UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

UFCW LOCAL 1500 WELFARE FUND, on behalf of itself and all others similarly situated, *Plaintiff*, v. THE NEW YORK AND PRESBYTERIAN HOSPITAL, *Defendant.*	Case No. **CLASS ACTION COMPLAINT** **JURY TRIAL DEMANDED**

Plaintiff United Food and Commercial Workers ("UFCW") Local 1500 Welfare Fund ("Plaintiff"), on behalf of itself and all others similarly situated, upon personal knowledge as to the facts pertaining to itself, based on the investigation of counsel, and upon information and belief, brings this class action complaint against the above-captioned Defendant, The New York and Presbyterian Hospital ("Defendant" or "NYP") for violations of federal antitrust law, the Donnelly Act, and common law, seeking actual damages, treble damages, disgorgement of profits, injunctive relief, a declaratory judgment, reasonable costs and attorneys' fees, and pre and post-judgment interest.

I. NATURE OF THE ACTION

1. NYP is one of the largest healthcare systems in the United States. In New York City, NYP is the largest hospital system by net revenue, inpatient days, and certified beds. NYP operates several prominent hospitals, including Columbia University Irving Medical Center, Weill Cornell Medical Center, and Brooklyn Methodist Hospital, and a number of other hospitals

in the New York City area. It is by far the highest-priced hospital system in the New York City area, with total operating revenues of over $13 billion in FY 2024.

2. For years, NYP has leveraged its market power in New York City to limit price competition in the market for general acute care inpatient hospital services ("GAC Services"). Specifically, NYP's contracts with health insurers impose "anti-steering" provisions which prevent the health plans from incentivizing their members to seek out lower-cost services from other hospital systems, to the detriment of payors of healthcare services ("payors"), such as Plaintiff and members of the Class (defined below). NYP imposes these provisions as a condition of including any NYP facilities in the networks of commercial health plans.

3. Part of NYP's anti-steering scheme is its imposition of "All Products Clauses" which require health insurers to include all of NYP's facilities in each of the health plans they offer and to place them in the best possible "tier" of each of their plans (typically "Tier 1"). These "all-or-nothing" provisions are a condition of including NYP in the insurance companies' networks, and they prevent insurers from creating "narrow-network" plans which exclude certain NYP facilities from the plan or placing NYP or certain NYP facilities in a lesser-preferred tier, which would financially encourage the health plan's members to seek care from lower-cost, high-quality providers.

4. NYP also takes a range of steps to limit the transparency of its pricing. NYP pressures insurers to accept "take it or leave it" pricing which is inappropriately based on consolidated average of rates at all NYP facilities, known as the "single negotiated rate," as opposed to more accurate facility-by-facility prices.

5. NYP also imposes "gag clauses" which prevent health plans from even disclosing the terms of NYP's pricing to their membership. Because of NYP's market power, insurers

generally must acquiesce and agree to NYP's anticompetitive provisions—they simply cannot exclude NYP from their networks and have the ability to sell commercial health plans to employers, unions, and other payors in New York City.

6. In addition, NYP leverages its market power to retaliate against payors that seek out alternative arrangements. When Local 32BJ of the Service Employees International Union ("32BJ"), a union which represents about 90,000 workers in New York City, sought an insurer to develop a narrow-network plan excluding NYP for elective procedures, NYP responded by asserting an illegitimate financial claim involving an allegedly unpaid bill of $25 million against the union. This was intended solely as punitive action to deter exclusionary network arrangements.

7. As a result of NYP's practices, competition among hospitals based on quality and cost has been severely constrained, and costs for health plans have increased. Analyses conducted by health fund actuaries reveal that common inpatient procedures at NYP, such as hip replacements, are routinely priced substantially higher than comparable procedures at competing hospitals ($83,000 at NYP versus $58,000 at other hospitals, according to public sources). In another example, an inpatient stay for recovery from a seizure at NYP costs approximately $37,771 on average, compared to an average of $22,393 at a Mount Sinai Health System facility and $15,581 at a NYU Langone Health facility.

8. NYP's anticompetitive contract provisions have caught the attention of the Antitrust Division of the United States Department of Justice ("DOJ"). On July 28, 2025, *The New York Times* reported that the DOJ is conducting a civil investigation of NYP to determine whether there have been "unlawful agreement[s] between New York Presbyterian Health Care System and health insurance companies relating to steering restrictions and contracting conduct."

9. NYP's contracting practices insulate it from competitive market pressures that would otherwise force it to lower prices or improve efficiency. Consequently, Plaintiff and members of the Class continue to suffer substantial financial harm through excessive healthcare expenditures directly resulting from NYP's anticompetitive restraints.

10. Plaintiff seeks judicial intervention to prohibit NYP from enforcing these anticompetitive contracting terms, thereby restoring competition in the healthcare market, reducing costs for healthcare payors, and expanding choices for patients across New York City.

II. JURISDICTION AND VENUE

11. **Subject Matter Jurisdiction.** This Court has subject matter jurisdiction under 28 U.S.C. §§ 1331, 1337(a), and pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Section 1 of the Sherman Antitrust Act, 15 U.S.C. § 1.

12. This Court also has subject matter jurisdiction over this action under 28 U.S.C. § 1332(d) because this is a class action involving common questions of law or fact in which the aggregate amount in controversy exceeds $5,000,000, exclusive of interest and costs; there are more than one hundred members in the proposed Class; and at least one member of the proposed Classes is a citizen of a state different from Defendant.

13. **Supplemental Jurisdiction**. In addition to its claim under the federal antitrust laws, Plaintiff also alleges that Defendant violated New York antitrust law and common law. The claims under federal and state law are based upon a common nucleus of operative fact and the entire action, therefore, should be commenced in a single case to be tried as one judicial proceeding. This Court, therefore, has supplemental jurisdiction over the state law claims under 28 U.S.C. § 1367(a). Exercising jurisdiction over the state law claims will avoid unnecessary duplication of actions and support the interests of judicial economy, convenience to the litigants, and fairness.

14. **Personal Jurisdiction.** This Court has personal jurisdiction over Defendant because it is based in, transacts business in, or may otherwise be found in this District.

15. **Venue.** Venue in this District is proper as Defendant transacts business or has registered agents in this District. Venue is also proper in this District because Defendant's conduct, as alleged herein, caused harm to Plaintiff and the Class in this District. Finally, Defendant has hospitals in this District.

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

III. PARTIES

A. Plaintiff

17. Plaintiff UFCW Local 1500 Welfare Fund is a self-funded employee welfare benefits fund with its principal place of business at 425 Merrick Avenue, Westbury, New York. Plaintiff is a multi-employer benefit fund that provides healthcare benefits to members and dependents of the union, UFCW Local 1500. Plaintiff offers members and dependents with hospital benefits as part of the healthcare benefits it provides.

18. UFCW Local 1500 is New York's largest grocery store union. With nearly 14,000 members, the union is one of the largest locals in the entire UFCW. The union represents people throughout New York, including residents of Queens, Staten Island, the Bronx, Brooklyn, and Manhattan, as well as Nassau, Suffolk, Westchester, Putnam, and Dutchess Counties. Union members work for a variety of grocery stores across New York, such as Fairway, King Kullen,

D'Agostino's, Stop and Shop, Gristede's, and Shoprite. The union has existed for almost 90 years.

19. During the Class Period, as defined below, Plaintiff paid for general acute inpatient hospital services provided by NYP. Plaintiff paid more than it would have absent Defendant's unlawful anticompetitive conduct and was injured as a result of the illegal and wrongful conduct alleged herein.

B. Defendant

20. Defendant NYP is a New York not-for-profit corporation located at 466 Lexington Avenue, New York, NY 10017. NYP is one of the nation's largest healthcare systems. NYP has more than 450 locations throughout Manhattan, Queens, Brooklyn, Staten Island, and Westchester and Putnam Counties. NYP has the most beds of any hospital system in New York City. It boasts over 4,000 beds and has more than 10,000 affiliated physicians. NYP has more than 2 million visits annually, including more than 620,000 emergency department visits.

21. Whenever reference is made herein to any act of any corporation, the allegation means that the corporation engaged in the act by or through its officers, directors, agents, employees, or representatives while they were actively engaged in the management, direction, control, or transaction of the corporation's business or affairs.

22. Defendants are also liable for acts done in furtherance of the alleged conduct by companies they acquired through mergers and acquisitions.

23. Various other persons, firms, and/or corporations not named as a Defendant engaged in anticompetitive conduct to inflate the rates paid by third-party payors and participated as co-conspirators with Defendant. These co-conspirators performed acts and made statements in furtherance of the conspiracy. Defendant is jointly and severally liable for the acts of these co-conspirators regardless of whether they are named as a Defendant in this Complaint.

