SEVENTH SUPPLEMENT TO MEMORANDUM 2024-24

Antitrust Law: Status Update (Public Comment)

This supplement provides additional public comment that the staff has received relative to the Antitrust Study.[1] The staff has received a number of public comments relating to the Antitrust Study. The most recent comments are attached as Exhibits to this memorandum. If the staff receives additional public comments, the comments will be provided in another supplemental memorandum.

Professor John Newman

This comment is submitted by Professor John Newman who is on the panel to respond to the expert reports as noted in Fourth Supplement to Memorandum 2024-24. The comment relates to his presentation.

Judy Wheeler Ditter, Towne Center Books

This comment is submitted by Judy Wheeler Ditter on behalf of Towne Center Books, an independent bookstore. The comment raises concerns about the impact of market consolidation on small bookstores.

Economic Security California and Six Other Organizations

This comment is submitted by Teri Olle on behalf of Economic Security California, American Economic Liberties Project, California Independent Booksellers Alliance, California Nurses Association, Ending Poverty In California, Small Business Majority, and TechEquity Action. The comment relates to the expert report on Technology Platforms that

[1] Any California Law Revision Commission document referred to in this memorandum can be obtained from the Commission. Recent materials can be downloaded from the Commission's website (www.clrc.ca.gov). Other materials can be obtained by contacting the Commission's staff, through the website or otherwise. The Commission welcomes written comments at any time during its study process.

Any comments received will be a part of the public record and may be considered at a public meeting. However, comments that are received less than five business days prior to a Commission meeting may be presented without staff analysis.

is on the Commission's June 20, 2024, meeting agenda.

California Nurses Association

This comment is submitted by Carmen Comsti on behalf of the California Nurses Association. The comment relates to the expert report on Mergers and Acquisitions that is on the Commission's June 20, 2024, meeting agenda.

Respectfully submitted,

Sharon Reilly
Executive Director

John M. Newman
Professor of Law
University of Miami School of Law
Advisory Board Member
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June 19, 2024

Dear Chairperson and Commissioners:

Thank you for your invitation to submit information and recommendations regarding competition in the digital marketplace. It is a great honor and a privilege to be able to contribute my views on merger enforcement and competition in digital markets, both of which lie at the core of my work as an academic and a former federal antitrust enforcers.

I am currently a professor at the University of Miami School of Law, a member of the advisory boards of the American Antitrust Institute and the Institute for Consumer Antitrust Studies, and an associate editor of the American Bar Association's Antitrust Law Journal. I have also practiced with both U.S. federal antitrust agencies, most recently as deputy director of the Federal Trade Commission's Bureau of Competition. In that role, I oversaw the agency's antitrust cases against Amazon, Meta, Microsoft, and others.

It is my view that the current state of merger enforcement, and antitrust enforcement more generally in digital markets, warrants substantial state-level reforms. Federal antitrust law has been hamstrung over the past several decades, and the unique features of digital markets cast this unfortunate development into sharp relief. I commend both the Expert Report: Mergers and Acquisitions and the Expert Report: Technology Platforms for their careful analyses. That said, I respectfully urge the Commission to consider—in addition to the proposals discussed in those Reports—the additional recommendations that I have set forth below.

Thank you again for the opportunity to contribute.

Warm regards,

John M. Newman

COMMENTS ON EXPORT REPORT: MERGERS AND ACQUISITIONS

Summary of Comments. The Report is generally fairly evenhanded in its description of the current legal landscape. That said, it exemplifies at least two shortcomings that the Commission should consider addressing. First, the probability of harm required to prohibit a merger should be lower than "more likely than not" (and far lower than a "certainty"). Second, for decades, the vast majority of stakeholders have focused on mergers that may "substantially lessen competition," ignoring mergers that may "tend to create a monopoly." Moreover, the Report does not discuss the possibility of creating a market-share-based presumption of illegality for non-horizontal mergers. Such a presumption would be warranted.

Recommendation 1: Clarify the Probability of Harm Required to Make a Merger Illegal

Clayton Act § 7 is the primary vehicle for both federal authorities and the State of California to challenge harmful mergers. This statute prohibits transactions whose effect "may be" harmful.[1] That language contemplates a "reasonable probability" of harm. Such a standard is—or should be—quite easy to meet. Courts in other contexts have repeatedly recognized that this standard is lower than "more likely than not,"[2] and far lower than a "certainty." Unfortunately, courts applying § 7 often wrongly limit the statutory scope to only those mergers that "will probably" or are "likely" to cause harm.[3] The Report describes the standard similarly.[4]

That is too high a bar. The harm from power-concentrating acquisitions is substantially higher—and the benefits much lower—than Chicago School assumed. Meanwhile, antitrust authorities are woefully underfunded. In litigation, defendants can out-spend enforcers by orders of magnitude. Particularly in cases against Big Tech firms, 10-to-1 is a conservative estimate; 100-to-1 is likely closer to accurate. It would be a welcome move for the State of California to adopt an anti-merger statute that expressly identifies the probability-of-harm requirement as "any appreciable risk" (or similar language). Such a law could increase statutory clarity and simultaneously pave the way for California state courts to develop a more sophisticated and effective body of case law than what the federal judiciary has managed to produce.

Recommendation 2: Clarify the Bar on Mergers That May "Tend to Create a Monopoly"

Like the vast majority of courts and commentators, the Expert Report focuses entirely on the first prong of Clayton Act § 7, which bars mergers that may "substantially . . . lessen competition."[5] But new research sheds light on the statute's long-forgotten second prong, which bars mergers that may "tend to create a monopoly."[6] Unlike the first prong, this language does

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[1] 15 U.S.C. § 18.
[2] *E.g.*, *United States v. Koziol*, 993 F.3d 1160, 1186 (9th Cir. 2021); *United States v. Tapia*, 665 F.3d 1059, 1061 (9th Cir. 2011); *see also United States v. Benitez*, 542 U.S. 74, 86 (2004) (Scalia, J., concurring in the judgment).
[3] *E.g.*, *United States v. UnitedHealth Grp. Inc.*, No. 1:20-22-cv-001481, at *12 (D.D.C. 2022) (requiring the government to prove that the challenged merger "is likely to" be harmful (quoting *United States v. AT&T, Inc.*, 916 F.3d 1029, 1032 (D.C. Cir. 2019)).
[4] *E.g.*, Expert Report: Mergers and Acquisitions, at *2.
[5] *Id.* (identifying this as the statute's "key phrase").
[6] Robert H. Lande, John M. Newman & Rebecca Kelly Slaughter, *The Forgotten Anti-Monopoly Law: The Second Half of Clayton Act § 7*, 103 TEX. L. REV. (forthcoming 2024).

not require "substantial[]" harm. This unique prohibition could help to prevent already-powerful incumbents from using relatively small acquisitions to further entrench or expand their power.

Unfortunately, this federal prohibition has remained dormant for several decades. Federal authorities have recently expressed some interest in reviving it. But the extent to which they will do so—and, if so, the extent to which they find success in federal court—are uncertain. In one case, the U.S. Department of Justice sought to use it to persuade a federal district court to block a merger, only for the court to ignore that part of the law altogether.[7] It would be a welcome move for the State of California to enact an anti-merger statute prohibiting acquisitions that may move an already-powerful firm "appreciably in the direction of" monopoly. Such a law could improve upon the Clayton Act's somewhat general language and pave the way for California state courts to develop a more effective body of case law than the federal analogue.

Recommendation 3: Create a Market-Share-Based Presumption of Illegality for Non-Horizontal Mergers

Beginning in the 1980s, federal antitrust authorities did not file a single litigated challenge against a vertical merger for nearly four decades. That extreme hands-off approach rested on a set of faulty theoretical assumptions.[8] Today, serious scholars agree that vertical mergers, especially by already-dominant firms, often pose a threat to open competition.[9] But federal courts have largely been hostile to federal antitrust agencies' attempts to revive vertical-merger enforcement.[10] Unfortunately, that has been true even where one of the defendants *already* controls a majority of the relevant market.[11]

One of the key differences between horizontal merger cases and vertical ones is that, in the latter, modern courts do not recognize any presumption of illegality based on market structures or shares. Such a presumption would be well-warranted. An incumbent that already controls, say, 50% of a market can and—based on my experience—most likely will use *any* additional control it can gain in a related market to further entrench and expand its existing power. It would be a welcome move for the State of California to legislatively impose a market-share-based presumption of illegality for vertical mergers. This would allow California enforcers to lead the way in righting the past mistakes made by federal enforcers in this area.

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[7] *United States v. UnitedHealth Grp. Inc.*, 630 F. Supp. 118, 133 (D.D.C. 2022) (stating that "the text of Section 7 is concerned only with mergers that '*substantially* . . . lessen competition," omitting the second prong entirely (emphasis and ellipses in original)).

[8] *See, e.g.*, Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 127 YALE L.J. 1962, 1963 (2018).

[9] *See, e.g.*, Jonathan B. Baker, Nancy L. Rose, Steven C. Salop & Fiona Scott Morton, *Five Principles for Vertical Merger Enforcement Policy*, ANTITRUST, Summer 2019, at 12–13.

[10] *See United States v. AT&T, Inc.*, 916 F.3d 1029 (2019); *FTC v. Microsoft Corp.*, No. 23-cv-02880-JSC (N.D. Cal. July 10, 2023); *United States v. UnitedHealth Grp. Inc.*, No. 1:20-22-cv-001481, at *12 (D.D.C. 2022).

[11] That appears to have been true in both *Microsoft* and *UnitedHealth*, as well as the *Illumina* case that produced a more plaintiff-friendly—but still mixed—result.

COMMENTS ON EXPERT REPORT: TECH PLATFORMS

Summary of Comments. This Report too is generally fairly evenhanded when describing the issues and various legislative proposals that have been generated in response. Over-concentration of power into a handful of firms has caused massive harm to societal welfare. One core means of accumulating that power has been mergers and acquisitions. The recommendations included above could be tailored to particular digital sectors, or to a subset of Big Tech firms (e.g., by limiting application to firms that control at least a certain percentage of a relevant digital market). Moreover, the Commission should seriously consider the basic framework identified by the Report for a digital-specific statutory framework.[12] Finally, I lay out a set of additional recommendations that could helpfully be enacted with general applicability, but could also be tailored to particular digital sectors and/or a subset of firms. These recommendations are offered as complements to (not necessarily as substitutes for) the proposals identified in the more comprehensive framework noted above.

Recommendation 1: Eliminate market-share-based "safe harbors" in conduct cases.

In Sherman Act cases, many federal judges have created market-share-based "safe harbors" that appear nowhere in the statutory text or legislative history. In the 1945 *Alcoa* decision, Judge Learned Hand at one point conjectured that a 90% market share was "enough to constitute a monopoly," but that a 60% or 64% share was "doubtful," and 33% was "certainly" not sufficient.[13] Despite the apparent lack of any empirical basis for this claim—no citations were provided—it has been quoted or cited by dozens and dozens of judicial opinions. Still other courts have arbitrarily selected various other market-share levels.[14]

A share-based presumption of *illegality* can reflect sound policy: in cases where harm is especially likely, it lightens the burden on enforcers while still allowing defendants to present rebuttal arguments. But a share-based *safe harbor* ends the analysis before a court can even ask whether harm is actually present, let alone hear both sides' evidence. And not all markets are the same. In some markets, a 50% share may not equate to monopoly power. But in a market with especially high barriers to entry—like some digital markets[15]—it can be more than enough. It would be a welcome development for the State of California to clarify that none of its antitrust statutes (including any new statutes that emerge from the present process) create safe harbors.

Recommendation 2: Clarify That Establishing a Violation Does Not Require Proof of Power to Control Any Single Aspect of Competition

In Sherman Act cases, some courts have inappropriately narrowed the path by which enforcers can prove that the defendant has market (or monopoly) power. For example, in 2018, the U.S. Supreme Court's 2018 *AmEx* opinion found for the defendant despite the fact that the

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[12] *See* Expert Report: Technology Platforms, at 12.
[13] *United States v. Aluminum Co. of Am.*, 148 F.2d 416, 424 (2d Cir. 1945).
[14] *E.g.*, *In re Abbot Labs. Norvir Anti-Trust Litig.*, 562 F. Supp. 2d 1080, 1086 (N.D. Cal. 2008) (65% required for monopoly power); *Union Carbide Corp. v. Montell N.V.*, 27 F. Supp. 414, 417 (S.D.N.Y. 1998) ("[F]irms with market shares of less than 30% are presumptively incapable of exercising market power.").
[15] *E.g.*, John M. Newman, *Antitrust in Digital Markets*, 72 VAND. L. REV. 1497, 1503–22 (2019).

government had proven harmful price effects *and* that the defendant had not passed through all of the resulting rents to its cardholders. Because overall demand had been increasing, the Court decided that there must not have been an antitrust violation—despite a trial record replete with proof of harm.[16] Similarly, the *Epic v. Apple* district court stated that, to show monopoly power using direct evidence, an antitrust plaintiff necessarily *must* prove that the defendant both raised prices and reduced output.[17]

This approach is wrongheaded as to any market or defendant, but especially as to dominant firms in digital markets. Output and welfare are not always directly correlated. Some anticompetitive conduct is not directed at output. And output effects are often difficult, and even practicably impossible, to prove. This is especially true of complex, interrelated digital markets. The State of California could helpfully clarify that no single particular type of effect is a requisite element of an antitrust violation. Monopoly power should be defined as the "ability to control an important aspect of competition" (not as power to "raise price *and* restrict output"). And anticompetitive effects should include any negative impact from exclusionary or collusive conduct, not just higher prices and lower output.

Recommendation 3: Empower Private Enforcers by Eliminating the Judge-Made "Antitrust Injury" Limitation

Historically, the most important issues in a given antitrust case were, simply, whether the defendant violated the law and whether that violation injured the plaintiff.[18] But in 1977, the U.S. Supreme Court endorsed what has become an increasingly elaborate and poorly understood additional hurdle for private enforcers: they must prove "antitrust injury".[19] Today, courts frequently dispose of cases on antitrust-injury grounds, even in cases where the plaintiff has alleged injuries that "could not possibly have been caused by anything other than an antitrust violation."[20] Courts interpreting the Cartwright Act have subsequently imposed a similar hurdle.[21]

But the need for this unusual hurdle—to the extent it was ever present at all—has passed. The temptation to wrongly dispose of cases for lack of "antitrust injury" is likely particularly strong in digital markets. The relevant markets and fact patterns are often complex, leaving some judges looking for an easy way out. And the relevant injuries may be unfamiliar, especially in digital markets that feature zero-price business models.[22] The State of California could help to revitalize private antitrust enforcement by doing away with the convoluted "antitrust injury" requirement. Of course, *some* causal connection between the violation and the plaintiff's injury should be required, but the standard showing of actual and proximate cause should be sufficient.

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[16] *Ohio v. Am. Express Co.*, 138 S. Ct. 2274, 2289 (2018).
[17] *Epic Games, Inc. v. Apple Inc.*, 559 F. Supp. 3d 898, 1031 (N.D. Cal. 2021).
[18] Ronald W. Davis, *Standing on Shaky Ground: The Strangely Elusive Doctrine of Antitrust Injury*, 70 ANTITRUST L.J. 697, 697 (2003).
[19] *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977).
[20] Davis, *supra* note 18, at 700.
[21] *See, e.g.*, *Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F. 3d 979, 991 (9th Cir. 2000).
[22] *See generally* John M. Newman, *Antitrust in Zero-Price Markets: Foundations*, 164 U. PA. L. REV. 149 (2015).

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I am the owner of independent bookstores in both Livermore and Pleasanton. In our 25 years in business, we have seen many changes in the retail market due to mergers, monopoly and monopsony allowing Amazon to give undue influence over what is published and terms of sale. Over the past four decades, merger regulations have failed to address how markets function.

Small business is a vital contributor to local and national economies. Market consolidation harms communities by displacing jobs and storefronts, leaving empty buildings and blight in our towns, while reducing choice and opportunities for consumers and entrepreneurs. As critical contributors to local and national economies, independent bookstores hold a direct, tangible interest in the approach taken towards enforcing mergers. As we've seen with Amazon, the absence of strong merger law enforcement has allowed Amazon to become a monopoly and a monopsony in our industry. Its unchecked industry domination has given them a stranglehold on the industry, influencing what's published, defining industry terms, and deterring competition and innovation.

We often see people wandering our stores looking for products they can buy cheaper on Amazon. Who can blame them? Amazon's use of books as loss leaders and extensive data collection have created unfair advantage. It has driven market prices up as the publishers look for ways to appease Amazon's hungry demands for discounts. Amazon's vertical and horizontal strength in the marketplace is strangling delivery options and raising prices for small businesses.

I urge you to strengthen the existing laws for mergers and acquisitions.

Thank you,
Judy Wheeler Ditter
Owner, Towne Center Books

June 19th, 2024

Amb. Chair David Huebner
Vice Chair Xochitl Carrion
California Law Review Commission (CLRC)
c/o Legislative Counsel Bureau
925 L Street, Suite 275
Sacramento, CA 95814

Dear Ambassador Huebner, Vice Chair Carrion, and Commissioners:

On behalf of the undersigned organizations, we respectfully submit for your consideration the following letter in response to the Working Group Report on Technology Platforms.

Of all the issues the Commission is tasked to examine pursuant to ACR 95, none would be more surprising to the original drafters of the Cartwright Act than digital technology. The scale and scope with which these digital platforms construct closed systems that privilege and reinforce their dominant market positions is unprecedented. Perhaps it is expected, then, that the Cartwright Act is not up to the task of addressing the full breadth and scope of challenges and harms of corporate concentration in this industry.

While people can – and do – argue about the tradeoffs between the benefits and the harms of the digital age, no one seriously disputes that technology will continue to advance and likely further expand into our lives. It is also evident that the power to dictate these choices about technological development, usage, and policy is increasingly concentrated in a few hands. As the U.S. House of Representatives Subcommittee on Antitrust, Commercial and Administrative Law of the Committee of the Judiciary put it in its sweeping report in 2020, "Investigation of Competition in Digital Markets:"

> To put it simply, companies that once were scrappy, underdog startups that challenged the status quo have become the kinds of monopolies we last saw in the era of oil barons and railroad tycoons. Although these firms have delivered clear benefits to society, the dominance of Amazon, Apple, Facebook, and Google has come at a price. These firms

> typically run the marketplace while also competing in it—a position that enables them to write one set of rules for others, while they play by another, or to engage in a form of their own private quasi regulation that is unaccountable to anyone but themselves.[1]

A handful of tech corporations have amassed so much power – in the market, in society, in our individual lives – that they rival that of our democratically elected government (and others around the world). Big Tech often has the upper hand, as demonstrated recently when Google temporarily shut down access to all news to all Californians on its platform because it opposed a legislative proposal (AB 886 - Wicks) that would have required it to share proceeds with local news outlets.[2] [3] Facebook/Meta made a similar flex in Australia, too, and elected to remove the "news" tab from Facebook after Meta refused to renew negotiated agreements that required payments to local news outlets for content Meta featured on its platform.[4]

The public is in a bind. The dominant digital tech is so intricately woven in the fabric of daily life that avoiding it is frankly impossible. The rise of Artificial Intelligence will only supercharge this reality. The public is increasingly concerned about the concentration of power in the tech industry and supports government intervention to address it. Polling from October 2023 shows that 76% of Americans, including 73% of Republicans, 80% of Democrats, and 75% of Independents, support regulating Big Tech companies as public utilities. As well, 76% believe Big Tech companies should not have so much power and should be prevented from controlling all aspects of AI. And 68% would support a proposal to break up the big AI companies to prevent them from controlling the entire sector.[5] In other words, strong majorities want the government to step in and counter the unchecked power of Big Tech, especially as the specter of AI looms.

With this context in mind, we urge you to consider the following as you develop your recommendations:

1. **Include in your analysis the impact of corporate concentration of the digital platforms on evolving, nascent trends, especially artificial intelligence (AI).**

We urge you to consider reforms that would address corporate concentration in the tech industry more broadly, in particular AI.

AI builds on the existing infrastructure dominated by the incumbent digital platforms. Their very nature as multi-sided platforms, giving them the ability to leverage data across multiple markets, network effects, and scale across vertical and horizontal integration, has meant that these are the same players with a built-in market advantage that will remain critical to address through policy and antitrust enforcement if we're serious about building a level playing field for smaller players, start-ups, and entrepreneurs.

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[1] https://democrats-judiciary.house.gov/uploadedfiles/competition_in_digital_markets.pdf, page 6.
[2] https://www.politico.com/news/2024/04/12/google-california-news-journalism-00151873
[3] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB886
[4] https://www.theguardian.com/media/2024/apr/02/facebook-shuts-news-tab-after-meta-vows-to-stop-paying-australian-publishers-for-content
[5] https://cdn.vanderbilt.edu/vu-URL/wp-content/uploads/sites/412/2023/10/09151420/VPA-AI-Polling-Report-10.9.23.pdf

Surprisingly, the Working Group Report on Technology Platforms does not consider or address the most significant aspect of the technology sector today: AI. We believe this is an omission that needs remedying. In many ways, the anticompetitive dynamics arising in AI are not new and instead only replicate the existing trends toward concentration at scale. While many of the single firm conduct business practices outlined by the Working Group Report on Technology Platforms that lead to monopolization by the tech platforms apply to AI as well, there are also important distinctions that the Commission should bear in mind as it carefully considers the need for updated antitrust laws for California's economy. For example, the tech platforms are not cementing their dominance and control over AI through conventional mergers and acquisitions, but instead by entering financial partnerships and investment arrangements that give them control over nascent, new AI players like OpenAI.[6] This dynamic must be studied and remedied to fully understand the scope and scale of Big Tech in our modern economy.

