

September 9, 2022

Attached please find responses to the Questions for the Record sent to Ahmer Qadeer for the hearing entitled “Antitrust Applied: Hospital Consolidation Concerns and Solutions” on Wednesday, May 19, 2021.

Sincerely,

Ahmer Qadeer

**Responses to Senate Judiciary Committee, Subcommittee on Competition Policy, Antitrust, and Consumer Rights, Questions to Ahmer Qadeer, Director of Strategic Initiatives, Service Employees International Union**

One need to look no further than HCA Healthcare Inc.'s (hereinafter "HCA") 2019 acquisition of the nonprofit Mission Health System (hereinafter "Mission") in Sen. Tillis' home state of North Carolina to see how hospital mergers and acquisitions adversely impact local communities. Our answers to the Senator's questions, as presented below, will mainly center around this case study.

- 1. Q:** One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

**A:** A wide body of research has shown that provider consolidation leads to higher health care prices, especially for private insurance. One analysis found that prices at hospitals acquired by out-of-market hospital systems increase by about 17% more than unacquired, stand-alone hospitals.<sup>1</sup> The purchase of Mission Health System by the out-of-state healthcare conglomerate HCA, is a stark case study of this exorbitant jump in healthcare costs following consolidation. HCA's activity illustrates the negative outcomes of hospital mergers, acquisition and market consolidation because increasing market share to bolster aggressive pricing is a central piece of HCA's overall operating strategy. A *Modern Healthcare* article from 2018 explained that "[s]ize and dominant market share have enabled HCA to negotiate higher prices from health insurers."<sup>2</sup> The article identifies HCA's clear expansion strategy: "When expanding into new territories, HCA eyes areas where it will dominate in terms of market share, which it can leverage into negotiating power to secure better rates from insurers."<sup>3</sup> Ultimately, "HCA's aggressive pricing, enabled by its market share and patient volume, is a major factor in its financial success."<sup>4</sup>

***HCA's Acquisition of Mission Bolsters its Dominance & Aggressive Pricing Strategy***

In 2019, HCA Healthcare – the nation's largest hospital system<sup>5</sup> – acquired Mission Health, a non-profit health system based in Asheville, North Carolina.<sup>6</sup> With this transaction, HCA acquired the dominant hospital system in the Western North Carolina market,<sup>7</sup> which had effectively operated as a legislatively authorized monopoly for over twenty years due to its possession of a Certificate of Public Advantage

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<sup>1</sup> <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

<sup>2</sup> Shelby Livingston, "HCA's success over 50 years banks on sticking with the basics," *Modern Healthcare*, October 06, 2018.

<https://www.modernhealthcare.com/article/20181006/NEWS/181009941/hca-s-success-over-50-years-banks-on-sticking-with-the-basics>

<sup>3</sup> Shelby Livingston, "HCA's success over 50 years banks on sticking with the basics," *Modern Healthcare*, October 06, 2018.

<https://www.modernhealthcare.com/article/20181006/NEWS/181009941/hca-s-success-over-50-years-banks-on-sticking-with-the-basics>

<sup>4</sup> Shelby Livingston, "HCA's success over 50 years banks on sticking with the basics," *Modern Healthcare*, October 06, 2018.

<https://www.modernhealthcare.com/article/20181006/NEWS/181009941/hca-s-success-over-50-years-banks-on-sticking-with-the-basics>

<sup>5</sup> Becker's Hospital Review, "100 of the largest hospitals and health systems in America | 2021," March 23, 2022.

<https://www.beckershospitalreview.com/100-of-the-largest-hospitals-and-health-systems-in-america-2021.html>

<sup>6</sup> Asheville Watchdog, "Attorney General's office had 'great concerns' Mission-HCA deal was rigged 'from the beginning,'" March 20, 2022. -

<https://www.northcarolinahealthnews.org/2022/03/20/hca-deal-was-rigged-ag-office-concerned>

<sup>7</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p.40

("COPA"). The COPA immunized Mission from State and Federal antitrust liability, while subjecting Mission Health to enhanced state oversight. The COPA arrangement with the State had ended in 2016. However, even after the COPA repeal, no new hospitals have opened in its service area.<sup>8</sup> As a result, Mission allegedly holds monopoly market share of 70% or more in 7<sup>9</sup> different counties<sup>10</sup> - in some counties and zip codes allegedly reaching as high as over 90%.<sup>11</sup> It is against this backdrop that HCA implements its "aggressive" pricing strategy. As noted *Modern Healthcare* following HCA's purchase of Mission: "Mission ... fits with HCA's long standing strategy of scooping up facilities that dominate their markets, which helps the company negotiate better rates with health insurers."<sup>12</sup> Unsurprisingly, this has resulted in exorbitant prices for communities in Western North Carolina.

### ***Ongoing Antitrust Lawsuits against HCA/Mission***

HCA/Mission's extractive behavior in Western North Carolina has recently landed the company as a defendant in multiple antitrust lawsuits. To date, local residents and municipalities have filed three antitrust lawsuits against HCA/Mission in less than a year - each one alleging that HCA/Mission is unlawfully using its monopoly power to extract supracompetitive rates from insurers.<sup>13</sup>

First, in August of 2021, a group of Western North Carolina residents filed a class action lawsuit against HCA/Mission.<sup>14</sup> Soon after, in June 2022, the City of Brevard, North Carolina also filed suit. Another class-action suit was filed this past July, this time jointly by the City of Asheville and Buncombe County.<sup>15</sup> Most recently, Brevard and Asheville and Buncombe have filed to consolidate their cases due to the similarities in their arguments.<sup>16</sup> Another Western North Carolina County, Madison County, has also announced it will be joining in on the class action antitrust lawsuit filed by Buncombe and Asheville.<sup>17</sup>

The suits allege, among other things, that HCA/Mission has abused its unregulated monopoly power by engaging in unlawful, anti-competitive tactics to bolster its power with insurers, extract higher rates, and force health plans to cover a wider range of its services. Specifically, they accuse HCA/Mission of

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<sup>8</sup><https://info.ncdhhs.gov/dhsr/coneed/comments/2022/june/Buncombe-Acute-Care-Beds-Project-ID-B-12232-22-Mission-Hospital-Comments-by-AG-Josh-Stein.pdf>

<sup>9</sup> Yancey (90.9%), Madison (90%), Buncombe (86.6%), Mitchell (85.4%), Transylvania (78.7%), McDowell (76.4%) and Macon (74.7%). Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21)

<sup>10</sup> <https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/>

<sup>11</sup> Certificate of Need Application for acute care beds submitted by MH Mission Hospital, LLLP. June 15, 2022, p. 54-57; Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 61

<sup>12</sup> Tara Bannow, "HCA finalizes Mission Health purchase," *Modern Healthcare*, February 01, 2019.

<https://www.modernhealthcare.com/article/20190201/NEWS/190209999/hca-finalizes-mission-health-purchase>

<sup>13</sup> <https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/>

<sup>14</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 3

<sup>15</sup> Buncombe County, City of Asheville v. HCA Healthcare, Mission Health (Case No: Case No. 1:22-cv-147, United States District Court - Western District of North Carolina, filed 07/27/22);

<https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/>; <https://mountainx.com/living/hca-mission-lawsuit-asheville-buncombe/>

<sup>16</sup> <https://www.citizen-times.com/story/news/2022/08/05/asheville-buncombe-brevard-lawsuits-v-hca-could-become-single-case/10241496002/>