IV. MARKET BACKGROUND

A. Insurer-Insured-Provider Relationships

24. The market for hospital services differs from many other service markets because, here, the consumer of hospital services (i.e. the patient) does not negotiate, or often know in advance, the full price of the services they are consuming. The patient also does not typically pay most of the costs of hospital services. For most individuals, the cost of these services is paid primarily by a third-party payor.

25. In general, there are two different models for how medical services are paid on behalf of insured patients. First, businesses, unions, or local governments, can purchase "fully-insured" commercial health plans for their employees. Under these plans, the organization pays premiums to a health insurance company which bears the risk and pays a large portion of the bills from hospitals and other healthcare providers for employees' healthcare. Employees often pay a portion of the premium out of their paychecks and out-of-pocket costs for their healthcare in the form of co-pays of coinsurance. In New York City, the largest health insurers that offer commercial health plans include Anthem Blue Cross Blue Shield ("Anthem") (formerly known in New York as "Empire BCBS"), Aetna, United HealthCare ("United"), and Cigna.

26. Second, many businesses, unions, and local governments can choose to be "self-funded," which means that the organization bears the risk and directly pays for most of the healthcare expenses their employees incur, while their employees may pay a portion of the premium and out-of-pocket costs in the form of co-pays or coinsurance. Employers and organizations that are self-funded rely on third-party administrators ("TPAs") to process and adjudicate claims and manage the plan's day-to-day affairs. The TPAs are typically the same large insurers which offer fully-insured commercial health plans, such as Aetna, Anthem, United,

and Cigna. Premiums for self-funded health plans are typically less expensive than premiums for fully-insured health plans.

27. An essential part of the services a TPA provides to self-funded organizations is access to their "provider network." A provider network consists of a set of healthcare providers with whom a large health insurer/TPA has negotiated a contract to provide services to health plan members at negotiated, "in-network" rates. In-network rates (also known as "allowed amounts") are prices negotiated between insurers and providers for each type of service provided by healthcare facilities and healthcare professionals. Health plan members receive more generous coverage and lower out-of-pocket costs when visiting an "in-network" provider, which incentivizes them to do so. Self-insured employers and organizations also pay lower rates for in-network providers. Going to an "out-of-network" provider means higher costs and more complicated administrative burdens for both the member and their employer or union.

28. Large health insurance companies tend to build their own provider networks for the commercial health plans they offer. These insurers use their bargaining leverage, technical knowledge, and established relationships to create a network with a large volume of high-quality providers at reasonable costs.

29. However, self-funded organizations, like Plaintiff, do not and cannot assemble their own provider networks. This is because of the logistical difficulties of conducting individualized rate negotiations with any number of hospitals, clinics, practices, and other providers where employees and their dependents receive care. Similarly, providers do not, and would not, negotiate thousands of separate contracts with various self-funded organizations.

30. So, in order to allow self-funded health plans streamlined access to a provider network, insurers will "rent" their networks out to self-funded health plans as part of the services

provided by TPAs. Health insurers often (though not always) "rent" the same provider networks they offer in their fully-insured plans to self-funded organizations.

31. Self-funded organizations retain little control over the in-network rates negotiated by insurers (their TPAs) but are ultimately responsible for paying them. On occasion, self-funded organizations will work with their TPAs to customize their provider networks to meet the needs of their members. However, employees and union members often demand that their organization's healthcare plan provide access to a broad network of providers close to where they live and work. This limits the ability of organizations to exclude large providers like NYP entirely from the health plans they offer.

32. All provider networks created by insurers, regardless of whether they are offered through a fully-insured or self-funded health plan, must meet certain needs in order to be attractive to employers and unions. First, they must include providers that offer a wide spectrum of healthcare services, from primary care to complicated inpatient hospital surgical care to labor and delivery. Second, they must offer providers located within close geographic proximity to the health plan's membership because patients typically want to receive healthcare near where they live or work. Last, they must include providers and facilities with a high quality of care available at in-network rates.

33. In a competitive market, healthcare providers compete to be included in insurers' networks by offering competitive pricing and providing high-quality healthcare. Insurers can decline to include services from a provider if their prices or quality of care are not on par with other providers, and providers know that, if their prices are too high or their quality of care is too low, insurers will decline to contract with them and instead contract with other providers.

34. Providers want to be included within insurance networks because patients are less likely to obtain medical services from an out-of-network provider. In addition, collecting payment for out-of-network services is uncertain, slow, and administratively burdensome. Exclusion from the networks created by insurers ultimately deprives providers of patient volume and revenue.

B. "Steering" by Health Plans Increases Price Competition

35. Steering is a method by which health plans provide financial incentives to patients to use a lower-cost provider within a network. Because insured patients do not pay the full cost of their healthcare and are typically only responsible for a smaller co-pay or coinsurance amount, they typically are not price-sensitive when selecting a healthcare provider. Health plans can use steering to encourage their members to obtain care from a lower-cost provider offering the same or better quality of care as higher-cost ones. For example, health plans might offer their members lower co-pays and more generous coinsurance when they use lower-cost providers and, conversely, they may subject members to higher co-pays and coinsurance when they use higher cost providers.

36. The threat of steering pressures healthcare providers to reduce their prices because these providers could lose patient volume if health plans opt to steer patients away from them. Steering therefore enhances both price competition once a provider is in-network and competition for inclusion in provider networks when an insurer and provider are negotiating in-network rates and preferential treatment within a network.

37. There are several forms of steering used by health plans. One is called "tiering." Typically, providers who offer high-quality, affordable healthcare are placed in the most preferred or top "tier" (*e.g.*, Tier 1) compared to more expensive or lower-quality providers, which are placed on "lower" tiers (*e.g.*, Tiers 2 and 3). The top tier of a health plan offers lower

out-of-pocket costs and more generous co-insurance coverage to the plan's members, which incentivizes them to choose providers in that tier.

38. Another form of steering is the use of "narrow networks," which health plans may offer to their membership as an alternative to the typical "broad-network" plan. Narrow networks involve a smaller set of healthcare providers than conventional health plans and exclude the most expensive providers. Members who choose the plan receive lower premiums and lower out-of-pocket expenses than those who choose a broad-network plan. Narrow network plans let health plans reduce costs for themselves and members while, at the same time, incentivizing providers to lower their in-network prices so that they can be included in the smaller networks. Narrow networks also push providers to compete over price and quality in their broad-network offerings in order to persuade other health plan members to still choose these broader options.

39. Still another method of steering comes from increased price transparency. Where health plans can provide members with accurate information about the prices for various services at competing facilities, members are able to access information, and, when possible, make informed choices based on this price and quality information.

40. Thus, steering both helps payors save money and encourages providers to lower prices and improve product quality so that plans will steer patients towards them. It is an important tool that health plans can use to exert downward price pressure on hospitals; an insurer can secure lower prices from a hospital or other provider by agreeing to place them in the top tier of their tiered network or include them in both their narrow-network and broad-network plans.

41. The procompetitive effects of steering have been recognized by economists and are borne out by empirical data. For example, a May 2017 academic study in *Health Affairs* found that tiered provider networks decrease medical spending by 5%.

42. Another May 2022 study in *Health Affairs* found that, in consolidated hospital markets, tools like steering, tiering, and price transparency are especially important:

> In addition to proactive oversight of mergers, acquisitions, and joint contracting, the actions of policy makers, insurers, and employers to empower health care consumers with information and incentives to choose lower-cost providers may help mitigate the price effects of consolidation. To this end, employers and health plans have increasingly offered enrollees access to cost transparency tools and benefit designs that include tiered copayments, reference, pricing, and incentives to seek care at centers of excellence. Such "steering" mechanisms have been shown to lower costs and put downward pressure on prices.[1]

C. The Detrimental Effects of Anti-Steering Provisions

43. Hospital systems with market power like NYP have a number of methods to prevent steering. They may prevent insurers from favoring other providers through financial incentives. They may enforce contractual provisions which prevent insurers from placing their hospital facilities in a less-preferential tier, excluding them from narrow networks, or from sharing detailed pricing information for the hospital system with health plan members.