2. **Examine the impact of ownership across multiple lines of business (including vertical and horizontal integration) as a key driver of Big Tech corporate concentration that threatens innovation and entrepreneurship necessary for a dynamic tech sector and consider structural separation to address it.**

To leverage economies of scale and gain efficiencies, digital platforms have pursued aggressive vertical and horizontal integration strategies, including through mergers and acquisitions to buy up and snuff out nascent and potential competitors. Today's enforcers have brought antitrust suits challenging Meta's practice of buying out the competition to maintain its dominant position.[7] Operating across multiple lines of business also creates incentives for dominant platforms to engage in anticompetitive practices that preference their own products and services, including price discrimination, tying goods and services so that customers have to purchase other products, and more. Structural separation can eliminate these incentives.

We have a long history of embracing structural separation as a tool to confront and prevent concentrated power in other industries. In the era when Cartwright was passed, railroads, banking, and telecom were all subject to strong structural separation regimes to ensure free and open markets.

A similar approach should be used in the tech sector. The Commission could consider legislation such as the *Ending Platform Monopolies Act* (H.R.3825 – Jayapal) that would limit ownership or control of an online platform and certain other businesses that utilize the covered platform for the sale or provision of products or services, offers a product or service that the covered platform requires a business user to purchase or utilize, or gives rise to a conflict of interest. A "conflict of interest" would be a situation where a platform operator owns or controls a line of business, and the platform's ownership or control of that line of business creates the incentive and ability for the platform to advantage its own products, services, or lines of business over those of a competing business or exclude or disadvantage the products, services,

[6] https://www.project-syndicate.org/commentary/ai-will-strengthen-big-tech-oligopoly-market-concentration-and-corporate-political-power-by-eric-posner-2024-01
[7] https://www.ftc.gov/legal-library/browse/cases-proceedings/221-0040-meta-platforms-incmark-zuckerbergwithin-unlimited-ftc-v

or lines of business on the platform of a competing business. For example, through its e-commerce platform, Amazon is both the marketplace *and* a competitor to many of the vendors selling goods on its platform.[8] This dual role in the marketplace has meant that Amazon occupies a unique advantage where it can leverage the data it gains about popular products to distort competition. A strong structural separation bill would also require individuals who serve as officers, directors, employees, or other institution-affiliated parties of a platform to terminate such service if it violates the conflict of interest provisions.

3. **Strengthen nondiscrimination requirements and require platform interoperability**

As a complement to structural separation and conflict-of-interest prohibitions, the Commission should propose that tech companies be required to treat other downstream businesses neutrally, prohibit them from engaging in self-preferencing, and prohibit them from inhibiting the free movement of downstream entities with lock-up provisions—even, and especially if—a single firm owns or controls vertically linked lines of business. For example, Apple and Google both own mobile app stores, which gives them the ability to control the marketplace by manipulating search results.

Nondiscrimination requirements would require the firm to treat downstream businesses neutrally, including its own vertically-integrated business lines. This would prevent dominant upstream tech providers (think cloud computing or hosting, digital platforms, etc.) from favoring their own products or services over those of competitors.

Interoperability rules require that upstream tech businesses must ensure that the systems they build are compatible with other systems.[9] Some digital platforms have at one point built interoperability into their systems; for example, Meta most recently introduced interoperability across its Messenger, Instagram, and WhatsApp messaging apps. With reduced switching costs, users can move between providers, which promotes competition and allows for new entrants in the market.

Thank you for your consideration of our perspective. We look forward to working with the Commission to develop a robust proposal for addressing market concentration in the technology sector.

Sincerely,

American Economic Liberties Project
California Independent Booksellers Alliance
California Nurses Association
Economic Security California
Ending Poverty In California
Small Business Majority
TechEquity Action

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[8] https://columbialawreview.org/content/the-separation-of-platforms-and-commerce/
[9] https://www.newamerica.org/oti/reports/promoting-platform-interoperability/online-platform-competition-is-hard-to-address

California Nurses Association
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June 19, 2024

The Honorable Ambassador David Huebner, Chair
California Law Revision Commission
c/o Legislative Counsel Bureau
925 L Street, Suite 275
Sacramento, CA 95814

RE: Comments on Antitrust Law - Study B-750, Mergers and Acquisitions

Dear Chair Huebner,

California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses (RNs) throughout California who provide direct patient care in hospital and other health care settings is please to submit the attached material for consideration by the California Law Revision Commission as you consider potential revisions to California's antitrust laws. In conjunction with the Commission's discussion regarding Antitrust Law – Study B-750 and the working group report on Mergers and Acquisitions at its June 2024 meeting, CNA submits several documents CNA has previously prepared on the subject matter.

Over recent decades, corporate conglomeration in the health care sector through mergers and acquisitions has resulted in concerning levels of concentration in health care services and employer labor markets. As bedside RNS, CNA members are acutely concerned about the harm that mergers and acquisitions may have on health care access and affordability for patients as well as on RNs and other health care workers' ability to advocate for better working conditions and patient safety. For RNs and other health care workers, monopsony power of employers also depresses wages and dilutes the power of workers to advocate for better working conditions and patient safety. In other words, anticompetitive behavior in the health care sector through market consolidation is a threat to the health and safety of nurses and other health care workers and is making our patients sicker.

CNA urges the Commission to consider strengthening merger review authority by California agencies and providing legal avenues for consumers and workers that may be harmed by a merger or acquisition to challenge transactions under California antitrust law. Importantly, CNA urges the Commission to consider changes to California antitrust law that would expressly allow for transaction review and challenge authority to include labor market impact analyses as well as analyses of non-price harms to consumers and workers.

At a minimum, California should consider (1) expanding its pre-merger notice requirements to significantly more transactions than those that meet the Hart-Scott-Rodino Act of 1976 threshold, (2) establishing under state law Attorney General's authority to challenge additional transactions beyond existing state enforcement authority under the Clayton Act, and (3)

expanding state regulatory and Attorney General review authority to a broad range of transactions, including vertical and cross-market mergers, and to a broad range of theories of market harm, including labor market harm and nonprice theories of harm.

CNA also urges the Commission to consider in its study the recent development in merger and acquisition review in the health care sector in California. For example, the newly established Office of Health Care Affordability recently issued new regulation requiring pre-transaction notice for material change transactions in the health care sector and on Cost and Market Impact Review. The Commission should consider whether these health care merger regulatory processes could be replicated in other sectors and whether these health care merger review processes should be strengthened.

CNA appreciates the opportunity to provide comments on Antitrust Law – Study B-750 and look forward to further engaging with the Commission on strengthening California's antitrust laws to protect nurses, other health care workers, and California's patients.

Respectfully,

Carmen Comsti
Lead Regulatory Policy Specialist
California Nurses Association/National Nurses United

Cc: Sharon Reilly, Executive Director, California Law Revision Commission

List of Attachments

1. National Nurses United, Comments to the Federal Trade Commission on "Draft Merger Guidelines, Docket FTC-2023-0043," *Federal Register*, Document # FTC-2023-0043-0001, September 18, 2023.

2. National Nurses United, "Fact Sheet: Health Care & Federal Antitrust Labor Market Impact Review," June 4, 2024.

3. California Nurses Association, Comments to the Office of Health Care Affordability on "Proposed Emergency Regulatory Action – Promotion of Competitive Health Care Markets; Health Care Affordability (Cost and Market Impact Review)," August 31, 2023.

4. National Nurses United, "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care," November 2020.

ATTACHMENT #1

California Nurses Association, Comments to the California Law Revision Commission

Antitrust Law - Study B-750, Mergers and Acquisitions

National Nurses United, Comments to the Federal Trade Commission on "Draft Merger Guidelines, Docket FTC-2023-0043," *Federal Register*, Document # FTC-2023-0043-0001, September 18, 2023.

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Via Regulations.gov

April 21, 2022

The Honorable Lina Khan, Chair
Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

The Honorable Jonathan Kanter
Assistant Attorney General, Antirust Division
U.S. Department of Justice
950 Pennsylvania Avenue Northwest
Washington, District of Columbia 20530

RE: Request for Information on Merger Enforcement (Docket No. FTC-2022-0003)

Dear Chair Khan and Assistant Attorney General Kanter:

On behalf of more than 175,000 registered nurses (RNs) across the country, National Nurses United (NNU) submits these comments in response to the Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) Request for Information on Merger Enforcement (Docket No. FTC-2022-0003) (hereinafter "RFI").

NNU is acutely concerned with the growth of monopoly and monopsony power of firms within the health care sector. The rise in conglomeration across the health care sector through vertical and horizontal integration of health care services and employer labor market dominance harms both patients and health care workers. As bedside RNs, NNU members are disturbed by trends in health care sector mergers and acquisitions that weaken nurses' ability to advocate for their patients and that exacerbate problems with health care access and affordability. For RNs and other health care workers, monopsony power of employers also depresses wages and dilutes the power of workers to advocate for better working conditions and patient safety. In other words, anticompetitive behavior in the health care sector through market consolidation is a threat to the health and safety of nurses and other health care workers and is making our patients sicker.

As NNU details below, in their revisions to merger guidelines, the FTC and DOJ can and should take into consideration how transactions in the health care sector can harm both patients and health care workers. The FTC and DOJ should also expand their merger analysis to examine cross-market mergers and the negative impact of monopsony power and employer concentration on worker wages, union density, and bargaining power over terms and conditions of employment such as occupational health and safety issues and safe staffing levels. Moreover, considering the post-acquisition trends of health care service closures, price increases, and other behavior by

dominant health care systems that threatens worker and patient safety, NNU urges the FTC and DOJ to presumptively consider any merger or acquisition in the health care sector, particularly hospital acquisitions, to be anticompetitive.

I. In light of growing conglomeration across the health care sector, the FTC and DOJ merger guidelines should be revised to consider negative effects of mergers and acquisitions on both patients and RN labor. (Responding to Questions 1d, 1g, 1h, 2e, 5g, 12i & 14b)

The FTC and DOJ should expand their definition of markets in the health care sector and should consider the effects of both horizontal and vertical mergers and acquisitions. As discussed below, market consolidation through mergers and acquisitions have been shown to have negative impacts beyond traditional conceptions of markets. Moreover, because large health systems and hospital chains are dramatically expanding into both services and supply chains within the health care sector, the FTC and DOJ should reconsider traditional distinctions between vertical and horizontal mergers to address the full scope of negative effects of mergers on both patients and RN labor markets. When large health care systems create a sector-wide monopoly within the health care sector, there is heightened risk of abuse of market power. For example, large hospital operators such as HCA Healthcare have engaged in mergers and acquisitions beyond hospital systems and are conglomerates in the health care sector that have vertically integrated their supply chains and expanded their health care services beyond the confines of hospitals and associated clinics. They also have among the highest charge-to-cost ratios and profit margins in the hospital industry.

The FTC and DOJ should also consider in their merger guidelines whether vertical integration in the health care sector may reduce the quality of health care services provided by firms after a merger or acquisition. The integration of corporate financial interests among firms that provide different kinds of health care or firms that control different types of health care facilities can incentivize interference with the professional judgment of practitioners and reduced practitioner autonomy. In addition, they incentivize pushing care to the setting that maximizes net revenue rather than providing care in the setting most appropriate for and individual patient. Finally, the FTC and DOJ should consider how private equity ownership may affect patient outcomes and safety. The strong tendency for private equity to focus on short-term profits, maximizing returns paid to investors, and minimizing liability by financing acquisitions through debt may lead to even greater damage than the typical profit-maximizing behavior in the health care sector. As explained more in this part, the quality of patient care often suffers as a result of vertical integration in the health care sector.

For these reasons and the reasons described throughout these comments, NNU urges the FTC and DOJ to revise their merger guidelines to consider the negative effects that horizontal and vertical integration in the health care sector may have on patients and RN labor, including analyzing their effects beyond the current understanding of what constitutes a health care market.

a. The FTC and DOJ should consider trends in health care mergers and acquisitions to expand the definition of markets and analysis of market concentration in their merger guidelines. (Responding to Questions 1d, 1g, 1h, 2e, 5g, 12i & 14b)

The FTC and DOJ in their merger and acquisition guidance should consider the growing trend of market concentration in the health care sector and how it affects health care prices. Health care market concentration is strongly associated with continual increases in the rates that insurance companies and other payers pay health care entities for items and services and the amount hospitals charge for health care services relative to their costs. Over the last several decades, the consolidation of the hospital industry has affected health care services in nearly every state and region in across the country. At least 2,041 successful hospital mergers or acquisitions have taken place since 1993.[1] Through those successful transactions, individual hospitals were bought and sold a total of 4,441 times.[2] Taking into account the facilities that were involved in multiple transactions, a total of 2,782 hospitals have been acquired or merged during this period.[3] According to the American Hospital Association (AHA), there were 5,261 total community hospitals in the United States in 1993,[4] which means, astonishingly, that over 50% of hospitals in the country have been bought or sold over the last three decades.

The high level of hospital merger activity over the past three decades has led to an alarming level of consolidation in the hospital industry. In 1994, about 37% of hospitals were affiliated with multihospital health care systems.[5] In 2020, the percentage of hospitals belonging to systems had grown to almost 68%.[6] This ever-increasing dominance of multihospital health care systems represents a transformative restructuring of the industry, as independent community hospitals slowly disappear from the health care landscape.

[1] Hospital transaction data based on NNU's preliminary analysis of Irving Levin Associates LLC Healthcare Deals database (accessed on Mar 14, 2022), as well as hospital news sources and public disclosures. The Irving Levin Associates LLC Healthcare Deals database is available at https://prohc.levinassociates.com/.

[2] *Id*.

[3] *Id*.

[4] American Hospital Association. 2022. "2022 AHA Hospital Statistics Database." *AHA Data & Insights.* https://www.ahadata.com/aha-hospital-statistics.

[5] "2022 AHA Hospital Statistics Database."

[6] *Id*.

While consolidation in the hospital industry has not improved patient care,[7] it is strongly associated with higher hospital charges relative to costs, or charge-to-cost ratios (CCR).[8] High concentration in hospital markets and in the health care sector overall allow hospitals and health systems to gain negotiating power relative to health insurance companies and other payers over hospital charges and reimbursement rates. Using Medicare cost reports for fiscal year 2020 available through the Centers for Medicare and Medicaid Services (CMS), non-government hospitals operated by multihospital health care systems, on average, charged $494 for every $100 in costs they sustained (or a 494% charge-to-cost ratio).[9] Independent hospitals, by comparison, charged $293 for every $100 in costs (or a 293% charge-to-cost ratio).[10]

This correlation between system status and CCR level is especially pronounced at the hospitals with the highest charges relative to their costs. In November 2020, NNU released a report on hospital CCRs in the United States which found that all of the 100 hospitals with the highest CCRs in the nation, with an average CCR of 1,350%, belong to multihospital systems and are not independently owned.[11] And 81 of those belong to just three for-profit firms: HCA Healthcare, Community Health Systems, and Tenet Healthcare.[12] A copy of NNU's 2020 report, "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care," is attached to these comments as Attachment 1.

b. Vertical integration of healthcare services undermines patient care.
(Responding to Questions 1d, 1g, 1h, 2e, 5g, 12i & 14b)

The FTC and DOJ should consider the potential harm to patient care from vertical integration of health care services through conglomeration in the health sector. Vertical integration has been shown to undermine patient care and, as discussed further in Part III, to increase health care prices. Vertical integration can occur in the health care sector in several ways. Often health care conglomeration occurs when a hospital system, which provides acute care, acquires or merges with firms providing non-acute health care services, such as a physician

[7] See Beaulieu ND et al. 2020. "Changes in Quality of Care After Hospital Mergers and Acquisitions." *NEJM* 382(1). doi: 10.1056/NEJMsa1901383.
Short MN, Ho V. 2020. "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality." *Med Care Res & Rev*. doi:10.1177/1077558719828938.
Koch T et al. Oct 2018. "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries." *Health Servs Res* 53(5), 3549–68. doi:10.1111/1475-6773.12825.

[8] See National Nurses United. Nov 2020. "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care." https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1120_CostChargeRatios_Report_FINAL_PP.pdf.

[9] Hospitals' Medicare cost reports are available at: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Last Modified March 7, 2022. "Cost Reports." https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.

[10] *Id*.

[11] See *supra* note 8 (Attachment 1).

[12] NNU calculated charge-to-cost data using Medicare cost reports for fiscal year 2020, from the Centers for Medicare and Medicaid Services. See also *supra* note 8 (Attachment 1).

practices, home health agencies, telehealth service providers, outpatient clinics, nursing homes, skilled nursing facilities, or other post-acute care facilities. This type of vertical integration may reduce the quality of services provided by firms after a merger or acquisition. The integration of corporate financial interests among different kinds of care can interfere with the professional judgment of practitioners and incentivize pushing care to the setting that maximizes net income, rather than providing the necessary and appropriate care for each individual patient. As alternative payment become increasingly common,[13] particularly those that require health care providers to assume risk, mergers and acquisitions to increase vertical integration are likely to increase. Thus, it is critical for the FTC and DOJ to review these types of mergers and acquisitions closely to ensure that patients, and those who care for them, are not harmed in the process.

NNU is particularly concerned with—and urges the FTC and DOJ to closely scrutinize—hospital or health system ownership of physician practices because, in addition to reducing competition and increasing prices, hospital and health systems may prioritize their financial interests at the expense of patient care. Pressure by a hospital or health system employer may undermine physician autonomy.[14] For example, physicians at a California hospital contend that the system to which the hospital belongs has standardized clinical guidelines through a shared electronic health record system that are "often driven by cost considerations" and that the guidelines "often [conflict] with their own judgment of best medical practices."[15] Physicians, and others with independent practice authority,[16] are the lynchpin in any payment model as they have the necessary license to determine whether to order tests and treatments, admit patients to health care facilities, prescribe medications, and otherwise determine what care is provided. Within a fee-for-service model, where providers are paid per service delivered, physicians may be pressured to increase utilization. In contrast, within alternative payment models, such as an Accountable Care Organization (ACO) or bundled payment model where providers are paid a flat fee per patient or diagnosis, physicians may be pressured to reduce utilization and deny care. Finally, regardless of payment model, physician referral patterns within a vertically integrated health system may negatively impact patient care when patients are referred to the most financially advantageous care setting and to specialists within the same health system instead of the care setting or specialist best suited to each patient's individual needs.[17]

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[13] Health Care Payment Learning & Action Network. 2021."APM Measurement Progress of Alternative Payment Models: 2020-2021 Methodology and Results Report." The MITRE Corp. Case Number 21-3907. http://hcp-lan.org/workproducts/APM-Methodology-2020-2021.pdf.

[14] Machta RM et al. 2020. "Health System Integration with Physician Specialties Varies Across Markets and System Types." *Health Servs Res* 55, 1062-1072.

[15] Wolfson BJ. Apr 13, 2021. "Orange County Hospital Seeks Divorce from Large Catholic Health System." *Kaiser Health News*. https://khn.org/news/article/orange-county-hospital-seeks-divorce-from-large-catholic-health-system/.

[16] This may include nurse practitioners and others with independent practice authority, depending on state licensure requirements.

[17] Greaney TL. 2018. "The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?" *J Law, Med & Ethics* 46(4), 918-926.

NNU is also concerned about—and again urges the FTC and DOJ to closely scrutinize—mergers and acquisitions that vertically integrate firms among acute care, post-acute care, and home health agencies within the health care sector may affect patient care by shifting care to unpaid family caregivers or unlicensed aides. Within a vertically integrated health system, a patient might be discharged prematurely from an acute care setting to a post-acute facility or home health agency because of financial incentives in alternative payment models. Although alternative payment models purportedly are meant to reduce costs to both commercial and government insurers, studies have been inconsistent on whether these models reduce costs when incentive payments are included. Citing two studies that show savings, one on Medicare ACOs[18] and one on bundled payments,[19] Chatterjee et al. note that the savings come largely from eliminating inpatient post-acute care and sending patients directly home from the hospital.[20] They argue that these models come with a hidden cost borne by informal caregivers, primarily women, who are providing patient care that should be provided by health care professionals.[21] They cite several studies showing that

> [i]nformal caregivers are more likely to take leave from a job, take out a loan or mortgage, spend savings; hold multiple jobs, or retire early; suffer harm to intimate relationships, family conflict, worsened health, decreased geographic mobility, and an inability to pursue life goals. These effects are more common among women; tend to be more severe among those with low educational attainment, depression, and social isolation; and can contribute to a cycle of household poverty.[22]

Based on developments within hospital and health system employers, as well as industry news reports,[23] NNU expects increased activity to integrate acute care hospitals, home health agencies, and telehealth providers. The shift to home health care has exploded during the Covid-19 pandemic, facilitated by telehealth technologies. CMS has waived numerous critical regulatory

[18] McWilliams JM et al. 2016. "Early Performance of Accountable Care Organizations in Medicare." *NEJM* 374(24), 2357-2366.

[19] Barnett ML et al. 2019. "Two-Year Evaluation of Mandatory Bundled Payments for Joint Replacement." *NEJM*. 380(3), 252-62.

[20] Chatterjee P et al. 2019. "Shifting The Burden? Consequences of Postacute Care Payment Reform on Informal Caregivers." *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/forefront.20190828.894278/full/.

[21] *Id.*

[22] *Id*., citing: Adelman RD et al. 2014. "Care of the Aging Patient: From Evidence to Action: Caregiver Burden." *JAMA* 311.10: 1052-59. Hoffman AK. 2016. "Reimagining the Risk of Long-Term Care." *Yale J Health Pol'y Law Ethics*.16(2):147-232. Van Houtven CH et al. 2013. "The Effect of Informal Care on Work and Wages." *J Health Econ*. 32(1), 240-52. doi: 10.1016/j.jhealeco.2012.10.006.

[23] For example, see Christ G. Jun 30, 2021. "Amedisys to Acquire Contessa Health in Move to Increase Patient Acuity." *Modern Healthcare*. https://www.modernhealthcare.com/home-health/amedisys-acquire-contessa-health-move-increase-patient-acuity.

