Defending Hospital Antisteering Clauses From DOJ Scrutiny

By **Derek Moore** (October 30, 2026)



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Antitrust challenges to antisteering provisions in hospital-insurer contracts have become more common over the past year.

On Oct. 2, the U.S. District Court for the Eastern District of New York denied a motion to dismiss by the defendant in Cement & Concrete Workers DC Benefit Fund v. The New York and Presbyterian Hospital.[1]

This follows several lawsuits and statements by the Trump administration earlier this year, demonstrating that challenging these clauses is an administration priority.

This article discusses the history of these and similar cases against hospital systems, important precedent from the U.S. Supreme Court, and some potential defenses.

Recent DOJ Enforcement Actions

In February, the U.S. Department of Justice filed U.S. v. OhioHealth Corp. against a Columbus, Ohio, healthcare services nonprofit in the U.S. District Court for the Southern District of Ohio.[2]

The DOJ then filed its own suit against NYP in March in the U.S. District Court for the Southern District of New York, U.S. v. The New York and Presbyterian Hospital.[3]

Both cases allege that defendant hospital systems impose contractual restrictions on health insurers that prevent insurers from steering patients to competing providers. The DOJ argues that these restrictions violate Section 1 of the Sherman Act because they reduce competition between providers, reduce patient choice, and ultimately increase costs for insurers and patients.

The DOJ's recent cases are the Antitrust Division's first foray into this area since U.S. and North Carolina v. Charlotte Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System, which was filed in 2016 and settled in 2019 in the U.S. District Court for the Western District of North Carolina.[4]

Trump Administration Interest

The Trump administration has made clear that these two cases are unlikely to be the end of its push, and hospital systems with similar contractual provisions should be concerned about potential investigations and lawsuits.

In June, the White House released a report claiming that banning antisteering and similar provisions in hospital contracts would lower patient payments.[5]

In September, in an address to the Fordham Annual Antitrust Conference, Stanley Woodward, associate attorney general and Antitrust Division leader, emphasized that the OhioHealth case supports the division's focus on "promoting competition in markets that affect every American household."[6]

Nicole Sarrine, a deputy assistant attorney general, emphasized in remarks to the Transparency Rising 2026 National Forum in May that these cases "serve as a template for future challenges where hospital systems persist" in maintaining antisteering terms in their contracts with insurers.[7]

The cases filed thus far follow a template. Relying primarily on Section 1 of the Sherman Act, the plaintiff alleges that the hospital system has market power in a particular geographic area for the provision of certain services — typically general acute care inpatient hospital services.

The plaintiff then argues that the hospital system uses its market power to impose antisteering terms on health insurers. These terms, the argument goes, prevent insurers from using incentives to steer patients toward lower-cost providers, which, absent the antisteering terms, would reduce costs for insurers and patients.

Accordingly, the cases allege that the antisteering terms inhibit competition between hospital systems by preventing competing hospitals from increasing patient volume by offering better prices, payment terms or quality.

American Express Precedent

The DOJ's 2016 case against the Carolinas Health System has limited value because important rulings in the litigation predated the Supreme Court's 2018 decision in Ohio v. American Express.

In that case, the DOJ and numerous states challenged an antisteering provision in contracts between American Express and merchants that prevented merchants from steering customers toward other lower-fee payment options.

The Supreme Court affirmed the U.S. Court of Appeals for the Second Circuit's reversal of the Eastern District of New York's ruling that Amex's antisteering provision violates Section 1 of the Sherman Act. In so doing, it articulated numerous important principles for how lower courts should evaluate claims that antisteering provisions are anticompetitive.

Notable factual differences exist between the antisteering provision at issue in American Express and the ones at issue in the hospital cases. In American Express, the antisteering requirement was imposed upon the provider (the merchants), by the intermediary (American Express).

In the hospital cases, however, the provider (the hospital system), is imposing the antisteering requirement upon the intermediary (the insurer). Nevertheless, the court in American Express made several holdings relevant to the hospital cases.

First, the court stated clearly that antisteering provisions are vertical restraints — "restraints imposed by agreement between firms at different levels of distribution" — that are judged under the rule of reason, which "requires courts to conduct a fact-specific assessment of market power and market structure [and to] assess the restraint's actual effect on competition."

The court's holding that these restraints are governed by the rule of reason is important, because research has demonstrated plaintiffs struggle to win rule-of-reason cases,[8] especially in cases challenging vertical restraints.[9]

Second, the court articulated a "three-step, burden-shifting framework" to evaluate antisteering provisions. Under this framework, a plaintiff has the initial burden to prove the provision caused "anticompetitive effect that harms consumers in the relevant market."

The burden then shifts to the defendant "to show a procompetitive rationale for the restraint," and finally "shifts back to the plaintiff to demonstrate that the procompetitive efficiencies could be reasonably achieved through less anticompetitive means."[10]

The district court in American Express, by contrast, had held that American Express' proffered justification that the antisteering provisions served to increase competition between credit card platforms for cardholders was not cognizable under its view of the law, and that even if it was, "[d]efendants have failed to establish that [the provisions] are reasonably necessary to robust competition ... or that any such gains offset the harm."[11]

The Supreme Court's reversal thus makes clear that lower courts must consider procompetitive rationales for vertical restraints like antisteering provisions, and that it is the plaintiff's burden to demonstrate the restraint is unnecessary to achieve the benefits, not the defendant's burden to show the reverse.