<sup>17</sup> <https://wlos.com/news/local/lawsuit-against-hca-healthcare-madison-county-will-join-buncombe-county-asheville-mission-attorney-confirms>

engaging in “all or nothing”<sup>18</sup> offers, anti-steering and anti-tiering contractual provision,<sup>19</sup> and “gag clauses” to aggressively negotiate for higher prices from insurers.<sup>20</sup> The plaintiffs also accuse HCA/Mission of failing to comply with the federal hospital price transparency rule that took effect in January 2021. The transparency rule requires that all US hospitals “provide clear, accessible pricing information online about the items and services.”<sup>21</sup> The lawsuits allege that “HCA has however failed to fully disclose this information in a timely, complete, and understandable manner,”<sup>22</sup> which has “kept community members, regulators, and the general public from learning of the grossly inflated, monopolistic prices that are being charged.”<sup>23</sup> While the complaints allege that, under non-profit ownership, Mission engaged in anti-competitive behavior to raise prices, the suits assert that HCA “has further exploited the system’s market dominance by raising prices and cutting costs in ways that have harmed quality of care.”<sup>24</sup> Specifically, they claim that under HCA’s ownership, “prices rose at an even higher rate than the State average, while at the same time HCA cut staffing to dangerously low levels to further increase its profit.”<sup>25</sup> Ultimately, the suits allege that HCA’s “conduct has restricted competition in the health care markets defined herein, thereby substantially and artificially inflating health care prices paid by plaintiffs and proposed class member health plans...”<sup>26</sup>

Notably, both North Carolina's Attorney General Josh Stein and State Treasurer Dale Folwell filed separate *amicus* briefs in support of the Plaintiff residents in *Davis et al. v. HCA Healthcare and Mission Health System*.<sup>27</sup> Some excerpts from which include:

- From State Treasurer Folwell: "The hospitals should be held accountable to comply with the Transparency Rule and with the antitrust law. In the area of a person’s healthcare, transparency and honesty are imperative and any other corporate approach frankly amounts to nothing more than a pattern of deceit." The *amicus* brief goes on to say, "... The ever-

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<sup>18</sup> City of Brevard, North Carolina v. HCA Healthcare and Mission Health System (Case No. 1:22-cv-114, United States District Court - Western District of North Carolina, filed 06/03/22), p. 34-35 ; “When a hospital system is the only entity in a given region to offer a product or service that health plans must include in their networks to be viable, that hospital system can refuse to sell services to health plans, or sell only with a significant price penalty, unless those health plans also agree to purchase other services from the hospital system, including services that the health plan would otherwise purchase from a different hospital system or set of providers for lower prices. Either orally during negotiations or in the contracts themselves, a hospital system can give the health plan what effectively is an “all-or-nothing” choice: Include everything the hospital system wants to sell at the price the hospital system dictates or pay much higher penalty prices or even get nothing at all.”

<sup>19</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64; Many insurers utilize steering arrangements that involve encouraging plan enrollees to use lower-cost facilities instead of a higher cost facility or provider through plan language or by making the patient’s personal financial responsibility (through out-of-pocket costs or copays) higher for use of the higher cost facility. Mission allegedly requires insurers “not to use steering or tiering language, or to use weaker language or provisions than the insurers would have desired to use, as a condition of obtaining access to Defendants’ ‘must have’ Mission Hospital-Asheville for their commercial health plans.”

<sup>20</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64; In which insurers are prohibited from revealing their Mission contract terms, preventing “competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by Defendants.”

<sup>21</sup> CMS, “Hospital Price Transparency.” <https://www.cms.gov/hospital-price-transparency>

<sup>22</sup> The rule is, of course, meant to improve care accessibility by allowing consumers to shop around for services and understand the cost of care before receiving services. Unfortunately, a February 2022 report by PatientRightsAdvocate.Org revealed that HCA is still not meeting these standards. In fact, the researchers found that 0% of HCA’s hospitals were in compliance. PatientRightsAdvocate.org, “Semi-Annual Hospital Price Transparency Compliance Report,” February 2022. <https://www.patientrightsadvocate.org/semi-annual-compliance-report-2022> at 3.

<sup>23</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 64

<sup>24</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 37

<sup>25</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 44-45

<sup>26</sup> Buncombe County, City of Asheville v. HCA Healthcare, Mission Health (Case No: Case No. 1:22-cv-147, United States District Court - Western District of North Carolina, filed 07/27/22); <https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/101718520-02/> ; <https://mountainx.com/living/hca-mission-lawsuit-asheville-buncombe/>

<sup>27</sup><https://www.citizen-times.com/story/news/2022/08/01/north-carolina-attorney-general-josh-stein-treasurer-dale-folwell-buncombe-asheville-hca-lawsuit/10183195002/>

increasing costs being charged with these multi-state behemoths like HCA HealthCare are of high concern."<sup>28</sup>

- From Attorney General Stein: "Healthcare costs place significant burdens on patients and their families who are often already dealing with stressful medical situations. In Asheville and the surrounding area—which is part of Mission Health's self-described service area—the cost of healthcare has become exorbitant. According to Plaintiffs' Complaint, residents of western North Carolina are sometimes paying up to 50 percent more for treatment than residents elsewhere in the state."<sup>29</sup> The *amicus* brief goes on to say: "[H]ospital consolidation further reduces choice. One of the few ways patients can control the price of their own healthcare is to choose a more affordable provider within the patient's network, if more than one choice exists. Plaintiffs allege that Mission Health robbed them of even that. According to Plaintiffs, Mission Health leveraged its overwhelming market share (between 70 and 90 percent) in acute inpatient treatment in the Asheville area to require insurers to agree to contract provisions that would prevent them from trying to direct patients to more affordable providers. These provisions, which prohibit the insurer from encouraging or incentivizing patients to use lower-cost providers, allow Mission Health to negotiate prices with insurers without fear of price competition. Insurers, unsurprisingly, pass some or all of Mission Health's high prices on to patients in the form of higher premiums, co-pays, deductibles, and other costs. In short, this case involves critical issues of competition and healthcare affordability that have a significant impact on consumers."<sup>30</sup>

### ***Mission's Charges Jump Significantly Following HCA's Acquisition***

HCA has a track record of raising charges at its acquired hospitals, enabled by its strategic grabs for market share. For example, following HCA's purchase of two Georgia hospitals (Memorial Satilla Health in 2017<sup>31</sup> and Memorial Health University Medical Center in 2018),<sup>32</sup> both went from having below-average charge-to-cost ratios to above-average charge-to-cost ratios after they were bought by HCA.<sup>33</sup> Overall, HCA's hospital markups are generally more than twice the national average, and many HCA hospitals have markups as high as 12 or 13 times the cost of care.<sup>34</sup>

A hospital's charge-to-cost ratio "is calculated as a hospital's total gross charges divided by its total Medicare-allowable cost."<sup>35</sup> Gross charges refer to a hospital's sticker price for each service—the price before private insurers' allowable amounts and predetermined Medicare and Medicaid rates. Medicare-allowable costs include costs associated with providing care to all patients, as reported on the

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<sup>28</sup> Amicus Brief filed in Support of Plaintiffs by State Treasurer, Dale Fowell - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from [https://drive.google.com/file/d/1DD8nHMEVDk\\_ITOxsR9Vi8DvGRCPouLbX/view](https://drive.google.com/file/d/1DD8nHMEVDk_ITOxsR9Vi8DvGRCPouLbX/view), p9

<sup>29</sup> Amicus Brief filed in Support of Plaintiffs by State AG Josh Stein - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from <https://drive.google.com/file/d/1CoJlqb4-T1t6EAwazGp4KuX4rKCNAqA5/view>, p2

<sup>30</sup> Amicus Brief filed in Support of Plaintiffs by State AG Josh Stein - *Davis et al. v. HCA Healthcare and Mission Health System* (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 12/13/21) Retrieved from <https://drive.google.com/file/d/1CoJlqb4-T1t6EAwazGp4KuX4rKCNAqA5/view>, p3

<sup>31</sup> Saunders, Jessica, "Hospital giant HCA acquires 231-bed hospital in Waycross, Ga.," Atlanta Business Chronicle, May 3, 2017, <https://www.bizjournals.com/atlanta/news/2017/05/03/hospital-giant-hca-acquires-231-bed-hospital-in.html>

<sup>32</sup> Skutch, Jan, "HCA completes \$456 million purchase of Memorial Health," Savannah Morning News, Feb. 1, 2018, <https://www.savannahnow.com/story/news/2018/02/01/hca-completes-456-million-purchase-memorial-health/13839711007/>

<sup>33</sup> SEIU analysis of Medicare cost report data

<sup>34</sup> Based upon SEIU analysis of Medicare Cost Reports.