Lagasse E. Mar 29, 2022. "UnitedHealth Group's Optum to Buy LHC Group to Expand Home Healthcare Presence." *Healthcare Finance*. https://www.healthcarefinancenews.com/news/unitedhealth-groups-optum-buy-lhc-group-expand-home-healthcare-presence.

requirements for hospitals, allowing them to provide acute-level hospital care in a patient's home. In particular CMS has waived the requirement that 24/7 registered nursing care be provided for patients admitted to an acute care hospital. Furthermore, hospitals that shift patients to hospital care at home often leave unlicensed family members or aides responsible for providing medical and nursing care.[24] Hospitals, health systems, and other corporate players have been lobbying aggressively to make these changes permanent. For all these reasons, NNU urges the FTC and DOJ to consider how the shift to informal caregivers, many of whom are unpaid, affects patient care, informal caregivers, and the RN workforce.

c. Examples of vertical integration of the health care supply chain through acquisitions by hospital and health care systems. (Responding to Questions 1d, 1g, 1h, 2e, 5g, 12i & 14b)

Vertical integration in the health care sector supply chain can occur in several ways. Health care conglomerates are more frequently merging with or acquiring firms that provide non-healthcare services, including nursing schools, medical debt servicing companies, clinical data aggregation firms, and nurse staffing agencies.

HCA Healthcare provides an example of conglomeration in the health care sector in which health care systems are moving to merge with or acquire firms along the health care supply chain. According to HCA Healthcare's filings with the Securities and Exchange Commission, it has over one thousand subsidiaries around the world, ranging from its regional health care systems and travel nurse agencies to medical debt collections companies and nursing schools.[25] For instance, in 2020, HCA Healthcare bought Galen College of Nursing and then quickly expanded the nursing program into markets where HCA Healthcare has a dominant market presence, which has given them extra leverage over the RN labor market.[26]

Two other examples of HCA Healthcare's vertical integration in the health sector supply chain are its two main subsidiaries in the U.S.: HealthTrust, a group purchasing organization, and Parallon, a revenue cycle management company (i.e., a medical debt servicing company). HealthTrust is one of the largest group purchasing organizations in the country, which leverages the purchasing power of a group of hospitals to obtain discounts from vendors and serves 1,600 hospitals and health systems, in addition to the 55,000 other health care providers including

[24] Saenger PM et al. 2022. "Cost of home hospitalization versus inpatient hospitalization inclusive of a 30-day post-acute period." *J Amer Geriatrics Soc'y*.

[25] HCA Healthcare, Inc. Feb 18, 2022. United States Securities and Exchange Commission Form 10-K. Exhibit 21. https://d18rn0p25nwr6d.cloudfront.net/CIK-0000860730/9eb42636-f4dd-45c9-9eac-1fcf2b3b397d.pdf.

[26] See, e.g., Galen College of Nursing. Press Release. Jan 1, 2022. "Galen College of Nursing and HCA Florida Healthcare Announce New Campuses in Gainesville, Sarasota." https://galencollege.edu/news/galen-college-of-nursing-and-hca-florida-healthcare-announce-new-campuses-in-gainesville-sarasota.

Jacobs J. Nov 17, 2021. "HCA Healthcare-Owned Nursing School Opening Campus in Chesterfield." *Richmond BiZSENSE*. https://richmondbizsense.com/2021/11/17/hca-healthcare-owned-nursing-school-opening-campus-in-chesterfield/.

ambulatory surgery centers and physician practices.[27] HealthTrust serves as the medical supply chain, staffing, and clinical data aggregation manager for HCA Healthcare. HealthTrust, as described further in Part II, also serves as the nurse staffing agency for HCA Healthcare. Leveraging HCA Healthcare's monopsony power over nurse labor, HCA Healthcare often requires that new graduate nurses, in order to work at an HCA Healthcare hospital, enter into contracts with HealthTrust, which require nurses to participate in so-called enhanced nurse training programs with steep financial penalties for leaving the program or HCA employment before a set number of years.[28]

Parallon, on the other hand, is one of the country's largest revenue cycle management organizations and medical debt collections companies, representing more than 4,300 hospitals and physician practices and collecting over $51 billion annually in medical debt from 49 million patients.[29] By having both the supply chain negotiation services of HealthTrust and the medical debt services of Parallon in-house, HCA Healthcare is able to control their supplies and micromanage their staffing and medical bills collection, as well as to profit from selling these services to other hospitals.

d. Private equity in the health care sector has been linked to surprise medical billing, decreased practitioner autonomy, and reduced patient care quality. (Responding to Questions 1d, 1g, 1h, 2e, 5g, 12i & 14b)

The FTC and DOJ should include analyses of the effect that private equity ownership has on medical debt, physician autonomy, and the quality of patient care in their merger guidelines. The private equity playbook includes maximizing profits over the short term, maximizing returns paid to investors, and minimizing liability by financing acquisitions through debt. All of these practices wreak havoc on workers in acquired corporations and the surrounding communities, regardless of the economic sector. In health care, private equity is particularly damaging and

[27] HealthTrust. Press Release. July 26, 2021. "HealthTrust and Steward Health Care Sign Long-term Renewal for Supply Chain and Group Purchasing Support Services." https://healthtrustpg.com/in-the-news/healthtrust-and-steward-health-care-sign-long-term-renewal-for-supply-chain-and-group-purchasing-support-services/.

[28] HealthTrust and its contracts with nurses working in HCA Healthcare hospitals is discussed further in Part II.

[29] Parallon. Accessed Mar 18, 2022. "About Us." https://parallon.com/about-us.

even deadly. Characteristics of health care organizations owned by private equity include lower staffing levels,[30] higher prices for care,[31] and higher medical debt for patients.[32]

Private equity has aggressively acquired medical practices and health care staffing services. Indeed, two private equity-owned staffing services, Envision and TeamHealth, alone control at least one-third of all Emergency Departments (EDs) in the country.[33] Like many ED physician staffing firms,[34] until recently, Envision's business strategy was to not participate in any insurer network,[35] making every insured patient subject to surprise medical bills for out-of-network services even if they received emergency care in an in-network hospital. Some anesthesiology practices, a top target of private equity,[36] also adopted the strategy of avoiding participating in insurance networks.[37]

These types of private equity practices are contributing to high rates of medical debt for U.S. residents. In 2020, nearly 18% of U.S. residents had medical debt, with 13% becoming indebted in the past year.[38] A 2018 poll of adults aged 18 to 64 asked about the past 12 months found that 39% of *insured* respondents reported receiving an unexpected medical bill and 10%

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[30] Applebaum E, Batt R. 2021. "Private Equity in Healthcare: Profits before Patients and Workers." *Cent for Econ & Pol'y Res*. https://www.cepr.net/private-equity-in-healthcare-profits-before-patients-and-workers/.

Cerullo M et al. 2021. "Private Equity Acquisition And Responsiveness To Service-Line Profitability At Short-Term Acute Care Hospitals: Study examines private equity acquisition at short-term acute care hospitals." *Health Affairs* 40.11. 1697-1705.

Fogel A et al. 2022. "Surgical Dermatology and Private Equity: A Review of the Literature and Discussion." *Derm Surgery*. 48(3), 339-343 doi: 10.1097/DSS.000000000000336.

Harrington C et al. 2012. "Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies." *Health Serv Res*. 47(1pt1), 106-128.

[31] Bruch JD et al. 2020. "Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition." *JAMA Intern Med* 180.11. 1428-1435.

Fogel, *supra* note 30.

La Forgia A et al. 2022. "Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners." *JAMA Intern Med*.

[32] Applebaum E, Batt R. 2020. "Private equity buyouts in healthcare: Who wins, who loses?" *Inst for New Econ Thinking Working Paper*. Series 118. doi: 10.36687/inetwp118.

[33] Morgenson G. Dec 21, 2021. "Doctors Sue Envision Healthcare, Say Private Equity-Backed Firm Shouldn't Run ERs in California." *NBC News*. https://www.nbcnews.com/health/health-news/doctors-sue-envision-healthcare-say-private-equity-backed-firm-shouldn-rcna9276.

[34] Bluth R and Huetteman E. Sep 11, 2019. "Investors' Deep-Pocket Push To Defend Surprise Medical Bills." *Kaiser Health News* and *The Daily Beast*. https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/.

[35] Applebaum E, Batt R. Mar 14, 2022. "Envision Healthcare Hits the Skids." *The American Prospect*. https://prospect.org/health/envision-healthcare-hits-the-skids/.

[36] Zhu JM, Hua LM, Polsky D. 2020. "Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016." *JAMA*. 323(7), 663–665. doi:10.1001/jama.2019.21844

[37] Levitt L. 2022. "Surprise Medical Bills Are Ending, but Controversy Continues." *JAMA Health Forum*. 3(1), e220060. doi:10.1001/jamahealthforum.2022.0060.

[38] Kluender R et al. 2021. "Medical Debt in the US, 2009-2020." *JAMA* 326(3), 250-256.

reported receiving an unexpected medical bill from an out-of-network provider.[39] Additionally, two-thirds of respondents were either very worried or somewhat worried about unexpected medical bills.[40] Prompted by public outrage, legislative and regulatory responses to surprise medical bills may force ED physician staffing firms, anesthesiology practices, and others who have capitalized on high out-of-network payments to change their approach. As the regulatory language has not been finalized or thoroughly tested in the courts, it is unclear how effective it will be at protecting patients from surprise medical bills.

Private equity-owned health care facilities, physician practices, and staffing services pose dangers to patients beyond medical indebtedness, including reductions in and undermining of physician autonomy, which the FTC and DOJ should consider in their merger analysis. As discussed above in Part I, Section b, hospital and health system ownership of physician practices may undermine physician autonomy and patient care. Given private equity's focus on short-term gains and maximizing investor returns, reduced physician autonomy and failure to prioritize patient care is likely widespread. Despite being hampered by non-disclosure agreements,[41] research and news reports are beginning to demonstrate that this is the case. For example, ED physicians working for Envision filed a lawsuit contending that Envision interferes with their medical judgment by imposing clinical standards and judging physician performance based on these standards.[42] Specifically, ED physicians claim that Envision "creates 'benchmarking' reports that compare physician performance to Envision-created standards, with the intention of modifying and interfering with the exercise of their independent medical judgment."[43] They further claim that Envision also sets physician staffing levels and patient throughput, both of which affect the quality of patient care. Dermatologists working for private equity-controlled organizations provide another example of an assault on physician autonomy and report being pressure to meet numerical quotas for procedures, sell skin creams and other products, and to refer patients to affiliated organizations for medical and cosmetic treatments.[44]

Patient care at health facilities owned by private equity has also suffered, which should be considered in the FTC and DOJ's merger analysis. Nursing homes owned by private equity score worse than nonprofit nursing homes on four quality measures. Compared to non-profit

[39] Levitt L. 2022. "Surprise Medical Bills Are Ending, but Controversy Continues." *JAMA Health Forum.* 3(1), e220060. doi:10.1001/jamahealthforum.2022.0060.

[40] Kirzinger A et al. Sep 5, 2018. "Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills." *Kaiser Fam Found*. https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/.

[41] Buntin MB. 2020. "The Blitzkrieg Acquisition of Medical Practices by Private Equity." *JAMA Health Forum.* 1(3), e200327. doi:10.1001/jamahealthforum.2020.0327.

[42] See *Am. Acad. Emerg. Med. Phys. Group v. Envision Healthcare Corp.* Dec 20, 2021. Complaint for Unfair Business Practices. Case No. 4:22-cv-00421 (CA Sup. Ct. CC). https://www.aaem.org/UserFiles/AAEMPGvsEnvisionCPOMComplaint-FINAL122021.pdf.

[43] *Id*.

[44] Resneck JS. 2018. "Dermatology Practice Consolidation Fueled By Private Equity Investment: Potential Consequences for the Specialty and Patients." *JAMA Dermatology* 154(1), 13-14.

nursing homes, private equity-owned nursing homes have less or lower quality staffing (with quality based on the level of education and training), higher levels of pressure ulcers, more regulatory deficiencies, and higher use of physical restraints, though the latter two were not considered statistically significant.[45] Another study of private equity ownership of nursing homes also found troubling trends: higher short-term mortality rates and lower mobility coupled with an 11% increase in spending.[46] The study attributed these effects to fewer nursing staff and their level of compliance with Medicare standards.

II. The FTC and DOJ should consider monopsony power and how employer concentration dilutes union density, weakens worker bargaining power, depresses wages, and enables industry-created staffing crises. (Responding to Questions 2a, 2b, 2d, 2e, 5g, 9f, 9g & 14b)

In their merger and acquisition guidelines, the FTC and DOJ should include an analysis of monopsony in labor markets, particularly in health care sector transactions. Concentration of employer power through mergers and acquisitions dilutes the bargaining power of workers over terms and conditions of employment. Decreased worker bargaining power vis-à-vis their employer has a negative impact on wages and other working conditions.

A 2021 study by Arnold on the effects of mergers and acquisitions on worker wages in the U.S. found that local concentration depresses wages by 4 to 5% relative to a fully competitive benchmark.[47] After mergers and acquisitions that cause significant increases in local labor market concentration, earnings fall by over 2% for workers at the firms involved in the merger or acquisition. The study found the largest effects in already concentrated markets. Mergers generating large concentration changes also reduced wages at other firms in the labor market.

The effects found by Arnold extend to the health care sector. Monopsony power has a substantial effect on labor market competition in the health care sector. As described in this section, monopsony power arising from labor market consolidation in the health care sector has led to industry-created staffing crises, coercive employment contracts, diluted union density, and wage depression in the health care sector. The FTC and DOJ should more closely examine monopsony power in their merger guidelines and, in their analysis of monopsony power under new guidelines, the FTC and DOJ should consider the risks to workers and the public at large from these consequences of consolidation beyond the impact on prices and wages. In addition to the impact of monopsony power on wages and prices, the FTC and DOJ should analyze, among other things, whether monopsony power dilutes worker bargaining power and union density and

[45] Ronald LA et al. 2016. "Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change." *PLoS Med* 13(4), e1001995.

[46] Gupta A et al. 2021. "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes." No. w28474. *Nat'l Bureau of Econ Res.*

[47] Arnold D. 2021. "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes." https://darnold199.github.io/jmp.pdf. *See also* Arnold D. 2019. "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes." doi: 10.2139/ssrn.3476369.

whether monopsony power increases unsafe working conditions, exploitative employment terms, and unsafe staffing.

a. The FTC and DOJ should consider how market consolidation of health care systems leads to industry-created staffing crises and the devaluation of nurse labor. (Responding to Questions 2a, 2b, 2d, 2e, 5g, 9f, 9g & 14b)

The FTC and DOJ in their merger guidelines should assess the negative effect that a health care sector merger or acquisition would have on nurse staffing levels, the health care worker labor market, and working conditions for health care workers. The FTC and DOJ should consider not only the more common analysis of the labor market effects of monopsony by examining diminished employment rates of workers in the target labor market, but it should also consider how labor market concentration will lead to worsening patient-to-nurse staffing levels and unsafe staffing. High levels of market concentration and monopsony power of employers in labor markets enable industry-created staffing crises, which are an acute problem in the health care sector because cuts in health care worker staffing and increased patient assignments for nurses endanger patients and is linked to poorer health outcomes of patients.[48]

Monopsony power in health care settings has a two-fold impact with respect to nurse and health care worker staffing—monopsony in the labor market can lead to both reduction in employment rates within a labor market and it can enable employers to engage in understaffing or unsafe staffing. Generally, market concentration results in lower staffing levels and reduced hiring. A 2021 study by Marinescu et al. observing labor markets in France found a 10% increase in labor concentration is associated with 3.2% fewer new hires.[49] For hospitals, increased market competition is associated with increased RN staffing levels.[50]

Monopsony power further enables employers to lower labor standards, wages, and otherwise treat nurses and other health care workers poorly, which contributes to nurses and other health care workers leaving bedside care or the nursing profession altogether. High concentration of employers that devalue the lives of nurses and other health care workers through

[48] Decades of studies have shown that low nurse staffing levels in acute care settings—where there are few nurses to take care of high patient workloads—is associated with increased medical complications and missed patient care. Summaries of leading literature on staffing ratios and patient safety can be found in several NNU publications. *See* National Nurses United. Accessed March 18, 2022. "The Science of Ratios." https://www.nationalnursesunited.org/science-of-ratios; National Nurses United. 2018. "RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals." https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/NNU_Ratios_White_Paper.pdf.

[49] Marinescu I et al. 2021. "Wages, Hires, and Labor Market Concentration," *J Econ Behav & Org.* 184(C), 506-605. *See also* Wasser D. Jan 2022. "Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets." *Cent for Econ and Pol'y Res*. https://www.cepr.net/report/literature-review-monopsony-employer-consolidation-and-health-care-labor-markets/.

[50] See Shin DY et al. 2020. "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective." *Risk Manag Healthcare Pol'y.* 13, 2103-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7568637/.

intentional understaffing, lack of health and safety precautions, and other poor working conditions has driven nurses away from bedside nursing. NNU issued a report, "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis," in December 2021 on the hospital industry-created staffing crisis, which is attached to these comments as Attachment 2.[51]

Importantly, hyperconcentration in a labor market and growing monopsony power of employers should be of utmost concern to the FTC and DOJ where large employers have a history of unsafe working conditions, union busting, and other violations of labor and employment standards. In the case of the health care sector, employers treat nurses as disposable, refusing to provide even the most basic occupational protections for nurses and other health care workers despite the critical necessity for nursing care and the inelastic demand for the services nurses provide. The result of decades of health care restructuring to reduce staffing, which was exacerbated by the Covid-19 pandemic, is that employers have manufactured a shortage of nurses. Concentration of monopsony power in a labor market enables employers to artificially reduce demand for labor, which in the health care sector results in unsafe patient care and high turnover.[52]

In other words, labor market effects of monopsony power go beyond the impact on prices in that concentration of employer power through market consolidation can result in exploitation of workers through unsafe staffing and poor working conditions. Unlike demand for health care, health care labor market supply is elastic—when working conditions are poor, nurses leave bedside nursing or the profession altogether; and when employers fail to protect nurses and other health care workers on the job, these workers experience career ending occupational injuries and illnesses at high rates. Without optimal infectious disease control measures on the job, nurses and other health care workers can also become infected and die from deadly infectious diseases, including Covid-19. NNU further describes how health care employers readily devalue nursing care and treat nurses as disposable in our report on the Covid-19 pandemic, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity," which is attached here as Attachment 3.[53]

Because non-price factors in the labor market—including staffing and other working conditions—are impacted by concentration of employer power, NNU again urges the FTC and DOJ to include in their merger guidelines the effect of monopsony power on nurse staffing levels and other working conditions for health care workers.

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[51] National Nurses United. Dec 2021 "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis." https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_StaffingCrisis_ProtectingOurFrontLine_Report_FINAL.pdf.

[52] *Id.*

[53] National Nurses United. Dec 2020. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

b. The FTC and DOJ should consider employer concentration and the emergence of coercive employment contracts, including nurse training repayment agreements. (Responding to Questions 2a, 2b, 2d, 2e, 5g, 9f, 9g & 14b)

Further, in their analysis of a health care sector transaction's anticompetitive effect, the FTC and DOJ should consider whether the acquiring or target firm has a training repayment agreement (TRA) for new graduate nurses or other coercive employment contracts for vulnerable workforces, such as nurses that are internationally recruited by a firm through employer-sponsored immigration. Hospitals and health care employers, particularly those with monopsony power over subsets of the health care workforce, use job-based financial agreements as conditions of employment to unduly gain financial power over nurses and other health care workers.[54] Employers with greater market share can use the threat of financial ruin over workers with weak bargaining positions in the health care labor market—like recent graduates from nursing school or immigrant nurses—to bust unions, silence whistleblowers, and prevent nurses from acting collectively to improve hospital working conditions for themselves, their coworkers, and their patients.

NNU previously, in September 2021, submitted comments to the FTC in response to the "Solicitation for Public Comment on Contract Terms that May Harm Competition" (Docket No. FTC-2021-0036) further discussing the use of TRAs by health care employers with newly graduated nurses. NNU's September 2021 comments to the FTC are attached to these comments as Attachment 4. In health care, these coercive financial repayment or services contracts are often dressed up as enhanced education and training programs. Under these kinds of coercive employment contracts nurses are required to work for their employer for a number of years or else pay a substantial penalty for the costs of employer-required training, typically for thousands of dollars.[55] Some TRAs are treated as loans[56] while others are liquidated damages provisions.[57] Under TRAs, RNs are often paid substantially less than prevailing rates, locked in for the entire

[54] For a detailed analysis of TRAs both in the health care sector and in other sectors, see a memorandum by the Student Borrowers Protection Center sent to the Consumer Financial Protection Bureau on January 19, 2022. Student Borrowers Protection Center. Jan 19, 2022. "Memorandum, Training Repayment Agreements." https://protectborrowers.org/wp-content/uploads/2022/01/SBPC_TRAs_ABRIDGED.pdf.

[55] See Attachment 4; NNU's September 2021 comments to the FTC are also available through regulations.gov at National Nurses United. Sept 29, 2021. "Comment from National Nurses United." Comment ID FTC-2021-0036-0275. https://www.regulations.gov/comment/FTC-2021-0036-0275.

[56] See examples in Attachment 4.

[57] For example, in *Paguirigan v. Prompt Nursing Employment Agency LLC d/b/a Sentosa Services et al.*, 827 Fed. Appx. 116 (2d Cir. 2020), more than 200 immigrant nurses prevailed in a Trafficking Victims Protection Act (TVPA) claim against their nursing home employers, which sponsored their employment-based immigration visas, and the Philippine recruitment agency. The Federal district court found that, inter alia, the contractual $25,000 liquidated damages penalty for a nurse's breach of contract, which the employer and recruiter claimed was for repayment of recruitment, training and other costs, was a "threat of serious harm" in violation of the TVPA and was unenforceable under state law.

term of the contract.[58] By requiring newly graduated or immigrant nurses to enter these so-called enhanced training programs, health care employers with monopsony power of the labor market are simply passing on to nurses the costs of basic on-the-job training required for any RN position at any hospital.