Third, the court held squarely that a plaintiff challenging an antisteering provision can satisfy its initial burden to show anticompetitive effect that harms consumers only by defining a relevant market. It cannot rely exclusively on direct evidence of anticompetitive effects.[12]

The court observed that because "[v]ertical restraints often pose no risk to competition unless the entity imposing them has market power," the reviewing court must define a relevant market first to evaluate whether the defendant indeed has the requisite market power.

Accordingly, the plaintiff in a hospital antisteering case will be required to go through the exercise of defining a relevant market and establishing that the defendant hospital system has market power.

Potential Defenses

Given the recent antitrust actions against hospital systems and the binding legal precedent in American Express, how should hospital systems with a significant footprint and similar provisions in their contracts with insurers think about defending themselves against potential cases by law enforcers and private plaintiffs?

A first line of defense relates to market definition and market power, which is an inherently fact-specific exercise that will vary among hospital systems and geographic areas. American Express makes clear that there are no shortcuts available to plaintiffs.

A second line of defense will be to argue that the plaintiff has failed to carry its initial burden of demonstrating anticompetitive effect — i.e., higher prices, lower output or reduced quality — which may require thorough economic reporting and testimony. Here, plaintiffs face an uphill battle because of a dearth of existing scholarship on the competitive effects of hospital antisteering provisions.

There is economics literature indicating that insurers' ability to steer patients toward lower cost providers can reduce costs for insurers and patients.[13] But this literature does not

establish the inverse proposition that a prohibition on steering raises costs, which is the plaintiff's burden to show. Moreover, to the extent certain steering is permitted — e.g., steering by insurers — or prices are apparent to patients, the plaintiff's burden will become even more challenging to surmount.

Here, hospital systems can argue that the provisions actually lower costs for patients and insurers because the provisions are functionally similar to a volume discount — the hospital system exchanges lower prices for the antisteering requirement to increase patient volume — and that prices would be higher absent the antisteering requirement. Such defenses may also inform hospitals' negotiating tactics.

Moreover, hospital systems can argue that the antisteering requirements improve the quality of care: They can drive increased volume to a single hospital system, which ensures each patient receives continuous care and charting across the system, and can justify the system's investment in costly technology or personnel, all of which can improve patient outcomes.

Such quality-based arguments are relevant to both the first and the second steps of the required rule-of-reason inquiry. At step one, a plaintiff showing higher nominal prices at the defendant hospital system will likely be insufficient to establish anticompetitive effect if the defendant hospital system is of higher quality than its rivals.

At step two, the court's opinion in American Express makes clear that district courts must assess whether the antisteering provisions do in fact facilitate care quality improvements. Indeed, hospitals may be able to show quality improvements extend not only to commercially insured members and plans, but also to the uninsured and those enrolled in government programs such as Medicaid and Medicare.

Hospital systems should take seriously the recent increased attention to antisteering provisions, and would be well advised to develop and substantiate their price- and quality-related justifications for including them in contracts with insurers, as well as their tactics in negotiations, as those justifications will be central in any lawsuit.

Hospital systems also may benefit from considering alternatives to broader antisteering provisions that may achieve similar benefits to the system while avoiding the cost of a protracted investigation or lawsuit.

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[1] Dkt. Entry 54, Memorandum Decision and Order, Cement & Concrete Workers DC Benefit Fund et al. v. The New York & Presbyterian Hospital, No. 2:25-cv-05571 (E.D.N.Y. Oct. 2, 2025).

[2] Compl., U.S. and Ohio v. OhioHealth Corp., No. 2:26-cv-207 (S.D. Ohio, Feb. 20, 2026).

[3] Compl., U.S. v. The New York and Presbyterian Hospital, No. 1:26-cv-02480 (S.D.N.Y. March 26, 2026).

[4] Final Judgment, U.S. and North Carolina v. Charlotte Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System, No. 3:16-cv-00311 (W.D. N.C., April 24, 2019).

[5] The Council of Economic Advisors, Executive Office of the President of the United States, Effects of Banning Hospitals' Anti-Steering, Anti-Tiering, and All-or-Nothing Contracts, June 2026, https://www.whitehouse.gov/research/2026/06/effects-of-banning-anti-competitive-hospital-contracts/.

[6] Stanley Woodward, Associate Attorney General, U.S. Dept. of Justice, Address to Fordham Annual Antitrust Conference, Sept. 17, 2026, https://www.justice.gov/opa/speech/associate-attorney-general-stanley-e-woodward-jr-delivers-remarks-53rd-annual-conference.

[7] Nicole Sarrine, Deputy Assistant Attorney General for Antitrust, U.S. Dept. of Justice, Remarks to the Transparency Rising 2026 National Forum, May 19, 2026, https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-nicole-sarrine-delivers-remarks-transparency-rising.

[8] Michael A. Carrier, The Rule of Reason: An Empirical Update for the 21st Century, 16 Geo. Mason L. Rev. 827 (2009); Michael A. Carrier, The Real Rule of Reason: Bridging the Disconnect, 1999 BYU L. Rev. 1265 (1999).

[9] Douglas H. Ginsburg, Vertical Restraints: De Facto Legality Under the Rule of Reason, 60 Antitrust L.J. 67 (1991).

[10] Ohio v. American Express, 585 U.S. 529.

[11] U.S. v. American Express, 88 F. Supp. 3d 143, 229-30 (E.D.N.Y. 2015).

[12] American Express, 585 U.S. at 542-43.

[13] See, e.g., Eline M. Van den Broek-Altenburg and Adam J. Atherly, The Relation Between Selective Contracting and the Healthcare Expenditures in Private Health Insurance Plans in the United States, 124 Health Policy 174 (2020).