44. Competition enforcers, economists, and policymakers recognize the anticompetitive effects of these anti-steering methods. For example, in 2016, the Antitrust Division of the Department of Justice filed a claim against Atrium Health, a North Carolina hospital system which imposed anti-steering and anti-tiering provisions on commercial health plans in the Charlotte area. *See* Complaint, *United States of America v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK (W.D.N.C. June 9, 2016). In the lawsuit, the government alleged that "steering restrictions reduce competition resulting in harm to Charlotte area consumers, employers, and insurers." *Id.* at 1. The case settled in 2019, with the hospital

[1] Vilsa Curto, Anna D. Sinaiko, & Meredith B. Rosenthal, *Price Effects of Vertical Integration and Joint Contracting Between Physicians and Hospitals in Massachusetts*, HEALTH AFFAIRS (May 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00727 (last accessed Sept. 8, 2025).

system agreeing not to impose anti-steering and anti-tiering provisions on insurers going forward. *See* Final Judgment, *United States of America v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, ECF No. 99 (W.D.N.C. Apr. 24, 2019).

45. On May 17, 2018, then-Deputy Assistant Attorney General for Antitrust Barry Nigro delivered Keynote Remarks at the American Bar Association's Antitrust in Healthcare Conference, in which he discussed the anticompetitive effects of anti-steering provisions: "Without these provisions, insurers could promote competition by 'steering' patients to medical providers that offer lower priced, but comparable or higher-quality services. Importantly, that practice benefits consumers, but the anti-steering restrictions prevented it."[2]

46. A 2020 Research Report on "Preventing Anticompetitive Contracting Practices in Healthcare Markets" by the Petris Center and UC-Hastings College of Law describes how "Health systems with market power can [] use anti-incentive clauses, also known as anti-steering and anti-tiering clauses, to hinder competition on price and quality."[3]

47. In addition, there is a growing recognition by lawmakers that anti-steering provisions are anticompetitive, as evidenced by recently enacted state statutes in Massachusetts, Connecticut, and Nevada (*see* Mass. Gen. Laws Ch. 176O, § 9A (Massachusetts); C.G.S.A. § 38a-477i (Connecticut); and N.R.S. § 598A.440 (Nevada)), as well as proposed federal legislation. *See* S. 2840, Bipartisan Primary Care and Health Workforce Act (Nov. 8, 2023). In

[2] "Deputy Assistant Attorney General Barry Nigro Delivers Keynote Remarks at the American Bar Association's Antitrust in Healthcare Conference," U.S. DEP'T. OF JUSTICE, ANTITRUST DIV. (May 17, 2018), https://www.justice.gov/archives/opa/speech/deputy-assistant-attorney-general-barry-nigro-delivers-keynote-remarks-american-bar (last accessed Sept. 4, 2025).

[3] Katherine L. Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets*, PETRIS CTR. at 39 (Sept. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/09/Preventing-Anticompetitive-Contracting-Practices-in-Healthcare-Markets-FINAL.pdf (last accessed Sept. 4, 2025).

addition, in 2022, New York passed the Hospital Equity and Affordability Law, known as the "HEAL Act," which prohibits providers from using gag clauses to hide the prices they charge from payors themselves or to forbid payors from revealing those prices publicly. NY INS § 3217 (b)(o).

48. As recognized by competition enforcers and legislators, anti-steering provisions imposed on insurers by hospital systems restrain competition by removing incentives for providers to compete on price and quality, preventing health plans from disclosing accurate information regarding hospital pricing, and preventing insurers from developing narrow networks or cheaper "tiers" of services for patients. Notably, the legislation described above applies *regardless* of whether a healthcare provider possesses market power.

V. MARKET STRUCTURE

49. NYP's ability to (a) profitably and persistently impose high prices for its hospital services, far above its competitors, in New York City, and (b) impose anticompetitive contract provisions in its insurance contracts is direct evidence of NYP's market power. Put differently, NYP's ability to raise and profitably maintain high prices as well as the anticompetitive effects of its contractual restraints, display its market power. This obviates the need to precisely define the relevant market or establish market power indirectly through a determination of market share within a relevant market.

50. NYP's anticompetitive conduct can also be judged as illegal given the facts alleged herein which indicate an actual adverse effect on competition, and can be established without precisely defining the relevant markets that NYP's conduct has harmed or demonstrating that NYP possesses market power in a relevant market.

51. Notwithstanding the foregoing, the relevant market in which NYP's conduct has resulted in anticompetitive effects is the provision of GAC Services provided to commercially

insured patients and sold to commercial payors in the New York City area (the "Relevant Market").

A. The Relevant Product Market

52. The relevant product market in this action affected by NYP's conduct is the market for GAC Services provided to commercially insured patients and sold to commercial payors (the "Relevant Product Market"). This market includes sales of such services to individual, group, fully-insured, and self-funded health plans. NYP provides GAC Services at six hospital facilities located throughout New York City.

53. GAC Services consist of a broad cluster of medical, surgical, diagnostic and treatment services which require a patient's overnight stay in a hospital. These services encompass a large number of medical and surgical procedures that may be effectuated by a variety of clinical personnel using technical equipment, pharmaceuticals, and medical supplies. Examples include major surgeries (*e.g.*, heart bypass surgery), treatment for severe illnesses or injuries, and labor and delivery.

54. Although individual GAC Services are not substitutes for each other (*e.g.*, obstetrics are not a substitute for cardiac services), it is appropriate to assess the effects of NYP's conduct on GAC Services as a "cluster market" because these services are offered by NYP, and other hospital systems in New York City, under substantially similar competitive conditions. GAC Services are often negotiated for as a package and face the same supply and demand conditions and same set of competitors in New York City.

55. Thus, insurers typically contract for GAC Services as a whole in a single negotiation with a hospital system. Even though individual enrollees in health plans do not consider individual GAC Services to be substitutes, these enrollees require their health plan to provide access to the entire range of GAC Services which they might need in the future.

Therefore, for health insurers to offer provider networks which are commercially viable, whether sold as fully-insured health plans or "rented" to self-funded health plans, the insurers must provide a full bundle of GAC Services.

56. Demand for GAC Services is inelastic because services that require an overnight stay in a hospital are necessary to prevent death or long-term harm to health. Accordingly, patients and payors will not switch to services provided by outpatient or other forms of healthcare facilities in response to a sustained increase in the pricing of GAC services. For example, facilities which only offer outpatient care are not viable substitutes for a hospital which provides GAC Services where a medical problem requires an overnight stay. In addition, in New York City, outpatient services are often offered by different service providers under different competitive conditions than providers of GAC Services. GAC Services also do not include services provided by facilities which do not address medical problems requiring inpatient care at a hospital, such as facilities focused primarily on transitional care, long-term psychiatric care, substance abuse treatment, or rehabilitation services. Such facilities provide specialized care and are not viable substitutes for an inpatient hospital that offers GAC Services.

57. The Relevant Product Market does not include sales of GAC Services to federal government payors, such as Medicare, Medicaid, and TRICARE. The federal government sets the rates and schedules at which the government pays healthcare providers for services for individuals covered by Medicare, Medicaid, and TRICARE. This is a separate system of determining prices from healthcare providers' negotiations with commercial insurers and payors, and functions under different competitive conditions.

58. The Relevant Product Market also does not include sales of GAC Services by hospitals which serve only military personnel and veterans. These hospitals do not sell their

healthcare services and products to the general public and are not viable substitutes for a hospital that offers GAC Services among their primary services. In addition, the reimbursement rates for such hospitals are established by government agencies and function under different competitive conditions.

B. The Relevant Geographic Market

59. The relevant geographic market is no larger than New York City, including all five boroughs: Brooklyn, the Bronx, Manhattan, Queens, and Staten Island.

60. As acknowledged in an article by two FTC economists, "[i]n healthcare markets, distance to medical provider is one of the most important predictors of provider choice."[4]

61. In general, patients choose to seek hospital care close to their homes or workplaces for their own convenience and that of their families because it takes less time to travel to a hospital nearby and it is easier to arrange for transportation and visitation. Thus, New York City residents prefer to obtain GAC Services locally. Moreover, residents of New York City who require emergency hospital services would not travel outside of New York City for emergency care without jeopardizing their health and well-being.

62. Accordingly, employers and unions whose employees and members are New York City residents must provide health plans that have New York City healthcare providers in their networks, and insurers who seek to sell their commercial health plans to employers and unions in New York City must include New York City hospitals in their provider networks. Self-insured employers and unions with members in New York City would not select a TPA or

[4] Devash Raval & Ted Rosenbaum, *Why is Distance Important for Hospital Choice? Separating Home Bias from Transport Costs*, FED. TRADE COMM'N (June 15, 2018), https://www.ftc.gov/system/files/documents/reports/why-distance-important-hospital-choice-separating-home-bias-transport-costs/working_paper_335_revised.pdf (last accessed Sept. 4, 2025).

insurer without New York City hospital systems in-network. Hospital systems outside of New York City are not reasonable substitutes for patients who live within New York City.