NNU raises one noteworthy example mentioned in our September 2021 comments to the FTC and DOJ again here. Newly hired new graduate RNs seeking employment at HCA Healthcare's Mission Hospital in Asheville, NC and a number of other HCA Healthcare hospitals are required to sign a TRA with HCA Healthcare subsidiary HealthTrust, a health care industry supply chain management company as mentioned above.[59] Under the contract, HealthTrust requires newly graduated nurses—who are fully licensed and working as RNs in HCA Healthcare hospitals — to complete the company-run StarRN program to receive so-called nursing coursework. Under the contract, these newly graduated nurses are required to take out a $10,000 promissory note for program costs and must for years accept suppressed wages that are frequently lower than other RNs working in the same job but outside the StarRN program. Additionally, as temporary employees these nurses do not receive benefits. After completing the program, nurses are required to work full-time for HCA Healthcare for two years or else they must repay the promissory note. RNs working at Mission Hospital who are in the StarRN program make a set rate of $24 an hour, potentially depressing wage growth, while the hourly median wage for RNs in the state is $32.13.[60]

c. The FTC and DOJ should analyze diluted union density and wage depression as a result of employer concentration. (Responding to Questions 2a, 2b, 2d, 2e, 5g, 9f, 9g & 14b)

Given the monopsonist labor market concentration in the health care sector, the FTC and DOJ should consider in their guidelines how a merger or acquisition would dilute union density and lead to wage depression.

Union density should matter in the FTC and DOJ's labor market analysis because mergers and acquisitions can dilute the power of workers to bargain for improved wages and working conditions against a monopsonist employer. Recent research by Prager and Schmitt shows that an increase in health care labor market concentration is associated with lower wages and less bargaining power for workers.[61] In markets with a labor market concentration of 2,500 points or higher on the Herfindahl-Hirschman index (HHI) of hospital full-time employee concentration within a commuting zone, wages are 1 to 4% lower than in perfectly competitive

[58] See examples in Attachment 4.
[59] See Attachment 4.
[60] See Exhibit 1 in Attachment 4; and U.S. Bureau of Labor Statistics, U.S. Department of Labor. May 2020. "Occupational Employment and Wage Statistics, May 2020." https://www.bls.gov/oes/.
[61] Prager E, Schmitt M. Last Revised Aug 24, 2020. "Employer Consolidation and Wages: Evidence from Hospitals." *Wash Cent for Equitable Growth Working Paper*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3391889.

labor markets. Prager and Schmitt also found that large hospital transactions that significantly increase concentration may result in a 6.3% decrease in wages for nurses. Importantly, they also found that a strong labor union presence "meaningfully attenuate[s]" post-merger wage depression but does not eliminate it.

Given the net positive effect that unionization has on nurse wages and on reducing racial and gender wage gaps, the FTC and DOJ should consider in their merger guidelines the negative impact that increased employer concentration and dilution of union density post-merger may have on nurse wages. In the health care sector, union density and labor market competition among employers play an important role in improving wages and working conditions for both union and nonunion registered nurses. Employer concentration in a labor market post-merger or acquisition may dilute the union density within a health system, diminishing the bargaining power of health care workers. Unionized workers receive a wage premium compared to their nonunion counterparts. For example, studies of nurse wages controlling for various variables, including type of health facility, geographic region, age, experience, position, and education, concluded that being in a union increases nurse wages, with estimated union wage premiums ranging between almost 8% to over 13%.[62]

Importantly, unionization can significantly diminish gender and racial wage gaps for nurses and other workers. The results of one study, applying several control variables, demonstrated that in the nonunion setting Black RNs earned almost 8% less in average hourly wage than white RNs but, for unionized Black RNs, this racial wage penalty was minimal (0.85%) or, in other words, being in a union reduced the racial wage gap for Black nurses by almost 89%.[63] Additionally, union membership shrinks the wage gap for nonunion professional women, who earn 73 cents for each dollar earned by their male counterparts, while professional women in unions earn 83 cents for each dollar earned by their male counterparts.[64]

Additionally, mergers of union and nonunion facilities may diminish union density within a labor market and, thus, diminish the net positive effect on wages and working conditions that unions have on nonunion nurses as well. In a competitive labor market where union density is high, there is a "union threat effect" where nonunion employers within a market may raise wages to avoid the threat of increased unionization. For example, with respect to nurses, high union density may result in a union threat effect on wages.[65] The FTC and DOJ should include in their merger guidelines an analysis of whether the union threat effect and nonunion nurse wages may

[62] Coombs C et al. Jun 4, 2015. "The Bargaining Power of Health Care Unions and Union Wage Premiums for Registered Nurses." *J Lab Res*. 36(4), 442–61. doi:10.1007/s12122- 015-9214-z. McGregory R. Mar 2011. "An Analysis of Black–White Wage Differences in Nursing: Wage Gap or Wage Premium?" *Rev Black Pol Econ.* 40(1), 31–37. doi:10.1007/s12114-011-9097-z.

[63] McGregory, *supra* note 62.

[64] Gould E, McNicholas C. Apr 3, 2017. "Unions Help Narrow the Gender Wage Gap." *Working Economics Blog.* Economic Policy Institute. https://www.epi.org/blog/unions-helpnarrow-the-gender-wage-gap.

[65] Coombs C et al., *supra* note 62; McGregory R., *supra* note 62.

diminish as a result of employer concentration following a large transaction between a union and nonunion employer.

Finally, analyzing union versus nonunion wages alone likely grossly underestimates the material benefit that union nurses can win through collective bargaining, including economic benefits such as paid sick leave and vacations, retirement benefits, disability benefits, and health insurance as well as improvements to their working conditions such as job security, safe staffing, and safe patient care practices. Thus, in their merger guidelines, the FTC and DOJ should also consider how diluted union density and loss of worker bargaining power in a highly monopsonist market will negatively impact other working conditions for nurses and other healthcare workers.

Again, NNU further discusses how employers devalue the health and lives of nurses in our report on nurses' experiences in "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity" (Attachment 3) and "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis" (Attachment 2). Together NNU's two reports demonstrate how outsized employer power over nurses, which in economic terms is partly derived from employer's monopsony power over a labor market, can harm nurses. These two reports identify several manifestations of unequal employer power over nurses which the FTC and DOJ should consider in their evaluation of the potential negative effects of monopsony power, including:

- Past practices of understaffing
- Evidence of moral distress, moral injury, post-traumatic stress disorder, depression, and anxiety in a firm's workforce
- Employee complaints of health and safety standard violations or citations by the Occupational Safety and Health Administration
- High levels of workplace violence or other occupational injury and illness
- Lack of paid sick and family leave
- Past practices of union busting, including lock-outs and use of union-busting firms
- Employee complaints of violations of other worker protection laws, including unfair labor practice charges under labor law, state and federal antidiscrimination law, wage and hour law, whistleblower complaints, etc.

III. The FTC and DOJ should expand their analysis of market concentration and lessening competition by assessing the following additional factors. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

In their merger guidelines, the FTC and DOJ should expand their analysis of market concentration and the potential for lessening competition as a result of a transaction to reflect the range of negative effects market concentration can have on health care workers and patients.

FTC and DOJ should include the following factors in the required analysis of a health care sector merger or acquisition in the guidelines.

a. Past practices of the buyer. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

The FTC and DOJ should consider the past practices of the party seeking to acquire another health care facility, health care service, or health system. As described throughout these comments, there are several post-merger trends in the health care sector that have harmed patients and workers. The FTC and DOJ should examine the following:

- Whether the acquiring party previously cut health care services or closed facilities post-acquisition (e.g., conversion of full-service acute care hospitals into freestanding emergency departments)
- Whether the acquiring party previously cut hospital capacity (e.g., decreased the number of hospital beds or closed particular hospital services) after a vertical merger or acquisition with a physician group, home care company, telehealth company, or other non-acute care health care service firm.
- Whether the acquiring party previously instituted practices encouraging practitioners to move patients to facilities with an inappropriate level of care intensity, particularly lower-levels of care, that are owned by the acquiring party or to refer patients inappropriately to other practices owned by the facility after a vertical merger or acquisition between a hospital or health system and physician group, skilled nursing facility, home care company, or other health service firm.
- Whether the acquiring party previously increased prices or fees post-acquisition (e.g., post-transaction increases in charge-to-cost ratios)
- Whether the acquiring party previously cut nurse staffing levels post-acquisition or whether the acquiring party has employed unsafe nurse-to-patient staffing ratios or engaged in intentional under- or short-staffing models.
- Whether the acquiring party previously has mandated new graduate nurses or immigrant nurses to enter into training repayment agreements or financially coercive employment contracts.

b. Higher charge-to-cost ratios for payers and patients. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

In analyzing hospital and health care system mergers for anti-competitiveness and market concentration, the FTC and DOJ should examine whether the party firm has a history of high charge-to-cost ratios and whether increased market concentration may lead to higher charge-to-cost ratios of the target health care facility. As discussed in Part I, higher average charge-to-cost

ratios are strongly associated with hospitals that are affiliated with health care systems. It should be noted that there is a large amount of variation in CCR levels among systems. The hospital systems that most aggressively push higher charges are mostly operated by for-profit entities. Among the 100 hospitals with highest CCR level in the country, 95 of them are owned by for-profit firms.[66] These corporations operate hundreds of facilities nationwide and have extremely high CCR levels across all their hospitals. NNU found in November 2020 that HCA Healthcare, one of the largest systems in the country, has an average CCR of 1,042.6%, which is over double the national average and triple the average public hospital.[67] Two other for-profit giants, Tenet and Community Health Systems, are not far behind with average CCRs of 990% and 912%, respectively.[68]

Additionally, in hospital and health care markets, firms that are targeted for acquisition often have higher-paying patient populations, meaning that there is a high percentage of patients served by a health care facility who have commercial health insurance coverage relative to patients enrolled in lower-paying public programs or underinsured patients. In other words, health care sector firms separate or tier patient populations by price—different patient populations are different markets depending on that patient's health care coverage. For example, NNU's analysis of CCRs has found significantly higher CCRs in metropolitan areas, where hospital and health care systems have larger market concentration and where there are higher rates of commercial payers. The average metropolitan hospital has a CCR of 4.90 times the cost of care, compared to 2.77 of a non-metropolitan hospital. For instance, 91% of hospitals owned by HCA Healthcare, which is the largest and wealthiest for-profit hospital operator in the world, are in metropolitan areas. In contrast, 34% of hospitals in metropolitan areas are public facilities. In effect, hospital and health systems with market dominance in the commercial insurance market can drive up prices in metropolitan areas, which, as discussed more below undercuts rural and safety-net providers and harms the quality of care to patients covered by noncommercial payers.

c. The impact on competitor health care providers' payer mix and financial risk to independent safety-net hospitals, critical access hospitals, and public health care facilities. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

Another concerning effect of market concentration in the hospital industry and health care sector is the potential negative impact on independent safety-net hospitals, critical access hospitals, and public health care facilities. In their evaluation of health care sector mergers and acquisitions, NNU urges the FTC and DOJ urges to consider how a transaction may permit health systems to use the leverage from large market share to monopolize patients with private

[66] See Attachment 1.

[67] NNU estimates that as of March 2022, HCA Healthcare CCR has increased since November 2020 to 1,053%. *See* Figure 12, Attachment 1.

[68] Charge-to-cost data is calculated using Medicare cost reports for fiscal year 2020, from the Centers for Medicare and Medicaid Services. *See also* Attachment 1.

insurance in a market and negatively impact competitor health care providers' payer mix, causing financial risk to independent safety-net hospitals, critical access hospitals, and public health care facilities.

Market concentration in the health sector can negatively impact the payer mix—the mixture of payers for health care services at a health care facility, including private insurance, public insurance, self-pay, and uncompensated care—of public hospitals, critical access hospitals, and other health care facilities that provide services to medically underserved communities or are in health professional shortage areas. Health care systems with large market share prefer patients with private insurance because these systems can negotiate higher reimbursement rates than those set by public payers.[69]

Health care firms with larger market share have more negotiating leverage with private insurers and can require that private insurance provider networks include all facilities owned and operated by their firm in a health plan network regardless of price and quality, sometimes called "all-or-nothing" agreements.[70] Dominant health systems can sometimes leverage their market power by requiring that insurers, in tandem with an "all-or-nothing" agreement, accept clauses that require insurers to place all system facilities in the most favorable tier ("anti-tiering" clauses) or that prohibits insurers from steering patients to other health systems ("anti-steering" clauses).[71] Market dominant health systems can capture higher-paying patients who have commercial health insurance through these kinds of favorable contract terms with commercial payers. But conversely, these anticompetitive contract clauses between large health systems and commercial payers can result in public facilities and critical access hospitals serving a disproportionately high mix of patients without insurance (uncompensated care) and patients enrolled in public health programs (e.g., Medicaid, Medicare). In short, market-dominant health systems can leverage their market power to divide patients by payer and manipulate their own and competitor payer mixes to the firm's advantage.

Likewise, NNU is concerned—and urges the FTC and DOJ to address in their merger analysis—that higher market and cross-market concentration of private payers into one health system can result in negative changes in the payer mix of public hospitals and critical access hospitals, placing these important health care facilities at risk of financial hardship. In other words, a firm that dominates a market can cherry pick patients who have insurance plans that will pay higher prices for health care services while leaving patients without health insurance or who are enrolled in public health care programs to public or critical access facilities. In turn, loss

[69] Lopez E. Apr 15, 2020. "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature." Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

[70] See Part V, discussing Sutter Health's "all-or-nothing" contracts with private insurers in California markets. See also Gudiksen K et al. 2021 "Mitigating the Price Impacts of Health Care Provider Consolidation." *Issue Brief,* Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf

[71] Gudiksen K et al. *supra* note 70.

of private payers in a critical access hospital or public health care facility's payer mix and attendant financial loss may make these facilities more susceptible to closing or being acquired by the dominant health care operator in the market.

Critical access hospitals, public health care facilities, and other safety-net health care facilities play crucial roles in providing health care services in medically underserved areas and health professional shortage areas. Many of these facilities are often stopgap facilities in medically underserved communities and serve high percentages of patients without health insurance or who are on Medicare, Medicaid, or other public health programs. Loss of revenue from changes in payer mix to these health care facilities can devastate the health and lives of communities across the country, many of which already have difficultly accessing health care. The FTC and DOJ should consider how mergers and acquisitions in the health care sector may exacerbate the financial shortfalls and budget constraints of these critical health care services.

d. Past anti-union behavior, dilution of union density, and wage depression. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

As described above in Part II, labor market concentration can lead to dilution of worker bargaining power over wages and working conditions. In other words, union density matters in the analysis of the effects of monopsonist mergers and acquisitions. Because unions help stem wage depression and give more opportunities to address other employment related issues, the FTC and DOJ should include in their merger guidelines an assessment of a transaction's potential dilution of working bargaining power over terms and conditions of employment as a result of employer monopsony concentration in a labor market.

Specifically, to measure the negative monopsony effects of a transaction, the FTC and DOJ should include in their merger guidelines an assessment of a firm's history of anti-union behavior and of union density post-merger. Where a firm has a history of anti-union behavior or where a transaction will result in dilution of union density among the firm's employees or in the regional labor market, the FTC and DOJ should consider these factors as evidence of a transaction lessening competition and having an anticompetitive impact.

The FTC and DOJ should also assess whether a transaction would result in wage depression both for workers of the firms that are party to the transaction and for other workers in the labor market. The FTC and DOJ, in particular, should consider dilution of union density post-transaction as evidence of a transaction's monopsonist effect and potential to depress wages. In a similar vein, the FTC and DOJ should consider how mergers of union and nonunion firms would weaken the union threat effect within a labor market and result in wage depression for nonunion workers.

e. Reduced competition and increased prices in vertical health care mergers without consistent or significant improvements in quality. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

NNU urges the FTC and DOJ to vigilantly monitor vertical health care mergers given that they have been shown to reduce competition and increase costs. FTC and DOJ analysis should include the formation or expansion of accountable care organizations (ACOs) as a characteristic of mergers and acquisitions that likely signifies anticompetitive vertical integration. Indeed, alternative payment models such as ACOs and bundled payments are motivating factors in consolidation of physician practices[72] as well as across the health care continuum[73] that have been shown to reduce competition and increase costs. Moreover, as discussed above in Part I, vertical integration in health care undermines patient care.

Studies demonstrate that hospital-physician integration increases costs of physician services,[74] laboratory tests and imaging,[75] and outpatient surgeries.[76] Whaley et al found that Medicare fee-for-service reimbursement was significantly higher for laboratory tests and imaging after hospital-physician integration, primarily from physicians shifting testing and imaging from non-hospital facilities to hospital facilities.[77] In contrast, Godwin et al found that even under site-neutral payments by commercial payers, a higher level of hospital ownership of physician practices was correlated with higher fee-for-service reimbursement rates for similar types of physician visits.[78] Consolidation and price increases are not limited to fee-for-service payment models, Kanter et al found a correlation between markets with high participation in a Medicare Shared Savings Program ACO and increased physician practice consolidation,

[72] Whaley CM et al. 2021. "Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration: Study Examines Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration." *Health Affairs* 40.5, 702-709. Citing:
Scheffler RM et al. 2012. "Accountable Care Organizations and Antitrust: Restructuring the Health Care Market." *JAMA* 307(14), 1493–4.
Frech HE III et al. 2015. "Market Power, Transactions Costs, and the Entry of Accountable Care Organizations in Health Care." *Rev Ind Organ* 47, 167–93.
Kleiner SA et al. 2017. "Antitrust and Accountable Care Organizations: Observations for the Physician Market." *Med Care Res Rev.* 74(1), 97–108.

[73] Cutler DM et al. Dec 2020. "Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities." *National Bureau of Economic Research.* No. w28305. doi: 10.3386/w28305.

[74] Godwin J et al. 2021. "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 58. doi: 0046958021991276.
Scheffler RM et al. 2018. "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices." *Health Affairs* 37(9), 1409-1416. doi: 10.1377/hlthaff.2018.0472.

[75] Whaley, *supra* note 72.

[76] Richards MR. 2020. "Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets." *RAND Corporation.* https://www.rand.org/pubs/working_papers/WRA621-1.html.

[77] Whaley CM et al., *supra* note 72.

[78] Godwin J et al., *supra* note 74.

particularly in hospital-owned and specialty physician practices. Additionally, hospital or health system ownership of physician practices limit competition through referrals that keep a patient base within its own facilities reducing the overall patient pool for competitors.[79]

Vertical integration of acute care hospitals and post-acute facilities also reduce competition and increase costs. For example, a study by Cutler et al found that hospital ownership of skilled nursing facilities tended to reduce competition yet failed to benefit patients or payers.[80] In sum, hospital-physician integration leads to higher costs to payers[81] without consistently or significantly improving quality.[82]

f. Degradation of patient privacy through data aggregation and information sharing between the technology and health care sectors. (Responding to Questions 1d, 1g, 1h, 2e, 11f, 12i & 14b)

In analyzing transactions in the health care sector, the FTC and DOJ should monitor parties for their relationships with technology and data aggregation companies. From a patient privacy perspective, health care mergers and acquisitions can lead to sharing of personal health data across subsidiaries of a health care conglomerate or with technology firms that have exclusive or similar partnership deals with the health care firm. In their health care sector merger analysis, the FTC and DOJ should characterize as anticompetitive any increase in the amount of patient data subject to aggregation under a data sharing contract after a merger or acquisition.

For example, HCA Healthcare and Ascension Health, the two biggest health care systems in the country, have deals to share patient health data with Google without informing patients or asking for consent.[83] The HCA deal gives Google information on 32 million annual patient interactions to build algorithms to "improve operating efficiency, monitor patients and guide doctors' decisions."[84] While Google and HCA Healthcare claim the data is anonymous and will be used only to develop algorithms for HCA Healthcare, experts say Google could easily use the

[79] Cutler DM et al., *supra* note 73.
Greaney, Thomas L. "The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?" The Journal of Law, Medicine & Ethics 46.4 (2018): 918-926.
[80] Cutler DM et al., *supra* note 73.
[81] See, for example, the following studies: Godwin J et al., *supra* note 74; Richards MR, *supra* note 76; and Whaley CM et al., *supra* note 72.
[82] Godwin J et al., *supra* note 74; Post B et al. 2018. "Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality." *Medical Care Research and Review* 75(4), 399-433. doi: 10.1177/1077558717727834.
[83] Hodge R. May 26, 2021. "Google Cuts a Deal to Help Develop Health Algorithms Using Patient Data." *CNET*. https://www.cnet.com/health/medical/google-cuts-a-deal-to-collect-patient-data-for-health-algorithm-development/.
[84] Evans M. May 26, 2021. "Google Strikes Deal with Hospital Chain to Develop Healthcare Algorithms." *Wall Street Journal*. https://www.wsj.com/articles/google-strikes-deal-with-hospital-chain-to-develop-healthcare-algorithms-11622030401.

data to identify sub-populations for advertising purposes.[85] Previously, Ascension Health shared millions of patient records, including names and medical information, with Google as part of a deal called "Project Nightingale."[86] *The Wall Street Journal* reported the hospital system was looking to mine data to identify additional tests or other ways in which the system could generate more revenue from patients.[87] The large health systems that have entered into patient data sharing deals with technology firms control substantial portions of the health care market in the U.S. The HCA Healthcare partnership alone gives Google data from 5% of hospital services in the U.S.[88] If the systems involved in these deals achieve market dominance, patients may not have a choice but to share their personal health data with Google.

IV. The FTC and DOJ should consider the risk of post-merger hospital or health care services closures in their merger and acquisition analysis. (Responding to Questions 2a, 2b, 2d, 2e, 7a & 14b)

An important consideration for the FTC and DOJ in analyzing any merger or acquisition involving a hospital or other health care facility is the risk that a firm may close facilities, reduce, or eliminate needed health care services, or otherwise engage in service downgrades following a merger or acquisition. Following a hospital acquisition, it is often the stated objective of the new owner to search for efficiencies and then eliminate redundancies in its operation.[89] After a merger or acquisition, firms frequently reduce or eliminate key health care services, such as maternal care, surgical care, and mental health access, or in some cases end inpatient care all together despite the need for such acute care facilities in that health care services area.[90]

An analysis of hospital merger and acquisition data shows a concerning pattern of hospitals being closed after the deal concludes. Of the 2,782 hospitals that have been involved in

[85] DeCiccio E. May 26, 2021. "Privacy Laws Need Updating After Google Deal with HCA Healthcare, Medical Ethics Professor Says." *CNBC.* https://www.cnbc.com/2021/05/26/privacy-laws-need-updating-after-google-deal-with-hca-healthcare-medical-ethics-professor-says.html.

