HEALTH CAPITAL Topics
Volume 19
Issue 6
June 2026
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

OhioHealth Settles DOJ Antitrust Claims Over Insurer Contracts

On June 16, 2026, the U.S. Department of Justice (DOJ) and the State of Ohio filed a proposed consent judgment in the U.S. District Court for the Southern District of Ohio to resolve their civil antitrust suit against OhioHealth Corporation, a nonprofit system that owns or manages 16 hospitals in the Columbus area.[1] The proposed judgment would void contract provisions the government alleged OhioHealth used to keep commercial insurers from steering patients toward lower-cost competitors; bar the system from seeking such terms again; and install an independent monitor, all without any admission of wrongdoing or payment of penalties.[2] This Health Capital Topics article examines the allegations, the terms of the proposed settlement, and how the case fits within a renewed federal and state focus on hospital-insurer contracting.

The DOJ and Ohio Attorney General sued OhioHealth on February 20, 2026, alleging that the system violated Section 1 of the Sherman Act and Ohio's Valentine Act by using its market position to impose anticompetitive terms on commercial payors.[3] According to the complaint, OhioHealth held over 35% of the relevant Columbus-area market for general acute care inpatient hospital services, a share the government argued made the system a "must have" in any viable network, reinforced by rural hospitals that are the sole providers in their counties.[4] The government further alleged that OhioHealth negotiated on an "all-or-nothing" basis, requiring a payor that wanted any of its providers to include all of them, and that it commanded "significantly higher" reimbursement rates than local rivals offering comparable quality.[5]

The complaint targeted contract provisions that the agencies view as central to price competition: prohibiting insurers from encouraging patients to select lower-cost or higher-value providers, designing narrow or tiered networks, and sharing price and quality information with plan members.[6] The government did not bring a monopolization claim, instead challenging the restraints under the rule of reason, an approach market analysts interpret as a strategy to reach large systems that may not qualify as "dominant" under traditional monopoly standards.[7]

Under the proposed final judgment, all OhioHealth contract provisions that prohibit, deter, prevent, or penalize steering, steered plans,[8] or price transparency are declared void and unenforceable, with an exhibit describing barred language, including clauses that triggered rate increases or contract termination when a payor excluded OhioHealth from a network or placed it in a less-preferred tier.[9] The system is also barred from seeking such terms going forward and from penalizing, or threatening to penalize, a payor for offering transparency or budget-conscious, steered plans.[10]

The settlement preserves several accommodations. OhioHealth may still negotiate to participate in a plan's most-preferred tier on the same terms available to any other provider, may restrict steering within a narrow network in which it is the featured provider, and need not disclose confidential pricing to competitors.[11] The settlement is specific to commercial and Medicare Advantage (Part C) contracts, and excludes Traditional Medicare, Medicaid, and TRICARE.[12]

OhioHealth must notify relevant payors within 15 business days that the barred provisions are unenforceable, file compliance affidavits every 45 days until specified actions are complete, and submit quarterly reports on new or amended payor contracts for five years.[13] An independent monitor, paid by OhioHealth and reporting to the DOJ and the State of Ohio, will oversee compliance for a five-year term.[14] The judgment expires after 10 years but may be terminated after five if the government determines it is no longer necessary, and the DOJ may reopen the matter within five years if violations persist.[15] As required by statute, the proposed settlement and a competitive impact statement will be published in the Federal Register for a 60-day public comment period before the court enters final judgment upon a public-interest finding.[16]

The OhioHealth resolution closely tracks the DOJ's 2018 settlement with Atrium Health, formerly Carolinas HealthCare System, which the agency sued in 2016 over anti-steering restrictions and resolved, like OhioHealth, without penalty or admission of wrongdoing.[17] The OhioHealth judgment's most-preferred-tier carve-out echoes the Atrium decree almost verbatim, indicating that the agency is reusing a framework refined nearly a decade earlier.[18] State enforcers have pursued parallel theories, most prominently California's 2019 settlement with Sutter Health over "all-or-nothing" clauses, for which the system agreed to pay $575 million.[19]

The nearer-term bellwether is the DOJ's nearly identical suit against NewYork-Presbyterian (NYP), filed in March 2026, which alleges that the largest hospital

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system in New York City uses all-or-nothing and anti-steering terms to insulate itself from price competition.[20] Unlike OhioHealth, NYP is contesting the case, arguing in a May 2026 filing that the challenged provisions are industry-standard, demanded by insurers, and ultimately lower prices.[21]

Two days after the proposed settlement was filed, the White House Council of Economic Advisers (CEA) released a memorandum estimating the effects of a nationwide ban on the three contracting mechanisms at the center of the OhioHealth and NYP cases: anti-steering, anti-tiering, and all-or-nothing bundled contracting. The CEA estimated that such a ban would lower hospital and affiliated-physician prices by 18% in directly affected markets, averaging approximately $4,100 per inpatient admission.[22] Scaled nationally, the report projected aggregate employer-sponsored insurance premium savings of approximately $45 billion per year.[23] The analysis is an administration economic memorandum rather than a binding policy, but its modeling of an industry-wide prohibition, released two days after the settlement, indicates the OhioHealth resolution may be a step toward broader limits on these terms rather than an isolated enforcement action.

The dispute underscores how contracting leverage shapes the economics of dominant regional systems. OhioHealth reported an operating margin near 10% in fiscal year 2025,[24] well above the 1.1% median Fitch Ratings reported for nonprofit hospitals,[25] a gap the contested provisions arguably helped sustain by foreclosing lower-cost competition. Because antitrust scrutiny now reaches the network and pricing terms that underpin those margins, the conduct at issue bears on the revenue assumptions embedded in the valuation of systems with concentrated local share.

Market analysts also caution that government enforcement can invite follow-on private litigation, noting that NYP already faces union suits predating the federal case and that the OhioHealth record could supply a roadmap for insurers or employers alleging similar harm.[26] With a binding template now on file in two large U.S. metropolitan markets, it brings into question whether dominant systems will preemptively unwind restrictive payor terms, or wait to learn whether NYP can persuade a court that the practices the government condemns are the ones the market in fact demands.

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11 *Ibid*, p. 6-8.

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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of The Value Examiner and QuickRead, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from NACVA. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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