<sup>35</sup> Ge Bai and Gerard F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios, Health Affairs, June 2015. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1414#:~:text=The%20charge%2Dto%2Dcost%20ratio%20is%20calculated%20as%20a%20hospital's,its%20total%20Medicare%2Dallowable%20cost>

hospital's Medicare cost reports. Therefore, a hospital's charge-to-cost ratio demonstrates how much higher a hospital's charges are compared to what it actually costs to provide that service. A higher ratio signals considerable profit motives.

We can see these high charges, as enabled by monopoly power, at play at Mission Hospital, Mission Health's flagship hospital in Asheville, NC. Based on our analysis of Medicare cost report data, Mission Hospital's charges increased significantly following HCA's acquisition, to the point that:

- Prior to HCA's acquisition, Mission Hospital's charge-to-cost ratio had consistently fallen below the average charge-to-cost ratio across all North Carolina hospitals, but shot up the year of the acquisition (in 2019) to above the state average;
- Mission Hospital's charge-to-cost ratio had been increasing at a rate relatively in line with the state average (in terms of percent change each year) but, following HCA's acquisition, began increasing at a much more rapid rate, one in the double digits;
- Mission Hospital's charge-to-cost ratio previously fell consistently below the national average but, as of 2020, is now significantly above the national average;
- While both the state and national average charge-to-cost ratio decreased from 2019 to 2020, Mission Hospital's increased by 14%, with the hospital now under HCA's ownership.

As of 2021, the most recent data we have, Mission has a charge-to-cost ratio of 539%. In other words, Mission charges approximately 5.4 times what it actually costs to deliver care.<sup>36</sup>

These shockingly high ratios serve as an indication of the exorbitant amounts consumers are being expected to pay out-of-pocket, of course disproportionately harming uninsured and underinsured patients. Numerous studies find a link between what a hospital charges and its actual prices. *The Quarterly Journal of Economics* published a study in 2019 of claims data from three of the five largest private US insurers. The study found that "23% of hospitals' inpatient cases have prices set as a share of hospitals' charges."<sup>37</sup> Moreover, "Prices at monopoly hospitals are 12% higher than those in markets with four or more rivals. Monopoly hospitals also have contracts that load more risk on insurers (e.g., they have more cases with prices set as a share of their charges)."<sup>38</sup> A 2016 study published in *Health Affairs* "using 2013 nationally representative hospital data from Medicare" found that, a one-unit increase in the charge-to-cost ratio was associated with a \$64 increase in patient revenue per adjusted discharge, suggesting that "hospitals still consider the chargemaster price to be an important way to enhance revenue."<sup>39</sup>

Additionally, high charges particularly harm uninsured patients, especially uninsured patients who are not covered by a hospital's charity care policy. Uninsured patients do not have the luxury of having a large company negotiate down a hospital's prices on their behalf. Therefore, uninsured patients are often forced to take on the entire sticker price, or only a slightly discounted version of it.<sup>40</sup> Of course, the higher a hospital's sticker price, the more significant the financial burden.

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<sup>36</sup> SEIU Analysis of Medicare cost report data

<sup>37</sup> Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107. [https://healthcarepricingproject.org/sites/default/files/Updated\\_the\\_price\\_aint\\_right\\_qje.pdf](https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf)

<sup>38</sup> Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107. [https://healthcarepricingproject.org/sites/default/files/Updated\\_the\\_price\\_aint\\_right\\_qje.pdf](https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf)

<sup>39</sup> Ge Bai and Gerard F. Anderson, "US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues," *Health Affairs*, September 2016. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0093>

<sup>40</sup> Melanie Evans, Anna Wilde Mathews, and Tom McGinty, "Hospitals Often Charge Uninsured People the Highest Prices, New Data Show," *The Wall Street Journal*, July 6, 2021. <https://www.wsj.com/articles/hospitals-often-charge-uninsured-people-the-highest-prices-new-data-show-11625584448>

Ultimately, high hospital prices translate into higher health insurance premiums - for individuals, employers, and public purchasers. When hospitals can charge private insurers supracompetitive rates due to a lack of competition in the market, these prices are passed onto individual patients in the form of higher premiums. This is what we are seeing happen in Western North Carolina. Due to Mission's monopoly power, "insurance premiums within Mission Health's service area are 30% higher than premiums in nearby counties, and over 50% higher than premiums in the State's other large metropolitan areas."<sup>41</sup> Importantly, this also harms public purchasers of health insurance. For example, the City of Brevard argues in its suit that since it is the purchaser for its employees' (and their families') health insurance coverage, Mission's behavior harms the city through its higher-than-average prices that force it to pay higher premiums.<sup>42</sup> North Carolina Treasurer Dale Folwell pointedly explained in his *amicus* brief mentioned above: "[a] significant part of the state's budget goes to health care . . . It is impossible to give appropriate raises to valued employees or take on new employees when so much funding has been budgeted for healthcare... The ever-increasing costs being charged with these multi-state behemoths like HCA HealthCare are of high concern."<sup>43</sup>

**2. Q:** I am particularly interested in the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

**A:** Mergers can impose significant burdens on rural and underserved communities. For example, HCA's acquisition of Mission Health has significantly impacted underserved communities in Western North Carolina, particularly those communities that are uninsured and underinsured.

### ***HCA Makes Drastic Changes to Mission's Charity Care Policy Following Takeover***

Since the acquisition, many have taken issue with HCA's drastic changes to Mission's charity care policy. In fact, the policy changes prompted community complaints to North Carolina AG Josh Stein, inquiries from AG Stein to HCA about the policy,<sup>44</sup> and even a lawsuit.<sup>45</sup> The policy changes include the following:

- The conditions covered by the policy for those under 200% of the Federal Poverty Level changed from non-emergent to emergent-only conditions, thereby narrowing the type of care for which patients can receive assistance.<sup>46</sup>
- Mission's new policy is unclear as to what services actually qualify under "emergent care" across hospitals—every provider interprets this term slightly differently, and HCA does not make available a list of diagnoses, procedures, or circumstances that it interprets to meet this criterion.<sup>47</sup>

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<sup>41</sup> NC DOJ Letter to HCA 16 March 2022, <https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022>

<sup>42</sup> City of Brevard, North Carolina v. HCA Healthcare and Mission Health System (Case No. 1:22-cv-114, United States District Court - Western District of North Carolina, filed 06/03/22)

<sup>43</sup> Derek Lacey, "NC Treasurer files interest in HCA antitrust suit; plaintiffs reiterate concerns, North Carolina Business Group on Health," <https://ncbgh.org/nc-treasurer-files-interest-in-hca-anti-trust-suit/>

<sup>44</sup> Stein Letter to HCA, February 25, 2020. <https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-02252020.pdf> at 3.

<sup>45</sup> Davis et al. v. HCA Healthcare and Mission Health System (Case No. 21 CV 03276, North Carolina Superior Court - Buncombe County, filed 08/10/21), p. 21

<sup>46</sup> Citizen Times, "Patient care to staff safety: Concerns over HCA's management of Mission run deep | OPINION," February 11, 2020. <https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/>

<sup>47</sup> Brian Gordon, "Patient criticisms and HCA's response: What to know about Mission charity care," Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-ashville-wnc/3107646001/>

- Mission’s policy is now only applied retroactively.<sup>48</sup> Prior to HCA’s acquisition of Mission, patients were pre-approved to receive charity care benefits for up to a year,<sup>49</sup> during which all of their medical bills were automatically covered by the policy.<sup>50</sup> Under HCA’s ownership, charity care is “episodic”—patients must re-apply for coverage with each new bill.
- HCA’s policy requires that a patient’s bill exceeds \$1,500 to qualify for coverage.<sup>51</sup> The idea that an individual or family earning 200% of the federal poverty level (Mission’s income eligibility threshold for a full write-off—e.g. \$33,975 for an individual or \$55,500 for a family of four) or less can afford to pay a \$1,400 medical bill, or even a \$500 medical bill, is absurd. An analysis conducted by Urban Institute reveals that the median medical debt currently in collections in some of the counties served by Mission includes: \$667 in Buncombe County, \$687 in Madison County, and \$533 in Yancey County.<sup>52</sup> A survey released in January 2021 revealed that only “39% of Americans [surveyed] can afford a \$1,000 unexpected expense.”<sup>53</sup> And, “for households making less than \$30,000, just 21[%] have a rainy-day fund to cover \$1,000.”<sup>54</sup> Clearly healthcare consumers in the multicounty service area served by Mission struggle with paying medical bills less than \$1,500. Mission states that it may provide charity care to applicants with bills under this minimum only under “extenuating circumstances,” however, this is also determined on a case-by-case basis.<sup>55</sup>