[86] Evans M. May 26, 2021. "Google Strikes Deal With Hospital Chain to Develop Healthcare Algorithms." *Wall Street Journal*. .

[87] Copeland R. Nov 11, 2019. "Google's 'Project Nightingale' Gathers Personal Health Data on Millions of Americans." *Wall Street Journal*. https://www.wsj.com/articles/google-s-secret-project-nightingale-gathers-personal-health-data-on-millions-of-americans-11573496790.

[88] Westman N. May 26, 2021. "Google to Use Patient Data to Develop Healthcare Algorithms for Hospital Chain." *Verge*. https://www.theverge.com/2021/5/26/22454817/google-hca-patient-data-healthcare-algorithms.

[89] Deloitte Center for Health Solutions, Healthcare Financial Management Association. 2017. "Hospital M&A: When Done Well, M&A Can Achieve Valuable Outcomes." https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf.

[90] Henke RM et al. Oct 2021. "Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers in Rural Areas." *Health Affairs* 40(10) https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00160.

a merger or acquisition since 1994,[91] at least 409 were closed following the deal.[92] Roughly translating this data, one hospital has closed for every seven hospital mergers or acquisitions since 1994. Hospital closures can have profoundly negative impacts on the health and economic status of the communities they occur in and should be a top concern for the FTC and DOJ when reviewing health care sector mergers and acquisitions.

a. Examples from HCA Healthcare demonstrate acquire and close tactics in the health care sector. (Responding to Questions 2a, 2b, 2d, 2e, 7a & 14b)

The FTC and DOJ should examine transactions in the health care sector for the acquiring firm's past practices of acquiring and then closing competitors. It is a routine strategy of some health care firms to increase their market power by purchasing a full-service acute care facility and then closing all or some of the acquired firm's non-emergency services, often converting the acquired full services acute care facility into a free-standing emergency room. Patients are then forced to travel long distances for non-emergency care, frequently provided by another facility owned by the acquiring firm. In other words, a health care firm can eliminate its competition in acute care services by buying a competing hospital and turning it into a freestanding emergency room. For example, since 2014, HCA Healthcare has bought and subsequently closed four hospitals, converting them into free standing emergency rooms. Freestanding emergency rooms often do not provide the same level of care as hospital-based emergency rooms, but regularly charge hospital emergency room prices for their services.[93]

In 2014, HCA Healthcare acquired Grandview Medical Center, a rural hospital in Jasper, Tennessee, to join their Parkridge Health System.[94]After the acquisition, HCA Healthcare shut down all inpatient services at Grandview Medical Center and converted the facility to a freestanding emergency department. Emergency patients who need hospitalization are transferred to Chattanooga, Tennessee, 30 miles away.

In 2017, HCA Healthcare acquired Cypress Fairbanks Medical Center in Houston, Texas as part of a major expansion which led HCA Healthcare to be the top provider of hospital

[91] Hospital transaction data based on NNU's preliminary analysis of Irving Levin Associates LLC Healthcare Deals database (accessed on Mar. 14, 2022), as well as hospital news sources and public disclosures. The Irving Levin Associates LLC Healthcare Deals database is available at https://prohc.levinassociates.com/.

[92] Hospital closure figures were compiled by NNU in March 2022 based on the American Hospital Association Annual Survey Database (https://www.ahadata.com/aha-annual-survey-database), U.S. Department of Health and Human Services hospital closure reports, newspaper reports and various state hospital associations. Please contact NNU for a full list of sources.

[93] Byrne E. June 3, 2019. "Texas has more than 200 freestanding ERs. Lawmakers just passed bills to combat patient confusion and price gouging." *Texas Tribune*. https://www.texastribune.org/2019/06/03/freestanding-emergency-centers-bills-legislature/#:~:text=Texas%20has%20more%20than%20200,fees%20patients%20may%20be%20charged.

[94] Belz K. Mar 27, 2015. "Parkridge West Shuttering Inpatient Services, Cutting Staff." *Chattanooga Times Free Press*. https://www.timesfreepress.com/news/local/story/2015/mar/27/parkridge-west-shuttering-inpatient-services/295557/.

services in the nation's fourth largest city. Just two years later, the health system converted Cypress Fairbanks Medical Center into a freestanding emergency department and laid off an estimated 600 employees.[95]

In 2019, North Carolina residents saw a substantial decline in services after HCA Healthcare acquired Mission Health, a non-profit community system. While the market concentration did not change in this acquisition, HCA Healthcare quickly eliminated Mission Health's rural cancer care services, wheelchair and sitting services, and closed primary clinics, lifelines for many rural NC residents, but maintained its flagship facilities in Asheville, North Carolina.[96] By centralizing these services to Mission Health's main locations in Asheville, North Carolina, some patients are forced to drive dozens of miles away for vital care. The Mayor of Franklin, North Carolina, described the changes being made to local health care delivery as "becoming sort of a triage area to send folks on over to Asheville."[97] In August of this year, patients in Asheville and the surrounding community filed a class action lawsuit against HCA Healthcare, alleging that the health system engaged in anticompetitive tactics, resulting in higher prices and lower quality care for patients.[98] Kelley Tyler, RN, an NNU member who works at Mission Health provided comments at the FTC-DOJ Listening Forum on April 14, 2022, about the impact of HCA Healthcare's acquisition of Mission Health, which are attached here as Attachment 5.

Likewise, in 2020, HCA Healthcare bought Shands Live Oak and Shands Starke hospitals in northern Florida from Community Health Systems. As part of the transaction, all non-emergency and inpatient services at the acquired hospitals were shut down to allow HCA Healthcare to operate the facilities as freestanding emergency rooms, each affiliated with hospitals more than 20 miles away. The mayor of Live Oak, Florida described the move as a "gut punch" to the city for its impact on patients and employees.[99] In November 2021, HCA shut down inpatient services at Plantation Medical Center in Davie, Florida, turning the facility into a freestanding emergency room.[100]

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[95] Deam J. Mar 27, 2019. "Hundreds Laid Off or Reassigned as Cypress Fairbanks Med Center Converts to Freestanding ER." *Houston Chronicle.* https://www.houstonchronicle.com/business/article/Hundreds-laid-off-or-reassigned-as-Cypress-13722031.php.

[96] Wicker M. Aug 12, 2020. "Mission to Move Rural Cancer Services To Asheville, Leave Area to Independent Provider." *Asheville Citizen Times.* https://www.citizen-times.com/story/news/local/2020/08/12/mission-health-move-rural-cancer-services-asheville/3334247001/.

[97] *Id.*

[98] Lacey D. Aug 10, 2021. "HCA/Mission Hit with Anti-Trust Lawsuit, Accused of Exorbitant Prices, Declining Quality." *Asheville Citizen Times.* https://www.citizen-times.com/story/news/2021/08/10/hca-mission-anti-trust-class-action-lawsuit-claims-higher-prices-lower-quality/5544976001/.

[99] Spradley A. Apr 20, 2020. "Suwannee Hospital Closing Amid Pandemic." *WCTV.* https://www.wctv.tv/content/news/Suwannee-hospital-closing-amid-pandemic-569807291.html.

[100] Goodman CK. Oct 27, 2021. "Plantation General Will Close All but the Adult ER. A New Davie Hospital Will Open." *South Florida Sun Sentinel.* https://www.sun-sentinel.com/news/fl-ne-plantation-general-to-close-20211027-fdcfbz7mgjg3tbbqimqacvqame-story.html.

b. Private equity and health care service closures post-merger or acquisition. (Responding to Questions 2a, 2b, 2d, 2e, 7a & 14b)

The FTC and DOJ should also investigate the potential for post-merger closure or reduction of health care services when private equity is involved in a transaction. The phenomenon of post-acquisition hospital closure is by no means limited to private equity. However, as discussed more in Part I, because of private equity firms' clear motivation to acquire and sell assets to secure profits for investors regardless of the impact on health care services, private equity transactions in the health care sector have the high potential for harm to patients and workers if hospital assets are broken apart and liquidated to capture returns on investment.

One widely publicized example of a private equity firm buyout leading to the liquidation and closure of a hospital is Paladin Healthcare's 2018 purchase and subsequent closure of the 171-year-old Hahnemann University Hospital in Philadelphia. Before its closure, Hahnemann was a major safety-net hospital for low-income, racially and ethnically diverse Philadelphia residents, serving over 50,000 patients through emergency visits alone each year, a majority of whom either had public health care coverage or were uninsured and two-thirds of whom were Black or Hispanic.[101] The private equity buyout of Hahnemann ultimately resulted in massive layoffs, followed by bankruptcy and liquidation of hospital assets (which included medical residents and fellows), and finally sales to real estate development firms.[102] The determination by private equity firm owners that liquidation was in the best interest for investor returns did not need to take into account the impact on patients, health care workers, or the health care market overall. For Philadelphia, the sudden closure of a large urban safety-net hospital brought major disruption to both short-term and long-term patient care in the city and will have lasting effects on health care access if other area hospitals do not have the capacity to absorb a closing hospitals patients and staff.[103]

The likelihood of post-acquisition closure of a hospital or health care facility should be included in the FTC and DOJ's merger guidelines in the health care sector, with particular presumptions of negative effects on health care quality and the health care labor market when private equity firms are parties to transaction.

[101] D'Mello K. 2021. "Hahnemann's Closure as a Lesson in Private Equity Healthcare." *J Hosp Med*. 15(5). https://cdn.mdedge.com/files/s3fs-public/issues/articles/jhm01505318.pdf.

[102] *Id.*

[103] See Reese P, Lin E, and Harhay M. Jun 22, 2020. "Preparing For The Next COVID-19 Crisis: A Strategy to Save Safety-Net Hospitals." *Health Affairs*. https://www.healthaffairs.org/do/10.1377/forefront.20200617.787349/full/.

V. The FTC and DOJ should redefine health care markets and expand their antitrust scrutiny to consider the potential harm of cross-market transactions and dominance. (Responding to Questions 2a, 2b, 2d, 2e, 6a, 6h, 7b & 14b)

NNU urges the FTC and DOJ to include cross-market merger analysis in their merger guidance. Traditionally, transactions that involve hospitals in different markets, sometimes referred to as cross-market mergers, have not raised antitrust concerns under the framework of the FTC and DOJ's Horizontal Merger Guidelines. Under the FTC and DOJ's existing horizontal merger framework, the anti-competitive effects of hospital mergers are based substantially on the substitutability of hospitals within defined geographic market. This enforcement approach, however, fails to protect patients and other payers from the anti-competitive impacts and price spikes resulting from cross-market hospital mergers.

Large healthcare systems, especially those which already have a major presence in a state or geographic region, likely have cross-market power. As discussed below, research has shown that, in the health care sector, the impact of horizontal mergers on price and care is not just limited to the geographic market in which the transaction takes place. Horizontal mergers may also have a negative effect on the payer mix of critical access hospitals, public health care facilities, and other facilities that may serve medically underserved communities or health care professional shortage areas. Moreover, vertical conglomeration of health care services can have a negative impact on prices and care across several types of health care services, which traditionally may have been examined by the FTC and DOJ as separate markets. HCA Healthcare, Sutter Health, and other big regional health care systems and providers are able to flex their market power over insurance companies and patients to raise the overall price of care across market boundaries.

When analyzing a health care sector merger or acquisition, the FTC and DOJ should consider the impact the transaction may have across geographical markets and across markets of different kinds of health care services. The FTC and DOJ should also consider how cross-market dominance may negatively impact critical access hospitals, public health care facilities, and other facilities that serve medically underserved communities or health care professional shortage areas, even those facilities that are outside of traditionally used geographically limited hospital referral regions.

a. Research demonstrates that cross-market dominance in the health care sectors leads to higher hospital prices. (Responding to Questions 2a, 2b, 2d, 2e, 6a, 6h, 7b & 14b)

The FTC and DOJ should consider in their merger guideline updates the large body of economic research which has been produced showing how firms with market power in one market can deploy tying, bundling, or other strategies to reduce competition in a second market.

Two recent studies have focused specifically on the impacts of cross-market mergers on hospitals, and both found evidence of substantial price increases resulting from such transactions. First, in a paper published in 2019 by *RAND Journal of Economics*, the authors examined over 300 hospitals involved in cross-market mergers between 1996 and 2012.[104] Their analysis revealed a 7 to 10% price increase at hospitals involved in cross-market transactions, relative to hospitals that were not. Likewise, another study by economists Lewis and Pflum, published in 2017, examined 81 independent hospitals that were acquired by out-of-market systems between 2000 and 2010.[105] The authors found prices at the acquired hospitals increased by as much as 17% relative to the standalone hospitals that were not acquired.

Indeed, when FTC economists Brand and Rosenbaum conducted a literature review in 2019 on cross-market mergers between health care providers, they concluded that "the empirical analyses in this literature provide credible evidence that prices have increased following such mergers" and that "a broadened antitrust enforcement agenda may be warranted" to address cross-market transactions.[106]

b. Example 1: HCA Healthcare's cross-market concentration in Florida and North Carolina. (Responding to Questions 2a, 2b, 2d, 2e, 6a, 6h, 7b & 14b)

HCA Healthcare's cross-market dominance in Florida demonstrates the impact of cross-market domination on health care costs. HCA Healthcare operates around a quarter of Florida hospitals and is the top provider in several key markets.[107] Calculated from Medicare cost reports, the average Florida hospital in a referral region charges 819% the cost of care, which is the highest average state charge-to-cost ratio in the country and twice the national average. However, this distinction is largely due to HCA Healthcare hospitals in Florida charging 1,325% the cost of care. As seen in Table 1, when HCA Healthcare is excluded, the average hospital charge-to-cost ratio in Florida is less than half of HCA Healthcare's but still some of the highest in nation.

[104] Leemore D et al. Summer 2019. "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry." *RAND J of Econ* 50(2). https://www.people.fas.harvard.edu/~robinlee/papers/PriceEffects.pdf.

[105] Lewis MS, Pflum KE. Fall 2017. "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions." *RAND J of Econ* 48(3). https://onlinelibrary.wiley.com/doi/abs/10.1111/1756-2171.12186.

[106] Brand K, Rosenbaum T. 2019. "A Review of The Economic Literature On Cross-Market Health Care Mergers." *Antitrust L J* 2, 533. http://www.tedrosenbaum.org/uploads/1/4/3/6/14360754/brand___rosenbaum_alj_82-2_final.pdf.

[107] HCA Healthcare, Inc. Feb 18, 2022. United States Securities and Exchange Commission Form 10-K. https://d18rn0p25nwr6d.cloudfront.net/CIK-0000860730/9eb42636-f4dd-45c9-9eac-1fcf2b3b397d.pdf.

Table 1: Average Hospital Charges: HCA Is Raising the Cost of Care in Florida (2019)*

	Average	> 2500 HHI	Metro Hospitals > 2500 HHI
HCA	1325%	1374%	1391%
FL Avg.	819%	881%	931%
HCA Excluded	652%	670%	725%
Sources: Medicare Cost Reports (2019)[108]; American Hospital Association (2020)[109]			

It is reasonable to infer that HCA Healthcare's scale and cross-market dominance in the state of Florida has given the health system the ability to raise their hospital charges throughout the state. Further, HCA Healthcare's dominance appears to give other hospitals leverage over insurers and payers. HCA Healthcare's high charges do not incentivize smaller hospital operators to provide lower prices, but, instead, seem to incentivize smaller employers to raise their own price for care.

c. Example 2: Sutter Health's cross-market dominance in California.
(Responding to Questions 2a, 2b, 2d, 2e, 6a, 6h, 7b & 14b)

Another example of the anti-competitive impact of cross-market mergers and dominance in the health care sector are the California civil antitrust case filed by United Food and Commercial Workers & Employers Benefit Trust in 2014 and later joined by the California Attorney General against Sutter Health in 2018, which alleged that the hospital system was using cross-market power to unlawfully drive-up prices.[110] Sutter Health at the time consisted of at least 24 acute care hospitals, 35 outpatient centers, physician's organizations with 5,500 members and 12,000 other partner physicians, medical research facilities, home health, hospice, and occupational health services, and long-term care centers throughout Northern California.[111] In the complaint, the California Attorney General alleged that Sutter Health used its strength in certain local markets to unlawfully drive up prices in all markets it operated in across Northern California and that it did so largely through its contractual practices with commercial payers.

[108] Hospitals' Medicare cost reports are available at: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Last Modified March 7, 2022. "Cost Reports." https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.

[109] American Hospital Association. 2020. "2019 AHA Hospital Statistics Database." *AHA Data & Insights.* https://www.ahadata.com/aha-hospital-statistics.

[110] The 2014 case filed by UFCW & Employers Benefit Trust and the 2018 case filed by the Attorney General were combined into a single case. See *People of the State of California Ex. Rel. Xavier Becerra v. Sutter Health*. Mar 20, 2018. Complaint for Violations of the Cartwright Act. CGC-18-565398. (CA Sup. Ct. SF). https://oag.ca.gov/system/files/attachments/press_releases/Sutter%20Complaint.pdf.

[111] *Id.* at ¶ 5.

Specifically, the California Attorney General alleged that Sutter Health negotiated with insurers on an "all-or-nothing" system-wide basis, violating antitrust law by tying or bundling each of its individual hospitals to all of its other hospitals and providers across its entire network. Through this practice of cross-market negotiation with payers, Sutter Health could leverage its market dominance in certain areas to force commercial payers to agree to uncompetitively high prices in all the other markets it operated in, allowing the health system to charge substantially higher prices than its competitors.

Furthermore, the California Attorney General's complaint alleged that Sutter Health used the excess profits it received from its cross-market pricing practices both to acquire additional health care providers, further entrenching its market power across multiple counties, as well as to finance extreme levels of executive compensation and wasteful innovation.[112] In 2021, Sutter Health came to a settlement with the Attorney General and agreed to the following remedies:[113]

- ***Pay $575 million*** *to compensate employers, unions, and others covered under the class action, and to cover costs and fees associated with the legal efforts.*
- ***Limit what it charges patients for out-of-network services****, helping ensure that patients visiting an out-of-network hospital do not face outsized, surprise medical bills.*
- ***Increase transparency*** *by permitting insurers, employers, and self-funded payers to provide plan members with access to pricing, quality, and cost information which helps patients make better care decisions.*
- ***Halt measures that deny patients access to lower-cost plans****, thus allowing health insurers, employers, and self-funded payers to offer and direct patients to more affordable health plan options for networks or products.*
- ***Stop all-or-nothing contracting deals****, thus allowing insurers, employers, and self-funded payers to include some but not necessarily all of Sutter Health's hospitals, clinics, or other commercial products in their plans' network.*
- ***Cease anticompetitive bundling of services and products*** *which forced insurers, employers, and self-funded payers to purchase for their plan offerings more services or products from Sutter than were needed. Sutter Health must now offer a stand-alone price that must be lower than any bundled package price to give insurers, employers, and self-funded payers more choice.*

[112] *Supra* note 110.

[113] California Department of Justice, Office of the Attorney General. Press Release. Mar 9, 2021. "Attorney General Becerra Secures Preliminary Approval of Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices." https://oag.ca.gov/news/press-releases/attorney-general-becerra-secures-preliminary-approval-settlement-sutter-health.

- ***Cooperate with a court-approved compliance monitor*** *to ensure that Sutter Health is following the terms of the settlement for at least 10 years. The monitor will receive and investigate complaints and may present evidence to the court.*
- ***Clearly set definitions on clinical integration and patient access considerations****. The settlement makes clear that for Sutter Health to claim it has clinically integrated a system, it must meet strict standards beyond regional similarities or the mere sharing of an electronic health record, and must be integrating care in a manner that takes into consideration the quality of care to the patient population. This is important because clinical integration can be used to mask market consolidation efforts by hospital systems, when in fact there is no true integration of a patient's care. For example, saying that hospitals are regionally close or that hospitals are sharing electronic health records is not enough, there must be close coordination that will lead to less costly, higher quality care for local communities.*

d. Example 3: California's Attorney General investigates cross-market effects of Cedars-Sinai Medical Center and Huntington Memorial Hospital merger. (Responding to Questions 2a, 2b, 2d, 2e, 6a, 6h, 7b & 14b)

Yet another example of the negative effects of cross-market mergers on health care prices is the 2020 merger of Cedars-Sinai Health System with Huntington Memorial Hospital in California. In March 2020, Cedars-Sinai Health System and Huntington Memorial Hospital announced their planned merger. Because both firms were operated as non-profits, the merger required the approval of the California Attorney General to move forward. However, because the respective markets for Cedars-Sinai's hospitals and Huntington Memorial Hospital did not overlap and because the affiliating hospitals shared few patients, the transaction did not trigger antitrust scrutiny or challenge from the Federal Trade Commission.

California's Attorney General (AG) at the time, Xavier Becerra, was concerned about potential anticompetitive effects of the cross-market merger. According to the AG Becerra's review of the transaction, the proposed affiliation would pose a serious risk of cross-market effects, specifically that one or more of the affiliating hospitals would substantially increase prices.[114] AG Becerra noted in his review that Cedars-Sinai Medical Center's prices were 32% higher than those charged at Huntington Memorial Hospital, and that one likely outcome of the merger would be for Huntington Memorial Hospital to raise its prices to achieve parity with its new parent facility.

[114] Xavier Becerra, Attorney General, State of California. Dec 10, 2020. "Attorney General's Conditions to Change in Control and Governance of Huntington Memorial Hospital and Approval of Affiliation Agreement by and between the Pasadena Hospital Association, the Collis P. and Howard Huntington Trust and Cedars-Sinai Health System." https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf.

