Articles + Publications | June 30, 2026

DOJ Settles Challenge to Ohio Health Care System's Insurance Contracting Practices

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KEY POINTS

- The DOJ and Ohio's attorney general settled an antitrust lawsuit against OhioHealth Corp., alleging the system's anti-steering and gag-rule contract provisions violated Section 1 of the Sherman Act and Ohio's Valentine Act.
- The complaint alleged that OhioHealth, in combination with at least two other competing health care systems, accounts for at least 85% of the commercial health insurance business in the Columbus area despite a pleaded market share for OhioHealth of only approximately 35%.
- The settlement voids and prohibits contract provisions that restrict insurers' ability to steer volume to other providers or that require prior approval for new health plans, while still permitting OhioHealth to negotiate for most-preferred tier participation on equal terms with competitors.
- A White House Council of Economic Advisers report issued two days after the settlement estimated that banning anticompetitive hospital contracts could reduce hospital and physician prices by 18% and generate roughly $45 billion in national savings annually.
- The settlement signals that health care providers with market shares as low as 30% to 35% should review historically lawful contracting strategies, including anti-steering and most-favored-tier provisions.

The Department of Justice (DOJ), Antitrust Division, and the attorney general of Ohio notched a win with a recent settlement (*Exhibit B – [Proposed] Final Judgment: U.S. and State of Ohio v. OhioHealth Corporation*) barring an Ohio health care system from attempting to obtain any insurance contract provisions that prohibit, deter, prevent, or penalize steering.

In February, the DOJ and Ohio sued OhioHealth Corporation (OhioHealth), claiming that the health care system abused its market power by negotiating for contract provisions frequently referred to as "anti-steering" and "gag rules." The complaint also alleges that OhioHealth requires an insurer that wants any of OhioHealth's providers in network to include all of OhioHealth's providers in the network. The DOJ further claims that OhioHealth is the largest hospital system in Columbus, OH, that its contracts restrict insurers accounting for at least 85% of the commercial health insurance business in the Columbus area, and that OhioHealth and two of its area competitors in the aggregate, control more than 85% of inpatient discharges.

OhioHealth's contracts allegedly "insulate it from price competition and help to maintain its extremely high prices" and violate Section 1 of the Sherman Act and Ohio's Valentine Act, the state's primary antitrust law, by blocking insurers from offering "health insurance plans that feature lower-cost hospitals and other providers and even from informing patients that lower-cost options are available." The DOJ contends that patients are harmed by OhioHealth's conduct because it "deprive[s] 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."

While the complaint does not quote the contractual provisions at issue, it claims that they restrict several key features needed for budget-conscious health plans, including:

- "Narrow network plans" that "include a relatively limited set of cost-effective providers;"
- "Tiered network plans" that allow members "to secure healthcare from the lower-priced favored tier of providers or to pay more for care from the more expensive tier of providers;"
- "Centers for excellence," which payors can create by identifying "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;"
- "Site of service steering," which can save patients money by incentivizing them "to have procedures done in a lower-cost site of service;"
- "Reference-based pricing" that fixes reimbursement rates for certain procedures, "often pegged to some reference point like a market average price;" and
- "Active transparency" by which payors share pricing information to help inform a patient's choice of health care provider.

The complaint pegged OhioHealth's market share at only approximately 35%, despite the fact that courts typically require a market share of at least 40-50% in similar cases.

Though denied by OhioHealth, the DOJ claims that commercial health insurers attempted to negotiate with OhioHealth to remove these restrictive contract provisions, but OhioHealth consistently refused. The health system's response to the agencies' challenge was that it competes with two other hospital systems for patient volume by competing for favorable insurance contracts and that this "competition for the contract" occurs regularly when contracts expire or are rebid and results in lower prices and other benefits to consumers. OhioHealth also countered that, to the extent it negotiated favorable contracts, it did so by being a better health system with better prices and better services.

The DOJ has obtained much of its requested relief through the settlement, which:

- Voids and prohibits the health system from seeking contract provisions that prohibit or deter steering or transparency, including:
  - Requirements of prior approval for the introduction of new plans; or
  - Requirements that OhioHealth be included in the most-preferred tier of plans, though it may seek to participate in the most-preferred tier of a plan.
- Bars conduct that penalizes, or threatens to penalize, an insurer for steering members to other providers or rate transparency to its members.
- Prohibits any contract provision that prohibits or deters steering or transparency, including by requiring inclusion in the most-preferred tier.

The settlement permits OhioHealth to participate in the most-preferred tier of a plan, but it must do so under the same terms and conditions as its competitors. If OhioHealth declines participation in the most-preferred tier, it must still participate in that plan on terms and conditions that are substantially the same as the terms and conditions of then-existing broad networks.

Two days after the settlement, the White House Council of Economic Advisers issued a report on health care pricing (Effects of Banning Anti-Competitive Hospital Contracts – The White House). The report concludes that prohibiting all-or-nothing, anti-steering, and anti-tiering contracting practices would save on health care costs by reducing "hospital and affiliated-physician prices by 18 percent (with a plausible range of 11 to 26 percent), averaging ~$4,100 per inpatient admission." The report also estimates that employer plan premiums could likewise fall by roughly 6.5% in markets affected by such contracting provisions, which could yield national savings of roughly $45 billion per year.

TAKEAWAYS

The OhioHealth litigation, the White House Council's report, and the DOJ's recent lawsuit challenging some similar contracting practices of a New York hospital system, signal to health care providers with market shares as low as 30-35% that historically lawful negotiation strategies need to be reviewed. Neither the litigation nor the settlement appears to take into consideration the lower rates that providers often offer in exchange for the increased volume that these types of restrictions can generate.

The settlement does make clear that regardless of the purported market power of a health care system, it is still permitted to negotiate to participate in a most-preferred tier as long as it does so under the same terms and conditions as any other provider, and it is able to restrict steering within a narrow network where it is the most-prominently featured provider. In addition, the settlement allows a provider to protect disclosure of its negotiated rates to competitors or the public and to challenge the dissemination of inaccurate information.

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