Community members, patients that rely on charity care assistance, and local leaders, have therefore expressed serious concern about Mission’s ability to meet its obligations to its low-income patients. For example, Harmony Owen, a resident of West Asheville, mother of two, and patient of Mission, explained to the *Asheville Citizens Times* that her family has now relied on charity care pre- and post-acquisition, and prefers the old policy. “We used charity care prior to the switchover several times, both myself and my husband,” Ms. Owen said. “Before, it was definitely more accessible and easier to apply.”<sup>56</sup> Ms. Owen specifically told the *Asheville Citizen Times* that having to reapply for each bill “[has] been a very huge strain on our family because of our finances.”<sup>57</sup> And because Mission’ is the dominant healthcare provider in the region, patients like the Owens do not have alternative options for care. Patients are forced to rely on Mission’s hard to navigate policy.

### 3. Q: Is it possible that government regulations actually caused the consolidation of hospitals?

<sup>48</sup> Citizen Times, “Patient care to staff safety: Concerns over HCA’s management of Mission run deep | OPINION,” February 11, 2020. <https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/>

<sup>49</sup> Citizen Times, “Patient care to staff safety: Concerns over HCA’s management of Mission run deep | OPINION,” February 11, 2020. <https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/>

<sup>50</sup> Brian Gordon, “Patient criticisms and HCA’s response: What to know about Mission charity care,” Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

<sup>51</sup> Brian Gordon, “Patient criticisms and HCA’s response: What to know about Mission charity care,” Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

<sup>52</sup> Urban Institute, “Debt in America: County-Level Medical Debt,” 2022. <https://datacatalog.urban.org/dataset/debt-america-2022>.

<sup>53</sup> Lorie Konish, “Just 39% of Americans could pay for a \$1,000 emergency expense,” CNBC, January 11, 2021.

<sup>54</sup> Jeff Ostrowski, “Survey: Fewer than 4 in 10 Americans could pay a surprise \$1,000 bill from savings,” Bankrate, January 11, 2021. <https://www.bankrate.com/banking/savings/financial-security-january-2021/>

<sup>55</sup> “Charity Financial Assistance Policy for Uninsured and Underinsured Patients,” MISSION HEALTH, [https://missionhealth.org/wp-content/uploads/2021/04/Charity-care-update- Oct-2020\\_recd-April-2021.pdf](https://missionhealth.org/wp-content/uploads/2021/04/Charity-care-update- Oct-2020_recd-April-2021.pdf). Item 9(A): “Patients with more than a \$1,500 patient liability that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than \$1,500 may be reviewed and a charity write-off applied.”

<sup>56</sup> Brian Gordon, “Patient criticisms and HCA’s response: What to know about Mission charity care,” Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

<sup>57</sup> Brian Gordon, “Patient criticisms and HCA’s response: What to know about Mission charity care,” Citizen Times, <https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/>

**A:** There are certain regulations that have helped facilitate the consolidation of hospitals. One such example is the “Certificate of Public Advantage,” or COPA laws. In fact, the FTC has been vocal about the dangers of “the use of COPAs to shield otherwise illegal hospital mergers.”<sup>58</sup> These laws are a significant example of government regulation actually permitting and promoting hospital consolidation.

### ***Certificate of Public Advantage “COPA” Laws***

Some states have allowed hospital mergers that would otherwise violate antitrust laws to occur under “Certificate of Public Advantage” (COPA) laws. Under such laws, states “allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation.”<sup>59</sup> The state often then imposes certain terms and conditions on the recipient hospital or health system, such as price controls, quality and staffing commitments, and profit margin caps. COPA laws thus attempt to “replace competition among healthcare providers with regulatory oversight by state agencies.”<sup>60</sup> In doing this, state-enacted COPA laws limit the FTC’s ability to challenge otherwise problematic consolidation. In other words, COPA laws allow hospitals to operate as unlawful monopolies, shielded from federal oversight, in exchange for agreeing to certain rules set by the state. As a recent FTC policy paper notes, “indeed, most COPAs that have been approved so far resulted in a single hospital monopoly.”<sup>61</sup>

Hospitals who lobby for COPA laws claim that such laws enable the many promised benefits of hospital mergers - like cost savings and efficiencies that bolster clinical improvements - while preventing the well-established harms of competition loss.<sup>62</sup> However, research has demonstrated otherwise, showing that COPA laws do not prevent hospitals from exploiting their market power. Instead, “[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power.”<sup>63</sup> To date, the FTC knows of “nine states that have approved hospital mergers pursuant to such legislation: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, Virginia, and Texas.”<sup>64</sup> However, three of those states - North Carolina, Montana, and Minnesota - have repealed their COPAs, along with “the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs.”<sup>65</sup> A 2020 paper by Chris Garmon, a professor at University of Missouri-Kansas City and former FTC economist, and Kishan Bhatt of the Princeton School of Public and International Affairs notes, “COPA-regulated hospitals have a strong incentive to evade regulation and pursue the removal of the COPA. Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality.”<sup>66</sup> We can see this exact situation in Mission Health.

### ***History of Mission’s Monopoly as a Case Study of Ineffective COPA Laws***

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<sup>58</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>59</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>60</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>61</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>62</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>63</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>64</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>65</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>66</sup> Garmon, Christopher and Bhatt, Kishan, Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina (June 24, 2020).

In 1995, Mission Hospital and St. Joseph’s Hospital, the only two private acute care providers in Asheville, decided to enter into a partnership.<sup>67</sup> While the deal created monopoly market share for the combined systems that would have otherwise led to antitrust challenges, Mission and St. Joseph’s were able to carry out the relationship under a Certificate of Public Advantage (COPA). In 1998, Mission sought to purchase St. Joseph’s and all of its assets, and the COPA was, in turn, amended to permit the acquisition. The merged entity, renamed “Mission Health System,” was thus permitted to operate as a monopoly under the COPA, “subject to certain terms and conditions – including margin, cost, and physician employment caps, as well as quality and contracting commitments.”<sup>68</sup>

Operating under these terms, Mission significantly expanded its footprint over the next twenty years (1995 to 2015), buying up multiple hospitals in surrounding counties and acquired many physician groups. In 2015, however, the state legislature repealed the COPA as a result of lobbying efforts by Mission Health.<sup>69</sup> The COPA officially ended in September of 2016, “leaving no meaningful competitive or regulatory constraint on Mission Health’s monopoly market power.”<sup>70</sup>

HCA, the largest and most profitable hospital chain in the country, saw Mission’s monopoly power with minimal regulatory constraint as an opportunity. Barak Richman, a law professor at Duke University who specializes in antitrust healthcare law, asserted of the deal, “I think the value of Mission to HCA increased dramatically after the COPA ended and that’s just simple economics.”<sup>71</sup> With the COPA no longer in place, there is nothing stopping HCA from engaging in monopolistic and harmful behavior.

### ***Mission Health COPA Studies***

Two separate studies of inpatient hospital services prices at Mission Health demonstrate that, even under a COPA that purported to quell the effects of monopoly power, prices rose significantly more at Mission compared to peer hospitals. First, a study of prices from “1996 to 2008 shows that Mission Health increased its prices by at least 20% more than peer hospitals”<sup>72</sup> during that period under the COPA. A second study of price changes during the remaining years of the COPA “found an average price increase of 25% through 2015, driven by large increases several years into the COPA period.”<sup>73</sup> Therefore, the above research suggests that “state COPA oversight did not prevent Mission Health from raising prices more than similar hospitals.”<sup>74</sup> Furthermore, when the COPA was repealed, Western North Carolina was left with a monopoly health system that now had essentially free reign to increase prices, cut services and staffing, and maximize profits, all at the expense of a community that has few other

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<sup>67</sup> U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, “Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System,” September 11, 2020.