Ultimately AG Becerra approved the deal but attached a series of conditions to limit cross-market effects of the affiliation. The conditions included a price cap of 4.8% per year for 5 years and a prohibition of all-or-nothing contracting for 10 years.[115] These conditions, for as long as they remain in effect, will likely limit the ability of the affiliated hospitals to use their cross-market power to raise healthcare costs for patients and other payers.

VI. When analyzing price discrimination in hospital mergers, the FTC and DOJ should consider payer mix in their definition of a market and consider evidence related hospital's service area and an entity's past post-merger practices.

(Responding to Questions 2b, 2d, 2e, 12e & 14b)

For health care sector mergers and acquisitions, the FTC and DOJ should examine in their analysis of price discrimination how a transaction and market concentration may impact the payer mix of target and other facilities within an area, particularly for independent safety-net hospitals, critical access hospitals, and public health care facilities. NNU has observed two related phenomena with respect to price discrimination in the health care sector: (1) price discrimination can occur between metropolitan and non-metropolitan hospitals, where metropolitan hospitals charge higher prices relative to costs; and (2) price discrimination can occur between hospitals with higher commercial payers in its payer mix and hospitals with larger public payers in its payer mix, with public payers paying lower prices for care.

As discussed in Part III, health care firms with large market share may attempt to monopolize patients with private insurance because commercial payers pay higher prices than uninsured self-pay patients or patients who have public health care coverage. Dominant health care firms can use various strategies to capture patients with commercial insurance—from closing safety-net competitors to forcing insurers to accept favorable contract terms for the health care system. By effectively separating patient population by price, dominant firms can manipulate the market such that patients with higher paying private insurance are steered towards or locked into services at the dominant health system while independent safety-net, critical access, and public hospitals have payer mixes with higher proportions of patients who are enrolled in public health care programs (Medicare and Medicaid) or who are uninsured. By creating tiers in the health care market based on payers and payer mix, dominant firms target acquisition of firms based on whether they service high numbers of patients with commercial insurance and drive up prices once they dominate the market. Such targeted consolidation and capture of commercial insurers under a single health system can in turn negatively impact the payer mixes of competitors, causing financial risk to independent safety-net hospitals, critical access hospitals, and public health care facilities.

[115] Gu AY. Aug 16, 2021. "Cedars-Sinai/Huntington Cross-Market Affiliation Settle with Revised Competitive Impact Conditions." *The Source on Healthcare Price & Competition*. https://sourceonhealthcare.org/cedars-sinai-huntington-cross-market-affiliation-settle-with-revised-competitive-impact-conditions/.

For these reasons and all the reasons described in Part III, the FTC and DOJ should factor in hospital payer mix into their analysis of price discrimination and how firms consider patient populations by their payer, in effect treating different patient populations as different markets.

a. Example: Price increases as a result of the Alta Bates Medical Center and Summit Medical Center merger in California. (Responding to Questions 2b, 2d, 2e, 12e & 14b)

One example of post-merger price increases in the health care sector is the 1999 merger of Sutter Health's Alta Bates Medical Center with Summit Medical Center, both of which were located within a few miles of each other in the San Francisco Bay area. The merger was ultimately allowed to move forward despite being initially challenged by the California Attorney General due to the potential for price increases resulting from the combined system.[116]

The results of this merger are now widely known. As the California Health Care Foundation explained in its analysis of the California Attorney General's authority to review health care mergers:

> Over a decade later, a Federal Trade Commission (FTC) retrospective study found that Summit's post-merger price increase was among the largest of any comparable hospital in California, being between the 95th and 99th percentile of price changes. Summit's prices before the merger were significantly lower than those of Sutter Alta Bates, but increased to align with Alta Bates' within a few years of the merger. Steven Tenn, the author of this FTC study, concluded that the presence of other hospitals, which patients and health plans can turn to, was an "insufficient constraint" to prevent an anticompetitive price increase.[117]

VII. The FTC and DOJ should create a rebuttable presumption that all health care sector mergers and acquisitions, especially hospital system transactions, are anticompetitive. (Responding to Question 5)

The FTC and DOJ should presumptively consider mergers and acquisitions in the health care sector, particularly hospital system transactions, to be anticompetitive due to features of the sector that make it particularly prone to monopolies and growing hyperconcentration in the health industry through vertical and horizontal integration. The burden should be on the parties to a health care sector transaction to show that the transaction is not anticompetitive. This presumption is justified by metrics and observable features of the health care sector, including a

[116] California Department of Justice, Office of the Attorney General. Press Release. Aug 10, 1999. "Attorney General Lockyer Files Antitrust Suit to Block Merger of Summit-Sutter/Alta Bates Medical Centers." https://oag.ca.gov/news/press-releases/attorney-general-lockyer-files-antitrust-suit-block-merger-summit-sutteralta.

[117] Chang SM et al. Apr 2020. "Examining the Authority of California's Attorney General in Health Care Mergers." *California Health Care Foundation*. https://www.chcf.org/wp-content/uploads/2020/04/ExaminingAuthorityCAAttorneyGeneralHealthCareMergers.pdf.

high preexisting level of market concentration, sharply limited demand elasticity due to the necessity of medical care, the limited ability of patients to freely choose between competitors due to the importance of location and the opacity of prices, and a long history of the use of monopoly and monopsony strategies by players in the field.

A presumption that health care sector transactions are anticompetitive is warranted because there is a high preexisting level of market concentration in hospital and other health care markets. As cited in the RFI, the U.S. Supreme Court in *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), held that a 30% market share presents a threat of undue concentration. Many hospitals in the United States already have a market share at or approaching this threshold. In 2016, 90% of Metropolitan Statistical Areas were highly concentrated for hospitals.[118] In 2019, the Health Care Cost Institute found that 74% of US hospital markets were designated as highly concentrated. More than half of all metropolitan areas' hospital markets experienced HHI increases since 2015.[119] In many rural areas, patients have only one or two options for hospital care, especially in an emergency where distance traveled can make the difference between life or death. In addition to concentration within regional markets, there is an increasing level of concentration nationally, where a few firms own many of the hospitals in the country through large national health systems.[120] Oligopolistic health systems have outsized leverage in negotiations with labor and insurance companies, which they use to increase their monopoly and monopsony power in each region.

Additionally, several structural factors in the U.S. health care system facilitate monopoly action in hospital care and health care in general. First, demand for health care is extremely inelastic because health care is a basic human need. Monopoly firms benefit greatly from inelastic demand because patients for many health care services simply cannot forgo medical care if the price is too high or the quality is too low lest they risk serious illness or death.[121] When people do forgo health care due to price, a phenomenon that has grown dramatically in recent years as out-of-pocket health care costs have skyrocketed, it leads to serious negative health consequences.[122] There are also limits to insurance companies' ability to forgo certain

[118] Fulton BD. Sept 2017. "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses." *Health Affairs* 36:9. doi: 10.1377/hlthaff.2017.0556.

[119] Kennedy K et al. Health Care Cost Institute. 2019. "Hospital Concentration Index." https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index.

[120] "2022 AHA Hospital Statistics." American Hospital Association.

[121] Ringel JS et al. 2002. "The Elasticity of Demand for Health Care." *RAND Corporation.* https://www.rand.org/pubs/monograph_reports/MR1355.html. Ellis RP, Martins B, Zhu W. 2017. "Health Care Demand Elasticities by Type of Service." *J Health Econ*. 55, 232-243. doi:10.1016/j.jhealeco.2017.07.007 (finding differences in elasticity by type of service with particularly low demand elasticity for emergency room care and preventative visits).

[122] Kearney A. Dec 14, 2021. "Americans' Challenges with Health Care Costs." *Kaiser Fam Found.* https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

Covermymeds. 2022. "2022 Medication Access Report." https://insights.covermymeds.com/research-and-analysis/industry-reports/2022-medication-access-report.

contracts without leaving the business altogether. Insurance companies are legally required to cover certain services and employers are unlikely to pay for a plan that does not cover the major hospital and physician's groups in the region.[123]

Other factors further enable anticompetitive behavior in the health care sector. The nature of emergency care means that patients often must be admitted to the closest emergency department, regardless of the cost or quality of care at that facility. Many patients have restrictive insurance networks, so even if there are multiple hospitals in a geographic area, the patient may have access to only one of them under an insurance plan.[124] Moreover, not all providers accept patients with public insurance (Medicare or Medicaid), [125] which tend to have lower reimbursement rates than private insurance,[126] and some hospitals have been found to prioritize patients with private insurance over public insurance.[127]

Health care prices are opaque to patients, as many hospitals do not publish their prices despite new transparency laws requiring that they do so.[128] Even if a price list is available, a patient who is ill is unlikely to be able to access the list, determine what set of services they will need in advance of being diagnosed by a licensed health care professional, and do the complicated math to determine what their insurance will and will not cover. A new law requires

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Chen J et al. 2011. "The Health Effects of Cost-Related Treatment Delays." *Amer J of Med Quality* 26:4, 261-71. doi:10.1177/1062860610390352. https://pubmed.ncbi.nlm.nih.gov/21478458/.

Catterson R et al. California Health Care Foundation. Jan 27, 2022. "The 2022 CHCF California Health Policy Survey." https://www.chcf.org/publication/2022-chcf-california-health-policy-survey/. (49% of Californians delayed or skipped health care in previous 12 months due to cost. 47% of those who postponed care reported that their condition worsened as a result.)

[123] *See* Vistnes GS, Sarafidis Y. 2013. "Cross-Market Hospital Mergers: A Holistic Approach." *Antitrust L J* 79:1.

[124] In 2019, 44% of workers on an employer health plan were covered by a Preferred Provider Organization (PPO) plan, 30% by a High-Deductible Health Plan with Savings Option, 19% by a Health Maintenance Organization (HMO), and 7% by a Point of Service Plan (POS). HMOs limit coverage entirely to network providers, except for emergency care, and PPOs and POSs offer greater coverage to services at network providers. High deductible plans may be structured as a PPO or HMO after the patient pays a high deductible. Kaiser Family Foundation. Sept 25, 2019. "2019 Employer Health Benefits Survey." https://www.kff.org/report-section/ehbs-2019-section-5-market-shares-of-health-plans/. In 2019, 69% of Medicaid beneficiaries were enrolled in managed care plans, which have similarly limited networks. Kaiser Family Foundation. 2019. "State Health Facts: Total Medicaid MCO Enrollment." https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/. In 2021, 42% of Medicare beneficiaries were enrolled in a limited-network Medicare Advantage plan. Freed M. Kaiser Family Foundation. June 21, 2021. "Medicare Advantage in 2021: Enrollment Update and Key Trends" https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

[125] Agarwal S. Dec 28, 2017. "Physicians Who Refuse to Accept Medicaid Patients Breach Their Contract with Society." *STAT*. https://www.statnews.com/2017/12/28/medicaid-physicians-social-contract/.

[126] Lopez E., *supra* note 69.

[127] See, e.g., Ross C, Joseph A. Mar 15, 2017. "Mayo Clinic: Privately Insured Patients to Get Priority Over Medicaid, Medicare Patients." *STAT*. https://www.statnews.com/2017/03/15/mayo-insurance-medicare-medcaid/.

[128] Kliff S. Aug 22, 2021. "How to Look Up Prices at Your Hospital, if They Exist." *NY Times*. https://www.nytimes.com/2021/08/22/upshot/health-care-prices-lookup.html.

health care providers to provide estimates to prospective patients[129] but limitations in insurance networks and the availability of specialists in some areas, lack of opportunity to negotiate, and the importance of continuing to receive care from the same provider for patient comfort and good health outcomes mean that the law will not go far to remedy the anti-competitive nature of the health care sector. Insurance companies are better placed to negotiate prices, but they have reduced incentive to negotiate because they are able to pass on ever-escalating costs to patients.[130] The prices that insurance companies pay are generally higher than public payers and vary widely between contracts.[131]

The structural barriers to competitive markets in the health care sector make it even more essential that FTC and DOJ preserve the competition that does exist by preventing a small set of firms from dominating the provision of hospital care for a service area and from creating oligopolistic conglomerates in the health care sector.

Health systems in the U.S. have taken advantage of these factors to engage in widespread anticompetitive behavior through horizontal and non-horizontal action. As detailed in the previous sections, health care entities in the United States have consistently acted to consolidate both horizontally and vertically to form large health care systems with higher charge-to-cost ratios than independent hospitals. Certain companies, notably HCA, engage in consistent patterns of buying and closing hospitals, replacing them with freestanding emergency rooms with limited but expensive service offerings. Cross-market dominance allows health care systems to exert their leverage with insurance companies to sharply increase prices while monopsony power lets them lower wages. The FTC and DOJ should not ignore the history of the industry. The clear, long-standing pattern of anticompetitive behavior following mergers and acquisitions in the health care industry requires that the FTC and DOJ closely scrutinize all health care mergers and acquisitions.

In light of the structural factors that enable anticompetitive behavior in the health care sector and the widespread past practice of the industry, FTC and DOJ should create a rebuttable presumption that all mergers or acquisitions in the health care sector are anticompetitive.

VIII. The FTC and DOJ should consider additional remedies in their merger guidelines to protect patients and workers. (Responding to Question 8a)

With respect to anticompetitive hospital and health care industry transactions, the FTC and DOJ should include in their guidelines additional remedies to protect both patients and health care workers from the harmful effects of such transactions. Considering the fundamental

[129] 42 U.S.C. § 300gg–136.

[130] See Kliff S, Katz J. Aug 22, 2021. "Hospitals and Insurers Didn't Want You to See These Prices. Here's Why." *N.Y. Times*. https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.

[131] Lopez E et al. Kaiser Family Foundation. July 7, 2020. "Comparing Private Payer and Medicare Payment Rates for Select Inpatient Hospital Services." https://www.kff.org/medicare/issue-brief/comparing-private-payer-and-medicare-payment-rates-for-select-inpatient-hospital-services/.

human need for health care services and attendant limitations in demand elasticity in health care markets, the FTC and DOJ can and should play an important role in protecting patient health. The FTC and DOJ can protect patient health by considering remedies—including transparency requirements, limits on post-transaction health care service downgrades or closures, and price controls—that protect affordable and equitable access to care.

First, the FTC and DOJ should include public reporting, notice, and transparency requirements as conditions for any mergers and acquisition in the health care sector. The FTC and DOJ should consider requiring as a condition of health care sector transactions that a hospital or health care facility provide, at a minimum, 180 days public notice of the transaction. Additionally, considering the profound public interest in such health care sector transactions, the FTC and DOJ should require transparent reporting of the terms of any health care sector transaction both pre- and post-transaction.

Second, the FTC and DOJ can pursue conditions on mergers to limit post-transaction hospital or health care service reductions, closures, or other downgrades. As explained above in Part IV, large health care systems have a growing propensity to purchase competitors and then close all or parts of newly acquired health care services post-merger. Large health care systems engage in this purchase and close behavior, in part, to concentrate health care services to flagship facilities with little to no regard to the impact of such closures on the access and affordability of health care services to patients within a service area. One result of health care sector monopolies is that health care corporations maximize revenue from payers by creating hyperconcentration of health care services in certain service areas or payers and health care deserts in for other services areas or payers.

To limit this kind of purchase and close behavior in the health care sector, the FTC and DOJ should require as a condition of a health care sector transaction that hospitals and other health care facilities remain open for a number of years post-transaction. Limiting future closures is important post-transaction in the health care sector to ensure that problems with access to health care services and regional health care shortages are not exacerbated following a health care sector transaction. Similarly, in areas where there are existing problems with equitable access to certain kinds of services rather than certain kinds of health care facilities, the FTC and DOJ could also prohibit closure of certain types of health care services post-transaction. For example, the FTC and DOJ could require that labor, delivery, and obstetrics care remain open post-transaction in rural or underserved areas.

At a minimum, the FTC and DOJ should require advance public notice for any future health care sales, service reductions, closures, or downgrades of a hospital or health care facility of the acquiring party of the health care sector transaction. Consistent with the most protective state law health care closure requirements, the FTC and DOJ should require a health care corporation to provide 180 days public notice prior to the sale of or reduction, closure, or downgrade of health care services for any facility that are owned by a party to or acquired through an FTC- and DOJ-investigated health care sector transaction.

Moreover, when considering anticompetitive health care sector transactions, the FTC and DOJ should consider health care service price freezes for set periods of time post-transaction in the health care sector or other price control conditions. As described above, one of the harmful effects of concentration in the health care sector is the rising prices of health care services. Ensuring fair and reasonable pricing of health care services would protect both patients and payers from health care price inflation. The FTC and DOJ could, for example, require as a condition of a health care sector transaction that prices charged by the party post-transaction not increase beyond a certain level and that the any future price negotiation with payers is public.

To prevent price discrimination post-acquisition and other anti-competitive pricing behavior, the FTC and DOJ should also consider 10-year bars on "all-or-nothing", "anti-tiering", and "anti-steering" clauses in the firm's contracts with insurers. The FTC and DOJ should also consider conditions on a transaction similar to the 2021 settlement provisions reached between the California Attorney General and Sutter Health.[132]

The FTC and DOJ can also look to see other conditions on sales or acquisitions that state Attorneys General and other state regulatory agencies may impose on health care sector closures.[133] For example, in addition to notice and Attorney General approval requirements, some states require public hearings (Maryland) or community forums (New York) on prior to a hospital or service closure. New York also requires judicial approval of the disposal of the assets of a non-profit entity. The FTC and DOJ should consider the remedial tools of public hearings and judicial review on future sales, service reductions, closures, and downgrades as conditions on health care sector related mergers and acquisitions.

IX. Conclusion.

NNU appreciates the opportunity to provide comments to the FTC and DOJ on Request for Information on Merger Enforcement (Docket No. FTC-2022-0003).

Sincerely,

Carmen Comsti
Lead Regulatory Policy Specialist
National Nurses United

[132] *Supra* note 110.

[133] The National Organization of State Offices of Rural Health has compiled a list of state regulatory requirements on hospital and health care service closures. National Organization of State Office of Rural Health. Sept 2016. "Regulatory Requirements for Closure of a Hospital." https://nosorh.org/wp-content/uploads/2016/11/Regulatory_Requirements_for_Closure_of_a_Hosp....pdf.

LIST OF ATTACHMENTS

1. National Nurses United, "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care" (Nov. 2020)

2. National Nurses United, "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis" (Dec. 2021)

3. National Nurses United, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity" (Nov. 2020)

4. National Nurses United, Comment to the FTC in Response to "Solicitation for Public Comment on Contract Terms that May Harm Competition" (Docket No. FTC-2021-0036), Comment ID FTC-2021-0036-0275 (Sept. 2021)

5. Statement by Kelley Tyler, RN, at the FTC-DOJ Listening Forum on Health Care (April 14, 2022)

ATTACHMENT #2

California Nurses Association, Comments to the California Law Revision Commission

Antitrust Law - Study B-750, Mergers and Acquisitions

National Nurses United, "Fact Sheet: Health Care & Federal Antitrust Labor Market Impact Review," June 4, 2024.

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FACT SHEET: Health Care & Federal Antitrust Labor Market Impact Review
June 4, 2024
National Nurses United

I. Introduction

This fact sheet addresses recent developments and evolving legal analysis for antitrust regulators regarding labor markets in the health care sector. Unions and workers have long engaged with antitrust review processes and other legal tools to respond to employer consolidation and anticompetitive practices that harm workers and the labor market. Specifically, this fact sheet discusses recent developments with respect to the Federal Trade Commission's and the U.S. Department of Justice's merger guidelines and other antitrust law to include worker impact analysis, prohibitions on noncompete and *de facto* noncompete agreements, labor market and labor welfare standards, and the role of unions in anticompetition law investigation and enforcement.

II. Monopsony, Worker Harm, and Merger Guideline 10

While labor market impacts of mergers and other single-firm conduct related to monopsony power have historically been ignored by federal regulators, the federal antitrust and consumer protection regulators, including the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ), have in the past few years began to concertedly develop regulation and guidance that would explicitly extend antitrust law enforcement to examine labor market power concentration and curbing its negative impacts on workers. Key to the monopsonist labor market analysis is the analysis of harm to workers as sellers in a labor market. Section 7 of the Clayton Act's framework to examine the effects of a merger of sellers can be used to provide a framework to examine the effects of horizontal combinations of buyers (or monopsony power), which includes the consolidation of employer power as buyers in a labor market.[1]

In July 2021, President Joe Biden issued an Executive Order, Executive Order 14036, asking antitrust agencies to both broaden enforcement efforts and to combat abuses of labor market concentration as well as concentration in healthcare markets, stating:

> [I]t is the policy of my Administration to enforce the antitrust laws to combat excessive concentration of industry, the abuses of market power, and the harmful effects of

[1] See Federal Trade Commission and U.S. Department of Justice, "Merger Guidelines" (Dec. 18, 2023), pp. 26-27, https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

> monopoly and monopsony – especially as the issues arise in labor markets, […] healthcare markets (including insurance, hospital, and prescription drug markets) […][2]

Executive Order 14036 was shortly followed by proposed updates to the FTC and DOJ merger guidelines and to Hart-Scott-Rodino Act merger filings. In January 2022, the FTC and DOJ issued a Request for Information on its Merger Guidelines, asking for public comment, in part, on the questions related to monopsony power analysis and labor markets, including metrics to be considered for markets involving labor.[3] The agencies stated that they "are particularly interested in aspects of competition the guidelines may underemphasize or neglect, such as labor market effects and non-price elements of competition like innovation, quality, potential competition, or any 'trend toward concentration.'"[4] In December 2023, the FTC and DOJ finalized its updated merger guidelines, making it explicit in Merger Guideline 10 that the agencies would look at labor market competition and the potential harm to workers as part of its antitrust enforcement practices.[5]

Additionally, in July 2023, the FTC noticed proposed updates to Hart-Scott-Rodino Act merger filings, which as proposed would require companies to provide information about their employees "to aid the agencies' evaluation of the impact of proposed transactions on competition for workers in labor markets."[6] The proposed rule would require the companies to detail employee job classifications, post-merger geographical information about workers, and worker and worker safety information, including a firm's history of labor law violations during a 5-year period before the filing. Past labor law violations would include penalties or findings filed by the U.S. Department of Labor, the National Labor Relations Board, and the Occupational Health and Safety Administration.

a. Employer Concentration and Worker Harms in Healthcare

An important aspect of federal regulator's explicit enforcement practices related to labor market concentration is that the agencies recognize that lessening competition for workers not only may result in lower wages for workers but also lower job quality for workers. The inclusion of reduced job quality as a factor in merger review is a recognition that employer concentration in a

[2] Executive Order 14036, "Executive Order on Promoting Competition in the American Economy," The White House (July 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/.

