Benefit Plans; or

2. requirements that Defendant be included in the most-preferred tier of Benefit Plans, though Defendant may seek to participate in the most-preferred tier of a Benefit Plan.

C. Defendant must not take any action that Penalizes, or threatens to Penalize, a Payor for (i) providing (or planning to provide) Transparency, (ii) engaging in (or planning to engage in) Steering, or (iii) designing, offering, expanding, or marketing (or planning to design, offer, expand, or market) a Steered Plan.

D. Defendant must not seek or obtain any contract provision that prohibits, deters, prevents, or Penalizes Steering, Steered Plans, or Transparency, including by requiring that Defendant be included in the most-preferred tier of any Benefit Plan. However, notwithstanding this Paragraph IV.D, Defendant may enter into a contract with any Payor that provides Defendant with the right to participate in the most-preferred tier of a Benefit Plan under the same terms and conditions as any other Provider, provided that if Defendant declines to participate in the most-preferred tier of that Benefit Plan, then Defendant must participate in that Benefit Plan on terms and conditions that are substantially the same as any terms and conditions of any then-existing broad-network Benefit Plan (*e.g.*, PPO plan) in which Defendant participates with that Payor. Additionally, notwithstanding Paragraph IV.D, nothing in this Final Judgment prohibits

Defendant from obtaining any criteria used by the Payor to (i) assign Providers to each tier in any Tiered Network; and/or (ii) designate Providers as a Center of Excellence.

V. PERMITTED CONDUCT

A. Defendant may exercise any contractual right it has, provided it does not engage in any Prohibited Conduct as set forth above.

B. For any Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Narrow Network.

C. Defendant may communicate with a Payor's members about considerations that may be important to patients when choosing a provider or site of service, provided it does not engage in any Prohibited Conduct as set forth above.

D. With regard to information communicated as part of any Transparency effort, nothing in this Final Judgment prohibits Defendant from reviewing its information to be disseminated, provided such review does not materially delay the dissemination of the information. Furthermore, Defendant may challenge inaccurate information or seek appropriate legal remedies relating to inaccurate information disseminated by third parties. Also, for a Payor's dissemination of price or cost information (other than communication of an individual consumer's or member's actual or estimated out-of-pocket expense or information made public under applicable law), nothing in the Final Judgment will prevent or impair Defendant from enforcing current or future provisions, including but not limited to confidentiality provisions, that (i) prohibit a Payor from disseminating price or cost information to Defendant's competitors, other Payors, or the general public except as required under applicable laws; and/or (ii) unless otherwise provided under applicable law, require a Payor to obtain a covenant from any third party that receives such price or cost information that such third party will not disclose that

information to Defendant's competitors, another Payor, the general public, or any other third party lacking a reasonable need to obtain such competitively sensitive information, provided the Defendant does not engage in any Prohibited Conduct as set forth above. Defendant may seek all appropriate remedies (including injunctive relief) in the event that dissemination of such information occurs.

VI. REQUIRED CONDUCT

A. Within fifteen (15) business days of the entry of this Final Judgment, Defendant must notify any Relevant Payor in writing that this Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract provision that would prohibit, prevent, or Penalize Steering, Steered Plans, or Transparency, or taking any other action that violates this Final Judgment.

B. While the Final Judgment is in effect, Defendant must notify, in writing, any Relevant Payors not previously notified pursuant to Paragraph VI.A that this Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract provision that would prohibit, prevent, or Penalize Steering, Steered Plans, or Transparency, or taking any other action that violates this Final Judgment, within five (5) business days of the exchange of written terms or a draft agreement between such Relevant Payor and Defendant about Defendant's participation in that Payor's Benefit Plan or Provider network.

C. For five (5) years from the entry of the Final Judgment, on the final business day of each calendar quarter, Defendant must provide a written report to the monitor and each Plaintiff identifying each Payor with which Defendant (1) agreed to new or amended contract terms, (2) declined to participate in any Tiered Network, and (3) contracted for the right to

participate in the most-preferred tier of a Benefit Plan that is described in Section IV.D of the Final Judgment.

VII. AFFIDAVITS

A. Within forty-five (45) calendar days of entry of the Stipulation and Order in this case, and every forty-five (45) calendar days thereafter until the actions required by this Final Judgment in Paragraphs VI.A, IX.A.1 and IX.A.3 have been completed, Defendant must deliver to the United States and the State of Ohio an affidavit, signed by Defendant's General Counsel, describing in reasonable detail the fact and manner of Defendant's compliance with this Final Judgment. The United States, in its sole discretion, may approve different signatories for the affidavits.

VIII. APPOINTMENT OF MONITOR

A. Upon application of the United States, which Defendant may not oppose, the Court will appoint a monitor selected by the United States in its sole discretion, after consultation with the State of Ohio, and approved by the Court. Defendant may propose up to three (3) monitor candidates to the United States. Once approved, the court-appointed monitor should be considered by the Plaintiffs and Defendant to be an arm and representative of the Court.

B. The monitor will have the power and authority to monitor Defendant's compliance with the terms of this Final Judgment and the Stipulation and Order entered by the Court, including compliance with Sections IV, VI, and IX. The monitor may also have other powers as the Court deems appropriate. The monitor will have no responsibility or obligation for the operation of the Defendant's business. No attorney-client relationship will be formed between Defendant and the monitor.

C. The monitor will have the authority to take such steps as, in the judgment of the monitor and the United States, may be necessary to accomplish the monitor's responsibilities. The monitor may seek information from Defendant's personnel, including in-house counsel, compliance personnel, and internal auditors. Defendant must establish a policy, annually communicated to all employees, that employees may disclose any information to the monitor without reprisal for such disclosure. Defendant must not retaliate against any employee or third party for disclosing information to the monitor.

D. Defendant may not object to actions taken by the monitor in fulfillment of the monitor's responsibilities under any Order of the Court on any ground other than malfeasance by the monitor. Disagreements between the monitor and Defendant related to the scope of the monitor's responsibilities do not constitute malfeasance. Objections by Defendant must be conveyed in writing to the United States, the State of Ohio, and the monitor within twenty (20) calendar days of the monitor's action that gives rise to Defendant's objection, or the objection is waived.

E. The monitor will serve at the cost and expense of Defendant pursuant to a written agreement, on terms and conditions, including confidentiality requirements and conflict of interest certifications, approved by the United States in its sole discretion. If the monitor and Defendant are unable to reach such a written agreement within fourteen (14) calendar days of the Court's appointment of the monitor, or if the United States, in its sole discretion, declines to approve the proposed written agreement, the United States, in its sole discretion, may take appropriate action, including making a recommendation to the Court, which may set the terms and conditions for the monitor's work, including compensation, costs, and expenses.

F. The monitor may hire, at the cost and expense of Defendant, any agents and consultants, including attorneys, and accountants, that are reasonably necessary in the monitor's judgment to assist with the monitor's duties. These agents or consultants will be directed by and solely accountable to the monitor and will serve on terms and conditions, including confidentiality requirements and conflict-of-interest certifications, approved by the United States, in its sole discretion. Within three (3) business days of hiring any agents or consultants, the monitor must provide written notice of the hiring and the rate of compensation to Defendant and the United States.

G. The compensation of the monitor and agents or consultants retained by the monitor must be on reasonable and customary terms commensurate with the individuals' experience and responsibilities.

H. The monitor must account for all costs and expenses incurred.

I. Defendant's failure to promptly pay the monitor's accounted-for costs and expenses, including for agents and consultants, will constitute a violation of this Final Judgment and may result in sanctions ordered by the Court. If Defendant makes a timely objection in writing to the United States to any part of the monitor's accounted-for costs and expenses, Defendant must establish an escrow account into which Defendant must pay the disputed costs and expenses until the dispute is resolved.

J. Defendant must use best efforts to cooperate fully with the monitor and to assist the monitor to monitor Defendant's compliance with its obligations under this Final Judgment and the Stipulation and Order, including with Sections IV, VI, and IX. Subject to reasonable protection for trade secrets, other confidential research, development, or commercial information, or any applicable privileges, Defendant must provide the monitor, and agents or

consultants retained by the monitor, with full and complete access to all personnel (current and former), agents, consultants, books, records, and facilities. Defendant may not take any action to interfere with or to impede accomplishment of the monitor's responsibilities.

K. The monitor must investigate and report on Defendant's compliance with this Final Judgment and the Stipulation and Order. The monitor must provide periodic reports to the United States and the State of Ohio setting forth Defendant's efforts to comply with its obligations under this Final Judgment and the Stipulation and Order. The United States, in its sole discretion, will set the frequency of the monitor's reports, but, at minimum, the monitor must provide written reports at least every one hundred and eighty (180) days for the first two (2) years of the term of the monitor's appointment, after which the monitor must provide written reports on at least an annual basis. The monitor must provide the first written report within one hundred and eighty (180) days of the monitor's appointment by the Court. The United States, in its sole discretion, may change the frequency of the monitor's written reports at any time, communicate or meet with the monitor at any time, and make any request of the monitor as the United States deems appropriate.

L. Within thirty (30) calendar days after appointment of the monitor by the Court, and on a yearly basis thereafter, the monitor must provide to the United States, the State of Ohio, and Defendant a proposed written work plan. Defendant may provide comments on the proposed written work plan to the United States, the State of Ohio, and the monitor within fourteen (14) calendar days after receipt, after which the monitor must produce a final work plan to the United States, the State of Ohio, and Defendant, for approval by the United States in its sole discretion. Any disputes between Defendant and the monitor with respect to any written work plan will be

decided by the United States in its sole discretion. The United States retains the right, in its sole discretion, to require changes or additions to a work plan at any time.

M. The monitor may communicate *ex parte* with the Court when, in the monitor's judgment, such communication is reasonably necessary to the monitor's duties under this Final Judgment, including if Defendant fails to pay the monitor's costs and expenses in a timely manner or otherwise violates this Final Judgment.

N. The monitor will serve for a term of five years after being appointed, unless the United States, in its sole discretion, determines a different period is appropriate.

O. If the United States determines that the monitor is not acting diligently or in a reasonably cost-effective manner, or if the monitor resigns or becomes unable to accomplish the monitor's duties, the United States may recommend that the Court appoint a substitute.

P. For the duration of the term of the monitor, Defendant must provide to the monitor a copy of each new contract and each new amendment to a contract that covers Healthcare Services that Defendant has executed with any Payor within the last one-hundred and eighty (180) calendar days. Defendant must provide the contracts to the monitor in batches every one-hundred and eighty (180) calendar days, or within ten (10) calendar days upon request of the monitor at any time during the monitorship. Defendant will also notify the monitor within thirty (30) calendar days of having reason to believe that Defendant, or any Provider on whose behalf Defendant negotiates, has a contract with any Payor with a provision that prohibits, prevents, or Penalizes Steering, Steered Plans, or Transparency.

IX. COMPLIANCE

A. Defendant must:

1. within fifteen (15) calendar days of entry of this Final Judgment, provide a copy of this Final Judgment to each of Defendant's directors and officers, and to each employee or agent whose job responsibilities include negotiating or approving agreements on behalf of Defendant with Payors for the purchase of Healthcare Services;

2. distribute in a timely manner a copy of this Final Judgment to any Person who succeeds to, or subsequently holds, a position at Defendant of director, officer, or other position for which the job responsibilities include negotiating or approving agreements with Payors for the purchase of Healthcare Services; and

3. within sixty (60) calendar days of entry of this Final Judgment, develop and implement procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures must ensure that Defendant's directors, officers, or employees have the opportunity to raise questions about this Final Judgment with counsel (which may be outside counsel).

B. For the purposes of determining or securing compliance with this Final Judgment or of related orders such as the Stipulation and Order or of determining whether this Final Judgment should be modified or vacated, upon the written request of an authorized representative of the Assistant Attorney General for the Antitrust Division or the Attorney General of the State of Ohio and reasonable notice to Defendant, Defendant must permit, from time to time and subject to legally recognized privileges, authorized representatives, including agents retained by the United States or the State of Ohio;

1. to have access during Defendant's business hours to inspect and copy, or at the option of the United States, to require Defendant to provide electronic copies of all books, ledgers, accounts, records, data, and documents, wherever located, in the possession, custody, or control of Defendant relating to any matters contained in this Final Judgment; and

2. to interview, either informally or on the record, Defendant's officers, employees, or agents, wherever located, who may have their individual counsel present, relating to any matters contained in this Final Judgment. The interviews must be subject to the reasonable convenience of the interviewee and without restraint or interference by Defendant.

C. Upon the written request of an authorized representative of the Assistant Attorney General for the Antitrust Division of the Attorney General of the State of Ohio, Defendant must submit written reports or respond to written interrogatories, under oath if requested, relating to any matters contained in this Final Judgment.

X. PUBLIC DISCLOSURE

A. No information or documents obtained pursuant to any provision in this Final Judgment, including reports the monitor provides to the United States and the State of Ohio, pursuant to Paragraph VIII.K, may be divulged by the United States, the State of Ohio, or the monitor, to any person other than an authorized representative of the executive branch of the United States or an authorized representative of the State of Ohio, except in the course of legal proceedings to which the United States or the State of Ohio is a party, including grand-jury proceedings, for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

B. In the event that the monitor receives a subpoena, court order, or other court process seeking or requiring production of information or documents obtained pursuant to any

provision in this Final Judgment, including reports the monitor provides to the United States and the State of Ohio, pursuant to Paragraph VIII.K, the monitor must notify the United States, the State of Ohio, and Defendant immediately, and no fewer than fourteen (14) calendar days prior to any disclosure, so that Defendant may address such potential disclosure and, if necessary, pursue alternative legal remedies, including if deemed appropriate by Defendant, intervention in the relevant proceedings.

C. In the event of a request by a third party, pursuant to the Freedom of Information Act, 5 U.S.C. § 552, or the Ohio Public Records Act, O.R.C. § 149.43, for disclosure of information obtained pursuant to any provision of this Final Judgment, the United States will act in accordance with that statute and the Department of Justice regulations at 28 C.F.R. part 16, including the provision on confidential commercial information at 28 C.F.R. § 16.7, and the State of Ohio will act in accordance with its applicable disclosure laws. Records containing any such information shall be deemed confidential law enforcement investigatory records under O.R.C. § 149.43(A)(1). When submitting information to the Antitrust Division, Defendant should designate the confidential commercial information portions of all applicable documents and information under 28 C.F.R. § 16.7. Designations of confidentiality expire 10 years after submission, "unless the submitter requests and provides justification for a longer designation period." *See* 28 C.F.R. § 16.7(b).

D. If at the time that Defendant furnishes information or documents to the United States or the State of Ohio pursuant to any provision of this Final Judgment, Defendant represents and identifies in writing information or documents for which a claim of protection may be asserted under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure, and Defendant marks each pertinent page of such material, "Subject to claim of protection under Rule

26(c)(1)(G) of the Federal Rules of Civil Procedure," the United States and the State of Ohio must give Defendant ten (10) calendar days' notice before divulging the material in any legal proceeding (other than a grand jury proceeding).