[https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf)

<sup>68</sup> U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, “Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System,” September 11, 2020.

[https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf)

<sup>69</sup> U.S. Federal Trade Commission, Bureau of Competition, Bureau of Economics, Office of Policy Planning, “Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System,” September 11, 2020.

[https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhscopacomment.pdf)

<sup>70</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>71</sup> <https://wlos.com/news/local/lawsuit-against-mission-health-could-have-an-impact-nationwide-says-law-professor>

<sup>72</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>73</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>74</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

options for care. The second study also “found prices increased by another 38% after the COPA was repealed in 2015 and before Mission Health was acquired by HCA Healthcare.”<sup>75</sup> And, we know from our analysis of charge-to-cost ratios pre and post-2019 (discussed in response to Question 1 above), that this has likely gotten even worse since HCA’s acquisition.<sup>76</sup> In fact, a recent RAND Corporation analysis of hospital claims data<sup>77</sup> found that Mission Hospital-Asheville, Mission Health’s flagship hospital charged commercial insurers an average of 305% above the Medicare price for General Acute Care Services, compared to the North Carolina average of 211% above Medicare.<sup>78</sup>

Ultimately, COPA laws have created many situations similar to that in Western North Carolina - a monopoly health system that has eroded consumer choice, increased prices, and jeopardized care quality. And HCA has capitalized on the fallout of an unsuccessful COPA law, at the expense of the local community. Unfortunately, in these cases, the policy decisions of state lawmakers have empowered hospital consolidation and harmed necessary competition.

**4. Q:** Looking past antitrust remedies and enforcement, are there other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

**A:** There are several actions that Congress should consider taking to address the dangers of hospital mergers and acquisitions. One is to move away from the “consumer welfare” standard framework in reviewing mergers and acquisitions. Another is to eliminate Certificate of Public Advantage (COPA) laws.

### Amending Antitrust Standards

The prevailing framework used by antitrust enforcement agencies (hereinafter “Agencies”) to assess whether mergers should be allowed is the “consumer welfare standard,” despite the fact that this standard appears nowhere in antitrust statutes like the Sherman or Clayton Acts. Under this standard, Agencies typically only examine whether consumers would benefit and operate under the assumption that “consumers are more important than all other economic agents, and that no anti-competitive behavior employed by a monopolist or a cartel can be unwound unless and until it can be shown to harm consumers, typically in the form of higher prices.”<sup>79</sup> As a result, this standard fails to address a wide range of implications from a merger, such as whether it would monopolize an industry, harm workers, or curb innovation.<sup>80</sup>

What’s more, even experts cannot agree on the standard’s meaning or its implications. According to Jonathan Kanter, the U.S. Assistant Attorney General for the Antitrust Division,

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<sup>75</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>76</sup> SEIU Analysis of Medicare cost report data

<sup>77</sup> RAND compared the prices negotiated from 2018 to 2020 by hospitals and private health plans—i.e. the total “allowed amounts (amount paid to a health care provider per service, including amounts paid by the health plan and any amounts due from the patient, such as deductibles, copayments, and coinsurance)” —to the rates set by Medicare.; “We gathered claims data, including provider identifiers and allowed amounts, for enrollees in employer-sponsored health plans from three types of data sources: self-insured employers; state-based all-payer claims databases from Arkansas, Colorado, Connecticut, Delaware, Maine, New Hampshire, Oregon, Rhode Island, Utah, and Washington; and health plans that chose to participate. Together, those data sources include claims data for hospital services provided by more than 4,000 hospitals in 49 states and Washington, D.C.” Christopher M. Whaley, Brian Briscoe, Rose Kerber, Brenna O’Neill, Aaron Kofner, “Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative”: RAND Supplemental\_Material (Excel File – Notes and Background Tab), RAND Corporation. 2022. <https://doi.org/10.7249/RAA1144-1>

<sup>78</sup> Christopher M. Whaley, Brian Briscoe, Rose Kerber, Brenna O’Neill, Aaron Kofner, “Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative.” RAND Corporation. 2022. <https://doi.org/10.7249/RAA1144-1> (data pulled from Excel File - Table 1. Hospitals and Table 3. States)

<sup>79</sup> <https://prospect.org/economy/antitrust-can-address-racial-inequities/>

<sup>80</sup> <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

“The consumer welfare standard gets a lot of discussion in narrow antitrust circles and I think it’s important, something I’d like to address. In my experience if you ask five antitrust lawyers, ‘What does the consumer welfare standard mean,’ you will get six different answers. The whole idea of there being a standard is that there be agreement as to what it means. We’re sitting here thirty, forty years later and there’s still no agreement as to what it means.”<sup>81</sup>

Thus, companies can always find expert testimony supporting their claims that their specific deal will “create efficiencies and reduce consumer costs.” According to economist Hal Singer, “the consumer welfare standard has [even] been used to thwart many attempted interventions.”<sup>82</sup> This results in turning “competition policy into a question of competing economic models rather than a question of power.” Kanter even cautioned that, “We must be mindful that economics—and expertise, more broadly—are merely tools to understand facts relevant to a particular case.”<sup>83</sup> As such, we believe that the current “consumer welfare standard” tool falls short in capturing the full picture of merger cases. It is essential to move away from the “consumer welfare standard” and to codify a more expansive, inclusive standard that not only protects consumers, but protects workers as well. The labor market should be given consideration when merger proposals are reviewed. Because there is a limited history of antitrust labor enforcement it is important that bright-line standards are established for anti-competitive consolidation and practices in labor markets. We recommend the following measures.

#### ***A. Review mergers for labor market concentration***

Proposed mergers are reviewed only for their effects on product markets, and not for their effects on labor markets. Mergers should be examined for their impact on labor market concentration and blocked if they would increase labor market concentration to levels that harm workers.

Moreover, labor markets become significantly less competitive at lower levels of concentration than product markets. Agencies should establish a lower market share threshold at which a firm is presumed to have market power. Research suggests an employer possesses market power if it controls 20 percent of a labor market. We urge 20 percent as the concentration threshold for labor markets in merger guidelines.

#### ***B. Require pre-merger review for potential increases in labor market concentration***

Labor market-related merger filing triggers should be established that would require merging parties to file for pre-merger review based solely on whether the merger would increase concentration in the local labor markets that would be affected by the proposed merger. Filing triggers could include, for example, the total number of workers affected, the total workers in a local labor market as a percentage of that labor market's population, or an HHI-like analysis of local labor market concentration. The triggers and any merger analysis should recognize the existence of particular mobility frictions for specific occupational groups such as licensed occupations, or occupations that have specific and narrow skill requirements.

#### ***C. Preserve existing collective bargaining agreements by merging parties***

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<sup>81</sup> <https://mattstoller.substack.com/p/peeking-in-the-economists-pool>; <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

<sup>82</sup> <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

<sup>83</sup> <https://prospect.org/economy/bottom-up-battle-against-corporate-power/>

In some mergers, the acquiring party seeks to void existing collective bargaining agreements in the course of the transaction. Allowing merging parties to nullify existing collective bargaining agreements undermines workers' statutorily guaranteed labor rights and the federal policy of guaranteeing these rights to promote labor peace. In addition, collective bargaining agreements mitigate the effects of increased labor market concentration because they prevent employers from exercising unilateral power over workers covered by the agreement. Therefore, Agencies should insist that any existing collective bargaining agreements must be respected and preserved in the course of a merger, as well as continue to consult with affected labor unions on the transaction.

***D. Utilize collective bargaining as a counterweight to increased employer power***

Collective bargaining requires employers to bargain over wages and working conditions with their employees, ensuring workers share power to co-determine their working conditions. In this way, collective bargaining mitigates employer power in labor markets. In mergers that would increase the employer concentration in local labor markets, collective bargaining should be considered as a remedy for such increases. In the event that workers are unorganized, a proposed remedy should include a fair process by which the affected workers can choose whether they want union representation. Tools such as collective bargaining agreements with anti-discrimination clauses, grievance procedures, as well as community benefits agreements have allowed workers in monopsonistic industries like coal, auto, and steel to level the playing field and make change over time, transforming dangerous poverty jobs (like hospital jobs) into work that builds communities.