[3] Federal Trade Commission; Antitrust Division of the U.S. Department of Justice, "Request for Information on Merger Enforcement," *Regulations.gov*, Docket No. FTC-2022-0003 (Jan. 17, 2022), https://www.regulations.gov/docket/FTC-2022-0003.

[4] *Id*. at 2.

[5] *Supra,* note 2.

[6] Federal Trade Commission, "Notice of Proposed Rule, Premerger Notification; Reporting and Waiting Period Requirements," Federal Register, 88 Fed. Reg. 42,178-218 (Aug. 29, 2023), https://www.ftc.gov/legal-library/browse/federal-register-notices/16-cfr-parts-801-803-premerger-notification-reporting-waiting-period-requirements.

labor market may negatively impact the bargaining power of workers over terms and conditions of employment. In short, the FTC and DOJ's updated merger guidelines establish a framework to analyze how decreased worker bargaining power *vis-à-vis* their employer has a negative impact on wages and other working conditions.

The agencies describe in Merger Guideline 10 that "worsen[ing] benefits or working conditions" or "in other degradations of workplace quality" may result from substantially lessening competition for workers.[7] The agencies further explain in a footnote to Merger Guideline 10 what may constitute labor market harm or reduced job quality:

> A decrease in wages is understood as relative to what would have occurred in the absence of the transaction; in many cases, a transaction will not reduce wage levels, but rather slow wage growth. Wages encompass all aspects of pecuniary compensation, including benefits. Job quality encompasses non-pecuniary aspects that workers value, such as working conditions and terms of employment.[8]

Merger Guideline 10 is consistent with the research literature on labor market concentration. A 2021 study by David Arnold on the effects of mergers and acquisitions on worker wages in the U.S. found that local concentration depresses wages by 4 to 5% relative to a fully competitive benchmark.[9] Arnold found that, after mergers and acquisitions that cause significant increases in local labor market concentration, earnings fall by over 2% for workers at the firms involved in the merger or acquisition. The study found the largest effects in already concentrated markets. Mergers generating large concentration changes also reduced wages at other firms in the labor market.

The effects of monopsony power on wages found by Arnold extend to the health care sector, and monopsony power arising from labor market consolidation in the health care sector can led to industry-driven staffing reductions, expansion of restrictive employment covenants, diluted union density, and, among other negative impacts on workers, unsafe working conditions. Generally, market concentration results in lower staffing levels and reduced hiring. A 2021 study by Marinescu et al. observing labor markets in France found a 10% increase in labor concentration is associated with 3.2% fewer new hires.[10] For hospitals, increased market

[7] *Supra,* note 2, at 26-27.
[8] *Ibid*.
[9] Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," working paper (Oct. 2021). *See also* Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," (2019), doi: 10.2139/ssrn.3476369.
[10] Marinescu I et al, "Wages, Hires, and Labor Market Concentration," *J Econ Behav & Org.* (2021), 184(C), 506-605. *See also* Wasser D, "Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets." *Cent for Econ and Pol'y Res* (Jan. 2022). https://www.cepr.net/report/literature-review-monopsony-employer-consolidation-and-health-care-labor-markets/.

competition is associated with increased registered nurse staffing levels.[11] Employer monopsony power in health care settings has a two-fold impact with respect to nurse and health care worker staffing—monopsony in the labor market can lead to both reduction in employment rates within a labor market and it can enable employers to engage in practice that result in understaffing or unsafe staffing in particular worksites.

The new merger guidelines recognize that the impact of labor market monopsony power go beyond the impact on labor market prices—i.e., wages—in that concentration of employer power through market consolidation can result in employer abuse or exploitation of workers and employer power to violate labor and employment law. With respect to job quality, the health care labor market supply is increasingly elastic—when working conditions are poor, nurses and other workers tend to leave bedside care jobs or their professions altogether; and when employers fail to protect health care workers on the job, these workers experience career ending occupational injuries and illnesses at high rates.[12] Similarly, as the Covid-19 pandemic demonstrated, without optimal infectious disease control measures on the job, nurses and other health care workers can also become infected and die from deadly infectious diseases, including Covid-19.[13] These kinds of non-price factors in the labor market—including staffing and other working conditions—can be impacted by concentration of employer power and could fall under the rubric of job quality in addition to wages.

b. Union Density and Worker Bargaining Power

Diluted union density and loss of worker bargaining power in a highly monopsonist labor market may negatively impact not only wages but other working conditions and job quality for nurses and other healthcare workers. Unionization has material benefit to economic benefits for health care workers such as paid sick leave and vacations, retirement benefits, disability benefits, and health insurance as well as improvements to their working conditions such as job security, safe staffing, and safe patient care practices.

In the health care sector, union density and labor market competition among employers play a significant role in improving wages and working conditions for both union and nonunion registered nurses. Unionization and union density impact the power of workers to bargain for improved wages and working conditions against a monopsonist employer. Employer concentration in a labor market post-merger or acquisition may dilute the union density within a

[11] *See* Shin DY et al. 2020. "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective." *Risk Manag Healthcare Pol'y.* 13, 2103-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7568637/.

[12] *See* National Nurses United, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity," National Nurses United (Dec. 2020), https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[13] *See ibid.*

more concentrated health system, diminishing the bargaining power of health care workers within highly concentrated health system within a labor market. However, mergers of union and nonunion facilities may diminish union density within a labor market and may dilute the bargaining power of health care workers *vis-à-vis* a monopsonist employer and, thus, diminish the net positive effect on wages and working conditions that unions have on nonunion health care workers. In a competitive labor market where union density is high, there is what is called a "union threat effect" where nonunion employers within a market may raise wages to avoid the threat of increased unionization. For example, with respect to nurses, high union density may result in a union threat effect on wages.[14]

Recent research by Prager and Schmitt shows that an increase in health care labor market concentration is associated with lower wages and less bargaining power for workers.[15] In markets with a labor market concentration of 2,500 points or higher on the Herfindahl-Hirschman index (HHI) of hospital full-time employee concentration within a commuting zone, wages are 1 to 4% lower than in perfectly competitive labor markets. Prager and Schmitt also found that large hospital transactions that significantly increase concentration may result in a 6.3% decrease in wages for nurses. Importantly, they also found that a strong labor union presence "meaningfully attenuate[s]" post-merger wage depression but does not eliminate it.

Dilution of union density within a health system post-merger of a union and nonunion facility may impact those workers ability to maintain the wage premium union workers receive compared to their nonunion counterparts. For example, studies of nurse wages controlling for various variables, including type of health facility, geographic region, age, experience, position, and education, concluded that being in a union increases nurse wages, with estimated union wage premiums ranging between almost 8% to over 13%.[16] Importantly, unionization can significantly diminish gender and racial wage gaps for nurses and other workers. The results of one study, applying several control variables, demonstrated that in the nonunion setting Black registered nurses earned almost 8% less in average hourly wage than white RNs but, for unionized Black registered nurses, this racial wage penalty was minimal (0.85%) or, in other words, being in a union reduced the racial wage gap for Black nurses by almost 89%.[17] Additionally, union membership shrinks the wage gap for nonunion professional women, who earn 73 cents for each dollar earned by their male counterparts, while professional women in unions earn 83 cents for each dollar earned by their male counterparts.[18]

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[14] Coombs C et al., "The Bargaining Power of Health Care Unions and Union Wage Premiums for Registered Nurses," *J Lab Res* (Jun 4, 2015), 36(4), 442–61, doi:10.1007/s12122- 015-9214-z.

[15] Prager E, Schmitt M, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* (Feb. 2021)*,* 111: 397-427. https://www.jstor.org/stable/27027692.

[16] Coombs C, *supra*, note 15; McGregory R, "An Analysis of Black–White Wage Differences in Nursing: Wage Gap or Wage Premium?" *Rev Black Pol Econ* (Mar. 2011), 40(1), 31–37, doi:10.1007/s12114-011-9097-z.

[17] McGregory, *supra,* note 15.

[18] Gould E, McNicholas C, "Unions Help Narrow the Gender Wage Gap," *Working Economics Blog.* Economic Policy Institute (2017), https://www.epi.org/blog/unions-helpnarrow-the-gender-wage-gap.

III. Merger Enforcement Actions & Labor Market Harm

While the U.S. Supreme Court has confirmed that antitrust law applies to buyer anticompetitive behavior and harmful effects of monopsony as it does to seller anticompetitive behavior and monopolies[19], theories of monopsony harm have rarely involved an analysis of labor market competition and harm to workers. Enforcement actions related to buyers have revolved around pricing-related anticompetitive behavior among buyers or cartel markets for goods and services. In the labor market context, antitrust challenges, albeit uncommon, typically arise as challenges under Section 1 of the Sherman Act as prohibited contracts "in restraint of trade"[20] or under Section 5 of the Federal Trade Commission Act as unfair or deceptive acts or practices that affect commerce.[21] However, until the Biden Administration's 2021 instruction to antitrust agencies to pursue enforcement against on the basis of labor market harms, the FTC and DOJ have never blocked or challenged a merger on the basis of its monopsonist labor market effects.

Importantly, antitrust law recognizes that worker consolidation of power is different than employer consolidation of labor market buying power. Section 6 of the Clayton Act creates an exception to antitrust law for workers and labor – unions – and activities for the purposes of "mutual help" of members of labor organizations – workers – from "lawfully carrying out the legitimate objects thereof."[22] This section of the Clayton Act further states that "nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws."[23]

a. Penguin Random House/Simon & Schuster Merger

In November 2021, shortly after the Biden Administration issued Executive Order 14036 directing antitrust agencies to take enforcement action related to labor market harm, the DOJ for the first time sued to block a merger, the acquisition of publisher Simon & Schuster by publisher Penguin Random House, on the basis of monopsony harm to a set of workers as sellers of labor as a result of buyer consolidation. The DOJ argued that the merger of Penguin Random House and Simon & Schuster, two of the largest publishers in the United States, would result in "substantial harm to authors of anticipated top-selling books and ultimately, consumers."[24] In its press release on the blocking litigation, the DOJ explained that "this merger will cause harm to

[19] See *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lunder Co.*, 549 U.S. 312, 317-18 (2007) (holding that "general theoretical similarities of monopoly and monopsony combined with the theoretical and practical similarities of predatory pricing and predatory bidding convince us that our two-pronged [Sherman Act test] should apply to predatory-bidding claims").

[20] 15 U.S.C. § 1.

[21] 15 U.S.C. § 45.

[22] 15 U.S.C. § 17.

[23] *Id.*

[24] Complaint, *U.S. v. Bertelsmann SE & CO. KGaA, et al*., No. 21-2886-FYP (D.D.C.) (Nov. 2, 2021), https://www.justice.gov/opa/press-release/file/1445916/dl.

American workers, in this case authors, through consolidation among buyers – a fact pattern referred to as 'monopsony.'"[25] The DOJ alleged that the proposed merger would eliminate buyer competition in the market for authors, resulting in lower advances, worse services, and less favorable contract terms for authors and ultimately fewer and less variety in books published for customers.

In October 2022, the DOJ obtained a permanent injunction blocking Penguin Random House's acquisition of Simon & Schuster.[26] Notably, the publishers argued that the definition of the analyzed market was inappropriately focused on a submarket of targeted sellers – the authors of anticipated top-selling books – and the anticompetitive harm to this submarket. The court's analysis centered on whether the market was appropriately defined and whether the merger would allow publishing companies to pay this submarket of authors less money for the rights to publish their work as well as the vulnerabilities of this submarket of authors to anticompetitive behavior, their unique needs, and preferences. The deal was scrapped by November 2022.

b. Kroger/Albertsons Companies, Inc. Merger

In February 2024, filing an administrative complaint and authorizing suit to block the acquisition of Kroger Company and Albertsons Companies, Inc., the FTC made its first challenge to a merger since the adoption of the updated guidance on the basis, in major part, of a labor market harm theory.[27] With eight states, the FTC also sued in the U.S. District Court in Oregon to block the merger.[28] The lawsuit and complaint allege that the merger would substantially lessen competition not only for grocery markets, negatively impacting consumers and raising grocery prices, but also allege that labor market competition would be eliminated, negative impacting Kroger and Albertsons workers and their ability to collectively bargain for stronger union contracts with improved wages, benefits, and working conditions.[29] Recognizing that Kroger and

[25] U.S. Department of Justice, "Justice Department Sues to Block Penguin Random House's Acquisition of Rival Publisher Simon & Schuster," Press Release, Office of Public Affairs (Nov. 2, 2021), https://www.justice.gov/opa/pr/justice-department-sues-block-penguin-random-house-s-acquisition-rival-publisher-simon.

[26] U.S. Department of Justice, "Justice Department Obtains Permanent Injunction Blocking Penguin Random House's Proposed Acquisition of Simon & Schuster," Press Release, Office of Public Affairs (Oct. 31, 2022), https://www.justice.gov/opa/pr/justice-department-obtains-permanent-injunction-blocking-penguin-random-house-s-proposed; Memorandum Opinion, *U.S. v. Bertselsmann SE & CO. KGaA, et al.*, No. 21-2886-FYP (D.D.C.) (Oct. 31, 2022), https://www.justice.gov/atr/case-document/file/1549941/dl .

[27] Complaint ¶ 7, *The Kroger Company and Albertsons Companies, Inc.* (*Kroger/Albertsons*), FTC No. D-9428 (Feb. 26, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/d9428_2310004krogeralbertsonsp3complaintpublic.pdf; Federal Trade Commission, "FTC Challenges Kroger's Acquisition of Albertsons," Press Release, Office of Public Affairs (Feb. 26, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/02/ftc-challenges-krogers-acquisition-albertsons.

[28] Complaint for Temporary Restraining Order and Injunctive Relief, *FTC et al. v. Kroger et al.,* No. 3:24-cv-00347 (D. Or. Feb. 26, 2024).

[29] See Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 101.

Albertsons are, respectively, the first and second largest traditional supermarket chain and largest employer of unionized grocery workers in the United States, the Kroger/Albertsons case is the first enforcement action by the FTC to analyze the impact of a merger on union workers and their collective bargaining power in relation to a monopsonist employer.[30]

An important aspect to the FTC and state challenges to the Kroger/Albertsons merger is that in many markets across the country both Kroger and Albertsons operate stores that employe union grocery workers, the vast majority of the workers who are represented by United Food and Commercial Workers (UFCW).[31] FTC argues that the relevant labor market to analyze the probable effects of the merger is defined by union grocery labor with the local collective bargaining agreement area as the relevant geographic market.[32]

The consolidation of Kroger and Albertsons would, the FTC argues, allow the new combined employer to gain increased bargaining leverage over workers and their unions to the workers' detriment, resulting in subpar terms of employment, slower wage growth, worse benefits, and potential degradation of working conditions.[33] The FTC's complaints highlights that workers and the union representatives play Kroger and Albertsons against each other, obtaining a favorable deal from one employer and then leveraging that deal against the other respondent to demand similar or better terms, but that this kind of leveraging is only possible because of the risk to the employers from losing either customers or workers to their competitor.[34] The complaints contrast situations where lack of alignment between Kroger and Albertsons during collective bargaining negotiations with union workers resulted in union contracts with more favorable salaries and benefits for workers with situations where the two employers had successfully coordinated.[35]

The FTC and states' complaints additionally analyze the potential negative effect the merger would have on union workers' ability to credibly leverage the threat of a strike or boycott to negotiate better contract terms.[36] The complaints explain how the merger would result in some geographical areas, including Denver, in Kroger/Albertsons being the only employer of union grocery labor. The FTC provides examples in Denver where UFCW Local 7 members who worked at Kroger's King Soopers supermarkets engaged in a strike, encouraging both customers and workers to transfer prescriptions to and shop at Albertsons stores. The Denver strike of King Soopers resulted in Kroger losing sales and profits, with Kroger agreeing to improvements to wages and safety protections in its workers' collective bargaining agreement. UFCW Local 7

[30] Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 76-101.
[31] Complaint, *Kroger/Albertsons,* at ¶¶ 61-62; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 80-81.
[32] Complaint, *Kroger/Albertsons,* at ¶¶ 63-67; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 82-86.
[33] Complaint, *Kroger/Albertsons,* at ¶¶ 69-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 88-101.
[34] Complaint, *Kroger/Albertsons,* at ¶¶ 71-72; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 90-91.
[35] Complaint, *Kroger/Albertsons,* at ¶¶ 78-81; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 97-100.
[36] Complaint, *Kroger/Albertsons,* at ¶¶ 73-77; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 92-96.

later was able to leverage the improved contract terms with Kroger into the same improvements in its contracts with Albertsons.

The FTC's administrative complaint and litigation are still in early stages with a hearing on the motion for preliminary injunction set to be heard before the U.S. District Judge in the District of Oregon on August 26, 2024.

a. Tapestry/Capri Merger

Most recently, the FTC sued to block Tapestry, Inc's acquisition of Capri Holdings Limited, which would combine three competitors in the "accessible luxury" brand market, in part for the deal's negative impact on the workers' wages, benefits, and working conditions.[37] Applying a different analysis of labor market impacts than the Kroger/Albertsons merger, the FTC complaint indicates that the companies employ thousands of non-union retail workers and that the companies follow the others' labor practices closes and that public disclosure of their employment policies prompts the companies to improve workplaces and worker benefits to attract and retain employees.[38] The FTC's blocking suit was filed in the U.S. District Court for the Southern District of New York.[39]

IV. FTC's Noncompete Rule

Federal regulators have also begun to expand their application of antitrust law to labor market conduct outside of the merger context. These challenges largely have involved wage fixing, noncompete provisions, or no-poach agreements among competitor employers as contracts in restraint of trade under Section 1 of the Sherman Act. Health care firm conduct has been subject to some leading cases on Section 1 enforcement against wage fixing and unlawful coordination of pay scales for doctors and nurses.[40]

More recently, federal antitrust agencies have also been looking to reign in the use of other restrictive covenants in employment contracts like provisions of a worker not to compete with a competitor firm, commonly referred to as non-competes. On January 5, 2023, the FTC issued a Notice of Proposed Rulemaking that seeks to ban most non-competes.[41] Issuing its Final Rule just in April 23, 2024, the FTC would eliminate most non-competes entirely, based on the FTC's authority under Section 5 of the Federal Trade Commission Act to restrict unfair methods of

[37] Complaint ¶ 8, *Tapestry, Inc. and Capri Holdings Limited*, FTC No. 9429 (Apr. 22, 2024).
[38] *Id*. at ¶¶ 9, 43-44, 55-57.
[39] *FTC v. Tapestry, Inc. et al*., No. 1:2024-cv-03109 (S.D.N.Y. Apr. 23, 2024).
[40] *See, e.g*., *Kartell v. Blue Shield of Mass*., 749 F.2d 922 (1st Cir. 1984).
[41] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," 88 Fed. Reg. 3,482 (Jan. 5, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

competition.[42] The Final Rule importantly includes independent contractors as well as statutory employees in the definition of "workers" to which the Rule applies. In order to streamline compliance, the FTC eliminated a proposed provision that would have required employers to legally modify existing non-competes and formally rescind them. Instead, the FTC requires employers to provide workers subject to an existing non-compete, with the exception of senior executives, with notice that the non-compete agreement will not be enforced against them in the future.

Notably, the FTC's Final Rule bans not just express non-compete provisions, but also agreements that "function to prevent" workers from seeking or accepting other work or starting a business after their employment."[43] The Proposed Rule had suggested that certain *de facto* non-competes, such as non-disclosure agreements (NDAs), non-solicitation agreements, or training repayment agreement provisions (TRAPs) could be considered a prohibited non-competes.[44] The preamble to the Final Rule, the FTC addresses the request by commenters to categorically ban NDAs, TRAPs, and non-solicitation agreements, instead explaining that the agency adopts a functional test:

> [T]he term "functions to prevent" clarifies that, if an employer adopts a term or condition that is so broad or onerous that it has the same functional effect as a term or condition prohibiting or penalizing a worker from seeking or accepting other work or starting a business after their employment ends, such a term is a non-compete clause under the final rule.[45]

Similar to non-compete provisions in employment contracts, TRAPs and other *de facto* non-competes can limit worker freedom within the labor market. Many employers mandate as a condition of employment or coerce employees to sign agreements that force them to pay the employers money if they quit before a prescribed period of time. Regulators and researchers have begun attempts to quantify the use of these contracts. The Consumer Financial Protection Bureau (CFPB) issued a report on "employer-driven debt" arrangements, including TRAPs and other "stay or pay" contracts, in 2023.[46] The CFPB found that employers began the use of TRAPs in the 1990s, predominantly for higher-skilled, higher wage workers but found TRAPs today being used for health care workers, transportation workers, and the retail industry. Similarly, in 2022, a National Nurses United survey of registered nurses (RNs) across the

[42] In November 2022, the FTC also adopted a statement of enforcement policy on unfair methods of competition under Section 5 of the FTC Act. FTC, "Statement of Chair Lina M. Khan, Section 5 Policy Statement," (Nov. 10, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/Section5PolicyStmtKhanSlaughterBedoyaStmt.pdf

[43] *See supra*, note 41, at 38,362 (describing Section 910.1(a) of the Final Rule).

[44] *Id.* at 38,362-66.

[45] *Id.* at 38,364.