63. In addition, New York state imposes network adequacy requirements and standards requiring health plans operating in New York City to offer in-network access to a "sufficient number and array of providers to meet the diverse needs of the insured population and to ensure that all services will be accessible without undue delay. This includes being geographically accessible."[5]

64. For these reasons, providers of GAC services outside of New York City are not viable alternatives in the networks of insurers that sell health insurance plans to New York City employers and unions.

C. Barriers to Entry

65. The market for GAC Services has extremely high barriers to entry including, but not limited to: the limited availability of ample real estate in New York City on which to build a hospital facility; the need to construct expensive, technologically and medically advanced facilities, hire skilled medical staff, and navigate the rigorous regulatory restrictions and approvals which govern the opening of new hospitals; the many years to build a facility; and the required capital to build and maintain the facility.

VI. NYP'S MARKET POWER

A. NYP's History

66. On January 1, 1998, The New York Hospital announced a full-asset merger with The Presbyterian Hospital to create NYP. Prior to the merger, the New York Hospital and the

[5] *Network Adequacy Requirements, Standards, and Submission Instructions*, NEW YORK STATE, https://www.dfs.ny.gov/apps_and_licensing/health_insurers/network_adequacy_reqs_standards_submission_instructions (last accessed Sept. 8, 2025).

Presbyterian Hospital had long histories, dating back to the mid-1700 and mid-1800s, respectively. The merger allowed NYP to be affiliated with two top medical schools, Columbia University College of Physicians and Surgeons, and Weill Cornell Medicine. Previously, Columbia was affiliated with The Presbyterian Hospital, while Cornell was affiliated with New York Hospital.

67. In NYP's own words, the merger was an "unprecedented event" where "two academic healthcare institutions combined to create the largest hospital system in New York, with over 13,000 employees and 2,200 patient beds."[6]

68. Relevant to this action are NYP's several large hospital facilities in New York City. These facilities include the following:

- **Manhattan:**
  - NewYork-Presbyterian Allen Hospital
  - NewYork-Presbyterian Alexandra Cohen Hospital for Women and Newborns
  - NewYork-Presbyterian/Columbia University Irving Medical Center
  - NewYork-Presbyterian Lower Manhattan Hospital
  - NewYork-Presbyterian/Weill Cornell Medical Center
  - NewYork-Presbyterian Morgan Stanley Children's Hospital, including the Sloane Hospital for Women located therein
  - Alexandra Cohen Hospital for Women and Newborns
- **Brooklyn:**

[6] *History*, NEWYORK-PRESBYTERIAN, https://www.nyp.org/about/history (last accessed August 18, 2025).

- NewYork-Presbyterian Brooklyn Methodist Hospital, including the Children's Hospital of New York located therein

- **Queens:**
  - NewYork-Presbyterian Queens, including the Children's Hospital of New York located therein.

B. NYP's Market Power

69. NYP is an extremely important hospital system for patients, employers, and insurers in New York City. Its market power is evidenced by its size and breadth of services, exorbitant pricing, high profits, importance in insurance networks, and its ability to impose anticompetitive contract provisions on insurers. Because of the breadth of NYP's services, residents of New York City will expect their health plan to provide them with access to NYP's facilities. This gives NYP market power to charge supracompetitive rates to insurers. Insurers cannot sell commercially viable provider networks which do not include NYP's GAC Services, and especially its emergency services. In addition, NYP's imposition of "all or nothing" contractual terms, as discussed herein, means that insurers must include all of NYP's facilities within their networks.

70. As of 2025, NYP is the largest hospital system in New York City by revenue and one of the largest in the United States. According to NYP's most recent Consolidated Financial Statements, in fiscal year 2024 NYP took in a total operating revenue of $13 billion, with a net operating income of $385 million. In the third quarter of 2024 alone, NYP had approximately $100 million in profit. NYP's high profits have been consistent in recent years. According to ProPublica's "Nonprofit Explorer," in FY 2023, NYP had revenues of over $10 billion, with an all-time high net income of over $498 million. In fact, NYP had net incomes over $200 million

in every fiscal year except 2020. In 2021, NYP reported a profit of almost $1.5 billion, 17% of its revenues, which was, as of then, "likely the biggest in the history of New York hospitals."[7]

71. NYP's capacity is massive, encompassing hospital campuses, primary and specialty care clinics and medical groups, plus an array of telemedicine services. NYP provides a wide range of services, including inpatient, ambulatory, and preventive care in all, or substantially all, areas of medicine. NYP's hospital network has over 4,000 beds, more than 10,000 affiliated physicians, and sees more than 2 million visits annually, including more than 620,000 emergency department visits.

72. NYP is often identified as, along with Northwell Health, NYU Hospitals, and Mount Sinai Health System, one of the four "mega-systems" operating across the entire state of New York. Unlike Northwell Health, which offers GAC Services across suburban counties which are not in the geographic market for NYC health plans, the vast majority of NYP's acute care beds are located within the borders of New York City. Of the 27 hospitals within Northwell's system, only four offering the full spectrum of GAC Services are located within the borders of New York City.

73. NYP's flagship hospital, NewYork-Presbyterian/Weill Cornell Medical Center, is a powerhouse on its own. According to public sources, this hospital alone has the highest number of discharges, and the highest net patient revenue, throughout the entire New York City metropolitan area.

[7] Bill Hammond, *New York's Hospital Profits Surged in 2021*, EMPIRE CTR. (Mar. 30, 2023), https://www.empirecenter.org/publications/new-yorks-hospital-profits-2021/#:~:text=The%20state's%20largest%20hospital%2C%20NewYork,hospitals%20(see%20Table%202) (last accessed August 19, 2025).

74. NYP's market power is particularly durable because of its brand status in New York City. For one, many patients in New York prefer to receive care at NYP because of its status as an academic medical center and reputation for offering cutting-edge treatment for certain specialty inpatient procedures. For example, NYP offers specialized facilities like the Heart Failure Research Institute which allow patients to potentially be a part of clinical trials researching cutting-edge treatments to prevent heart failure.

75. In addition, NYP has cultivated a perception as a medical provider which offers high-quality treatment to high-income individuals. For example, certain NYP hospitals offer an "elite" wing with luxury amenities not available at most other New York hospitals. High-income individuals who desire these amenities will expect NYP to be included within their insurance networks.

76. NYP is also a leader in certain specialty procedures, including pediatric care. NewYork-Presbyterian Morgan Stanley & Komansky Children's Hospitals has been ranked #1 in New York State and among the best nationally across all 10 pediatric specialties by U.S. News & World Report for over 17 consecutive years. The facility specializes in specialized pediatric care for potentially debilitating physical and neurological issues, including kidney care, digestive diseases, and sickle cell disease.

77. NYP has pursued its growth, in part, through an aggressive series of acquisitions. For example, in late 2016, NYP acquired New York Methodist Hospital, then the third largest hospital in Brooklyn by bed count.

78. NYP also gains market power from its importance in geographic areas of New York City which are "medically underserved," and therefore depend on access to nearby NYP hospitals. One of the areas considered medically underserved is "Lower Manhattan," defined

herein as the area of Manhattan below 14th Street. NYP owns NewYork-Presbyterian Lower Manhattan Hospital which is located in Lower Manhattan near the Financial District.

79. The U.S. Health Resources and Services Administration calculates an Index of Medical Underservice ("IMU") score for communities across the U.S. This IMU calculation includes the ratio of primary medical care physicians per 1,000 persons to the infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population over the age of 64. The score is used to determine if a geographic area qualifies as a "Medically Underserved Area." According to a "Community Health Needs Assessment" released on December 31, 2023 by Verite Healthcare Consulting and Mount Sinai Beth Israel using this methodology, much of Lower Manhattan, including neighborhoods like the Lower East Side and Chinatown, qualifies as "medically underserved."

80. In addition, according to a Health Equity Impact Assessment carried out from December 2023 to January 2024 by the Community Coalition to Save Beth Israel and New York Eye and Ear Infirmary, at that time Lower Manhattan had only .81 hospital beds per 1,000 residents below 14th Street, less than half the statewide rate of 2.4 beds per 1,000.

81. Lower Manhattan has suffered from this lack of GAC Services since, at least, 2008. That year, Cabrini Hospital closed, followed by St. Vincent's Hospital in 2010. In the years since, only one free-standing emergency department has opened, the Lenox Hill Greenwich Village facility. Yet this department lacks inpatient services, and a patient presenting to this facility with conditions requiring inpatient treatment often must be transferred to a full-service hospital.