XI. RETENTION OF JURISDICTION

The Court retains jurisdiction to enable any party to this Final Judgment to apply to the Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

XII. ENFORCEMENT OF FINAL JUDGMENT

A. If at any time during the five-year period following entry of this Final Judgment, the United States determines in its sole discretion that the Final Judgment has failed to fully redress the violations alleged in the Complaint, then the United States may re-open this proceeding to seek additional relief. Such additional relief may be ordered by this Court upon a finding by a preponderance of the evidence that there is a reasonable probability that the proposed Final Judgment did not fully redress the violations alleged in the Complaint.

B. The United States, or the State of Ohio, retains and reserves all rights to enforce the provisions of this Final Judgment, including the right to seek an order of contempt from the Court. In a civil contempt action, a motion to show cause, or a similar action brought by the United States or the State of Ohio relating to an alleged violation of this Final Judgment, the United States or the State of Ohio may establish a violation of this Final Judgment and the appropriateness of a remedy therefor by a preponderance of the evidence, and Defendants waive any argument that a different standard of proof should apply.

C. This Final Judgment should be interpreted to give full effect to the procompetitive purposes of the antitrust laws and to restore the competition the United States and the State of Ohio allege was harmed by the challenged conduct. Defendant may be held in contempt of, and the Court may enforce, any provision of this Final Judgment that, as interpreted by the Court in light of these procompetitive principles and applying ordinary tools of interpretation, is stated specifically and in reasonable detail, whether or not it is clear and unambiguous on its face. In any such interpretation, the terms of this Final Judgment should not be construed against any party as the drafter.

D. In an enforcement proceeding in which the Court finds that Defendant has violated this Final Judgment, the United States may apply to the Court for an extension of this Final Judgment, together with other relief that may be appropriate. In connection with a successful effort by the United States or the State of Ohio to enforce this Final Judgment against Defendant, whether litigated or resolved before litigation, Defendant must reimburse the United States or the State of Ohio for the fees and expenses of its attorneys, as well as all other costs including experts' fees, incurred in connection with that effort to enforce this Final Judgment, including during the investigation of the potential violation.

E. For a period of four (4) years following the expiration of this Final Judgment, if the United States has evidence that Defendant violated this Final Judgment before it expired, the United States may file an action against Defendant in this Court requesting that the Court order: (1) Defendant to comply with the terms of this Final Judgment for an additional term of at least four years following the filing of the enforcement action; (2) all appropriate contempt remedies; (3) additional relief needed to ensure Defendant complies with the terms of this Final Judgment; and (4) fees or expenses as called for by this Section XII.

XIII. EXPIRATION OF FINAL JUDGMENT

Unless the Court grants an extension, this Final Judgment will expire ten (10) years from the date of its entry, except that after five (5) years from the date of its entry, this Final Judgment may be terminated upon notice by the United States to the Court, Defendant, and the State of Ohio that the continuation of this Final Judgment is no longer necessary or in the public interest.

XIV. RESERVATION OF RIGHTS

This Final Judgment terminates only the claims stated in the Complaint against Defendant and does not affect other charges or claims the United States or the State of Ohio may file.

XV. PUBLIC INTEREST DETERMINATION

The parties have complied with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, including by making available to the public copies of this Final Judgment and the Competitive Impact Statement, public comments thereon, and any response to comments by the United States. Based upon the record before the Court, which includes the Competitive Impact Statement and, if applicable, any comments and response to comments filed with the Court, entry of this Final Judgment is in the public interest.

Date: _____

[Court approval subject to procedures of Antitrust Procedures and Penalties Act, 15 U.S.C. § 16]

_____
Algenon L. Marbley
United States District Judge

EXHIBIT A

Examples of contract provisions that are void and unenforceable according to the Final Judgment.

Examples of contract provisions that prohibit, deter, prevent or Penalize Steering, Steered Plans, or Transparency.

1.

If [OhioHealth's] Network Exclusion or inclusion in limited benefit plan product offerings as described in [another section] above results, in the good faith and reasonable opinion of [OhioHealth], in an adverse and material financial impact on any [OhioHealth's] volumes or revenues received for Covered Services in excess of [amount] per year, [the contracting payor] agrees to an adjustment in the Company Rate to offset such impact, applicable to and as proposed by [OhioHealth].

2.

In the event [payor] causes a Network Exclusion for [an OhioHealth] provider or includes [OhioHealth] Hospital as a participating provider in any limited benefit plan products (i.e., products with individual annual benefit maximum [amount]), then this Agreement will automatically terminate on the 90th day following implementation of the Network Exclusion, unless, by the end of such 90 day period:

(A) [Payor] obtains the written consent of [OhioHealth] as to its Network Exclusion or inclusion in limited benefit plan product offerings as described in [another section].1 above; and

(B) If [OhioHealth]'s Network Exclusion or inclusion in limited benefit plan product offerings as described in [another section] above results, in the good faith and reasonable opinion of [OhioHealth], in an adverse and material financial impact on any [OhioHealth] Providers' volumes or revenues received for Covered Services in excess of [amount] per year, Company shall agree to an adjustment in the Company Rate to offset such impact, applicable to and as proposed by such affected [OhioHealth] Provider.

No such termination or Company Rate adjustment shall be made if the reason for the [OhioHealth] Provider's Network Exclusion is a failure by [OhioHealth] Provider to meet any non-financial selection criteria established by Company for similarly situated providers in the Other Network Benefit Plan product or service as stipulated in [another Section], or [OhioHealth] Provider willingly chooses not to be a Participating Provider in such Other Network Benefit Plan product or service.

3.

Under no circumstances shall [payor], [a payor] Affiliate, Plan or a sponsor, or their respective affiliates, subsidiaries and independent contractors (collectively or individually, as the case may be, "[a payor] Advisor") provide verbal, written, website or other advice, counseling or information to Covered Individuals, their representatives, treating physicians or practitioners or others regarding higher payment rates and/or charges of Covered Services provided at OhioHealth Provider facilities versus other provider facilities, or undertake any strategy to

directly or indirectly steer Covered Individuals to provider facilities other than those of any OhioHealth Provider, based on price/charge differences, or for any reason other than the availability of health care services at the OhioHealth Provider (collectively or individually, as the case may be, a "Rate Comparison Program"), except for Rate Comparison Programs permitted under [other sections].

EXHIBIT 4

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, Defendant.	1:26-cv-02480 Hon. Paul A. Engelmayer, USDJ Hon. Ona T. Wang, USMJ

THE NEW YORK AND PRESBYTERIAN HOSPITAL'S ANSWER

Pursuant to Fed. R. Civ. P. 8(b)(3), The New York and Presbyterian Hospital denies, by "general denial," all allegations of the Complaint "except those specifically admitted" below.[1]

PRELIMINARY STATEMENT

NYP shares the United States' stated interest in lowering health care costs for Americans. But the well-documented driver of rising healthcare costs is concentration in the commercial health insurance industry.[2] In this case, however, the Department of Justice ("DOJ") has focused on a handful of decades-old, industry standard contract provisions that insurers themselves demanded, which lower prices and guarantee patients access to high-quality care at the hospital of their choice.

[1] For any answer where NYP asserts that it does not know or is not aware of a particular alleged fact, NYP specifically means and avers that it "lacks knowledge or information sufficient to form a belief about the truth of [the] allegation," and so denies the allegation under Fed. R. Civ. P. 8(b)(5). Unless otherwise noted, all emphasis added, internal citations and quotation marks omitted, and capitalizations conformed without brackets.

[2] *Health Insurance Costs are Increasing As Markets Become More Concentrated with Fewer Insurance Companies*, U.S. GOV'T ACCOUNTABILITY OFF. (Dec. 5, 2024), https://www.gao.gov/blog/health-insurance-costs-are-increasing-markets-become-more-concentrated-fewer-insurance-companies-interactive-map.

Challenging such contract provisions will not lower costs; it will enable the nation's largest insurers to enhance their market dominance and expand their profits at patients' expense.

New York Presbyterian: Two Centuries of Mission-Driven Care

For more than two centuries, NYP has stood at the center of American medicine. NYP traces its roots to The New York Hospital, founded in 1771, and The Presbyterian Hospital, founded in 1868. Today NYP combines the clinical, research, and teaching missions of two of the world's great medical schools – Columbia University Vagelos College of Physicians and Surgeons and Weill Cornell Medicine – into one of the nation's premier integrated academic health systems.

NYP's flagship campuses at Columbia University Irving Medical Center and Weill Cornell Medical Center have pioneered many of the most important advances in modern medicine, including the first-ever infant domino partial heart transplant, the first domino split-liver transplant in adults in the United States, and transcatheter aortic valve replacement surgery. These are not isolated achievements. They result from a sustained, institution-wide dedication to care and millions of dollars of annual investment in support of its non-profit mission to help those in need.

For 22 years, NYP has been ranked among the Best Hospitals by the *U.S. News & World Report*. Last year, it named NYP the Number 1 hospital in New York and one of only twenty hospitals nationwide on its 2025–26 Best Hospitals Honor Roll—the only hospital in the country ranked in the top fifteen in fourteen of fifteen adult specialties.

Commercial Insurers Dominate The Highly-Competitive Market

NYP Competes in a Highly Competitive Market

NYP does not have market power, and it cannot dictate terms to insurers. New York has one of the least concentrated hospital markets in the country: a recent Yale study ranks New York the eleventh *least* concentrated state for hospital provider markets (39 states have more

concentrated hospital provider markets than New York).[3] New York has 188 licensed hospitals, approximately sixty of which are in New York City. NYP operates eight acute care hospitals and two campuses that provide inpatient and outpatient behavioral health care. The DOJ's Complaint recognizes New York City hosts many of the nation's large, multi-hospital systems, all of whom compete head-to-head with NYP—among them Mount Sinai, NYU Langone, Northwell Health, NYC Health + Hospitals, Maimonides Medical Center, and Montefiore Einstein.

NYP also competes with regional hospitals throughout New York, New Jersey, and Connecticut for routine cases, and with leading academic centers nationally and internationally for higher acuity cases. Notably, in prior antitrust enforcement actions, the DOJ has defined the appropriate relevant market for insurer-provider negotiations – not as Manhattan or the four Burroughs – but the entire "downstate New York" metropolitan area, which includes northern New Jersey, Hudson Valley, and Long Island.[4]

NYP's share of the market is small, far less than the Complaint alleges. In fact, because the Complaint seeks to protect the insurers' design of provider networks in the region, the proper measure of market share is NYP's share of medical expenses under the insurers' plans. By that measure, NYP's share is less than 1%.

The Complaint turns NYP's "reputation" for quality against it, alleging that because it provides high quality medical services, that it is a "must-have" hospital that insurers can't do without. But a reputation for excellence is neither direct nor indirect evidence of the legally

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[3] Zack Cooper, Andrea Harris & Mathilda Hill, *A Ranking of All 50 States by Hospital Consolidation*, Health Care Affordability Lab at Yale: Blog (Mar. 9, 2026), www.healthcareaffordabilitylab.org/commentary-press-release-posts/a-ranking-of-all-50-states-by-hospital-consolidation.

[4] Plaintiffs' Proposed Finding of Fact, *U.S. v. Anthem*, 1:2016-cv-1493, ECF 483, ¶ 404-407 (D.D.C. Dec. 20, 2016).

required market power for the DOJ to bring this type of case. And the Complaint is internally inconsistent because it contends on one hand, that insurers want to exclude NYP from their networks, and at the same time that NYP is a "must-have" hospital system. The evidence also shows that insurers repeatedly threaten to exclude NYP and several have made good by notifying members of NYP's exclusion. An institution that insurers can credibly threaten to exclude is, by definition, not a must-have institution and does not possess market power.

Insurers Possess Immense Market Power and Bargaining Leverage

The Complaint concedes that five insurers "account for a dominant majority of commercial health insurance business in New York City." These five insurers control over ***eighty*** percent of the health insurance market, with Empire alone accounting for more than half.[5]

The insurers' control over patient volume gives them tremendous market power and bargaining leverage. If contract negotiations break down, insurers can remove NYP from their network, denying coverage for NYP services and forcing their members to use other providers in their extensive networks. The impact on insurers is minimal and manageable. The reverse, however, is not true.

The DOJ has repeatedly recognized this imbalance and the anticompetitive consequences that flow from insurers' control over patient steerage. The DOJ has already alleged the modern healthcare marketplace is dominated by insurers: "today, the industry is dominated by five large insurers," which gives them a "clear advantage and provides opportunities to drive margin growth."[6] Their ability to earn excess profits is not through economies of scale, but through the exercise of monopsony power. "Market power arising from [insurers'] market share," the DOJ

[5] *Private Enrollment Market Share in New York Counties*, Mark Farrah Assoc. (June 19, 2023), https://www.markfarrah.com/mfa-briefs/private-enrollment-market-share-in-new-york-counties/.

[6] Complaint, *U.S. v. Anthem*, 1:16-cv-01493, ECF 1, ¶ 6 (D.D.C. July 21, 2016).

has found, "is corroborated by [their] demonstrated ability to exercise that power by raising [insurance] prices, restricting [provider] output, erecting barriers to entry, and excluding competitors."[7]

The "All Products" clause that the DOJ now challenges as an exercise of provider power to increase rates is one that the DOJ has previously found is an anticompetitive tool that **insurers** used to maximize their monopsony power and decrease provider rates:

> "[Insurers'] '***All Products***' clause – which requires a [provider] to participate in all of [the insurer's] health plans if [it] participates in any [insurer] plan –significantly increases the volume of business [a provider] would lose if [it] rejected [the insurer's] offered reimbursement on any given plan…. Terminating the provider thus would mean that [the provider] not only would lose [its] own patients that participated in the plan, but also access to other patients.… [This enables the insurer] to ***depress … reimbursement rates*** …, likely leading to a ***reduction in quantity or degradation in the quality*** of [provider] services."[8]

The use of the All Products clause reflects a "textbook case of monopsony" in which the "monopsonist depresses the input price it pays below the competitive level by reducing the input quantity it purchases."[9]

The Challenged Contract Provisions Are
Industry-Standard, Insurer-Demanded, and Pro-Competitive

Respectfully, the DOJ also misconstrues the provisions it purports to challenge and the central role they play in the managed care bargain.

The Complaint refers to general "plan restrictions." But NYP's contracts contain no exclusivity provisions, do not require preferential treatment, and do not guarantee NYP any level

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[7] Complaint, *U.S. v. Blue Cross Blue Shield of Michigan*, 10-cv-14155, ECF 1, ¶ 34 (E.D. Mich. Oct. 18, 2010).

[8] Complaint, *U.S. v. Aetna*, 99-cv-1398, ECF 1, ¶ 32-33 (N.D. Tex.).

[9] *See* Marius Schwartz, DOJ Economics Director of Enforcement, Address at 5th Annual Health Care Antitrust Forum, Northwestern Univ. Sch. of Law: Buyer Power Concerns and the Aetna-Prudential Merger, at II.A (Oct. 20, 1999).

of patient volume or market share. The Complaint targets industry-standard provisions known as "All Products" provisions: a provider agrees to offer discounts for its services, and the insurer agrees in turn to include the provider as one of many in-network options for the insurer's enrollees. That is not exclusionary. It is inclusionary.