Empowering workers lessens the negative labor market impacts of consolidation. Likewise wage boards, sectoral working standards for working conditions, broad-based bargaining and other labor market supports can attenuate the negative impacts of employer concentration.

***E. Prohibit balancing away competitive harms to workers***

Although it is contrary to black-letter antitrust law, some courts permit defendants to rebut showings of competitive harm by showing procompetitive benefits like lower prices, including in markets other than the market where the harm occurred. Parties should be permitted to prove an antitrust violation by showing anti-competitive harm from a dominant firm's conduct in a labor or product market, and firms should not be able to defend, or rebut, evidence of abusive conduct by offering a pro-competitive justification, whether the benefit occurs in the same market or not. Merger guidelines should establish that procompetitive benefits will not offset harms to competition.

Workers are subject to many harms from consolidated employer power, and these extend even beyond wages and benefits. We propose the inclusion of labor market considerations in merger guidelines. Employer claims to "efficiencies" from consolidation should be scrutinized for whether these would be realized by simply transferring a greater burden to individual workers.

***Eliminate or Strictly Regulate COPA Laws***

As explained above, COPA laws enable dangerous hospital monopolies with the promise of effective state regulation. However, ultimately, "competition has proven to be more reliable and effective than COPAs for controlling healthcare costs while preserving quality of care, including in rural areas facing

economic challenges.”<sup>84</sup> The FTC has recognized that “There are certainly circumstances where a bona fide regulatory approach that has the side effect of limiting competition may be an appropriate way to implement important public policy goals. Yet, the available evidence shows COPAs do not achieve the purported policy goals of reducing healthcare costs and improving quality.”<sup>85</sup> For the reasons explained above, FTC staff has recommended that: state lawmakers not enact COPA laws; in states where COPA laws already exist, states should repeal these laws provided there is not an active COPA currently in place; and, in states where there is already an active COPA in place, states should not approve any new COPA applications.<sup>86</sup> Unfortunately, under current federal law, the FTC cannot currently do much more than recommend against these laws.<sup>87</sup>

Therefore, we urge federal limitations on state COPA laws. We recognize COPAs may be a good idea in extremely limited circumstances, but stringent minimum guidelines must be met. These guidelines must include active oversight by state and federal regulators, limitations on pricing changes, service alterations, and capital expenditures, and specific binding agreements to unwind mergers and consolidations when these conditions are not met.

**5. Q:** How have federal government healthcare policies—again, looking at them holistically—influenced the closure of hospitals in rural and underserved areas?

**A:** Uneven government support of safety-net hospitals, convoluted financing of U.S. healthcare, and unchecked competitive advantages and expansions by wealthier hospital players has influenced the closure of hospitals in underserved areas. Taken together, these factors endanger care for underserved, low-income populations.

### ***Growing Divide Between Wealthy Hospitals and Poor Safety-Nets***

Safety-net hospitals are generally hospitals with a stated mission or mandate of serving low-income populations, regardless of patients’ insurance coverage, ability to pay or immigration status. Safety-nets usually will not turn away patients who cannot pay and have high numbers of uninsured and Medicaid patients.<sup>88</sup>

Safety-net hospitals typically depend on public funding,<sup>89</sup> but researchers say that “every time the government does shell out a dollar, it’s underpaying for what the services actually cost.”<sup>90</sup> For example, Medicaid reimbursements to hospitals are often much lower than those of private insurers — a disparity that has made it more difficult for safety nets to cover their costs and stay afloat.<sup>91</sup> As a result, the disparity between safety-nets and their much wealthier competitors (e.g. for-profits, non-profits etc.) has been growing for the past two decades as medical costs have increased, but “the political will to pay for healthcare for the poor has not kept pace.”<sup>92</sup>

### ***Current Financing of Safety-Nets Falls Short***

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<sup>84</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>85</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>86</sup> [https://www.ftc.gov/system/files/ftc\\_gov/pdf/COPA\\_Policy\\_Paper.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf)

<sup>87</sup> <https://www.modernhealthcare.com/mergers-acquisitions/ftc-wants-states-scrap-certificate-public-advantage-laws>

<sup>88</sup> <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

<sup>89</sup> <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

<sup>90</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

<sup>91</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

<sup>92</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

But even funding measures meant to aid safety nets, such as Disproportionate Share Hospital (DSH) payments for example, currently fall short due to its uneven distribution and lack of transparency. Since Medicaid often does not pay enough to cover the costs of care – leaving hospitals about \$19 billion short every year – the government gives hospitals additional Medicaid funding called “supplemental” or “DSH” payments to help offset losses and costs of caring for the uninsured.<sup>93</sup> States distribute this funding to hospitals that theoretically meet one of two federal standards: either by serving a higher percentage of Medicaid patients than the state average, or by having at least 25% of their patients qualify as low-income.

But due to variations in each state’s Medicaid program, states do not have to give all of the funding to hospitals that meet the federal criteria. As a result, the congressional commission overseeing Medicaid found there’s “no clear relationship between the hospitals that get DSH payments and the hospitals with the highest proportions of low-income or uninsured patients.” According to Bruce Siegel, the president and CEO of America’s Essential Hospitals, some of “those hospitals that are really faithful to their mission are not getting the support they need, while other organizations who may treat relatively very few Medicaid or uninsured patients still receive support.”<sup>94</sup>

There’s also a lack of transparency surrounding the DSH program. The latest report on how states distribute DSH money is reportedly from 2015. According to Paula Chatterjee, an assistant professor of general internal medicine at the University of Pennsylvania, that years-long lag means “we don’t have a lot of understanding of how state and local governments are deciding to support those hospitals,” she said. “Where does that funding come from? Does it change from year to year? We actually don’t know the answers to those questions.”<sup>95</sup>

### ***Wealthier Hospital Players Squeeze Out Safety-Nets***

According to an investigation by *NPR and Frontline*, “the growth of hospital chains and the subsequent consolidation of the industry have created a progressively more competitive environment, making it harder for safety-net hospitals to live up to their mission and stay afloat.”<sup>96</sup> The *NPR/Frontline* investigation cites the case study of the Chattanooga, Tennessee market, where a county-owned safety-net hospital named Erlanger Hospital is struggling to compete with two other players in town, the non-profit Memorial Hospital and HCA’s for-profit Parkridge Hospital. The investigation found that “in 2019, the year before COVID, HCA’s Parkridge reported \$78 million in operating profit, a margin of almost 24%. Memorial took in \$40 million, a nearly 7% margin. Erlanger lost about \$13 million.”<sup>97</sup> This HCA hospital has the luxury of treating more profitable, “private pay” patients, while safety-nets shoulder the responsibility of treating poorer, underserved populations. According to former U.S. Senator and former Chattanooga Mayor, Bob Corker, “By having a safety-net hospital in the market, where more of the lower-pay, no-pay patients are going to go, ends up being of benefit to the other facilities.”<sup>98</sup>

In fact, this was not the first time HCA has been accused of trying to capture private pay patients. In 2015, HCA’s TriStar system tried to build a freestanding Emergency Department near the Old Hickory Boulevard exit on Interstate 65 in Brentwood, Tennessee. Two non-profits, Williamson Medical Center

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<sup>93</sup> <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

<sup>94</sup> <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

<sup>95</sup> <https://www.pbs.org/wgbh/frontline/article/what-is-a-safety-net-hospital-covid-19/>

<sup>96</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

<sup>97</sup> <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

<sup>98</sup> <https://www.pbs.org/wgbh/frontline/documentary/the-healthcare-divide/transcript/>

and Vanderbilt University Medical Center, opposed that project arguing “it was a tactic to lure away the wealthy, insurance card-carrying patients who live in Williamson County.” They claimed “HCA has used freestanding emergency departments as proving grounds for potential hospitals in the past, and [...] alleged the company planned to do the same in Brentwood.”<sup>99</sup>

What’s more, the COVID pandemic has only exacerbated this divide, as “hospitals that treat more ‘profitable’ patients have often pulled further ahead, while many of those that treat more patients who are on Medicaid or are uninsured have fallen further behind.”<sup>100</sup> According to *NPR and Frontline*, these are often the same hospitals that have been seeing influxes of COVID-19 patients from communities disproportionately impacted by the disease. According to Dr. Brad Spellberg, chief medical officer at LAC+USC Medical Center, a safety-net hospital, “We serve a community of working poor. We serve people who are working essential jobs. ... We are expected to care for the patients the other hospitals won’t care for.”<sup>101</sup> It is no surprise then that hospital chains like HCA, who are profiting off the backs of safety net hospitals, are doing quite well during the pandemic. In 2020, for example, HCA had posted a \$3.8 billion profit, more than it made in 2019.<sup>102</sup> In 2021, HCA’s profits jumped to \$6.96 billion<sup>103</sup> despite the pandemic.