82. The decrease in providers of GAC Services in Lower Manhattan has been further exacerbated by the closure of Mount Sinai Beth Israel on April 9, 2025. In a survey conducted

before the hospital's closure, almost half of local respondents said they would "would face a long or difficult commute to other hospitals."[8]

83. One of the only remaining providers of GAC Services in Lower Manhattan is NYP's facility, NewYork-Presbyterian Lower Manhattan Hospital. Put another way, following the closure of Beth Israel, "only one major hospital [is] left remaining below 28th St., a branch of NewYork-Presbyterian."[9] Indeed, NYP is aware of this, "making moves to increase capacity and ease ER overcrowding" following the closure of Beth Israel.[10] Residents of Lower Manhattan therefore will expect any commercial health plan to provide access to NYP, one of the few full-service providers of GAC Services near them.

84. Similarly, areas of Brooklyn which are in close proximity to NewYork-Presbyterian Brooklyn Methodist Hospital qualify as medically underserved, including neighborhoods like Gowanus, Sunset Park, and Bedford-Stuyvesant. Again, the relative lack of providers of GAC Services in these areas means that residents of these areas will expect their health plan to provide them with access to NYP's Brooklyn facility.

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[8] Maya Kaufman, *Beth Israel Closure Threatens Vulnerable Patients, Coalition Finds*, POLITICO (Jan. 29, 2024), https://www.politico.com/newsletters/weekly-new-york-health-care/2024/01/29/beth-israel-closure-threatens-vulnerable-patients-coalition-finds-00138283 (last accessed August 19, 2025).

[9] Jack Ahern, *Community Group Warns of "Dire Consequences" if Beth Israel Closes; Draws Support from Epstein and Gonzalez*, OUR TOWN (Feb. 4, 2024), https://www.ourtownny.com/news/community-group-warns-of-dire-consequences-if-beth-israel-closes-draws-support-from-epstein-and-gonzalez-AE3107299 (last accessed August 19, 2025).

[10] Maya Kaufman, *Emergency Medical Visits on the Rise Across New York City*, POLITICO, (Sept. 3, 2024), https://www.politico.com/newsletters/weekly-new-york-health-care/2024/09/03/emergency-medical-visits-on-the-rise-across-new-york-city-00177007#:~:text=As%20more%20and%20more%20New%20Yorkers%20show%20up,off-campus%20emergency%20departments%2C%20adding%20beds%20and%20boosting%20staffing (last accessed Sept. 5, 2025).

85. Last, evidence of NYP's market power is shown through its consistently demonstrated ability to inflate the prices charged to health plans to supracompetitive levels without offering services of substantially better quality.

86. NYP charges substantially higher prices than its competitors, including for procedures which generally have little variation in quality or cost across providers. In a competitive market, prices for such procedures would not vary substantially from provider to provider, and NYP would not be able to charge supracompetitive prices. NYP's ability to charge substantially higher prices than its competitors for these procedures displays its market power.

87. For example, a March 21, 2025 review by the New York City Department of Health and Mental Hygiene examining 2023 insurer fee-for-service payments for covered medical services found that NYP had the highest overall facility expenditure per inpatient admission, at $92,727. In addition, NYP had the highest prices for 11 of 12 inpatient procedures analyzed.

88. NYP is able to charge these supracompetitive prices despite not offering GAC Services of markedly better quality than other providers. In 2022, hospital safety grades compiled by The Leapfrog Group, an independent nonprofit with grades pulled from a variety of data sources, and described as "the gold standard measure of patient safety," gave all of NYP's facilities, including its flagship facility at Weill Cornell, "C" grades for patient safety. One NYP facility, Brooklyn Methodist, received a score that ranked it among the worst nationally in hand-washing, a basic and essential aspect of patient safety.

89. 2023 was not much better, with four NYP facilities receiving "C" grades, and only two receiving "B" grades. NYP's continued growth in profitability during its periods of lower quality care indicates that the reason for its continued growth is not superior quality, but its

market power. Although NYP's facilities received "A" grades from Leapfrog in 2024, the high profitability in the earlier years indicates that NYP was able to charge supracompetitive prices regardless of the quality of its care.

90. As a result of its market power, NYP facilities are considered in-network for almost all significant health plans in New York City. The fact that NYP is always in-network for such plans despite charging supracompetitive prices shows that NYP possesses and exercises market power in the Relevant Market.

91. For the aforementioned reasons, insurers cannot sell commercially viable provider networks which do not include NYP's GAC Services, and especially its emergency services. In addition, NYP's imposition of "all or nothing" contractual terms, as discussed herein, means that insurers must include all of NYP's facilities within their networks.

92. The strength of NYP's market power was put on display during a recent set of negotiations between the Mount Sinai Health System ("Mount Sinai") and United. Mount Sinai is an elite health system in New York City and has been on the *U.S. News & World Report* "Honor Roll," a list of the nation's top 20 hospitals, for ten consecutive years. In the 2025-2026 "Honor Roll," Mount Sinai was nationally ranked in 12 adult specialties and three pediatric specialties, and was rated "High Performing" in all 22 procedures and conditions assessed in the report. *U.S. News & World Report's* evaluation included Mount Sinai Hospital, the Kravis Children's Hospital, and Mount Sinai Queens. Mount Sinai has six major hospital campuses and numerous other smaller facilities throughout New York City.

93. During 2024 price negotiations with United, Mount Sinai proposed raising its prices by 43% over the next three years. United refused to agree to those prices and dropped Mount Sinai from its network in response to these "egregious" price hikes. Throughout the

ongoing dispute, Mount Sinai commented that NYP received about 40% more from United than Mount Sinai did for common procedures. Mount Sinai and United ultimately reached a deal, but the fact that United was willing to drop Mount Sinai (and announce that it was out of network) but has not dropped NYP from its network—as well as the fact that Mount Sinai was not able to charge the supracompetitive prices of NYP—shows the power of NYP compared to a competing, elite hospital system in New York City.

94. NYP's market power is best summed up by Alan Muney, a former Cigna executive, who described it as such: "They're a must-have in the network, which gives them the power they want in negotiating contracts with insurers."[11]

95. NYP's market power is further evidenced by its ability to impose anticompetitive provisions on insurers, as explained below.

VII. ANTICOMPETITIVE CONDUCT

A. NYP's Anti-Steering Provisions

96. Throughout the Class Period, NYP has imposed a number of anticompetitive contractual restrictions that prevent health plans from steering patients to lower-cost healthcare providers, allowing NYP to maintain its supracompetitive pricing. These restrictions are the "All Products Clause," the use of a single negotiated rate, and "gag clauses."

97. Central to NYP's anticompetitive scheme is its coercive imposition of the "All Products Clause" into all contracts it enters with insurers. Under this provision, insurers who wish to include NYP in any network are obligated to include all NYP facilities within every

[11] Anna Wilde Mathews, *Hospital to Union: Pay Up or You're Stuck With Us in Your Health Plan*, THE WALL ST. JOURNAL (May 21, 2024), https://www.wsj.com/health/healthcare/new-york-presbyterian-hospital-payment-union-3b2100f5?msockid=30remove%20e010cf6965e538d7f60dce6e64e8 (last accessed September 8, 2025).

network offering. In addition, the "All Products Clause" requires the insurer to place all NYP facilities in the top tier or benefit level of each health plan, regardless of whether a facility is competitive on price and quality. Consequently, payors lose the ability to create more affordable options which exclude a particular NYP facility or assign NYP's system as a whole to less preferred tiers, fundamentally undermining their efforts to manage healthcare costs.

98. The "All Products Clause" also has the effect of imposing "all or nothing" contracting on insurers. Prohibiting the exclusion of any individual high-priced or low-quality hospital facility within NYP's system from "broad" or "narrow" networks offered by insurers functions as a form of steering, because removing that hospital facility from the network incentivizes plan members to not obtain services there, and places pressure on the hospital to lower prices or improve quality. NYP's "all or nothing" contractual provisions suppress this competition by forcing NYP's less competitive hospitals to be included in networks not based on their merits but based on their contractual links to more desirable hospital facilities.

99. Along with the "All Products Clause," NYP limits the transparency of its pricing by using a single negotiated rate across their multiple hospitals in New York City. On information and belief, NYP refuses to negotiate different rates across these combined facilities regardless of their location, quality, costs, or other factors which would normally affect negotiated rates for each facility.

100. NYP's single negotiated rate is reflected in the pricing data NYP recently began publishing on its website to comply with federal price transparency laws. Where other hospital systems publish separate data files for each of their facilities, thereby reflecting the differing rates at each facility, NYP publishes one set price which applies to all its facilities. This

combined price does not differentiate among NYP's different hospitals in any way, instead reporting a single negotiated rate for each insurance plan and service.