The marketplace result of an All Products provision is an Open Access Network—a network that gives patients freedom to access *any* provider of choice without penalty. It does not require insurers to include other providers in the network, but it also does not prohibit them from doing so. It only prohibits *discrimination*. So, from among the multitude of steerage provisions that can be negotiated, an "All Products" provision is about as non-restrictive as possible.

At the other end of the spectrum are Restricted Choice Networks—networks that require *exclusion* of and *discrimination* against certain providers. The DOJ characterizes them in benign, insurer-friendly language: "narrow networks" or "tiered networks." But regardless of the label, insurers create these networks using an interrelated system of incentives and penalties – including policy exclusions, elevated deductibles, higher payment rates, and differential co-insurance obligations – to steer patients away from excluded or disfavored providers to the favored ones.

The Managed Care Bargain

The All Products provisions exist because *insurers* proposed them and insisted on them decades ago to obtain the benefit of provider discounts. The economics are straightforward: insurers include NYP in Open Access Networks (meaning insurers will not penalize patients who choose NYP as their provider) which in turn enables NYP to offer lower rates of payment. Patients gain access to world-class care at lower cost-share. Insurers gain the benefit of a volume discount. NYP gains volume.

The Complaint concedes in Paragraph 4 that negotiations based on plan and network design are procompetitive. But it incorrectly asserts that the All Products provision prevents that

competition. The All Products provision *is* the competition over plan design—it is the outcome of NYP successfully competing for in-network status against other hospitals and against being excluded or restricted.

Competition to include or exclude hospital systems in the New York region is intense. An open, non-exclusionary, non-discriminatory network – guaranteed by an All Products provision – is not a foregone conclusion. At contract renewal, insurers can create Restricted Choice Networks—and they can try to extract additional concessions from *other* providers in exchange for the promise to exclude NYP. And, even if they don't ultimately choose to create such networks, they can – and do – use the threat of exclusion to secure more favorable rates.

This is consistent with how a competitive market works. Volume discounts are efficient and benefit patients. In high-fixed-cost industries, like hospital care, providers offer lower rates to spread their fixed costs over a larger base of business. Filling beds with patients is output-enhancing. And that is what NYP does. Consistent with *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2008), and *Ortho Diagnostic Systems, Inc. v. Abbott Laboratories, Inc.*, 920 F. Supp. 455 (S.D.N.Y. 1996), NYP's rate concessions are procompetitive, incapable of excluding equally efficient rivals, and cannot raise prices above competitive levels.

The All Products Provision Is a Reasonably Ancillary, Inseparable Part of the Managed Care Bargain

When NYP is successful in negotiating for in-network status, the contract reflects the outcome of that *competitive* negotiation. Volume discounts are the product of network inclusion; the two cannot be divorced from each other without fundamentally changing the economics of the parties' negotiations. It is a quintessential ancillary provision.

The Complaint posits that network exclusion is a solution and seeks to enjoin NYP from competing for inclusion as an in-network provider across any insurer's entire book of business by offering lower prices.

NYP Does Not Negotiate on an All or Nothing Basis

The Complaint incorrectly asserts that NYP competes on an "all-or-nothing basis." Not so.

The *insurers* have monopsony power. Just as a *monopolist* raises prices by restricting output, a monopsonist *depresses* prices by restricting its *demand*. The DOJ argues that these twin evils are "mirror images" of each other.[10] Here, the Complaint claims that NYP has *seller* power but fails to allege the facts needed to support such an allegation. For example, the Complaint does not allege that NYP has sought to restrict output. In fact, NYP has sought to *expand* output and maximize patients' freedom of choice. Restricted Choice Networks are therefore not evidence of providers' market power, but insurers' power.

The Complaint's claim – that NYP "effectively force[s] the major payors … to contract on an all-or-nothing basis" – is also incorrect. This allegation ignores the *ex ante* negotiations, while focusing only on the contractual provisions *ex post* after the negotiations have ended. *Ex ante*, NYP competes for the incremental volume insurers may wish to steer away from it through Restricted Choice Networks. When NYP succeeds in keeping the network open, the All Products provision operates as intended. That is competition in action. The alternative would be to permit NYP's *competitors* to pay insurers to exclude or discriminate against NYP, but to prevent NYP from responding with a competitive offer of its own.

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[10] Schwartz, *Buyer Power Concerns*, *supra* note 8, at II.A (1999) ("The textbook case of monopsony is the mirror image of monopoly."); DOJ Supp. Mem. on the Buy-Side Case, *U.S. v. Anthem*, 1:16-cv-1493, ECF 410, at 5 (D.D.C.) ("monopsony is the 'mirror image' of monopoly.")

NYP does not require insurers to negotiate on an "all or nothing" basis and NYP has often agreed to modify, limit, or delete the All Products provision to accommodate insurer network designs.

Restricted Choice Network Reduce Price Competition; Open Access Networks Preserve It

The Complaint alleges that Restricted Choice Networks benefit patients because they preserve price competition, while Open Access Networks eliminate it. NYP respectfully disagrees. Healthcare markets involve two stages of competition: provider competition for network inclusion in stage one, and provider competition for patients in stage two. Open Access networks maximize price competition at both stages.[11]

The Complaint focuses only on stage one and says that the market is devoid of price competition at stage two because patients are insured and insulated from price at point of care. Not so. Insurers design their plans to *maximize* stage two price competition among in-network providers, using a combination of deductibles, policy limits, and co-insurance. These plan features cause patients to consider cost and, consequently, provide strong incentives for providers to offer attractive rates.

Restricted Choice Networks, in contrast, eliminate *ex post* price competition. They exclude providers not based on the *provider's* price, but the *insurer's* discriminatory penalties. As such, excluded providers have no practical ability to compete against favored providers. Restricted

[11] "Price" is used to refer to (1) what consumers pay for health insurance; (2) the negotiated rates of payment NYP receives from insurers; and (3) the charges NYP uses for itemized bills and which may appear in statements of patients who are not insured. How prices for (3) are set is a complicated technical process and not related to competition, market demand, and supply. NYP's revenue collected on the basis of charges or even a percent discount of charges is not material. This litigation is about (1) and (2).

Choice Networks therefore only permit stage two price competition among *favored* providers, not the full slate of providers that would compete in Open Access Networks.

That Open Access Networks enhance price competition is exactly why sophisticated insurers – who design plans for their own commercial advantage – have gravitated towards them. As the Supreme Court recognized, "***there is nothing inherently anticompetitive about … anti-steering provisions***."[12] Insurers use them, not just with NYP but with all types of hospitals – large and small, high-priced and low – because that is how they negotiate maximum discounts and provide patients with the choices they want.

NYP's Contracts Do Not Produce Anticompetitive Effects

Anticompetitive effects require competitive foreclosure: a reduction in the number of competitors or an increase in rivals' marginal costs. The Complaint alleges neither. It identifies no hospital exit, forestalled entry, or rival scale impairment. Nor could it. NYP's contracts do not prevent insurers from designating other providers as in-network providers. Other hospitals remain free to compete for patients just as NYP does.

Rather than allege any output reduction, this Complaint alleges that NYP's rates are too high, and attributes that not to NYP's quality and reputation but to the All Products provision.

The Complaint alleges that NYP's "quality," "brand," and "reputation" make it a "must-have" hospital. Yet, it also alleges that those same attributes would not enable NYP to set rates that reflect those attributes. Both sets of allegations cannot be true at the same time. If NYP provides high quality services, then an arms-length negotiation over rates will reflect that quality. That has nothing to do with market power or the All Products provision.

[12] *Ohio v. Am. Express Co.*, 585 U.S. 529, 547 (2018).

Finally, the DOJ claims that NYP harmed the insurance market—a market in which it does not compete. In its view, if the Court enjoins NYP from competing for network inclusion, insurers would create more Restricted Choice Networks, and employers would foist those restrictive plans on their employees. But this speculative chain of events does not justify penalizing patients who want to obtain care at NYP or preventing NYP from engaging in arms-length negotiations when insurers seek to utilize discriminatory tactics. In fact, the Restricted Choice Networks sought by the Complaint can reduce patient choice and shrink the volume providers have to spread within their fixed costs. Accordingly, most insurers have chosen to negotiate with NYP on a non-restrictive, non-exclusionary basis, as reflected in the All Products provisions the Complaint challenges.

The principal effect of the requested relief would be to increase profits of the nation's dominant insurers. As the D.C. Circuit has noted, because insurers have "monopsony power" and operate in "highly concentrated markets," they "are less constrained by competition and thus tend to find it more profitable to *capture* medical savings and *increase* premiums."[13] That is the opposite of what Congress wanted when it passed the Sherman Act.

And even if it did, the principal effect of the requested relief would be to increase profits of the nation's dominant insurers. As the D.C. Circuit has noted, because insurers have "monopsony power" and operate in "highly concentrated markets," they "are less constrained by competition and thus tend to find it more profitable to *capture* medical savings and *increase* premiums."[14] That is the opposite of what Congress wanted when it passed the Sherman Act.

NYP's answer to the Complaint's specific allegations follows.

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[13] *United States v. Anthem*, 855 F.3d 345, 453 (D.C. Cir. 2017) (emphasis added).

[14] *United States v. Anthem*, 855 F.3d 345, 453 (D.C. Cir. 2017) (emphasis added).

The United States brings this action pursuant to Section 1 of the Sherman Act, 15 U.S.C. § 1, to stop The New York and Presbyterian Hospital ("New York-Presbyterian" or "NYP") from continuing to stifle competition among New York City healthcare providers. NYP's contracts with health insurance companies unlawfully deny patients the choice of insurance plans that prioritize NYP's lower-cost competitors. The United States seeks an order prohibiting NYP from entering into or enforcing these illegal contractual plan design restrictions, which reduce competition among hospitals, raise healthcare costs, and deny consumers seeking healthcare in New York City access to budget-conscious health insurance plans.

Answer: NYP's contracts lower prices, increase access and patient choice, and benefit consumers. NYP respectfully submits that the order the Complaint seeks here would do the opposite. To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

INTRODUCTION

1. Healthcare costs weigh heavily on the minds and budgets of American families and businesses. The cost of health insurance is too high, often because many large hospital systems charge high prices. Hospital-driven restraints on the availability of innovative, budget-conscious health insurance plans contribute to these high prices. For years, many price-conscious consumers have sought, and some insurance companies in New York City have tried to offer, health insurance plans that are designed to give individuals choices that can reduce their healthcare costs.

Answer: NYP admits that the costs of healthcare *insurance* weighs on the minds and budgets of American families and businesses. The reason for the high cost of health insurance, however, is that commercial insurance market is highly concentrated and dominated by just five insurers. The DOJ has repeatedly recognized that these insurers possess market power and are largely responsible for the high cost of health care in the country.

Consumers, the Complaint alleges, are seeking plans that reduce healthcare costs through the use of network restrictions and differential cost-sharing that penalize patients in order to steer them away from certain providers that those consumers prefer. This further assumes that any resulting reimbursement reductions will first be passed through by insurers to employers and then from employers to employees in the form of lower premiums or other economic benefits. But that assumption is speculative, particularly in a highly concentrated insurance market where insurers may retain all of the savings. The Complaint also does not adequately account for the burdens

imposed on patients and families when plan designs limit access to preferred providers or materially increase out-of-pocket costs for obtaining care from those providers.

The Restricted Choice Networks sought by the Complaint can reduce patient choice and shrink the volume providers have to spread their fixed costs. Accordingly, most insurers have chosen to negotiate with NYP on a non-restrictive, non-exclusionary basis, as reflected in the All Products provisions the Complaint challenges. In the few instances where insurers have experimented with Restricted Choice Networks and have presented NYP with concrete economic proposals for NYP's exclusion, NYP has negotiated on that basis.

To the extent not expressly admitted, NYP denies all allegations of this Paragraph.

2. Americans deserve the benefits of vigorous competition between healthcare providers. Robust competition that is unrestrained by NYP's plan design restrictions would be a powerful mechanism to lower healthcare costs for consumers. But rather than compete on price to serve patients who seek healthcare in New York City, NYP has chosen to prevent competition from rival providers.

Answer: NYP respectfully denies the conclusory assertion that NYP has not "competed on price." NYP vigorously competes to remain in network with insurers, and American consumers have benefited tremendously from the increased choice that NYP has secured for them. NYP has not restrained any insurer's plan designs; it has negotiated based on the plan designs they have presented to NYP. NYP has also repeatedly adjusted its rates of payment in response to insurers' threats to exclude NYP from their networks.

The Complaint does not identify any instances in which "rival providers" were prevented from competing on price. The fact that they charge different prices for their services proves that price competition among providers is robust, not restrained.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

3. NYP is the largest and most powerful hospital system in Manhattan and throughout New York City. For decades, NYP has used its market power to protect its position—as well as its

high prices—by using its leverage over commercial health insurers ("payors") to block them from selling health insurance plans that feature hospitals and other providers that offer lower prices.

Answer: Denied.

NYP is not the largest or most powerful hospital system in Manhattan or New York City. NYP's market share is in the low teens or less, and NYP is not the city's largest health system. Health + Hospitals alone has over 20% market share, and Mount Sinai, Montefiore Health System, NYU Langone Health, and Northwell are of similar size to NYP. NYP also competes with hospitals outside New York City, both for patients that live or work there, or located elsewhere.

NYP has not blocked insurers from selling insurance plans that feature hospitals and other providers that offer lower rates of payment. To NYP's knowledge, no insurer has been blocked from selling any insurance plan that features hospitals and other providers that offer lower rates. NYP's contracts do not exclude any providers. They maximize patient choice and provider competition—they do not "block" or "restrict" it.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

4. Consumers benefit when payors negotiate competitive prices with healthcare providers and pass those savings along. Payors can create a budget-conscious insurance plan by designing a network (a group of participating providers) or a benefit structure (e.g., copays and coinsurance) that encourages patients to select providers that offer more competitive prices. For providers, the promise of being featured in this kind of plan is an opportunity to attract more patients by reducing their prices. Providers that elect to keep their prices significantly higher than their rivals' prices risk not being featured in budget-conscious plans and thus losing patient volume.

Answer: Consumers benefit from plan designs that offer maximum choice without penalties for using their preferred providers. NYP's contracts ensure exactly that.

Insurers use plan design to maximize their control over patient steerage to exploit their monopsony power and bargaining leverage in negotiations with providers. By imposing a range of incentives and penalties on their own members, insurers can steer patients to specific providers. Insurers then negotiate with providers based on the market power they amassed by placing patient

choice under their exclusive control. In this paragraph, the Complaint concedes that the ability to *restrict* patient choice is what provides insurers with "an opportunity to [offer providers] more patients."