**6. Q:** Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

**A:** As noted above, while many claim that provider consolidation leads to better quality care, research has actually indicated the opposite. Studies suggest that market consolidation—particularly for horizontal consolidation—can actually lead to lower quality care.<sup>104</sup> Thus, it is no surprise that community members, patients, staff, and local and state leaders have consistently voiced concerns over the quality of care provided by Mission Health following HCA's acquisition of the health system.

### ***Community Repeatedly Voices Concerns about Diminished Quality of Care at Mission Post-HCA Takeover***

As of September of 2021, North Carolina’s Attorney General had received 290 complaints about Mission Health since HCA’s acquisition of the system in February of 2019.<sup>105</sup> In contrast, in 2017, prior to the sale of the health system to HCA, the Attorney General received just seven complaints.<sup>106</sup> Notably, *WLOS ABC-News 13* conducted an analysis of the complaints submitted to Attorney General Stein between April 2020 and April 2021 and found that nearly a quarter were related to concerns over quality of care.<sup>107</sup>

Some common themes have emerged from these concerns, including:

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<sup>99</sup> <https://www.bizjournals.com/nashville/news/2021/05/27/freestanding-ed-tristar-century-farms-will-open.html>

<sup>100</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

<sup>101</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggle-endangers-care-for-low-income-patients/>

<sup>102</sup> <https://www.pbs.org/wgbh/frontline/article/safety-net-hospitals-struggled-covid-wealthy-hospitals-millions-profits/>

<sup>103</sup> HCA 2021 10K, p. 75, (See: Net Income attributable to HCA Healthcare, Inc.) Accessible at

<https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312522046707/d32297d10k.htm>

<sup>104</sup> <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

<sup>105</sup> Clarissa Donnelly-DeRoven, “AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story” Asheville Citizens Times, September 20, 2021.

<https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-ashevelles-hca-mission/8370318002/>

<sup>106</sup> Karen Zatkulak, “‘A concerning number,’ Attorney General describes recent Mission Health complaints filed,” WLOS ABC-News 13, June 8th 2021.

<https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

<sup>107</sup> Karen Zatkulak, “‘A concerning number,’ Attorney General describes recent Mission Health complaints filed,” WLOS ABC-News 13, June 8th 2021.

<https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

- Understaffing- Because labor is the largest cost driver for hospitals, lowering staffing levels boosts profitability. HCA’s profits are astonishingly strong—with \$6.96 billion in profits in 2021 alone,<sup>108</sup> despite the pandemic; and since 2010, the company has paid out more than \$29 billion to investors in dividends and share repurchases.<sup>109</sup> Thus, HCA has more than enough resources to properly staff its facilities for the sake of patient care and worker safety. Yet, time and again the company fails to do so.

Staffing is a problem across HCA hospitals, with a pattern of lower than average staffing ratios at HCA’s facilities nationwide.<sup>110</sup> In 2020, HCA hospitals had about 33% fewer full-time equivalent (“FTE”) staff per adjusted occupied bed (“FTE rate”, or “staffing rate”) than the national average for acute care and critical access hospitals.<sup>111</sup> This ratio measures the total number of staff at a facility compared to the total volume of patients in a year. The trend of lower FTE rates at HCA hospitals is consistent over time. Between 2014 and 2020, the HCA system’s staffing rate was between 29% and 33% below the national average.

Patient and staff testimonials show that Mission Health is, unfortunately, no different. HCA does not allocate the proper resources at its hospitals to provide high-quality care. Examples include:

- Forrest Johnson, who presented to Mission Hospital’s emergency room after falling and breaking her leg told the *Asheville Watchdog* that she laid “for nearly six hours in the emergency room without water, ice, a blanket, a pillow to elevate her leg, food, or pain medication.” She explained “I just had a very busy nurse... He just didn’t have the time to care for me,” and recalled that the nurse had apologized that he would not be able to check on her every 15 minutes as would normally be expected of him because of under-staffing.”<sup>112</sup>
- A complaint submitted in 2021 to the Attorney General by a Mission employee stated: “I do not feel safe in my practice and I do not feel safe for my patients,” and claimed that some patients “are having to sit in their own excrement for hours because our floor is expecting 1 CNA to look after 44 patients.”<sup>113</sup>
- A nurse described the staffing situation in her unit to the *Asheville Watchdog*, explaining that on a unit with several dozen beds, nurses are assigned six or seven patients, which is double their usual workload, and are only provided one CNA when protocols require four: “It’s just not safe. It’s led to an increase in falls, and I believe people are getting sicker ... patients are lying in their own feces for up to an hour ... and they are not getting their meds for hours.”<sup>114</sup>

<sup>108</sup> HCA 2021 10K, p. 75, (See: Net Income attributable to HCA Healthcare, Inc.) Accessible at <https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312522046707/d32297d10k.htm>

<sup>109</sup> Based on an analysis of HCA’s filings, press releases, investor presentations and an article by Pitchbook.

<sup>110</sup> Based upon SEIU analysis of Medicare Cost Report data for short-term general acute care hospitals and critical access hospitals. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full time equivalents/ (Adjusted inpatient days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities

<sup>111</sup> Based upon SEIU analysis of Medicare Cost Report data for short-term general acute care hospitals and critical access hospitals. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full time equivalents/ (Adjusted inpatient days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities. These averages are weighted averages.

<sup>112</sup> Barbara Durr, “Quality of Care Concerns Rise at Mission Hospital,” *Asheville Watchdog*, May 20, 2021.

<https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/>

<sup>113</sup> Clarissa Donnelly-DeRoven, “AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story” *Asheville Citizens Times*, September 20, 2021.

<https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-asheville-hca-mission/8370318002>

<sup>114</sup> Barbara Durr, “Quality of Care Concerns Rise at Mission Hospital,” *Asheville Watchdog*, May 20, 2021.

<https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/>

- Cuts in service - HCA has cut or eliminated services at Mission, which has forced workers to perform tasks outside their scope and affected patient care. A *Fortune Magazine* article published in March 2022 revealed that, after acquiring Mission, HCA chose to eliminate many of Mission's Health Unit Coordinators, forcing other staff to pick up the slack for this reckless decision. Nurses also told the publication that "they often ended up delivering food and emptying trash bins after HCA outsourced the hospital's food service and janitorial functions."<sup>115</sup> One nurse who submitted a complaint to the AG's office explained to *News 13*: "When we say that patient care is number one and then we're cutting services that allow for us to provide better patient care, that just doesn't add up to me and I couldn't be a part of that."<sup>116</sup>

### ***Regulatory Enforcement due to Care Breakdowns at Mission Post-HCA Takeover***

What's more, lapses in care following HCA's takeover of Mission prompted CMS to send Mission Hospital a letter threatening to terminate its Medicare contract in November of 2020.<sup>117</sup> According to CMS, this drastic measure of terminating a provider agreement is "generally a last resort after all other attempts to remedy the deficiencies at a facility have been exhausted."<sup>118</sup> In other words, threats of contract termination from CMS are rare.<sup>119</sup> Therefore, when CMS does choose to take this action, it is clearly in response to something very serious.