101. NYP's insistence on using one single negotiated rate for each insurer and health plan across multiple facilities is reflected in the American Hospital Directory's financial data reports for NYP, which states that data from New York Presbyterian/Columbia University Irving Medical Center, New York Presbyterian/Weill Cornell Medical Center, New York-Presbyterian Lower Manhattan Hospital, New York Presbyterian Westchester, New York Presbyterian Allen Hospital, New York Presbyterian Brooklyn Methodist Hospital, New York Presbyterian Morgan Stanley Children's Hospital, and New York Presbyterian Westchester Behavioral Health Center is reported on a consolidated basis. Similar consolidated reporting does not occur for other large hospital systems, such as Mount Sinai.

102. In addition, in order to further prevent insurers from incentivizing patients to switch away from NYP during the Class Period, NYP's agreements contain "gag clauses" which prevent insurers and health plans from telling patients the price of care at NYP before they receive it. *The Wall Street Journal* has identified NYP as a hospital system which insists on "contract clauses [that] prevent patients from seeing a hospital's prices by allowing a hospital operator to block the information from online shopping tools that insurers offer."[12] NYP's gag clauses prevent health plan members from knowing in advance what their cost-sharing responsibilities will be for NYP. This undermines price competition, because the clauses prevent

[12] Anna Wilde Matthews, *Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition*, THE WALL ST. JOURNAL (Sept. 18, 2018), https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963?msockid=307ce010cf6965e538d7f60dce6e64e8 (last accessed August 26, 2025).

consumers from knowing the real cost of NYP's programs, and reduce NYP's incentives to compete on price.

103. In December of 2022, New York passed the HEAL Act to prohibit gag clauses such as NYP's. Though Plaintiff is not aware whether NYP's gag clauses are still in effect, throughout the Class Period, these clauses helped to effectuate NYP's ongoing effort to impose anti-steering provisions.

104. NYP's anticompetitive contractual terms have been effective in insulating NYP from price competition for some time. In 2017, Cigna and Northwell Health discussed developing a narrow network to reduce costs for health plans. However, they were unable to do so: "The problem was a separate contract between Cigna and NewYork-Presbyterian, the powerful hospital operator that is a Northwell rival. Cigna couldn't find a way to work around restrictive language that blocked it from selling any plans that didn't include NewYork-Presbyterian[.]"[13]

B. NYP's Anticompetitive Conduct Toward 32BJ SEIU

105. NYP's pattern of anticompetitive conduct is exemplified by its long-running dispute with the 32BJ Service Employees International Union. 32BJ is one of New York's largest unions, and sponsors a self-funded health plan, the 32BJ Health Fund, which is the fourth largest purchaser of healthcare in the state.

106. In 2020, after analyzing its claims data, 32BJ realized that NYP charged, on average, 358% more than Medicare, far more than competing hospital systems of comparable quality to NYP.

[13] *Id.*

107. Public data confirms that NYP's costs are far higher than those charged by competing hospital systems. According to 2023 data, for various inpatient services, the costs NYP charged to Anthem were, on average, 396% that of Medicare, while NYU Langone charged 305% of Medicare, Northwell charged 276%, and Mount Sinai charged 202%. Similarly, for Cigna, the costs NYP charged were 287% that of Medicare, as opposed to 222% for Northwell Health, 180% for NYU Langone, and 161% for Mount Sinai. Last, for United, NYP's average charge was 256% of Medicare, while Mount Sinai charged 201%, NYU Langone charged 161%, and Northwell charged only 142%.

108. Upon recognizing the prohibitively high cost of NYP's services, 32BJ attempted to steer its patients away from NYP and towards other hospitals in its network. For example, for a time 32BJ required members who went to NYP to make co-payments which were 10 times higher than other hospitals.

109. However, 32BJ found out that NYP inserted language into its contract with 32BJ's TPA, Empire BCBS, requiring that NYP always be a preferred provider in Empire BCBS's network, meaning 32BJ "could not place [NYP] 'in a non-preferred tier with higher copays.'"[14] NYP's stringent anti-steering provisions ultimately forced 32BJ to stop steering members away from NYP.

110. By 2021, 32BJ sought to exclude NYP from its network altogether. Kyle Bragg, Local 32BJ SEIU President, described how "The doctors, nurses, and other frontline medical

[14] Joseph Goldstein, *U.S. Opens Antitrust Investigation Into New York-Presbyterian*, THE NEW YORK TIMES (July 28, 2025), https://www.nytimes.com/2025/07/28/nyregion/doj-ny-presbyterian-health.html (last accessed August 18, 2025).

staff at New York-Presbyterian deliver excellent care, but due to hospital administrators' refusal to lower their prices, keeping the system in our network would be fiscally irresponsible."[15]

111. However, 32BJ struggled to exclude NYP because union health officials were consistently informed by insurers that their contracts with NYP "prevented them from excluding the hospital system." Union health officials were told by one insurer that "anyone who tells you they can exclude NYP is lying."[16]

112. In addition, according to Sara Rothstein, director of 32BJ's health fund, at that time some 23,000 members of 32BJ's 135,000 members used NYP, and they wanted NYP's facilities in their network.

113. 32BJ attempted to work out a deal. In March 2021, 32BJ wrote directly to NYP's CEO Dr. Steven Corwin asking the system to lower prices for its membership and make its negotiated rates public. In response, Senior Vice President Dov Schwartzben stated: "We do not think it's appropriate to discuss with you terms and conditions of any agreement NYPHS Hospitals may have with any insurer or third-party administrator to which 32BJ is not a party."[17]

114. By 2022, 32BJ was able to exclude NYP from its health plan, which was, at that time, administered by Anthem. In 2023 alone, 32BJ saved some $35 million by keeping NYP's system out of its network.

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[15] HARLEM WORLD, *32BJ and NY Lawmakers Decry New York-Presbyterian Anti-Competitive Practices and Out-of-Control Care Costs* (Dec. 3, 2021), https://www.harlemworldmagazine.com/32bj-and-ny-lawmakers-decry-new-york-presbyterian-anti-competitive-practice-and-out-of-control-care-costs/ (last accessed Sept. 8, 2025).

[16] Goldstein, *supra* note 14.

[17] Maya Kaufman, *New York-Presbyterian, Empire BCBS contract dispute thrusts union workers into the crossfire*, CRAIN'S NEW YORK BUS. (Apr. 29, 2021), https://www.crainsnewyork.com/health-care/new-york-presbyterian-empire-bcbs-contract-dispute-thrusts-union-workers-crossfire (last accessed Sept. 4, 2025).

115. Near the end of 2024, 32BJ planned to leave Anthem and begin using Aetna as its TPA. 32BJ intended to keep excluding NYP from its health plan in order to replicate the cost savings it experienced in prior years. However, Aetna informed 32BJ that it could not generate a network which excluded NYP because Aetna's contract with NYP required the insurer to get a signoff from NYP to omit it from a client's plan.

116. NYP also informed 32BJ that, if 32BJ intended to modify its use of Aetna's network by excluding NYP, NYP would pursue an action against 32BJ for $25 million, a figure the hospital system claimed 32BJ owed it for past medical services. This act was not intended to recoup NYP's unpaid medical bills but, instead, was intended as a punitive act to punish 32BJ for attempting to create a network which excluded NYP. Ultimately, NYP's negotiation tactics led to NYP declining to use Aetna, its first choice, as its TPA for 2025.

117. Although 32BJ was eventually able to exclude NYP from its plan by staying with Anthem, it was, by far, the exception in doing so. This is shown by the fact that NYP's list of plans which participate in its hospitals *specifically mentions* 32BJ, listing, at the end, an "Important Notice for 32 BJ Health Fund Members," stating that NYP is not included in their network. No other health plan is specifically identified as excluding NYP from its network.

118. In addition, 32BJ could not even exclude NYP for all GAC Services. According to NYP's website, only elective services (i.e., procedures that can be scheduled in advance) at NYP are out-of-network for 32BJ Health Fund members; emergency care at NYP "will continue to be covered the same as in-network care."[18] This reveals that, for many GAC Services, NYP is too important a hospital system to be excluded from networks.

[18] *Hospital Participating Plans*, NEWYORK-PRESBYTERIAN, https://www.nyp.org/patients-visitors/paying-for-care/hospital-participating-plans (last accessed September 8, 2025).

119. In sum, 32BJ, a very large health fund, went through extraordinary efforts to exclude NYP from its health plan after its attempts to steer members to lower cost options were blocked by NYP. It was then only able to "exclude" NYP facilities by working with one specific insurer—and even then, it could only exclude NYP for non-emergency GAC Services.