Patients do not benefit when insurers exercise that control. Beyond the obvious harm of restricted choice itself, patients do not directly realize the benefits of insurers' rate negotiations. To the extent patients perceive the costs of care, it is only through the system of incentives and penalties the insurer has imposed to *deter* care or maximize *control* over steerage. That generates substantial profits for insurers. And because there are only five major insurers – which the Complaint concedes account for a "dominant majority of commercial health insurance business in New York City" – they "are less constrained by competition and thus tend to find it more profitable to *capture* medical savings and *increase* premiums."[15] Put simply, it is not accurate to suggest that rate negotiations with payors over network access increase employees' wages.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

5. NYP is one of these high-priced providers. It protects its high prices by imposing contractual plan design restrictions ("plan restrictions") that prevent payors from offering budget-conscious insurance plans. NYP's plan restrictions generally forbid payors from offering plans that either exclude NYP or offer more generous benefits (e.g., lower copays) when patients choose a rival provider. As a result, these restrictions deprive patients of a choice among a full spectrum of competitive health insurance plans, where patients could decide for themselves whether going to NYP for care is worth NYP's high prices.

Answer: NYP is not a high-priced provider. Its rates reflect the substantial investment NYP has made in its facilities, its people, and its commitment to cutting-edge care. On an apples-to-apples basis, and accounting for patient mix, quality, and acuity, NYP's prices are comparable with those of other similarly situated health care providers.

[15] Cmplt. ¶ 26; *United States v. Anthem*, 855 F.3d 345, 453 (D.C. Cir. 2017) (emphasis added).

Those rates are also the product of arm's-length negotiations with insurers, who have successfully exploited their market power, bargaining leverage, and control over patient steerage to obtain significant volume discounts from NYP.

NYP's contracts do not impose any plan design restrictions on insurers. They reflect the *outcome* of negotiations in which insurers have unilaterally decided that it is better to maintain Open Access Networks than to discriminate against specific providers. They make that choice because they know they cannot steer the same patient twice. If insurers force a patient to go to Provider A, they cannot simultaneously force the same patient to go to Provider B. So, insurers must choose: discriminate among providers through Restricted Choice Networks or let patients decide through Open Access Networks.

The Complaint posits that Restricted Choice Networks should be more common. But in deciding to keep their networks largely open, insurers recognize that, aside from their exercise of monopsony power, the economic benefit of steerage is limited. Steerage to Provider A may prompt it to lower its rates because it can spread its fixed costs over a larger base. But Provider B's rates will increase by a proportionate amount because it will be deprived of that *same* fixed-cost contribution. Since the aggregate cost (fixed and incremental) is constant, the blended rates across both providers are steerage or plan design invariant.

Patients, however, dislike restricted choices in selecting their provider. They perceive out-of-network penalties and denial of benefits as frustrating and unjustified. For that reason, insurers typically choose Open Networks, using only the *threat* of network exclusion as leverage during negotiations. The Complaint does not allege that NYP's contracts prevent insurers from using that threat, and the evidence shows that insurers have effectively wielded that leverage to great effect during NYP's negotiations.

Contrary to the Complaint's allegation, NYP does not "forbid" any insurers from offering plans that either exclude NYP or provide greater benefits for using rival providers. Insurers are free to create Restricted Choice Networks that penalize patients for choosing NYP. At contract renewal (or upon notice of termination), insurers can propose to take away the volume they previously or historically committed to NYP. When they do, NYP considers the discounts it can offer or continue to extend to keep the network open—to obtain or maintain the incremental volume the insurer has threatened to take away. In doing so, NYP does not penalize or threaten insurers. It approaches rate negotiations based on the incremental profit principle enunciated in *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2008), and *Ortho Diagnostic Systems, Inc. v. Abbott Laboratories, Inc.*, 920 F. Supp. 455 (S.D.N.Y. 1996).

NYP respectfully denies that patients are "deprive[d] … of choice among [a] full spectrum of [hypothetical] health insurers plans, where patients could decide for themselves whether going to NYP for care is worth NYP's high prices." Restricted Choice Networks do not provide patients with more choice than the Open Access Networks NYP's contracts guarantee. Patients do not benefit from being compelled to participate in plans that deny them care at preferred providers.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

6. NYP's anticompetitive conduct insulates it from price competition—or, as NYP calls it, "erosion of rates of payment"—and helps it to maintain its high prices. Without its unlawful contracts, NYP would need to compete more vigorously against other providers, and its rivals could compete to attract additional patients by lowering their own prices or investing in quality improvements. All employers and patients who purchase healthcare in New York City would benefit from lower prices and higher quality as the healthcare marketplace becomes more competitive.

Answer: NYP's contracts reflect the outcome of vigorous competition. The Complaint's citation to provisions guarding against insurers' arbitrary "*administrative* erosion of rates of payment" in misplaced—those simply address insurer denials of payment for services rendered.

This is not related to steerage or any of the contractual terms at issue here. NYP denies that the All Products provision raises prices or prevents the "erosion of rates."

NYP's rates of payment with a particular insurer would likely be higher, not lower, without the challenged contractual provisions. NYP extends discounts to maintain Open Access Networks that include NYP. If the insurer chose nonetheless to exclude NYP, then NYP would have to spread its fixed costs across a smaller volume base, resulting in rate increases.

NYP denies that its rivals have *decided* not to compete on price or have *intentionally* withheld investment in quality because of NYP's contracts. Every provider competes for inclusion in insurers' networks at stage one, and then competes on price and quality at stage two against every other provider admitted to the network at the same benefit level. Because providers must compete against NYP in Open Access Networks (but not in Restricted Choice Networks that exclude NYP), rivals face *greater*, not less, competition as a result of the challenged provisions.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

7. The United States of America brings this civil antitrust action to stop NYP from using unlawful plan restrictions that lessen healthcare competition in New York City in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. NYP's restrictions deter the emergence and development of money-saving health insurance plans and reduce competition among hospitals and other providers on both price and quality. The result is reduced choice of insurance plans, higher healthcare costs, and less competition for high-quality healthcare for employers and patients who purchase healthcare in New York City.

Answer: This allegation is repetitive of the prior paragraphs. To the extent a further answer is required, NYP denies the allegation in its entirety.

NEW YORK-PRESBYTERIAN

8. NYP is a not-for-profit healthcare system with its principal place of business in New York City. NYP owns or manages hospitals, outpatient facilities, and physician groups throughout New York City. Its two flagship facilities are New York-Presbyterian/Columbia University Irving Medical Center and New York-Presbyterian/Weill Cornell Medical Center. It operates a total of eight general acute care hospitals in the New York area, which includes six hospitals in New York City and four hospitals in Manhattan.

Answer: Admitted.

9. Although larger and more powerful than its rivals, NYP competes with other hospitals and hospital systems in Manhattan and New York City, including Mount Sinai, NYU Langone, and Northwell, all of which are academic medical centers that offer hospital services. Mount Sinai operates six hospitals in New York City, including four in Manhattan; NYU Langone operates three hospitals in New York City, including two in Manhattan; and Northwell operates six hospitals in New York City, including two in Manhattan

Answer: NYP admits that it competes with other hospitals and hospital systems, including Mount Sinai, NYU Langone, Montefiore Einstein, and Northwell Health. NYP also competes with approximately 60 other acute care hospitals in the city, and with scores of others in the New York Metropolitan area, and throughout the nation. However, NYP denies that it is larger or more powerful than its competitors. For example, Northwell is considered by the American Medical Association to be the "largest not-for-profit health system in the Northeast" and is affiliated with the largest physician group in the New York area.[16] Similarly, Health + Hospitals – a city-backed competitor – is also far larger than NYP and possesses substantially greater market power. To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

10. NYP has substantially higher prices than its competitors, even though its major competitors offer similarly high-quality healthcare. For example, NYP's prices are significantly higher than its two largest rivals, NYU Langone and Mount Sinai, which are both academic medical centers with prestigious medical schools, significant research programs, and strong reputations for quality.

Answer: On an apples-to-apples basis, properly adjusted for patient mix, acuity, and other factors, NYP's rates are comparable to those of similarly situated providers.

[16] *Northwell Health*, AM. MED. ASS'N, https://www.ama-assn.org/topics/northwell-health (last visited May 19, 2026) ("Northwell is the largest not-for-profit health system in the Northeast, serving residents of New York and Connecticut with 28 hospitals, more than 1,000 outpatient facilities, 22,000 nurses and over 20,000 physicians."); *We are Northwell Fact Sheet* 2, NORTHWELL HEALTH (Apr. 2022), https://www.northwell.edu/sites/northwell.edu/files/2022-04/we-are-northwell-fact-sheet-april-2022.pdf.

The alleged comparison is not based on any disclosed data or any reliable methodology. Both NYU and Mount Sinai are large systems with different mixes of patients and services across many locations. While NYP does not know the specific rates those systems charge or how they negotiate them, industry practice suggest they likely negotiate rates for all their services – and potentially for adjacent services, like physician services – with insurers simultaneously, making it nearly impossible to adjust for implicit bundling and cross-subsidization.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

11. NYP has market power over payors, which it uses to extract high reimbursement rates for treating commercially insured patients across a range of services. NYP's market power is built on the scale, breadth, and configuration of its providers, including, among other things, its large size, many locations, and strong brand and reputation. NYP leverages its market power to effectively force the major payors that offer commercial insurance to patients in New York City to contract with it on an all-or-nothing basis, which means that the payor must include all of NYP's hospitals (including associated outpatient facilities and other healthcare services) in its networks if it wants to have any NYP facilities or services in its network. Payors cannot resist this exercise of market power because they cannot viably do business in New York City without at least one plan that includes access to NYP's hospitals. NYP's market power is further evidenced by its ability to impose on payors the anticompetitive plan restrictions that are the focus of this Complaint.

Answer: Denied.

NYP has a minimal market share and lacks market power. In addition, the Complaint's market definition is flawed at both at the product and geographic level. The relevant product market is not a single-sided provider market, but the two-sided market in which insurers intermediate transactions between providers and their patients. In this market, the insurers hold all the power.

On the provider side of this market, NYP does not possess market power. The Complaint does not include significant market share in its list of reasons why NYP has market power. Instead, it asserts that NYP has "scale, breadth, and configuration of … providers," which along with a

"strong brand and reputation," makes it desirable to patients. This is not an allegation of market power—it confirms that NYP cares about the health and well-being of the community.

That insurers and patients choose NYP for some small percentage of their care does not mean that NYP has exercised "power." NYP does not force major payors to contract with it on an all-or-nothing basis. Rather, insurers generally prefer Open Access Networks to Restricted Choice Networks. In the few instances where insurers wanted to penalize patients for exercising their freedom of choice, NYP has not refused to deal with the insurer. Instead, it has offered to negotiate appropriate exceptions and exclusions from its contracts. Insurers that want to develop Restricted Choice Networks have always been, and remain, free to negotiate rates with NYP at contract renewal based on the incremental volume associated with their plan design decisions.

To the extent not expressly denied, NYP denies all other allegations in this paragraph.

12. NYP knows the implications of its plan restrictions. In a recent strategic planning document, NYP acknowledged that there is "consumer price sensitivity" among patients. If consumers could act on this sensitivity through budget-conscious plans, NYP may experience "pricing pressure" because of its high prices, which may "impact [NYP's] margins"—that is, the profits it garners from treating patients.

Answer: The Complaint cites a document that simply discusses the well-documented trend toward outpatient ambulatory care—the migration of treatments that historically required inpatient hospitalization to outpatient ambulatory centers. Nothing in the document refers to "budget-conscious" insurance plans, or the hospital-to-hospital *inpatient* competition at issue here.

The document also contradicts the Complaint's allegations that NYP is insulated from "payer steerage" or immune from the effects of "consumer price sensitivity."

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

JURISDICTION AND VENUE

13. The Court has subject-matter jurisdiction over this action under 28 U.S.C. §§ 1331, 1337(a), and 1345. Plaintiff brings this action pursuant to Section 4 of the Sherman Act, 15 U.S.C. § 4, to prevent and restrain violations of Section 1 of the Sherman Act, 15 U.S.C. § 1. The Court

has personal jurisdiction over NYP under Section 12 of the Clayton Act, 15 U.S.C. § 22. NYP maintains its principal place of business and transacts business in this District.

Answer: NYP admits that it maintains its principal place of business and transactions business in this District.

14. Venue is proper under 28 U.S.C. § 1391 and Section 12 of the Clayton Act, 15 U.S.C. § 22. NYP transacts business and resides in this District and the events giving rise to this action occurred in this District.

Answer: NYP admits that it transacts business and resides in this District, and that some of the events giving rise to this action occurred in this District.

15. NYP engages in interstate commerce and in activities substantially affecting interstate commerce. NYP provides healthcare services for which employers, payors, and individual patients remit payments across state lines. NYP also purchases supplies and equipment that are shipped across state lines and otherwise participates in interstate commerce.

Answer: NYP notes that the Complaint's allegation that the activities at issue involve conduct that "crosses state lines" defeats its alleged market, which is limited to confines of Manhattan or four of the five Boroughs of New York City. NYP does not otherwise dispute that it engages in interstate commerce.

HOSPITAL COMPETITION BENEFITS PATIENTS AND EMPLOYERS

16. Hospitals and hospital systems (all called "hospitals" here for convenience) participate in commercial insurance plans that payors sell directly to individuals and, more often, to employers or other plan sponsors such as unions. Payors individually negotiate reimbursement rates and contract terms with each hospital so that their members can use the hospital's services. Payors design the commercial features, such as premiums, co-payments, and deductibles, for each plan they sell. Two important plan features that payors negotiate with hospitals are the hospitals and other providers to include in each specific plan and how much members will pay for various healthcare services.

Answer: NYP admits that insurers design plans with specific network participation requirements and benefits levels to attract providers, employers, and patients. But the Complaint's description of the competitive dynamic fails to recognize the two-sided nature of the market or the immense bargaining power and control insurers wield.

Healthcare contracting is inherently multi-sided. Insurers, providers, patients, and employers are all linked through a single contracting platform, with insurers at its center, intermediating the relationships among them and controlling which providers patients can see and which patients providers can treat.

Insurers' steerage – accomplished through an interrelated set of incentives and penalties, generally referred to as "plan benefits" – is integral to this two-sided market. If insurers steer too heavily, they deny patients choice, rendering the insurance plan less attractive to them. If insurers steer too lightly, they deliver less volume to favored providers, and network participation becomes less attractive to those favored providers. Insurers must therefore balance both sides of the market through what they unilaterally decide is their profit-maximizing level of steerage.

Armed with the power to steer, insurers then "individually negotiate reimbursement rates and contract terms with each hospital" for network inclusion. The Complaint correctly notes that reimbursement rates and network access provisions – including the provisions it challenges here – are inseparable and ancillary to the resulting agreement. Participation in the network is the *quid pro quo* for the rate concession.

NYP denies, however, that insurers negotiate with providers over "how much members will pay for various healthcare services." Insurers retain sole and exclusive discretion to establish the set of incentives and penalties – colloquially, "plan benefits" – that determine what patients actually pay. Hospitals may negotiate the rates they charge *insurers*, but patients pay what insurers tell them to.

When an insurer creates an Open Access Network, it is agreeing *not* to penalize patients or to discriminate. When an insurer offers to create a Restricted Choice Network in exchange for a

rate concession from a favored provider, it is, by definition, promising to penalize patients who use excluded providers.