However, this is not the first time CMS has threatened to terminate its contract with an HCA hospital, suggesting a system-wide pattern of poor behavior. HCA's Good Samaritan Hospital in San Jose received a "Notice of Termination" from CMS in July of 2021.<sup>120</sup> In a 65-page inspection report detailing a series of deficiencies,<sup>121</sup> regulators noted that management had failed to address "serious, systemic, and recurring issues."<sup>122</sup>

**7. Q:** Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

**A:** HCA has a track record of shuttering community clinics and safety net services, as well as driving physicians away following its acquisition of local community hospitals. Both of which deeply affect a community's access to care in general, let alone access to comprehensive integrated care.

### ***Mission Clinic Closures Post-HCA Takeover***

<sup>115</sup> Ericka Fry, "America's largest hospital company is booming. So why is one community trying to run it out of town?", *Fortune*, March 31, 2022.

<https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/>

<sup>116</sup> Karen Zatkulak, "'A concerning number,' Attorney General describes recent Mission Health complaints filed," *WLOS ABC-News 13*, June 8th 2021.

<https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed>

<sup>117</sup> Jennifer Emert, "What changes have been made since Medicare threatened to cut Mission Hospital's contract?" *WLOS ABC-News 13*, May 5, 2021.

<https://wlos.com/news/local/news-13-investigates-what-changes-have-been-made-since-medicare-threatened-to-cut-mission-hospitals-contract>

<sup>118</sup> Rebecca Carballo, <https://www.houstonchronicle.com/business/article/houston-hospital-medicare-feds-violations-16688960.php>

<sup>119</sup> Jennifer Emert, "What changes have been made since Medicare threatened to cut Mission Hospital's contract?" *WLOS ABC-News 13*, May 5, 2021.

<https://wlos.com/news/local/news-13-investigates-what-changes-have-been-made-since-medicare-threatened-to-cut-mission-hospitals-contract>

<sup>120</sup> Candice Nguyen and Michael Bott, "Medicare Agency Hits Good Samaritan Hospital With "Notice of Termination,"" *NBC Bay Area*, July 13, 2021.

<https://www.nbcbayarea.com/investigations/exclusive-good-samaritan-hospital-hit-with-immediate-jeopardy-notice-by-regulators/2593774/>

<sup>121</sup> <https://www.documentcloud.org/documents/21044034-good-sam-cms-report>

<sup>122</sup> Candice Nguyen, Michael Bott and Mark Villarreal, "Good Samaritan Hospital Leadership Blasted in Medicare Agency Report," *NBC Bay Area*, September 23, 2021. <https://www.nbcbayarea.com/investigations/good-samaritan-hospital-leadership-blasted-in-medicare-agency-report/2633470/>

Since HCA's takeover, Mission Health has shuttered at least two of its primary care outpatient clinics.<sup>123</sup> These clinics played a vital role in providing care access. Dr. Tim Plaut, a former physician with the Mission Candler clinic, notes that the closure of a safety net clinic such as Candler has "created a lot of hardship for our patients." Dr. Plaut "estimates that more than 7,000 patients total, many uninsured or underinsured, were treated at the two clinics."<sup>124</sup> He worries that some patients "fell through the cracks" in the transition to other providers because when physician offices shutter, patients may have trouble accessing transportation to travel to another clinic further away. He states, "Our practice in Candler was one of the original safety nets through Mission and we took care of a lot of Medicaid and Medicare; we had homeless folks and severe mental illness."<sup>125</sup> Dr. Kate Rasche, a former family medicine physician with Mission adds, "HCA was more focused on seeing financial data from the clinics rather than seeing it as part of the big picture of keeping the region healthy."<sup>126</sup> Perhaps HCA's questionable conduct is best summed up by Geoff Noblitt, a patient at the former Mission Candler clinic: "The closing of this office with no notice to the community, the staff that works there or the patients they serve, show that HCA cares nothing about their patients or the community," said Noblitt. "The little people get crushed under big corporate greed again. It's messed up."<sup>127</sup>

### ***Mass Exodus of Physicians Following HCA's Takeover of Mission***

What's more, according to the *Asheville Watchdog*, more than 200 physicians have left the Mission Health System following HCA's takeover in 2019.<sup>128</sup> Mission physicians reportedly departed the system for a range of reasons, including frustrations with declining patient care, understaffing, the imposition of HCA's corporate metrics, and HCA's focus on profits above all else.<sup>129</sup> Here is what some current and former Mission doctors had to say about HCA's approach to physician relationships and patient care:

- "Unfortunately, the change in ownership has shifted this system's priority away from the health of Western North Carolina to the health of the stockholders."<sup>130</sup> HCA was "Restructuring physician contracts to where it's fully based on how many patients you see and how high of a level you bill them versus focusing some on quality outcomes and some on productivity ... the portion of pay that was for quality metrics and things like that was significantly decreased and the focus on how many patients you were seeing was increased."<sup>131</sup> — Dr. Kate Rasche, Family Medicine
- "HCA "was run primarily by doctors and nurses and now it's being run by businessmen." And, "Patient suffering is off their (HCA management's) radar."<sup>132</sup> — Dr. Martin Palmeri, Oncology

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<sup>123</sup> Mackenzie Wicker. "Mission Health to stop primary care services in Biltmore Park, Candler." Asheville Citizen Times. Sept. 16, 2020. - <https://www.citizen-times.com/story/news/local/2020/09/16/mission-health-stop-primary-care-services-biltmore-park-candler/5818247002/>

<sup>124</sup> Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. - <https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

<sup>125</sup> Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. - <https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

<sup>126</sup> Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. - <https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

<sup>127</sup> Mackenzie Wicker. "Mission Health: What has changed under HCA Healthcare and why?" Asheville Citizen Times. Sept. 27, 2020. - <https://www.citizen-times.com/story/news/local/2020/09/27/mission-health-and-hca-what-has-changed-and-why/5852325002>

<sup>128</sup> Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog, March 23, 2022, <https://avwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/>

<sup>129</sup> Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog, March 23, 2022, <https://avwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

<sup>130</sup> Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. - <https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

<sup>131</sup> Karen Zatkulak. "Clinics closed, dozens of doctors leave Mission Health since HCA takeover." WLOS ABC-13 News. Feb 23, 2021. - <https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover>

<sup>132</sup> Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog, March 23, 2022, <https://avwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

- Many patients are skeptical “that HCA has their best interests in mind as a for-profit company.”<sup>133</sup> — Dr. Ben Aiken, Primary Care
- An anonymous doctor told the Asheville Watchdog that nurses in the emergency room are caring for more patients while management concentrates on meeting minimum standards and “metrics.” “When HCA came in, there were so many emails on metrics,” he said. “We’ve gone from providing amazing care to mediocre care.”<sup>134</sup>

HCA's actions following its acquisition of Mission Health suggests that hospital consolidation by a company like HCA – which seemingly places a greater emphasis on profit above community needs – can alienate physicians, staff, and patients and deeply affect a community's access to care.

## Conclusion

In closing, perhaps North Carolina Attorney General Josh Stein summed up these antitrust issues best with the following: “Lack of competition and inordinate market power can provide a health care provider with countless other ways to increase costs and harm consumers, especially in light of the complex, byzantine nature of our health care system.”<sup>135</sup> As such, we appreciate the efforts by Congressional leaders to take a closer look at these issues and we thank you for this opportunity to share our perspective.

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<sup>133</sup> Barbara Durr and Sally Kestin, “How Many Doctors Have Left Mission? HCA Won’t Say,” Asheville Watchdog, March 23, 2022, <https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

<sup>134</sup> Barbara Durr and Sally Kestin, “How Many Doctors Have Left Mission? HCA Won’t Say,” Asheville Watchdog, March 23, 2022, <https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say>

<sup>135</sup> <https://info.ncdhhs.gov/dhsr/coneed/comments/2022/june/Buncombe-Acute-Care-Beds-Project-ID-B-12232-22-Mission-Hospital-Comments-by-AG-Josh-Stein.pdf>