C. The DOJ Opens Investigation Into NYP's Anticompetitive Practices

120. The DOJ has recognized the gravity of NYP's conduct, as it recently opened a civil antitrust investigation into NYP's practices. According to a *New York Times* article about the investigation, the DOJ seeks to determine if there have been "unlawful agreement[s] between New York Presbyterian Health Care System and health insurance companies relating to steering restrictions and contracting conduct."[19]

121. The DOJ did so following a memo from 32BJ to the Justice Department requesting that they investigate NYP due to the hospital systems' anticompetitive practices. This 28-page memo "asserted that [NYP] repeatedly tried to thwart the union's efforts to steer its members to other lower-cost hospitals, which, the memo said, impeded competition and contributed to high hospital costs across the city."[20]

122. *The New York Times* article described how 32BJ examined its claims data and found that NYP was "consistently more expensive," noting that a hip replacement at NYP cost the health fund $83,000 on average, where it cost about $58,000 elsewhere. As part of the investigation, DOJ subpoenaed 32BJ.

[19] Goldstein, *supra* note 14.
[20] *Id.*

VIII. ANTICOMPETITIVE EFFECTS

123. NYP has, through its market power and imposition of anticompetitive contractual provisions on insurers, insulated itself from fair competition and been able to raise, fix, and/or maintain the allowed amounts for GAC Services paid by Plaintiff and Class Members at supracompetitive levels. This conduct has directly injured Plaintiff and Class Members and restrained competition in the market for GAC Services.

124. Today, NYP is the most expensive, and largest, hospital system in New York City, and charges supracompetitive prices for GAC Services. Its conduct significantly drives up the costs for GAC Services for payors in New York City.

125. NYP is consistently able to charge supracompetitive prices for GAC Services. According to March 21, 2025 data from the New York Department of Health displaying "Average Rate Rankings by Health System," which averages the rates charged by hospital systems to a range of commercial health insurers, Medicare, and cash payers for various inpatient hospital services, NYP had the highest average rate for 11 of 12 listed inpatient procedures, some ***91%*** of all total procedures.

126. For example, when patients stay at NYP for "Cellulitis without a Major Chronic Condition," NYP's average rate is $39,993. This amount is over $10,000 more than the second ranked provider, Montefiore Medical Center, which has an average rate of $28,817, and almost *twice* as much as Mount Sinai, which has an average rate of $21,756.

127. To give another example, when patients stay at NYP for a "Full-Term Neonate with Major Problems" (*i.e.*, a newborn carried to full term with a serious medical episode), NYP charges an average rate of $140,817. That amount is substantially more than the second highest cost provider, Montefiore Medical Center, which has an average rate of $105,987, and more than *three times* that of Mount Sinai, which charges $42,685.

128. The NYP rates described above, if anything, understate NYP's exorbitant pricing. These "average rates" incorporate rates charged to government-sponsored plans, under Medicare, which tend to have lower rates than commercial health plans. For example, NYP charged Anthem's commercial plan $56,647 for services related to Cellulitis Without a Major Chronic Condition, much higher than its already sky-high average rate of $39,993.

129. NYP is able to charge these supracompetitive prices despite not offering care of markedly better quality than other New York City hospital systems. For example, in the 2025-26 U.S. News & World Report list of the Best Regional Hospitals, NYP's two highest ranked facilities, NewYork-Presbyterian Columbia University Medical Center and NewYork-Presbyterian Weill Cornell Medical Center, were tied with facilities from NYU Langone Hospitals and Mount Sinai. Another NYP facility, New York-Presbyterian Queens Hospital, was ranked much lower, at No. 15. Many other NYP facilities were not ranked at all. NYP, through the conduct alleged herein, was able to charge supracompetitive prices across their range of facilities despite offering worse, or the same, care as facilities with substantially lower costs.

130. NYP was able to charge supracompetitive prices through the conduct alleged herein. NYP's "All Products Clause" prevented Plaintiff and Class Members from steering patients to lower-cost, higher-quality services. These policies insulated the prices of NYP's GAC Services from market forces, thereby depriving Class Members, including Plaintiff, as well as their members the benefit of price competition and a fair market.

131. NYP's "All Products Clause" also had the effect of extending access to NYP's network on an "all or nothing" basis, further insulating it from market forces. The "all or nothing" requirement forced health plans to treat all of NYP's facilities as a single unit regardless of quality, price, location, or service. NYP thereby raised, fixed, and/or maintained the

supracompetitive prices paid by Class Members to access GAC Services at every facility by not allowing a fair negotiation for rates based on the quality of individual facilities.

132. NYP's "gag clauses" further prevented Plaintiff and Class Members from even informing patients of the price of GAC Services before they received it. This further insulated NYP from competitive market forces and almost eliminated NYP's incentive to compete. Thus, NYP could raise, fix, and maintain the price of GAC Services at supracompetitive levels.

133. The totality of NYP's actions deprived Plaintiff, Class Members, and patients from the benefits of a competitive market, forcing Class Members and Plaintiff to directly pay NYP artificially elevated prices.

134. Accordingly, Plaintiff and members of the Class suffered antitrust injury through the conduct alleged herein, which caused them to pay higher prices for GAC Services and reduced their choices for the same.

IX. CLASS ALLEGATIONS

135. Plaintiff brings this action for damages and injunctive relief on behalf of itself and a class of similarly situated entities pursuant to Federal Rules of Civil Procedure Rules 23(a) and 23(b)(3), with the Class initially defined to include ("the Class"):

> All entities whose funds were used to pay Defendant for GAC Services in New York City at any point during the period from July 25, 2021 to the present (the "Class Period").

136. This class definition specifically excludes the following persons or entities: (a) Defendant and Defendant's subsidiaries, affiliates, officers and directors, and any entity in which Defendant has a controlling interest; (b) all federal governmental entities; (c) all individuals who make a timely election to be excluded from this proceeding using the correct protocol for opting out; (d) the judges and chambers staff in this case, as well as any members of their immediate families; (e) Plaintiff's counsel; and (f) all jurors assigned to this case.

137. Also excluded from the Class are individuals or entities whose only payment to Defendant were co-pays, co-insurance, and/or other out-of-pocket payments, or any payments for out-of-network claims.

138. Plaintiff reserves the right to modify or amend the definition of the proposed Class before the Court determines whether certification is appropriate.

139. **Numerosity.** Plaintiff does not know the exact number of Class members because such information presently is in Defendant's control. However, given the number of health plans who contract for GAC Services in New York City, Plaintiff expects that the Class is so numerous that joinder of all members is impracticable.

140. **Commonality.** There are questions of law and fact common to the Class, which predominate over any questions affecting only individual members of the Class. These common questions of law and fact include, without limitation:

a. Whether Defendant violated the antitrust laws;

b. Whether Defendant engaged in anticompetitive conduct;

c. Whether Plaintiff and members of the Class suffered an injury;

d. Whether Plaintiff and members of the Class are entitled to damages and other relief.

141. **Typicality.** Plaintiff's claims are typical of those of other members of the Class because Plaintiff, like every other member of the Class, was harmed by way of the anticompetitive conduct alleged herein. Plaintiff is advancing the same claims and legal theories on behalf of itself and all other members of the Class, such that there are no defenses unique to Plaintiff. The claims of Plaintiff and those of the other members of the Class arise from the same operative facts and are based on the same legal theories. Plaintiff and other Class members were

injured by the same unlawful conduct, which resulted in their paying more for in-network GAC Services than they would have in a competitive market.

142. **Adequacy of Representation.** Plaintiff will fairly and adequately represent and protect the interests of members of the Class because Plaintiff used its funds to purchase in-network GAC Services from Defendant in New York City during the Class Period. Plaintiff has no disabling or disqualifying conflicts of interest that would be antagonistic to those of the other members of the Class. The damages and infringement of rights Plaintiff suffered are typical of other members of the Class, and Plaintiff seeks no relief that is antagonistic or adverse to the members of the Class. Furthermore, Plaintiff has retained sophisticated and competent counsel who are experienced in prosecuting antitrust class actions, as well as other complex litigation. Plaintiff intends to prosecute this action vigorously.

143. **Superiority of Class Action.** Class action treatment is a superior method for the fair and efficient adjudication of the controversy in that, among other things, such treatment will permit a large number of similarly situated persons to prosecute their common claims in a single forum simultaneously, efficiently, and without the unnecessary duplication of effort and expense that numerous individual actions would engender. The relatively small damages suffered by individual members of the Class as compared to the expense and burden of individual prosecution of the claims asserted in this litigation means that, absent a class action, it would not be feasible for members of the Class to seek redress for the violations of law herein alleged. Further, individual joinder of all damaged members of the Class is impractical, and the prosecution of separate actions by individual members of the Class would create the risk of inconsistent or varying adjudications, establishing incompatible standards of conduct for Defendant. Accordingly, the benefits of proceeding through the class mechanism, including

providing injured entities with a method of obtaining redress for claims that are not practicable for them to pursue individually, substantially outweigh any difficulties that may arise in the management of this class action.