NYP has only affirmatively negotiated to participate in Open Access Networks; and has not requested that any insurer penalize patients or discriminate against its rivals. NYP has not asked for or agreed to any exclusionary network participation agreement. NYP has declined to participate in such Restricted Choice Networks, believing that patients should be free to obtain care at the provider of their choice. NYP declined a demand for additional rate discounts from one major commercial insurer in exchange for excluding NYP's rivals from its contemplated Restricted Choice Network. NYP has not entered into any agreement that excludes or restrains competition.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

17. Many employers and other plan sponsors offer their employees or members a choice among insurance plans that differ in their benefit features because consumers value these features differently. Payors generally offer broad network plans that appeal to consumers who are willing to pay higher premiums for the benefit of access to a broad panel of providers in their area. Payors in competitive markets across the United States also generally offer plans that either allow their members to save money by using a more limited network of cost-effective providers or require members to pay more for choosing more expensive providers. These plan designs create incentives for patients to use certain providers and are sometimes called "steered plans" because they may influence patients' decisions about where to receive treatment. These "steering" features reward competition by allowing hospitals or other providers to compete to be included or featured in the plans.

Answer: This allegation concerns the variety of health plans insurers offer in the insurance market—a market in which NYP does not participate and over which it has no control.

NYP does not know what plans insurers offer employers.

The Complaint confirms that this case involves the system of incentives and penalties insurers use to control patient provider choice, otherwise referred to as "steering." These plans restrict patient choice by making it uneconomical to seek care at providers the insurer disfavors. In effect, a patient who uses a disfavored provider is forced to pay twice for coverage: first, when

the patient pays premiums for coverage (often through direct payroll deductions), and again when the insurer denies full coverage at point of care. The Restricted Choice Network plans the Complaint refers to as "Steered Plans" thus impose significant harm to patients who are channeled into them by their employers.

Steering does not "reward" competition. It aggregates the individual purchases of patients and channels them through a single gatekeeper—the insurer. But the DOJ previously conceded that this control gives the insurer significant monopsony power, which they use to depress reimbursement rates, "likely leading to a reduction in quantity or degradation in quality."[17] The DOJ has previously alleged that insurers in the downstate New York market – including New York City – operate in a highly concentrated buyside insurer market and presumptively exercise monopsony power in their dealings with providers.[18]

To the extent not expressly admitted, NYP denies the allegations of the Paragraph.

18. Although not all patients or employers choose to save money by using plans with cost-saving plan designs, patients and their employers deserve the opportunity to make these choices. Health plans that allow patients to save money by choosing not to use high-cost providers may particularly appeal to budget-conscious employers and patients.

Answer: Patients and employers deserve the opportunity to choose among the health insurance plans that insurers have decided to offer. In most cases, however, insurers have chosen to offer plans with Open Access Networks for the reasons explained above. These plans maximize competition among providers and provide patients with greatest choice.

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[17] Competitive Impact Statement, *United States v. United Health Grp., Inc., et al.*, 05-cv-02436, ECF 10, at 8 (D.D.C. Mar. 3, 2006).

[18] Plaintiffs' Proposed Finding of Fact, *U.S. v. Anthem*, 2016-cv-1493, ECF 483, ¶ 404-407 (D.D.C. Dec. 20, 2016) (noting that, because of insurers' monopsony power, "reduced payments to providers may compromise quality of care.").

Even within Open Access Networks, insurers retain many ways to steer "budget conscious" patients to lower priced, lower-quality facilities—including co-insurance, deductibles, and policy limits and exclusions. NYP denies that the Restricted Choice Networks would benefit patients or employers.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

19. Budget-conscious plans can take a variety of forms. But they all emphasize competition, either by creating price competition among hospitals and other providers to be included in a network or by creating competition among hospitals and other providers to attract patients once the provider is included in a health network. The tools that payors can use to create budget-conscious plans can be used either in combination with each other or on their own. Some of these tools are described below.

Answer: These so-called "budget conscious" plans all involve Restricted Choice Networks, in which patients are forced to pay ***more*** for their provider of choice. That benefits neither patients nor competition.

Ex ante, Restricted Choice Networks eliminate competition. If the excluded provider were permitted to compete *ex ante* for inclusion in the network, and succeeded, the resulting network would *not* be Restricted Choice Network at all; it would be an Open Access Network, and the contract would contain a provision like the All Products provision the Complaint challenges. In fact, the only way to prevent Restricted Choice Networks from becoming Open Access Networks – and to guarantee, by central planning or judicial decree, a market where Restricted Choice Network plans persist – is to prevent providers from competing to participate in such networks.

That is the antithesis of competition. As the Supreme Court has held, "competition for increased market share is not activity forbidden by the antitrust laws."[19]

[19] *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 116 (1986).

Restricted Choice Networks also eliminate *ex post* competition by preventing excluded providers from competing for patients within the network. Open Access Networks, by contrast, preserve that competition: every in-network provider remains free to compete for patients on both *quality and price*.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

20. **Narrow network plans** include a relatively limited set of cost-effective providers. When a payor creates a narrow network, it gives providers an incentive to offer competitive prices to participate in the plan in exchange for the added patient volume from being included in the network. Payors recruit cost-effective providers to participate in narrow networks because they are willing to provide services at lower prices. Providers are also sometimes willing to discount their prices to participate in narrow network products in exchange for the incremental flow of patients that may result from being included in a narrow network. Narrow network plans can charge lower premiums to employers and patients than broad network plans because the payors are not paying as much to providers. Some employers will offer employees a choice between narrow and broad network plans, allowing the employee to pay the additional cost for the broad network plan if the employee values the additional provider options.

Answer: Narrow network plans are Restricted Choice Networks that penalize patients for using providers the insurer disfavors. When an insurer promises a provider that it will steer patients to that provider and will penalize patients who use rivals, the favored provider can spread fixed costs across a broader volume base. The disfavored provider – forced to cover similar fixed costs across a smaller volume base – must proportionately raise its own rates.

Insurers may also use narrow networks to steer patients to lower-*quality* providers, which is a form of quantity or demand suppression associated with the exercise of monopsony power. For example, HMOs, which are a type of health insurance plan, are the quintessential Restricted Choice Narrow Network. As Judge Posner explained:

> "Many people don't like [HMO's] because of the restriction on the patient's choice doctors or because they fear that HMOs skimp on service… The HMO's incentive is to keep you healthy if it can but if you get very sick … to let you die as quickly and cheaply as possible…. HMOs compensate for these perceived drawbacks by

charging a lower price…. All that is important [is that] … HMOs are not an unalloyed blessing."[20]

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

21. **Tiered network plans** use broad networks but reward members with lower out-of-pocket expenses if they choose cost-effective providers in the preferred tier within the network. For example, a plan may charge members different co-insurance payments for hospitals in different benefit tiers. Payors may assign a lower co-insurance payment to lower-cost hospitals to give members an incentive to use hospitals that offer better value. Members of tiered network plans can choose to receive care from the lower-priced preferred tier of providers or to pay more for care from the more expensive tier of providers.

Answer: Tiered networks are Restricted Choice Networks. Nominally, they include all providers in the network. But because insurers impose penalties that force patients to forego disfavored providers, lower tiered providers are effectively out-of-network.

Contrary to the Complaint's allegation, the mechanism of exclusion is not patient financial responsibility itself; it is the *discriminatory* use of coinsurance as a penalty. Non-discriminatory patient financial responsibility – a uniform percentage across all providers (such as 20% of charges) – facilitates stage-two price competition in both Open Access Networks and within tiers of Restricted Choice Networks. If Provider A charges twice as much as Provider B, the patient's financial responsibility for Provider A is twice that for Provider B, and the patient chooses accordingly. That is competition operating through price and is a feature of many insurance plans.

Tiered networks are different. They assign providers to tiers and impose patient responsibility differentials – or other economic terms – that bear no relationship to the *actual* price difference between the providers. An insurer may, for example, impose a 20% financial responsibility penalty on patients who use a disfavored provider while giving patients who use a

[20] *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995).

favored provider a free pass. That is not proportionate to the provider rate difference and is just a penalty.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

22. **Centers of excellence** give patients with broad network plans an incentive to seek specific healthcare services from designated groups of providers that offer better value within a broad network. When creating a center of excellence, payors identify specific cost-effective programs of excellent quality—such as orthopedic surgery or oncology programs—and encourage their members to choose care at those facilities by reducing or waiving the fees that the patient must pay. Members can then choose whether to seek care from the "center of excellence" providers that their plan has designated or to seek care from costlier providers at a higher price.

Answer: As the Complaint acknowledges in this Paragraph, the term "Centers of Excellence" as used by insurers is a misnomer. Insurers make cost-based determinations about the providers to whom they want to steer patients. They will then award them the moniker "Center of Excellence" using metrics that treat price as a significant, if not predominant, factor alongside a few minimum quality criteria. That does not make "Centers of Excellence" centers excellent. Nonetheless, insurers use the moniker to create Restricted Choice Networks that penalize patients who choose providers that have not been so designated.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

23. **Site of service steering** is a plan feature that saves patients money by incentivizing them to have procedures done in a lower-cost location (site of service)—such as an ambulatory surgery center—instead of a higher-cost site of service, such as a hospital.

Answer: NYP admits that insurers could create Restricted Choice Networks by imposing "site of service" policies, restrictions, and penalties. The policies have nothing to do with provider-to-provider *inpatient* competition, which is the focus of the Complaint's market definition and claim.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

24. Because these plan design tools allow members to save money by choosing cost-effective hospitals and other providers while still obtaining high-quality care, they create price and quality competition among providers. Not all patients choose plans with these money-saving

features, just as not all consumers choose lower-cost products in other areas of their lives. But the ability to make that choice as a consumer is the very essence of competition. NYP impedes this competition by restricting payors from offering budget-conscious plans that would result in more patients choosing rival hospitals and other providers instead of high-priced NYP providers. NYP's restrictions do not allow the essential features of competition to take hold in New York City.

Answer: Denied.

NEW YORK-PRESBYTERIAN VIOLATES THE SHERMAN ACT

A. New York-Presbyterian's Contractual Restrictions Unlawfully Restrain Competition

25. NYP restricts payors from designing and offering budget-conscious plans that promote competition among healthcare providers. Instead, NYP effectively forces payors to include NYP in almost all networks for commercial insurance products and requires that NYP be featured at the most favored level of benefits in each plan, regardless of how NYP's prices compare to its competitors. Illustrating how NYP insists upon this treatment, NYP told a payor that had attempted to exclude it from a network that NYP "expect[s] to be in every network offered." Rather than compete to earn the opportunity to be in payors' networks through lower prices or better value, NYP relies on its market power to impose contractual restrictions to ensure its participation.

Answer: NYP denies that it has restricted payors from designing or offering "budget conscious" Restricted Choice Networks. The Complaint also miscites the document it purports to quote. The document summarized a junior executive's phone call with an insurer that indicated it was considering creating some unspecified Restricted Choice Network. The insurer relayed a rumor he heard from some unidentified third-party that NYP would be "ok with being excluded" so long as the insurer agreed to exclude NYP's competitors. The executive correctly responded that the rumor was inconsistent with NYP's general contracting practices, which is to offer discounts in exchange for NYP's *inclusion*, not for competitors' *exclusion*.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

26. NYP's plan restrictions deter the payors that account for a dominant majority of commercial health insurance business in New York City from introducing budget-conscious plans that exclude or charge more for access to NYP's hospitals. Payors that serve New York City already design and offer budget-conscious plans in other parts of the United States. These payors want to provide budget-conscious plans in New York City too but are restrained from doing so by NYP's plan restrictions. For example, a commercial payor repeatedly reported to NYP that it needed "to offer a low-cost insurance option in the NY market," but NYP's unlawful plan

restrictions prohibited it from creating a viable product. Similarly, payors have frequently sought to change their plan designs to favor less expensive providers, only to be told by NYP that they are violating their contract with NYP

Answer: NYP admits that the five insurers that this lawsuit will benefit would represent the "dominant majority of commercial health insurance business in New York City" and have market power in the alleged provider, insurance, and two-sided markets at issue in this case.

NYP denies that NYP has deterred these dominant insurers from introducing Restricted Choice Networks. A customer that buys from Provider A because it offered a better deal has not "deterred" Provider B from competing. Here, the Complaint only alleges that NYP offered attractive rates to insurers to encourage them to keep NYP as an in-network provider. That is not restriction on competition. It is simply an offer to sell a service.

Nor have insurers been restrained from creating and offering Restricted Choice Networks. As noted earlier, several such networks have been offered, and NYP has not refused to do business with the insurers that have offered them.

The Complaint takes out of context a 2017 comment by one insurer who was considering entering into an agreement with a large NYP's competitor to penalize patients who choose NYP. Under the insurer's proposal, the insurer would impose *thousands* of dollars of penalties on *each* patient who chose NYP for their care. Notably, the insurer also believed that the proposed "offering is unattractive and unlikely to have any material enrollment." Nonetheless, NYP offered to negotiate rates based on NYP's exclusion from the proposed Restricted Choice Network.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

B. Inpatient General Acute Care Hospital Services Are a Relevant Product Market

27. Defining a relevant product market helps courts assess, among other things, the products or services for which the defendant wields market power and the anticompetitive impact of the challenged restraints. Although the contractual restrictions imposed by NYP affect both inpatient services and other NYP healthcare services, the sale of inpatient general acute care

("GAC") hospital services to commercial payors and their members is a relevant product market in which to assess the market power that NYP wields and the competitive effects of NYP's contractual restrictions. The market includes sales of such services to payors' individual and group, fully insured and self-funded health plans.

Answer: A relevant market is a required element in a rule of reason vertical restraint case. NYP denies that the single-sided General Acute Care hospital services market is the relevant market in which to assess insurers' network design and plan benefit decisions.

The relevant market in which to assess insurers' network and plan benefit design decisions is the two-sided network market in which insurers intermediate healthcare transactions between patients and employers on one side and the provider on the other.[21] On provider side, the insurer negotiates inclusion or exclusion from the network. On the patient/employer side, the insurer markets plans to employer and designs benefits packages that steer patients to particular providers.

Strong indirect network effects link the two sides. A broader network – or fewer provider restrictions – makes the plan more attractive to health plan enrollees; a larger enrollee base – or enhanced steering power – makes network participation more attractive to providers.

As such, an insurer can make its plan more attractive to the patients *either* by lowering premiums or by expanding the provider network. Similarly, the insurer can make participation more attractive to providers either by increasing rates or by attracting or steering more patients. Those are two sides of the same coin, working in opposite directions. *See* François Bardey & Jean-Charles Rochet, *Competition Among Health Plans: A Two-Sided Market Approach*, 19 J. Econ. &

[21] The relevant market is not only a two-sided network market, it is also a two-sided transaction market. This is most obvious when the insurer acts as a third-party administrator. In that case, the employer pays the TPA for the care delivered to the patient, and the TPA pays the provider for that same care. Though partially obscured, the same is true even when the insurer acts as an insurer. In that case, the risk-diversification function is layered on top of the same transaction market, but there is still an obligation that flows from the insurer to the patient, and a *simultaneous* obligation that flows from the insurer to the provider at the point of care for the service provided.

Mgmt. Strategy 435, 437 (2009) (discussing two-sided network effects and noting "health plans compete for policyholders on one side but also compete to attract physicians on the other").

Elsewhere the Complaint recognizes that the market is a two-sided market, because the alleged anticompetitive effects occur solely on the patient/employer side of the market. The Complaint alleges no provider-side harm—no lessening of output, no reduction in the number of competitors, no forestalled entry, and no increase in rivals' marginal costs. But on the patient/employer side, the Complaint alleges price effects, including reduced availability of "budget-conscious health insurance plans." Providers neither purchase nor sell the plans and don't participate in that side of the market.

Because insurers operate in a highly concentrated market, in which they "account for a dominant majority of commercial health insurance business in New York City," they possess significant market power, which allows insurers to profit from spread between the two sides of the market—the rates charged by the provider and the fees paid by the patient or employer.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

28. Inpatient GAC hospital services consist of a broad group of medical and surgical diagnostic and treatment services provided to adult and pediatric patients that include the patient's overnight stay in the hospital. Although individual inpatient GAC hospital services are not substitutes for each other (e.g., obstetrics is not a substitute for cardiac services), payors typically contract for the various individual inpatient GAC hospital services as a bundle, the services are sold under similar competitive conditions, and NYP's contractual restrictions have an adverse impact on the sale of all inpatient GAC hospital services. Therefore, individual inpatient GAC hospital services can be analyzed together.

Answer: Denied.

"In the United States today, most hospital care is bought in two stages. [*First*,] insurers and hospitals negotiate" over network inclusion and reimbursement rates; *second*, "hospitals

compete to attract patients."[22] Here, the Complaint's claims are focused on the first stage of the competition—the terms on which insurers negotiate with providers for inclusion in or exclusion from insurers' networks. So, if the Court were to determine, over NYP's objection, that the appropriate market is single-sided, the relevant market would be the collection of healthcare services insurers purchase from providers for inclusion in their health plans in stage one, not the individual services a particular patient may purchase from the hospital in stage two.

Insurers do not enter into separate contracts for the purchase of individual services at point of care. They enter into annual or multi-year contracts with providers for network inclusion for a comprehensive array of healthcare services across broad geographic regions in order to assemble a "network" or roster of providers for the comprehensive plans they offer to employers.

No insurer has negotiated with NYP for just GAC services in Manhattan or the Four Boroughs. As such, there is no *stage one* market for GAC services in Manhattan because no insurer enters into individually negotiated contracts for such services. That is, the product the DOJ claims is a "relevant market" is not an actual product that anyone buys or sells.

That is not because NYP "ties" separate services together. Insurers themselves want to lock in rates across the full panoply of services they offer to enrollees, both for their own economic certainty and to design coherent benefits packages. They want to list participating providers, not a jigsaw puzzle of provider-specific included and excluded services that patients have to try to piece together.

That is why insurers and providers *throughout the country* – without regard to any market power – routinely contract based on the full range of healthcare services the provider offers. This results in price negotiations that are largely not service-specific and that often involve cross-

[22] *FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016).

subsidization among the services. Under *Brown Shoe's* "commercial realities" test, that precludes finding a market is limited to just one component service that ***no one*** individually contracts for.

Closer to home: Insurers offer employer healthcare plans for the full range of healthcare services patients need. They do not offer cardiac health insurance, knee-replacement insurance, etc. This is true even though no insurance plan would be viable without cardiac coverage. The relevant market is health insurance, not cardiac health insurance, which cannot be individually purchased. Nor does the Complaint allege, when it asserts anticompetitive effects, that there has been any increase in markets for "GAC health insurance plans" because such plans do not exist.

So too here. Insurers contract with providers for the full range of services they offer and that insurers want to include in their plans. Providers, therefore, are competing against all other providers that are, or could reasonably be, included in those plans, even though each one offers a slightly different but overlapping mix of services.

The relevant market, therefore, is the market for healthcare services offered to insurers for inclusion in healthcare plans. In that market, insurers have many options, and pricing dynamics depend on the interrelationships across products and geographies that are included in the plan.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

29. Inpatient GAC hospital services do not include psychiatric care, substance abuse, rehabilitation services, or outpatient services, as these services may be offered by a different set of competitors under different conditions from inpatient GAC hospital services and are not substitutes for inpatient GAC hospital services. The relevant market also does not include sales of inpatient GAC hospital services to government payors, e.g., Medicare (covering people age 65 and up or people with certain disabilities or medical conditions), Medicaid (covering low-income persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations for commercial insurance plans are separate from the process used to determine the rates paid to providers by government payors.

Answer: Denied.

To the extent the Complaint is simply defining what it proposes as a candidate market, the allegation is a definition, not an allegation of fact. To the extent, the allegation purports to reflect how healthcare services are bought and sold during stage one competition, it is wrong.

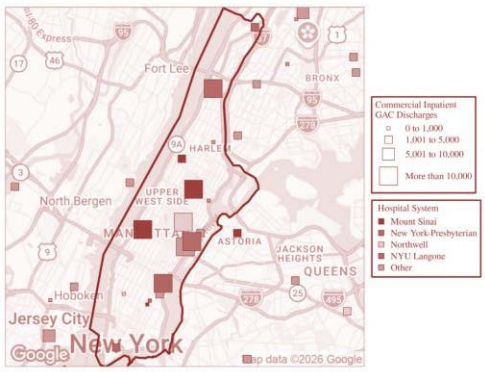
To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

30. There are no reasonable substitutes or alternatives to inpatient GAC hospital services. Consequently, a hypothetical monopolist of inpatient GAC hospital services sold to payors would likely profitably impose a small but significant price increase or other worsening of terms for those services over a sustained period of time.

Answer: Denied.

C. Manhattan, and the Four Boroughs of the Bronx, Brooklyn, Manhattan, and Queens, are relevant geographic markets.

31. Defining relevant geographic markets helps courts assess, among other things, the geographic area in which NYP wields market power and the anticompetitive impact of the challenged restraints. The borough of Manhattan is a relevant geographic market. The following map shows the GAC hospitals located in and around Manhattan.



Answer: NYP denies that Manhattan is a relevant geographic market.

Insurers do not negotiate separately for Manhattan GAC hospitals, and there is significant outmigration out of Manhattan to other areas, and significant in-migration from other areas into Manhattan. Hospitals outside of Manhattan compete successfully for patients that would otherwise go to Manhattan hospitals.

Manhattan residents may choose to go to other boroughs for in-patient hospital services. This is especially true of people who live in "border communities" in Manhattan, which includes

those zip codes closest to neighboring boroughs. For example, residents in Uptown Manhattan neighborhoods such as Inwood, Washington Heights, or Fort George may choose to receive inpatient GAC services in a hospital in the South Bronx as opposed to one in Manhattan. Moreover, many services performed on a non-emergency basis – the type of which are most susceptible to insurers' steering restraints – involve much larger geographic service areas.

In addition, insurers do not sell health plans just to residents or employers in Manhattan; they sell their plans to employers or members in broader geographic areas. The provider networks insurers consider the entire geographic reach of their membership and the full spectrum of covered services when deciding which providers to contract. For that reason, insurers typically do not contract with providers just on the basis of GAC services within a narrow geographic area, but across the entire system. For example, most insurer plans marketed to employers and patients in New York City include hospitals such as Hackensack Meridian, RWJ Barnabas, Atlantic Health, Yale New Haven, Stamford, and dozens of other hospitals across the three states. And because different providers and systems provide different but overlapping services and geographic reach, the market must include all overlapping providers.

A hypothetical monopolist of a GAC services in Manhattan could not profitably increase prices above competitive levels. Competing systems can defeat any such increase by offering offsetting discounts on other services or in other regions. For example, NYU operates a large network of Ambulatory Centers and can, if it wants to, cross-subsidize lower GAC rates at its flagship hospitals with higher ASC rates, or vice versa. Northwell too has many facilities outside of Manhattan and can cross-subsidize lower Manhattan GAC rates with higher rates elsewhere. Each of these large systems negotiate with insurers on a system-wide, integrated basis, not on a piecemeal hospital-by-hospital, or service-by-service basis. The Complaint's proposed

implementation of the hypothetical monopolist test ignores this. But a geographic or product market that ignores the commercial reality of how services are actually contracted and sold is not a relevant market.

To the extent not expressly admitted, NYP denies all other allegations in this paragraph.

32. Manhattan is a geographic market in which market power in the sale of inpatient GAC hospital services can be exercised. It satisfies the hypothetical monopolist test. A hypothetical monopolist consisting of all hospitals in Manhattan likely would undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Many patients who seek healthcare in New York City prefer to receive inpatient GAC hospital services at the well-regarded hospitals in Manhattan. Because of this, a payor without any in-network hospitals located in Manhattan would not be competitive in selling commercial health plans to many employers and individuals in New York City, including those in Manhattan. To continue selling commercial health insurance to individuals and employers in New York City, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

Answer: Denied.

As an initial matter, the Complaint's articulation of the "hypothetical monopolist" test misses the mark. The test asks whether a hypothetical monopolist of all the sellers in the candidate market could profitably impose a small but significant and non-transitory price increase on all the products sold in that market. The thought experiment is designed to identify which products are reasonably close substitutes and should be considered part of the relevant market, and which products are too far removed and thus not a sufficiently strong constraining force on price. The thought experiment, however, is not a test of market power or competitive effects within the defined market. For that reason, the test requires that the price increase apply market-wide within the candidate market, not, as the Complaint alleges, a single price increase by a single hospital within the candidate market.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

33. The area comprising the boroughs of the Bronx, Brooklyn, Manhattan, and Queens is also a relevant geographic market (the "Four-Borough Market") in which market power in the sale of inpatient GAC hospital services can be exercised.

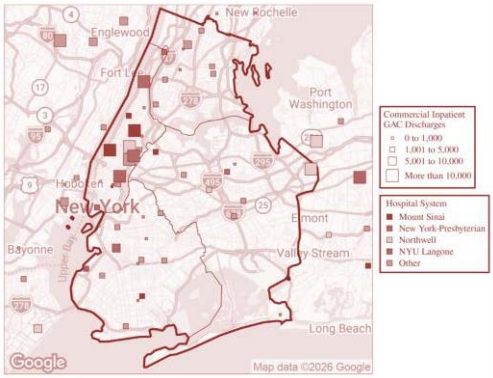
Answer: Denied.

34. The Four-Borough Market excludes Staten Island. Few patients using hospitals in the Four-Borough Market consider hospitals located on Staten Island to be a close substitute to hospitals in the Four-Borough Market.

Answer: Denied. The Complaint's exclusion of areas in the city where NYP does not have a hospital does not comport with any known market definition test. NYP serves many patients who live or work on Staten Island, meaning that NYP competes for those patients against hospitals that have their physical presence on Staten Island. For example, Staten Island University Hospital is an academic medical center affiliated with Northwell Health and has been recognized as having one of the top-rated cardiac surgery programs in the United States. Furthermore, patients in Brooklyn's "border neighborhoods," which includes those zip codes closest to neighboring boroughs, may decide to receive care in Staten Island if they believe it to be higher quality or if the nearest in-network hospital is on Staten Island. Similarly, residents in South Brooklyn neighborhoods of Bay Ridge, Dyker Heights, Fort Hamilton, and Bensonhurst, may choose to travel to Staten Island if their insurance has Northwell as an in-network provider but does not include systems present in South Brooklyn, such as NYU Langone or Mount Sinai, in network.

To the extent not expressly admitted, NYP denies all other allegations in this paragraph.

35. The following map shows the GAC hospitals in and around the Four-Borough Market.



Answer: NYP does not have sufficient information to deny or admit that this map is a fair and accurate representation of the information it purports to depict. NYP denies that this is, in fact, a relevant geographic market. To the extent not expressly admitted, NYP denies the allegations of this paragraph.

36. The Four-Borough Market satisfies the hypothetical monopolist test. A hypothetical monopolist that consists of all hospitals in the Four-Borough Market likely would undertake at least a small but significant increase in price or other worsening of terms over a sustained period of time for at least one hospital. Patients who seek healthcare in the Four-Borough Market prefer to receive inpatient GAC hospital services at the well-regarded hospitals in the Four-Borough Market and at hospitals that are close to where they live and work. Because of this, a payor without any in-network hospitals located in the Four-Borough Market would not be competitive selling commercial health plans to many employers and individuals in New York City. To continue selling health plans to individuals and to employers in New York City, payors would be forced to accept a price increase imposed by the hypothetical monopolist.

Answer: Denied. As set forth in response to Paragraph 27, the HMT test is not satisfied.

D. New York-Presbyterian Wields Market Power to Harm Competition

37. NYP has market power in inpatient GAC hospital services in Manhattan and the Four-Borough Market. NYP is by far the largest hospital system in both markets. In 2024, NYP's share of inpatient GAC hospital discharges was more than 30 percent in Manhattan and more than 25 percent in the Four-Borough Market.

Answer: Denied. NYP does not possess market power in the alleged relevant markets or in any well-defined relevant market. In this paragraph, Complaint seeks to infer market power from market share in its alleged relevant markets. But even then, NYP's market share is in the low teens.

There are many larger hospitals systems operating in Manhattan and the Four Boroughs, including the City's own Health + Hospitals system and Northwell. Other systems, such as Mount Sinai, Montefiore, and NYU are also of similar sizes. And systems that draw patients from the same patient pool are also of similar or larger size. In addition, NYP faces competition from other academic hospitals and regional hospitals that the Complaint has chosen to exclude.

Moreover, the Complaint ignores its own allegations that the five insurers "dominate" the market possess market power, which negates any ability of NYP to restrict output and raise prices above competitive levels. Indeed, the entire theory of this Complaint is based on output expansion, not output restriction, which is inconsistent with seller power.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

38. Market power confers the ability to raise prices above those that could be charged in a competitive market, and NYP's supracompetitive rates provide compelling evidence of its possession and exercise of market power. Unlike firms in a competitive market, NYP does not fear losing patients to its rivals if it charges higher prices than they do. NYP's most senior contracting executive testified that its rivals' offering of lower prices to payors "has no relevance to me." NYP can be unconcerned about its competitors' lower prices because NYP's market power allows it to impose plan restrictions that insulate it from price competition.

Answer: Market power in the hands of sellers confers the ability to restrict output, and thereby, raise prices above levels that could be charged in the absence of such output restrictions. Market power in the hands of buyers confers the ability to restrict demand, and thereby, lower prices below the levels that could be charged in the absence of such demand restrictions. The Complaint alleges facts only demonstrating insurer-side (or buyer-side) market power.

Here, the Complaint only alleges demand restrictions by insurers, not output restrictions by NYP or providers. The Complaint further concedes that NYP has obtained the incremental volumes associated with the Open Access Networks it challenges by offering lower – not higher – prices. That pricing pattern reflects buyer or insurer-side market power, not seller or provider side market power. Indeed, offering lower prices to obtain incremental volume is the essence of competition, and is necessarily procompetitive absent incremental prices below incremental cost (*i.e.*, negative incremental profit) that leads to competitive foreclosure of equally-efficient rivals, which has not been alleged.

NYP's rates of payment do not reflect the possession of market power. Higher rates for differentiated, higher-quality services are not evidence of market power; they are the expected

output of quality competition, especially where quality differences are the product of substantial investment. NYP offers the highest quality healthcare in the world; and it invests in equipment, facilities, and personnel to deliver such exceptional care. The fact that its rates may be higher than some of its other competitors who do not invest as much is not evidence of market power, but superior quality.