144. **Predominance.** The questions of law and fact common to the members of the Class predominate over any questions affecting only individual members, including issues relating to liability and damages.

145. The litigation of the claims brought herein is manageable. Defendant's uniform conduct, the consistent provisions of the relevant laws, and the ascertainable identities of members of the Class demonstrate that there will be no significant manageability problems with prosecuting this lawsuit as a class action.

146. This proposed class action does not present any unique management difficulties. This class action is superior to other alternatives for the fair and efficient adjudication of this controversy. Prosecuting the claims pleaded herein as a class action will eliminate the possibility of repetitive litigation. There will be no material difficulty in the management of this action as a class action.

X. CAUSES OF ACTION

FIRST CAUSE OF ACTION
Restraint of Trade in Violation of the Sherman Act (15 U.S.C. § 1)

147. Plaintiff realleges and repeats the allegations contained in paragraphs 1-146 as if fully set forth herein.

148. Beginning at a time currently unknown to Plaintiff, but at least as early as July 25, 2021, although further investigation and discovery may reveal an earlier date, and continuing through the present, Defendant entered into, and continues to enter into, anticompetitive

contracts with insurers to unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

149. NYP has market power in the Relevant Market. That market power has enabled NYP to impose anticompetitive restraints in written agreements and/or in contract negotiations with insurers.

150. GAC Services is a valid Relevant Product Market.

151. New York City is a valid Relevant Geographic Market. The relevant geographic market is no larger than New York City, based on the commercial realities of the market where insurers need to create networks for commercial health plans that appeal to consumers and consumers' desire to obtain healthcare close to where they live and work.

152. NYP imposed its anticompetitive restraints in its negotiations with all or nearly all the insurers it negotiates with in New York City.

153. NYP enforces these restraints to prevent steering which would increase price competition between NYP and its competitors and lower prices in the Relevant Market.

154. NYP also requires insurers to accept its pricing on a consolidated basis, thereby preventing price competition between NYP and its competitors and increasing prices in the Relevant Market.

155. NYP also imposes "gag clauses," which prevent price competition between NYP and its competitors and increases prices in the Relevant Market.

156. By compelling insurers to agree to these anticompetitive terms, NYP unlawfully restrains trade and limits the ability of competitors to compete in the Relevant Market. The anticompetitive effects of NYP's conduct outweigh any purported non-pretextual, pro-competitive justifications.

157. Because NYP imposes these restraints on all or nearly all insurers, NYP's anticompetitive contracting terms have affected competition as a whole in the Relevant Market.

158. As a proximate result of NYP's unlawful conduct, Plaintiff and members of the proposed Class have been, and continue to be, harmed by having paid and continuing to pay NYP prices that are higher than they would have been absent NYP's anticompetitive conduct.

159. Plaintiff and members of the Class have been injured in their business or property by NYP's antitrust violation. That injury consists of paying higher prices for GAC Services during the Class Period than would have been paid in the absence of the antitrust violations. Plaintiff and Class members' injuries are injuries of the type the antitrust laws were designed to prevent and flow from that which makes NYP's conduct unlawful.

160. This conduct is unlawful under the *per se* standard. Defendant's conduct is also unlawful under either a "quick look" or rule of reason analysis because the agreement is anticompetitive with no valid procompetitive justifications. Moreover, even if there were valid procompetitive justifications, such justifications could have been reasonably achieved through less restrictive means of competition.

161. Plaintiff and members of the Class are entitled to treble damages, attorneys' fees and costs, and an injunction against Defendant to end the ongoing violations alleged herein.

SECOND CAUSE OF ACTION
Restraint of Trade in Violation of the Donnelly Act (N.Y. Gen Bus. Law § 340, *et seq.*)

162. Plaintiff realleges and repeats the allegations contained in paragraphs 1-146 as if fully set forth herein.

163. Beginning at a time currently unknown to Plaintiff, but at least as early as July 25, 2021, although further investigation and discovery may reveal an earlier date, and continuing

through the present, Defendant entered into, and continues to enter into, anticompetitive contracts with insurers to unreasonably restrain trade in violation of the Donnelly Act.

164. NYP has market power in the Relevant Market. That market power has enabled NYP to impose anticompetitive restraints in written agreements and/or in contract negotiations with insurers.

165. GAC Services is a valid Relevant Product Market.

166. New York City is a valid Relevant Geographic Market. The relevant geographic market is no larger than New York City, based on the commercial realities of the market where insurers need to create networks that appeal to consumers and consumers' desire to obtain healthcare close to where they live and work.

167. NYP imposed its anticompetitive restraints in its negotiations with all or nearly all insurers it negotiates with in New York.

168. NYP enforces these restraints to prevent steering which would increase price competition between NYP and its competitors and lower prices in the Relevant Market.

169. NYP also requires insurers to accept its pricing on a consolidated basis, thereby preventing price competition between NYP and its competitors and increasing prices in the Relevant Market.

170. NYP also imposes "gag clauses," which prevent price competition between NYP and its competitors and increases prices in the Relevant Market.

171. By compelling insurers to agree to these anticompetitive terms, NYP unlawfully restrains trade and limits the ability of competitors to compete in the Relevant Market. The anticompetitive effects of NYP's conduct outweigh any purported non-pretextual, pro-competitive justifications.

172. Because NYP imposes these restraints on all or nearly all insurers, NYP's anticompetitive contracting terms have affected competition as a whole in the Relevant Market.

173. As a proximate result of NYP's unlawful conduct, Plaintiff and members of the proposed Class have been, and continue to be, harmed by having paid and continuing to pay NYP prices that are higher than they would have been absent NYP's anticompetitive conduct.

174. Plaintiff and members of the Class have been injured in their business or property by NYP's antitrust violations. That injury consists of paying higher prices for GAC Services during the Class Period than would have been paid in the absence of the antitrust violations. Plaintiff and Class members' injuries are injuries of the type the antitrust laws were designed to prevent and flow from that which makes NYP's conduct unlawful.

175. This conduct is unlawful under the *per se* standard. Defendant's conduct is also unlawful under either a "quick look" or rule of reason analysis because the agreement is anticompetitive with no valid procompetitive justifications. Moreover, even if there were valid procompetitive justifications, such justifications could have been reasonably achieved through less restrictive means of competition.

176. Plaintiff and members of the Class are entitled to damages, attorneys' fees and costs.

THIRD CAUSE OF ACTION
Unjust Enrichment

177. Plaintiff realleges and repeats the allegations contained in paragraphs 1-146 as if fully set forth herein.

178. Alternatively, from NYP's unfair acts as alleged above, NYP has been unjustly enriched at the expense of Plaintiff and members of the Class.

179. NYP has been unjustly enriched by retaining artificially high payments for GAC Services collected from Plaintiff and members of the Class.

180. NYP has been enriched at the expense of Plaintiff and members of the Class.

181. The retention of these payments by NYP violates the fundamental principles of justice, equity, and good conscience and should be returned to Plaintiff and members of the Class.

XI. DEMAND FOR RELIEF

WHEREFORE, Plaintiff, on behalf of itself and the Class, respectfully ask this Court for a judgment that:

A. Certifies the Class pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(3) and directs that reasonable notice of this Action, as provided by Federal Rule of Civil Procedure 23(c)(2) be given to the Class, and appoints Plaintiff as representative of the Class;

B. Appoints Plaintiff's counsel as class counsel;

C. Enters judgment against Defendant, and in favor of Plaintiff and the Class, holding Defendant liable for the antitrust violations as alleged herein;

D. Grants permanent injunctive relief enjoining Defendant from continuing to engage in the anticompetitive conduct described above;

E. Awards Plaintiff and the Class actual, treble, and exemplary damages as permitted plus interest in accordance with the law;

F. Awards such equitable relief as is necessary to correct for the anticompetitive market effects as caused by Defendant's unlawful conduct;

G. Awards Plaintiff and the Class all other appropriate equitable relief, including disgorgement, restitution, and/or the creation of a constructive trust to remedy NYP's unjust enrichment;

H. Awards Plaintiff and the Class their costs of suit, including reasonable attorneys' fees;

I. Awards Plaintiff and the Class pre- and post-judgment interest; and

J. Directs such further relief as it may deem just and proper.

XII. JURY TRIAL DEMAND

182. Plaintiff and members of the Class demand a trial by jury on all claims so triable under Federal Rule of Civil Procedure 38(b).

Dated: September 8, 2025

Respectfully submitted,

/s/ Gregory S. Asciolla

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