The Complaint's citation to a single testimonial snippet does not support its assertion. The actual quote is that "I have told payors for many years, the only thing that matters [is] the costs of doing business… If we negotiate rates payment that are below our costs of doing service, that's not particularly helpful. If other organizations have agreed to lesser amounts, that has no relevance to me." That is ***exactly*** the type of statement that any firm in a *perfectly* competitive market would make. It is also exactly the type of statement a seller subjected to the awesome power of a monopsonist would make when faced with the monopsonist's threats to restrict demand and depress prices below the competitive level.

The Complaint implies that NYP's contracting executives should give weight to rumors and unverified competitor pricing information is also misplaced. In competitive markets, sellers price their products based on their own costs and may not even know, much less focus on, what rivals are charging for their services. Hospitals often do not have reliable information about their competitors' prices, and so their prices are not relevant during the negotiation process. Moreover, antitrust laws can prohibit certain exchanges of pricing information among rivals and thus competitor's pricing information is irrelevant in negotiations. A lack of consideration of such information does not make each competitor a monopolist.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

39. The fact that large payors cannot do business in Manhattan or the Four-Borough Market without contracting with NYP is also telling evidence of NYP's market power. Because of

NYP's size, brand, and reputation, and the many hospitals and other providers it controls, a payor selling health insurance plans to individuals and employers in Manhattan and in the Four-Borough Market must-have NYP as a participant in at least some of its provider networks to have successful health insurance products. Without NYP—a large hospital system that is well-known by generations of New Yorkers—an insurance plan would not be attractive to the employers and residents who prefer a broad network plan that covers medical care from the full range of providers.

Answer: The Complaint's conclusory allegation that NYP is a "must-have" hospital is both incorrect and conflicts with other allegations.

The Complaint asserts that "large payors cannot do business in [the Complaint's incorrectly pled relevant markets] without contracting with NYP." But the Complaint offers no facts to support this assertion. The Complaint only alleges that insurers have opted for Open Access Networks for the majority of their books of business—except when they have chosen not to. That does not establish that NYP is a "must-have" hospital.

Indeed, the Complaint itself acknowledges that insurers have created several Restricted Choice Networks. The fact that these Restricted Choice Networks exist in the market today is evidence that NYP is not a must-have hospital, and also negates the unfounded assertion that NYP negotiates on an "all or nothing" basis.

More fundamentally, the allegation that NYP is a "must-have" hospital is inconsistent with other allegations. If NYP was a "must-have," insurers would not seek to exclude it from their networks because it is a "must-have." Indeed, it is precisely because NYP is ***not*** a must-have that insurers might want to create Restricted Choice Network plans that exclude it.

That many insurers have chosen to give patients choice by offering Open Access Plans is not evidence that a hospital is a "must-have." All hospitals offer features that make insurers want to include them in-network; that insurers do so does not give each hospital in the network "market power" as a "must-have" hospital.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

40. NYP understands that payors must contract with NYP to successfully sell health insurance and exerts this leverage in its negotiations with payors. Payors that sell commercial health insurance plans in the relevant geographic markets have tried to negotiate the removal of plan restrictions from their contracts with NYP, but NYP has summarily refused. The inability of large payors to overcome this costly refusal is further evidence of NYP's market power.

Answer: Denied.

NYP has always negotiated with payors to offer discounts to keep their networks open, non-exclusionary, and non-discriminatory, and where insurers insist on nonetheless imposing penalties on NYP's patients has always offered to negotiate based on the incremental volume for the incremental volume at issue. NYP has not summarily refused to negotiate with insurers over potential network exclusions or insurers' imposition of discriminatory penalties on patients who may prefer NYP. Instead, it has negotiated consistent with principles articulated in *PeaceHealth* and *Ortho*.

Insurers do sometimes try to renege on their agreement to include NYP as an in-network provider or otherwise breach their contractual commitments. But mid-contract conduct is governed by contract law, not free market forces.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

41. NYP's plan restrictions harm the process by which NYP and other Manhattan and Four-Borough Market hospitals would otherwise compete on the prices of the services they sell. Indeed, NYP recognizes the risk of increased competition that would occur without these restrictions in its disclosures to bond holders, noting that "[i]nsurers may further encourage competition among hospitals and providers on the basis of price, payment terms and quality" and that doing so "may lead to increased competition among hospitals based on price where insurance companies attempt to steer patients to the hospitals that have the most favorable contracts."

Answer: NYP's contracts reflect the outcome of the ideal operation of the competitive process.

Insurers seek to maximize their discounts by offering to grant non-exclusive, non-discriminatory in-network status to NYP across all of the patient demand the insurer controls. For its part, NYP has always competed for incremental volume by reducing its rates, consistent with

the principles articulated in *PeaceHealth* and *Ortho*. When insurers opt for Open Access Networks, NYP can spread its high fixed costs across a larger patient base, thereby allowing it to reduce rates. The price competition that NYP engages to keep insurers' networks open and non-exclusionary, rather than restricted and discriminatory, reflects competition in action.

And the results of this vigorous competition, when NYP is successful in competing to keep the networks open, are then memorialized in the parties' contract. In some cases, that memorialization takes the form of an express All Products clause (or some variation of it), in which the consideration for NYP's *ex ante* rate reductions is the insurers' express promise to preserve patient choice and keep the network open and non-exclusionary. In other cases, insurers decline to commit to open networks, even where they have no specific plans to create Restricted Choice Networks. In those cases, the parties remain free to renegotiate if the insurer decides to change its practices in ways that undermine the benefits of the bargain they had reached. Either structure reflects the free market reaching competitive outcomes among sophisticated contracting parties.

This is far more procompetitive than the Complaint's proposed remedy in which insurers pay to exclude competitors from insurers' networks. In the DOJ's view, Restricted Choice Networks are more procompetitive than Open Access Networks. But Restricted Choice Networks involve insurers demanding, and providers paying, money to exclude rival providers. NYP has declined to participate in such Restricted Choice Networks, believing that patients should be free to obtain care at the provider of their choice. For example, when a major commercial insurer demanded additional discounts to exclude NYP's rivals from its contemplated Restricted Choice Network, NYP declined.

NYP also denies that NYP's contracts have prevented other providers from competing on price. That price competition exists both *ex ante* and *ex post*. *Ex ante*, other providers lower their

prices to prevent themselves from being excluded from the network. That is, they do exactly what NYP does. They offer price discounts for inclusion, and when they are successful, the result is that the insurer opts for Open Access Networks, rather than Restricted Choice Networks that exclude them. The resulting contracts similarly memorialize that outcome, and thus, the All Products provision is, whether *de facto* or *de jure*, endemic in virtually all providers' contracts with all insurer health plans.

NYP's contracts also enhance price competition *ex post*. Whereas Restricted Choice Networks eliminate *ex post* price competition; Open Access Networks enhance it. Insurers typically include deductibles, policy limits, and co-insurance provisions as part of the benefits package. Each of these cause *patients* to choose among in-network providers based, in part, on price. Providers in Open Access Networks are, therefore, incentivized to set prices in ways that encourage patients to choose them over their rivals. The *ex post* price competition vanishes in Restricted Choice Networks. In those networks, the *insurer* penalizes patients for using out-of-network providers, so those providers have no incentive to set prices to compete for patients' business, and consequently, in-network providers do not need to set prices to compete with out-of-network providers. The steerage penalties in Restricted Choice Networks do all the work, leaving no room for *ex post* price competition.

The Complaint's citation to the "risk factors" section in NYP's SEC filings does not support that the theory that NYP's contracting practices restrict competition. The SEC filings do not speak to NYP's contracting practices, or the difference between Open Access Networks and Restricted Choice Networks. It simply reflects the fact that one risk factor for NYP is that insurers possess extreme levels of market power, and can use that power to adversely impact NYP. Indeed,

the fact that NYP had to disclose this risk factor runs counter to allegations that NYP wields powers and insurers have none.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

42. NYP uses its market power in inpatient GAC hospital services to impose both high prices and plan restrictions that obstruct the competitive process. These plan restrictions lessen competition between NYP and the other hospitals that provide inpatient GAC hospital services in Manhattan and the Four-Borough Market. Because of NYP's plan restrictions, NYP's rivals cannot effectively win more commercially insured business by offering lower prices or better value. The restrictions thus help insulate NYP from price competition and make it difficult for other hospitals to win patients and market share from NYP.

Answer: Prices do not "obstruct" the competitive process. The Sherman Act does not prohibit high or low prices; it prohibits unreasonably exclusionary or restrictive contracts. Prices are not restrictive or exclusionary. *Verizon Commc'ns Inc. v. Trinko*, 540 U.S. 398, 407 (2004) ("The mere possession of monopoly power, and the concomitant charging of monopoly prices, is not only not unlawful; it is an important element of the free-market system"). As noted, NYP's rate reductions – offered to keep networks open – is the antithesis of restrictive conduct and reflects the ideal operation of the competitive process.

NYP's rivals can effectively compete for more commercially insured business in many ways. *First*, providers can compete for Restricted Choice Networks *ex ante* by paying insurers more for exclusionary provisions that exclude NYP from a Restricted Choice Network than NYP is willing to pay to keep the network open and non-exclusionary. *Second*, providers can compete *ex post* by lowering their prices and encouraging patients – who are subject to deductibles, co-insurance, or policy limits – to choose them over their rivals, including NYP. *Third*, providers can compete simply by investing in their facilities, operations, and personnel to provide better quality than they currently offer.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

43. NYP recognizes that its plan restrictions protect its high prices. NYP's most senior contracting executive took credit for protecting NYP's plan restrictions and prices. He acknowledged: "Notwithstanding national and local trends to the contrary, [NYP] retained the Hospitals' … terms and conditions that protect against administrative erosion of rates of payment or steerage away from the Hospitals."

Answer: Denied.

The Complaint cites the same out-context documentary snippet it cited in Paragraph 6 above. As noted there, the document simply addresses insurers' arbitrary "*administrative* erosion of rates of payment," *i.e.*, insurer policies that relate to insurer's denial of payment for care already provided. That is unrelated to steerage or any of the contractual terms at issue here. Moreover, the separate comment – joined by the disjunctive "or" – relating to insurer steerage merely demonstrates that NYP was forced to continue offering substantially discounted rates to keep that insurer's network open. To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

44. NYP further recognizes that protecting its high prices through its plan restrictions benefits NYP's bottom line because payors, employers, and consumers would often seek care elsewhere if they had the option to choose budget-conscious plans. For example, during an internal planning process involving some of NYP's most senior executives, NYP calculated the financial impact to NYP if businesses and patients were able to implement budget-conscious plan designs. According to this analysis, the introduction of tiered plans alone would reduce profits by hundreds of millions of dollars, and other forms of steerage would also cause that same outcome for NYP. Similarly, NYP recognized that efforts by payors to incentivize patients to use providers who offer better value "could impact margins, particularly for standardized procedures."

Answer: The first document the Complaint cites is unrelated to the contractual provisions the Complaint challenges, or the creation of Restricted Choice Networks. It reflects analysis of hypothetical situations in which the federal or state government implements direct *rate regulation*, or insurers exercising their right to entirely exclude NYP from their networks or its functional equivalent—the banishment of NYP into non-economic and discriminatory tiers. The discussion about such Restricted Choice Networks relates solely to the loss of *volume*. It is unrelated to prices or rates.

Moreover, the document undermines the Complaint's characterization that NYP is a "must-have" and an insurer cannot credibly exclude NYP from the network. A genuine must-have hospital would not project hundreds of millions in lost profit from network exclusion because exclusion of that magnitude would not be possible. That NYP modeled such losses demonstrates the market power of insurers, and NYP's corresponding lack of market power.

The second document is just a repeat of the same document cited in Paragraph 12. It is unrelated to in-patient competition, competition among GAC hospitals, or the contractual provisions at issue.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

45. NYP has admitted that the mere risk that payors might implement steering in the future could increase competition and reduce prices in its market. In a 2023 bond offering memorandum for the issuance of $300 million of bonds, NYP noted that steering would be a risk to NYP's financial standing: "Payors have used the threat of patient steerage [in other markets] . . . to drive provider prices lower."

Answer: This is a rehash of the same document the Complaint cites in Paragraph 41. The Complaint's citation to the risk factors section of NYP's SEC filings does not support its claims.

The observation that insurers have used threats of patient steerage to lower rates is true, both in this market and in other markets. Indeed, the Complaint's theory is premised on the notion those threats do *not* occur in this market because those threats are not credible. The fact that NYP recognizes steerage as a risk factor proves that NYP is not a must-have hospital and that insurers can – and do – credibly threaten to discriminate against NYP in Restricted Choice Networks.

Indeed, insurers routinely – and effectively – threaten to exclude NYP from their networks. In several instances, insurers have gone so far as to publicly inform members that NYP is being excluded as a way to force NYP to lower its rates. The threat to exclude NYP from the network is the ultimate form of "patient steerage," and insurers have wielded that weapon to force NYP to

lower rates. Insurers' use of this threat also demonstrates that NYP is not a musthave provider, as the Complaint alleges, and that insurers, not NYP, possess the market power in the relationship.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

46. NYP uses its market power in inpatient GAC hospital services to impose the same plan restrictions on outpatient services. Outpatient services comprise a wide range of diagnostic, treatment, and surgical services that do not require an overnight stay, including but not limited to imaging, infusions, lab services, and less-complex surgeries. Outpatient services can be provided at hospitals but also at freestanding facilities. Outpatient services are included in the same contracts with payors and covered by the same contract terms under which NYP provides inpatient GAC hospital services.

Answer: Outpatient services are not part of the Complaint's defined relevant markets. Nor is there any allegation that NYP possesses market power over outpatient services.

That insurers want to contract with NYP for the full range of services that NYP offers does not suggest that NYP has, or is using, market power when contracting. Virtually every hospital in the nation that offers any form of outpatient services contracts with insurers for the provision of both in-patient and out-patient services. That does not mean that every hospital has restrained competition; it reflects the fact that insurers find it efficient to contract for both in-patient and out-patient services at the same time.

Moreover, the Complaint's theory that NYP uses inpatient market power to impose anticompetitive terms in a separate outpatient market is a leveraging or tying theory devoid of any allegations relating to actual tying or anticompetitive effects in the outpatient market.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

47. NYP's plan restrictions effectively prevent payors from providing incentives to patients to select outpatient services outside of NYP at facilities or other hospitals that charge less and would thus save money for patients and employers. This effectively prevents rival providers or potential new entrants from competing on price to attract patients. For instance, in 2022, NYP invoked its plan restrictions to stop a payor from charging patients lower copays for certain outpatient radiology services performed at less expensive hospitals or at other facilities rather than at NYP's hospitals.

Answer: Nothing in any NYP contract prevents patients from selecting outpatient services from other providers. NYP has offered rates to incentivize insurers to maintain Open Access Networks. Insurers that have chosen to do so agree not to discriminatorily penalize patients for choosing their preferred provider.

The Complaint's reference to an *ex post* breach of contract by one insurer – after obtaining significant discounts *ex ante* – does not suggest that the contract the insurer originally negotiated and that provides for open access is anticompetitive. Nor does the document suggest that the insurer was prevented from lowering the co-pay at other facilities. The insurer could – consistent with the contract it entered – also lower the co-pay for patients that use NYP's radiology services.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

48. NYP's plan restrictions protect its high prices in outpatient services. For example, in 2023, NYP stopped a payor from shifting outpatient colonoscopies away from NYP's hospitals. NYP observed that even stopping a single payor from moving outpatient colonoscopies out of NYP's hospitals was "worth ~250k [dollars] to [a physician group in NYP's system] and multiples more to [NYP]."

Answer: The cited document says nothing about protecting high prices, competition among hospitals, or negotiations for network inclusion or exclusion.

To the extent not expressly admitted, NYP denies the allegations of this Paragraph.

49. As a result of this reduced competition from NYP's plan restrictions, individuals and employers who seek healthcare in New York City pay higher prices for health insurance coverage and have fewer insurance plans from which to choose. In the absence of these plan restrictions, payors would be free to offer budget-conscious plans that allow patients to save money by choosing high-quality and cost-effective hospitals and outpatient services that compete with NYP, such as those offered by NYU Langone or Mount Sinai. NYP might also lower the prices that it charges payors for participating in their broad-network plans if it were forced to compete with its rivals on price through payors' offering or threatening to offer budget-conscious plans

Answer: NYP denies that its contracting practices have any discernible effect on the prices that employers or patients pay for coverage.

As the Complaint concedes, any consumer harm in this case must manifest at the insurance premium stage—yet the causal chain between NYP's contracts and the premiums charged by third-party insurers is both outside NYP's control and tenuous at every link.

To the extent any further response is required, NYP denies the allegations of this paragraph.

50. Entry or expansion by other hospitals in the relevant geographic markets has not prevented NYP from exercising its market power by imposing plan restrictions, nor has it counteracted the resulting actual and likely competitive harms. And in the future, such entry or expansion is unlikely to counteract these harms to competition. Building a hospital anywhere in the Four-Borough Market would entail significant time and cost for construction and permitting. And building a hospital with a strong reputation that can attract physicians and patients is difficult, time-consuming, and expensive. In fact, NYP's plan restrictions raise barriers to entry or expansion for healthcare providers by making it significantly more difficult for them to attract more patients by offering lower prices or more value.

Answer: To prove that a contract unreasonably restrains trade, the DOJ must show that the contract is exclusionary and has foreclosed competition in the relevant market. This requires an allegation that rivals were forced out business, prevented from entering the market, or their marginal cost of providing the service increased. The Complaint makes no such allegations.

The Complaint similarly offers no support for its conclusory statement that potential entrants were deterred from entering the market. Nor could it. The Complaint acknowledges that nothing in any NYP contract prevents a hospital from being in-network with insurers or competing based on price or other factors for patient volume.

To the extent not expressly admitted, NYP denies the allegations of this paragraph.

51. NYP's restrictions on budget-conscious plans do not have any procompetitive effects. Any arguable benefits of NYP's plan restrictions are outweighed by their actual and likely anticompetitive effects and/or could be achieved through less restrictive means. Without these restrictions, NYP can seek to maintain its patient volume and market share by competing to offer lower prices, higher-quality, and better value than its competitors.

Answer: Denied. As set forth above, NYP's contracts – which reflect the negotiated outcome in which NYP offers lower rates to be included in insurers' Open Access Networks – are procompetitive, and reflect exactly the type of competition for market share that the Sherman Act

exalts. The provisions the Complaint challenges are also reasonably ancillary to the managed care bargain. Without the challenged provisions, NYP's patients would be stripped of their choice and be subjected to exorbitant penalties set solely at the discretion of powerful insurers. Similarly, under the Complaint's theory, NYP would alone be prohibited from competing *ex ante* for inclusion in insurers' networks and forced to compete for volume solely *ex post* as an out-of-network provider that must overcome the penalties imposed by insurers. To the extent not expressly admitted, NYP denies the allegations of this paragraph.

CLAIM FOR RELIEF

Plaintiff incorporates paragraphs 1 through 51 of this Complaint.

Answer: NYP incorporates by reference its answers to paragraph 1 through 51 above.

52. NYP has market power in the sale of inpatient GAC hospital services in Manhattan and in the Four-Borough Market.

Answer: Denied.

53. NYP has and likely will continue to negotiate and enforce contracts containing restrictions on budget-conscious plans with commercial payors in the relevant geographic markets. The contracts containing these plan restrictions are contracts, combinations, and conspiracies within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

Answer: Denied.

54. NYP's contractual restrictions on budget-conscious plans have had, and will likely continue to have, the following substantial anticompetitive effects in the relevant markets, among others:

a. protecting NYP's market power and enabling NYP to maintain at supracompetitive levels the prices of inpatient GAC hospital services;

b. substantially lessening competition among hospitals in their sale of inpatient GAC hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and better value for inpatient GAC hospital services;

d. reducing patients' incentives to seek inpatient GAC hospital services from more cost-effective providers; and

e. depriving New York residents and their employers of the benefits of a competitive market for their purchase of inpatient GAC hospital services.

Answer: Denied.

55. The challenged restrictions unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

Answer: Denied.

RELIEF REQUESTED

WHEREFORE, Plaintiff requests that the Court enter judgment in its favor and provide the following relief:

a. adjudge that all of the restrictions on budget-conscious plans in the contracts between NYP and any commercial payors violate Section 1 of the Sherman Act, 15 U.S.C. § 1;

b. enjoin NYP, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts a payor from offering, or attempting to offer, plans that give or inform members about financial incentives to use any healthcare provider;

c. enjoin NYP from substituting other unlawful and anticompetitive means of restricting budget-conscious plans that would replicate the effects of its plan restrictions;

d. enjoin NYP from retaliating, or threatening to retaliate, against any insurer for offering, or attempting to offer, budget-conscious plans; and

e. award Plaintiff its costs in this action and such other relief as the Court may deem just and proper.

Answer: This paragraph does not contain any factual allegations, and as such, no response is required. To the extent a response is required, NYP denies that it is liable and denies that Plaintiff is entitled to any relief.

AFFIRMATIVE DEFENSES

NYP asserts the following affirmative defenses. In doing so, NYP does not assume any burden of proof, persuasion, or production with respect to any issue where the applicable law places the burden upon Plaintiff.

First Affirmative Defense
(Core Economic Activity)

1. NYP incorporates by reference each and every response, denial, and allegation set forth in its Answer, as though fully set forth and re-alleged in this section.

2. The challenged contractual provisions are not unreasonable restraints of trade under Section 1 of the Sherman Act, 15 U.S.C. § 1, because they reflect the core economic activity of the managed care agreements between NYP and commercial insurers for the provision of healthcare services to the insurers' members. *See Texaco Inc. v. Dagher*, 547 U.S. 1, 6-8 (2006).

3. In any contract for the sale of services, prices and quantity are material terms the absence of which renders the contract void for want of consideration. The managed care agreements at issue here are no different. The challenged provisions reflect the volume commitments – in the form of network placement commitments –insurers make through plan design in exchange for rate concessions. They are an integral part of the managed care bargain.

4. Insurers make network placement commitments instead of making specific volume commitments because insurers do not directly control patient volume. They do not control when a patient gets sick or suffers an injury. They also do not know in advance of contracting how many covered lives they will need to contract for. Contracting for specific volume levels, therefore, would be an illusory agreement without volume guarantees, which would require insurers to assume the risk of making those financial guarantees.

5. Rather than contract over volume they do not directly control, insurers contract over actions they do control: the placement within the networks they design. These network placement provisions determine, indirectly, and with a reasonable degree of certainty, the amount of volume an insurer is capable of delivering to the provider and constitute legally binding consideration for any rate concession offered by the provider.

6. The challenged network placement provisions *define* the services for which the insurer is contractually obligated to make payment. Insurers' plan benefits design determines the coverage obligations insurers have for their enrollees' healthcare expenses, which often depends on the network placement of the provider. By designating a provider as "in-network," the insurer is both *simultaneously* creating contractual obligations *to the enrollee* and triggering reimbursement obligations *to the provider*. The challenged network placement provisions also contractually obligate providers to provide care to the insurers' covered patients at the agreed-upon discounted rates. These provisions are, therefore, inseparable from the contract.

7. Without the challenged provisions, insurers offer nothing of value to providers in exchange for rate concessions. Insurers' obligations to cover their members' care are owed under separate insurance contracts with patients and employers, not providers. Patients, in the absence of any further agreement with providers, would be obligated to pay providers' higher billed charges, as adjusted by applicable regulations. An insurer seeking to lower its financial obligations from this pre-existing set of contractual obligations – through additional rate concessions – must offer consideration in return. The challenged network placement provisions are that consideration.

8. The challenged provisions are not separable from the rate terms they support. They cannot be modified or eliminated without changing the anticipated volume of services under contract, and without dissolving the consideration that supports the rate concessions on the other

side of the bargain. As such, they are core economic terms of the managed care bargain, not restraints attached to it.

9. The challenged provisions are not "restraints" – ancillary or otherwise – because they are not exclusionary and do not prevent insurers from contracting with other providers. An agreement to buy a product is not a "restraint" even if it means that the purchaser no longer needs to buy the same product from someone else. For the same reason, an agreement to place a provider in an insurers' network is not a "restraint" of trade, but the *existence* of trade itself. Negotiation over such placement is "core activity" of both the provider, including NYP, and the insurer.

10. The plaintiffs' claims are therefore barred in whole or in part.

Second Affirmative Defense
(Reasonable Ancillary Restraints)

11. NYP incorporates by reference each and every response, denial, and allegation set forth in its Answer, as though fully set forth and re-alleged in this section.

12. Even if the challenged contractual provisions were considered "restraints," they do not violate Section 1 of the Sherman Act, 15 U.S.C. § 1, because they are reasonably ancillary to legitimate and procompetitive transactions for the provision of healthcare services to insurers' members.

13. Agreements for the provision and reimbursement of healthcare services to insurers' members are legitimate and procompetitive commercial transactions. The transaction secures for insurers the ability to have their members treated at specified, agreed-upon rates. This enhances predictability, reduces potential for legal disputes over payment, provides discounts from billed charges or otherwise applicable costs, and ensures member access to a comprehensive range of services. The transaction also secures for patients seamless access to high quality care, streamlined billing, and reduced costs.

14. Network placement provisions – including the challenged contractual provisions – are subordinate to the transaction for the provision of healthcare services to insurers' members. Network placement provisions define the class of patients that are the subject of the overall provider healthcare services contract. These provisions further determine the volume of patients that providers can reasonably expect to treat under that contract, which is integral to the ability of providers, like NYP, to set appropriate rates.

15. The challenged provisions are reasonably necessary to achieve the legitimate and procompetitive purposes of the overall healthcare transaction. Without these provisions, insurers would deliver different or lower levels of volume under the contract, which would undermine the economic basis on which rates were negotiated and would undermine the benefit of the bargain.

16. There are no less restrictive alternatives that could achieve the legitimate and procompetitive purposes of the overall healthcare services contract. Contracts without network placement provisions do not contain necessary volume commitments, which are material terms in the contract, or indeed, any contract for the provision of services.

17. Nor can the network placement provisions be replaced or supplanted with specific volume commitments, market share requirements, or other proxies for network placement. Such provisions either are economically equivalent to the challenged provisions, undermine the basis on which volume-based rates were negotiated, or require insurers to incur unacceptable financial risk for conduct and circumstances beyond their control.

18. Network placement provisions that do not permit NYP to contract to be an in-network provider for all the plans an insurer offers is not a less restrictive alternative because it eliminates competition from NYP for the excluded plans, reduces volume under the contract, and deprives the insurer of the rate concessions associated with such volume.

19. The plaintiffs' claims are therefore barred in whole or in part.

Third Affirmative Defense
(Procompetitive Justifications)

20. NYP incorporates by reference each and every response, denial, and allegation set forth in its Answer, as though fully set forth and re-alleged in this section.

21. The challenged contractual provisions do not violate Section 1 of the Sherman Act, 15 U.S.C. § 1, because they achieve significant procompetitive benefits that outweigh any alleged anticompetitive effects.

22. The challenged provisions enable NYP to compete against other providers on a non-discriminatory and non-exclusionary basis for inclusion in insurers' networks. Competition for increased market share is a procompetitive justification. Because the challenged provisions do not exclude any provider from gaining access to patients as an in-network provider, the procompetitive benefits of the challenged provisions outweigh any alleged anticompetitive effects.

23. The challenged provisions expand output and reduce costs by providing NYP with access to patients, which are necessary to cover NYP's high costs of care, including the high fixed costs required to operate one of the world's premium healthcare systems. Consumers benefit when NYP can cover its fixed costs because it enables NYP to lower its rates and improve quality. Because the challenged provisions do not prevent any competitors from competing to gain patients as an in-network provider, the procompetitive benefits of the challenged provisions outweigh any alleged anticompetitive effects.

24. The challenged provisions provide patients with access to greater choice and more competitive options for healthcare. To the extent the challenged provisions are considered "restraints," they only restrain insurers from imposing discriminatory penalties, incentives, or other restrictions on members to strip them of their choice to use their preferred provider. When

insurers discriminate against providers, such as NYP, they eliminate or significantly hamper stage two competition among providers. By preventing such discrimination, the challenged provisions preserve access to NYP and facilitate stage two competition. In stage two, NYP can compete with other in-network providers across price and non-price dimensions. Because the challenged provisions do not require insurers to favor NYP over any other provider, the procompetitive benefits of the challenged provisions outweigh any alleged anticompetitive effects.

25. The challenged provisions expand output and preserve quality by ensuring that all insured patients have access to high quality providers at affordable rates. The commercial healthcare insurance market in the alleged relevant markets is concentrated among a small number of insurers that exercise substantial monopsony power, and – according to the DOJ – would use that power to assemble Restricted Choice Networks composed of providers that would accept rates so low that investment in facilities, equipment, and personnel is compromised. Members – who in many cases may not have been provided with a meaningful choice of health plans – cannot reasonably or readily switch and are, instead, channeled into those reduced-quality networks. The challenged provisions ensure that those members retain access to NYP's higher-quality care. Because the challenged provisions do not prevent any insurer from continuing to offer its members access to the same providers that would otherwise comprise the Restricted Choice Network, the procompetitive benefits of the challenged provisions outweigh any alleged anticompetitive effects.

26. There are no less restrictive means to achieve the procompetitive benefits of the challenged provisions. Any alternatives – including partial-network arrangements, *ex post* steering restrictions, and specific volume commitments – either are economically equivalent to the challenged provisions, fail to provide the volume certainty necessary to support *ex ante* rate

concessions, impose unacceptable financial risk on insurers for conduct beyond their control, or eliminate competition between NYP and the favored providers.

27. The plaintiffs' claims are therefore barred in whole or in part.

PRAYER FOR RELIEF

The New York and Presbyterian Hospital requests that the Action be dismissed and that Judgment be entered in its favor.

Dated: May 26, 2026

/s/ Colin R. Kass

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