[46] Consumer Financial Protection Bureau, "Consumer risks posed by employer-driven debt," CFPB Office of Consumer Populations, Issue Spotlight (Jul. 20, 2023), https://www.consumerfinance.gov/data-research/research-reports/issue-spotlight-consumer-risks-posed-by-employer-driven-debt/full-report/.

country found that almost 40% of RNs who started their careers within the past decade were subject to a TRAP.[47] In March 2023, a number of legal and business academics published new research finding that up to 1 in 12 workers in the United States are subject to a TRAP.[48]

For example, the preamble to the Final Rule cites examples of TRAPs that can "function" as a non-compete provided by a commenter. The FTC highlights as potential provisions that function as non-competes both a TRAP "that required entry-level workers at an IT staffing agency who were earning minimum wage or nothing at all during their training periods to pay over $20,000 if they failed to complete a certain number of billable hours" and a TRAP "requiring nurses to work for three years or else repay all they have earned, plus paying the company's 'future profits,' attorney's fees, and arbitration costs."[49] The FTC goes on to state that these kinds of TRAPs "may be functional non-competes because when faced with significant out-of-pocket costs for leaving their employment—dependent on the context of the facts and circumstances—workers may be forced to remain in their current jobs, effectively prevented from seeking or accepting other work or starting a business."[50]

While the FTC expressly declined to categorically prohibit all TRAPs, its discussion in the Proposed Rule regarding the need for a categorical ban on non-completes is helpful in understanding the harmful impact of these types of employment contracts on labor market competition:

> The Commission is proposing a categorical ban on non-compete clauses because, fundamentally, non-compete clauses obstruct labor market competition through a similar mechanism for all workers. Non-compete clauses block workers in a labor market from switching to jobs in which they would be better paid and more productive. This harms workers who are subject to non-compete clauses. This also harms other workers in the labor market, since jobs that may be better matches for those workers are filled by workers who are unable to leave their jobs due to non-compete.[51]

While some employer assert that employer financial investment into an employee's training may justify restrictions on labor market mobility, this may serve merely as a pretense to justify the restrictive covenant to work a minimum period of time with the employer. Indeed, some health

[47] Berger R, "Caught in a TRAP," *National Nurse Magazine* (Dec. 2022), https://nnumagazine.uberflip.com/i/1489186-national-nurse-magazine-october-november-december-2022/15.

[48] Prescott J, Schwab S, Starr E, "First Evidence on the Use of Training Repayment Agreements in the US Labor Force," *Promarket* (Mar. 27, 2024), https://www.promarket.org/2024/03/27/first-evidence-on-the-use-of-training-repayment-agreements-in-the-us-labor-force/.

[49] *Id.* at 38,365.

[50] *Ibid.*

[51] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," Federal Register, 88 Fed. Reg. 3,482 (January 19, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

care employers, which have come under scrutiny for their use of TRAPs, assert that they will stop using TRAPs but will still use other "stay or pay" hiring or signing "bonuses."[52]

Finally, as further indication of the FTC's renewed scrutiny on anti-competitive activity in the employment context by a single firm outside of mergers, the FTC recently entered into a memorandum of understanding with the U.S. Department of Labor, agreeing to share information about potential labor and competition law violations, including "non-compete and nondisclosure provisions."[53]

[52] *See, e.g.*, Betancourt M, "Health Care Companies Are Using Debt to Trap Nurses on the Job," *Mother Jones* (Sept. – Oct. 2023), https://www.motherjones.com/politics/2023/08/nurse-debt-trap-training-repayment-agreement/.

[53]" Memorandum of Understanding Between the U.S. Department of Labor and the Federal Trade Commission," at 2 (Aug. 30, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/23-mou-146_oasp_and_ftc_mou_final_signed.pdf.

ATTACHMENT #3

California Nurses Association, Comments to the California Law Revision Commission

Antitrust Law - Study B-750, Mergers and Acquisitions

California Nurses Association, Comments to the Office of Health Care Affordability on "Proposed Emergency Regulatory Action – Promotion of Competitive Health Care Markets; Health Care Affordability (Cost and Market Impact Review)," August 31, 2023.

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August 31, 2023

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RE: Proposed Emergency Regulatory Action – Promotion of Competitive Health Care Markets; Health Care Affordability (Cost and Market Impact Review)

Dear Chair Ghaly, Director Landsberg, Deputy Direct Pegany, and Ms. Brubaker:

The California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses (RNs) in California, appreciates the opportunity to submit written comments to the Office of Health Care Affordability (OHCA) on its Proposed Emergency Regulatory Action on Cost and Market Impact Review (CMIR). CNA strongly supports OHCA's development of CMIR regulations on an emergency basis to implement its authority to review market failures or market power within the health care sector in California.

As bedside RNs, CNA members are alarmed by market trends in the health care sector that weaken nurses' ability to advocate for their patients and that exacerbate problems with health care access and affordability. CNA is acutely concerned with the growth of monopoly and monopsony power of health care entities in our state and across the country. Increasing conglomeration across the health care sector through vertical and horizontal integration of health care services and employer labor market dominance harms both patients and health care workers. For RNs and other health care workers, monopsony power of employers not only depresses wages but also dilutes the power of workers to advocate for better working conditions and safe patient care. In other words, anticompetitive behavior in the health care sector through market consolidation is a threat to the health and safety of patients, nurses, and other health care workers.

To further strengthen the CMIR emergency rule's protections for patients and health care workers, CNA urges OHCA to make a number of additions and clarifications to its proposed CMIR emergency rule as described in our comments below.

1. **As a factor in determining whether to conduct a CMIR under § 97441(a)(2), OHCA should expressly include labor market impacts, such as employer concentration, potential impacts on health care worker wages and benefits, safe staffing levels, and other working conditions, and a health care entity's past labor practices.**

We understand and appreciate that OHCA intends to evaluate negative labor market impacts as part of its CMIR. However, there is no clear indication in the current draft emergency rule that labor market impacts could be a factor in OHCA's determination to initiate a CMIR or as a factor evaluated in the CMIR itself. To clarify OHCA's intent to evaluate labor market impacts in the CMIR process, CNA urges OHCA to expressly list labor market impact in § 97441(a)(2) as a factor for determining whether to conduct a CMIR.

The emergency rule should further detail that labor market review include an analysis of whether labor market concentration or monopsony will have negative impacts on health care workers, including unsafe staffing levels, unsafe occupational safety and health conditions, job loss, exploitative employment terms, or other negative impacts on health care worker wages or benefits. Moreover, a labor market review should include a review of a health care entity's past labor practices such as past post-transaction changes in staffing or reductions in force, past health care worker wage or benefits reductions, and past complaints of or citations for violations of state or federal worker protection laws, including unfair labor practice charges under labor law, state and federal antidiscrimination law, wage and hour law, and whistleblower complaints. Accordingly, CNA proposes the inclusion of new subparagraphs to § 97441(a)(2) and we have included proposed language in Appendix below.

Including express language on analyzing the labor market impact of transactions would be consistent with the Federal Trade Commission (FTC) and the U.S. Department of Justice (U.S. DOJ) update to federal merger guidelines.[1] These federal antimonopoly and antitrust regulators are also evaluating whether a transaction would harm or lessen competition for workers and have drafted merger guidelines that expressly state that the FTC and U.S. DOJ will analyze the impact of a merger on workers and labor market competition.

Health care employer concentration has a substantial negative effect on labor market competition because dominant employers in highly concentrated labor markets have more power to exploit the health care workforce. Employer concentration and monopsony power enables health care employers to lower labor standards, depress wages, maintain unsafe staffing levels, force health care workers into coercive employment contract terms, and otherwise treat nurses and other health care workers poorly.

Importantly, because registered nurses and the health care workforce are the backbone of our health care system, the potential impact of labor market competition on health care worker staffing levels should be a critical component of OHCA's CMIR determinations. Employer concentration in the health care labor market can lead to reduction in employment rates within a

[1] Federal Trade Commission and the U.S. Department of Justice. Jul. 2023. "Draft Merger Guidelines U.S. Department of Justice and the Federal Trade Commission." https://www.ftc.gov/system/files/ftc_gov/pdf/p859910draftmergerguidelines2023.pdf.

labor market. Generally, market concentration results in lower staffing levels and reduced hiring. A 2021 study by Marinescu et al. in France found a 10% increase in labor concentration is associated with 3.2% fewer new hires.[2] For hospitals, increased market competition is associated with increased RN staffing levels.[3]

Market concentration in the health care sector also enables dominant employers to pursue polices of unsafe and understaffing nurses. However, cuts in health care worker staffing, particularly registered nurses, place patients in danger. Decades of research demonstrates that increases in patient assignments for registered nurses endanger patients is linked to poorer health outcomes of patients.[4] Ultimately, because the health care labor market is elastic (unlike the demand for health care), nurses are driven away from bedside nursing and sometimes the profession altogether when employers devalue their lives through intentional policies of understaffing, failing occupational health and safety precautions, and other unfair wages and poor working conditions.[5]

In short, it is important for OHCA to evaluate the potential impact of labor market competition on health care worker staffing levels and working conditions for health care workers because hyper-concentrated employers have sufficient market power to exploit our health care workforce, which ultimately harms patient care.

2. Like the FTC and U.S. DOJ's proposed updated merger guidelines, OHCA's emergency rules should clearly allow for CMIR review under § 97441(a)(2) solely based on labor market impact.

CNA further urges OHCA to clearly indicate that labor market impact can provide a stand-alone basis for OHCA to initiate a CMIR. Adding labor market impact as a factor listed under § 97441(a)(2) would address this issue. As this change would be consistent with the FTC and U.S. DOJ's draft update to their merger guidelines, OHCA should clarify that labor market impact can provide the sole basis for CMIR. The FTC and U.S. DOJ's draft merger guideline states:

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[2] Marinescu et al. 2021. "Wages, Hires, and Labor Market Concentration," *J Econ Behav & Org.* 184(C), 506-605. *See also* Wasser D. Jan 2022. "Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets." *Cent for Econ and Pol'y Res.* https://www.cepr.net/report/literature-review-monopsony-employer-consolidation-and-health-care-labor-markets/.

[3] *See* Shin et al. 2020. "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective." *Risk Manag Healthcare Pol'y.* 13, 2103-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7568637/.

[4] Decades of studies have shown that low nurse staffing levels in acute care settings—where there are few nurses to take care of high patient workloads—is associated with increased medical complications and missed patient care. Summaries of leading literature on staffing ratios and patient safety can be found in several National Nurses United publications. *See* National Nurses United. 2018. "RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals." https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/NNU_Ratios_White_Paper.pdf.

[5] *See* National Nurses United. Dec 2021. "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_StaffingCrisis_ProtectingOurFrontLine_Report_FINAL.pdf.

> The Agencies will consider whether workers face a risk that the merger may substantially lessen competition for their labor. Where a merger between employers may substantially lessen competition for workers, that reduction in labor market competition may lower wages or slow wage growth, worsen benefits or working conditions, or result in other degradations of workplace quality. When assessing the degree to which the merging firms compete for labor, any one or more of these effects may demonstrate that substantial competition exists between the merging firms.[6]

As described below, CNA also urges that OHCA clarify that labor market impact, and all other factors listed in § 97441(a)(2), can provide the basis for OHCA's decision to conduct a CMIR regardless of whether the factor is tied to a material change transaction.

3. As a factor in determining whether to conduct a CMIR under § 97441(a)(2), OHCA should expressly include the risks of health care service reductions, closures, or shifts, and a health care entity's past practices of service reductions, closures, or shifts.

CNA appreciates and supports OHCA's inclusion of "the availability or accessibility of health care services" in § 97441(a)(2)(A) as a factor in determining whether to conduct a CMIR. We further urge OHCA to clarify that § 97441(a)(2)(A) includes the risks of health care service reductions, closures, or shifts in the location, availability or acuity level of service, particularly higher acuity services. CNA proposes the inclusion of a new subparagraph to § 97441(a)(2) and we have included proposed language in Appendix.

An important consideration for OHCA in its CMIR is analyzing the risk that a health care entity may close facilities, reduce, or eliminate needed health care services, or otherwise engage in shifts or downgrades in the location, availability, or acuity level of services. Following a hospital acquisition, it is often the stated objective of the new owner to search for efficiencies and then eliminate redundancies in its operation.[7] After a merger or acquisition, health care firms frequently reduce or eliminate key health care services, such as maternal care, surgical care, and mental health access, or in some cases end inpatient care all together despite the need for such acute care facilities in that health care services area.[8]

An analysis of national hospital merger and acquisition data shows a concerning pattern of hospitals being closed after the deal concludes. Of the 2,782 hospitals that have been involved in a merger or acquisition from 1994 through May 2022,[9] at least 409 were closed following the

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[6] *See supra* note 1, at 26 (citations omitted).

[7] Deloitte Center for Health Solutions, Healthcare Financial Management Association. 2017. "Hospital M&A: When Done Well, M&A Can Achieve Valuable Outcomes." https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf.

[8] Henke et al. Oct 2021. "Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers in Rural Areas." *Health Affairs* 40(10). https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00160.

[9] Hospital transaction data based on CNA's analysis of Irving Levin Associates LLC Healthcare Deals database (accessed on Mar. 14, 2022), as well as hospital news sources and public disclosures. The Irving Levin Associates LLC Healthcare Deals database is available at https://prohc.levinassociates.com/.

deal.[10] Roughly translating this data, one hospital has closed for every seven hospital mergers or acquisitions since 1994.

Hospital and health services closures, reductions, and shifts can have profoundly negative impacts on the health and economic status of the communities they occur in and should be a top concern for OHCA in the CMIR process. There are several post-merger trends in the health care sector that have harmed patients and workers which OHCA should analyze in its CMIR determinations. These trends include:

- Cuts in health care services or closed facilities post-acquisition (e.g., conversion of full-service acute care hospitals into freestanding emergency departments).
- Cuts in hospital capacity (e.g., decreased the number of hospital beds or closed hospital services) after a vertical merger or acquisition with a physician group, home care company, telehealth company, or other non-acute care health care service firm.
- Policies encouraging practitioners to shift patient care to newly acquired health care facilities with an inappropriate level or intensity of care, particularly lower levels of care (e.g., shifts in acute care from a hospital to outpatient settings after a vertical merger or acquisition between a hospital and physician group, skilled nursing facility, home care company, or other health service firm).
- Increased use of "just-in-time" lean staffing models and short-staffing models, which can result in decreased availability and capacity of facilities to provide care.
- High charge-to-cost ratios in highly concentrated health care markets[11] and post-acquisition price or fee increases, which can lead to decreased access to care as health care prices become unaffordable for patients and payers.

4. The market failure or market power factors for conducting a CMIR under § 97441(a)(2) should be clarified to ensure that OHCA can conduct a CMIR without being tied to a transaction.

Our understanding is that OHCA's authority to conduct a CMIR based on "market failure or market power" need not be linked to a noticed material change transaction. Accordingly, OHCA should clarify that the factors, listed in § 97441(a)(2), that OHCA will use to determine whether to conduct a CMIR do not have to be linked to a material change transaction.

[10] Hospital closure figures were compiled by CNA in March 2022 based on the American Hospital Association Annual Survey Database (https://www.ahadata.com/aha-annual-survey-database), U.S. Department of Health and Human Services hospital closure reports, newspaper reports and various state hospital associations. Please contact CNA for a full list of sources.

[11] Higher average charge-to-cost ratios are strongly associated with hospitals that are affiliated with health care systems, but it should be noted that there is a large amount of variation in chare-to-cost levels among systems. *See* National Nurses United. Nov. 2020. "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care." https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1120_CostChargeRatios_Report_FINAL_PP.pdf.

The current draft language in § 97441(a)(2) confusingly prefaces each factor with the phrase "[i]f the transaction[.]", which could be misconstrued to limit OHCA's market failure-based or market power-based CMIR to impacts that are a directly linked to a merger, acquisition, or other market transaction. Moreover, by including the reference to "transactions" in § 97441(a)(2), OHCA may inadvertently be creating an additional burden of proving a causal and temporal link between a transaction and the factor listed. Market failures and the impact of market power may not be felt by patients, workers, or health care entities until years after the closing of a transaction.

For these reasons, we encourage OHCA to add language throughout § 97441(a)(2) to clarify that the factors apply to all market failures or market power impacts or remove the reference to "transactions". To this end, CNA suggests adding the phrase "the market failure, or market power" after each reference to "the transaction" in subparagraphs (A) to (E) of § 97441(a)(2). CNA's proposed amendments to 97441(a)(2) are available in their entirety in Appendix.

5. **As a factor considered in a CMIR under § 97441(e), OHCA should expressly include the negative effect on labor markets, including employer concentration, potential impacts on health care worker wages and benefits, safe staffing levels, and other working conditions, and a health care entity's past labor practices.**

For the same reasons described above in Comment #1, CNA urges OHCA to expressly list negative labor market impacts as a factor under § 97441(e) that OHCA evaluates in a CMIR. To reiterate, we appreciate that OHCA intends on analyzing the labor market impacts of health care transactions. This intention to review labor market impacts should be clear in the draft emergency CMIR rule. To clarify OHCA's intent to evaluate labor market review, CNA urges OHCA to expressly include labor market impacts in its list of factors examined when conducting a CMIR. Accordingly, CNA proposes the inclusion of new subparagraphs in § 97441(e), and we have included proposed language in Appendix.

6. **OHCA should clarify that the "availability and access" factor considered in a CMIR under § 97441(e)(1) includes the risk of health care service reductions, closures, or shifts, and a health care entity's past practices of service reductions, closures, or shifts.**

For the same reasons described above in Comment #3, CNA urges OHCA to expressly list the risk of service reductions, closures, or shifts as factors under § 97441(e)(1) that OHCA evaluates in a CMIR. To reiterate, we appreciate that OHCA intends on analyzing the effect on the availability or accessibility of health care services to the community affected by the transaction. It remains important to clarify in the emergency rule that the "availability and access" factor includes a review of potential service closures, reductions, or shifts in the location, availability, or acuity level of services. CNA proposes the inclusion of additional language in § 97441(e)(1) and a new subparagraph in this section and have included proposed language in the Appendix.

7. As a factor considered in a CMIR under § 97441(e), OHCA should expressly include the effect on premiums, deductibles, provider network, prior authorization, out-of-pocket costs to patients, step therapy, surprise billing, medical debt collection, and other financial and administrative barriers to care for patients.

While recognizing that OHCA intends that a CMIR will analyze the "availability and accessibility" of health care services under § 97441(e)(1), CNA urges OHCA to also clarify that a CMIR will evaluate the effect on premiums, deductibles, provider network, prior authorization, out-of-pocket costs to patients, step therapy, surprise billing, medical debt collection, and other financial and administrative barriers to care for patients. CNA proposes the inclusion of additional language in § 97441(e), and we have included proposed language in Appendix.

California's patients have long identified financial and administrative barriers to care in our fragmented system of health insurance—such as copayments, deductibles, premiums, lack of coverage, and limited choice of doctor—as leading problems in our health care system. These community concerns were reflected in the 2021 survey of low-income Californian's experiences with our health care system that was prepared for the Healthy California for All Commission.[12] Low-income Californians reported that "costs of services/expensive (co-pay, deductible, premiums, etc.)" as the leading reason why they are "dissatisfied" with their current health insurance (27%). Other leading reasons for dissatisfaction with their current health insurance was that all services/treatments were not covered (26%) and limited choice of doctor (16%).

As health care providers and other health care entities more frequently enter into risk-sharing and risk-bearing arrangements, it remains important for the CMIR to specifically evaluate how health care transactions and market power can result in harm to patients through insurance barriers to care. Insurance barriers to care can be both financial barriers to care (e.g., premiums, deductibles, copayments, coinsurance, etc.) or administrative barriers to care (e.g., narrow networks, prior authorization, step therapy, etc.). Additionally, although surprise billing and medical debt collection often occurs after a health care service is provided, these and other related billing and collection behaviors can result in patients forgoing ongoing or future care to avoid additional financial penalties.

In short, OHCA should clearly include in the factors analyzed in CMIRs the effect of financial and administrative barriers to care on patients.

8. It is important that OHCA monitors out-of-state transactions by health care entities in California under § 97411(a)(2)(F) and serial or patterns of transactions under § 97441(e)(5).

CNA strongly agrees with and supports OHCA's inclusion of out-of-state transactions in and serial or patterns of transactions in its CMIR notice and review process. In recent years, there

[12] See "Community Voices: Priorities and Preference of Californians with Low Incomes for Health Care Reform." Prepared for the Healthy California for All Commission. Oct. 2021. https://www.chhs.ca.gov/wp-content/uploads/2021/10/Final-Report-Community-Voices-Priorities-and-Preferences-of-Californians-with-Low-Incomes-for-Health-Care-Reform-October-2021.pdf.

has been increasing vertical, horizontal, and cross-market conglomeration within the health care sector. These kinds of unprecedented consolidation of market power among health care corporations across state lines have the potential to harm patients, payers, and health care workers. A number of academic studies have found price increases following "cross-market" mergers in the 7-17% range.[13] The potential for harm is particularly true as firms outside of the health care sector, including technology firms based in California, are increasingly seeking to acquire health care entities.

As mentioned by commentors at the CMIR regulatory workshop on August 15, 2023, there is a pressing need for OHCA to review out-of-state transactions by California health care entities. This need is underscored by the announced acquisition of Geisinger Health System, a Pennsylvania-based health care system, by Risant Health, an organization created by Kaiser Foundation Hospitals, a California-based hospital system. OHCA's review of out-of-state transactions is additionally important because Kaiser Foundation Hospitals also announced that the Geisinger acquisition is the first of many acquisitions of large health systems across the country and that it created Risant Health for the purposes of placing future health system acquisitions into Risant Health.[14] The proposed Kaiser-Geisinger transaction exemplifies the growing vertical and cross-market conglomeration in the health care sector. Geisinger Health System includes hospitals and other health care facilities, health insurance plans, a multi-specialty medical group, and a school of medicine. OHCA must be vigilant in reviewing the growing national reach of California health care entities to ensure that California's patients and workers are not negatively impacted through price increases, service cuts, job loss, or other changes in health care delivery that result from cross-market market consolidation.

In cross-state transactions that involve California entities, it is important for OHCA to review the financial condition of the out-of-state entity because potential market failures or financial shortfalls of the out of state entity may indirectly result in price increases, service cuts, staffing cuts, or shifts to dangerous health care outsourcing or workforce gigification models in California. In the case of the Risant Health, it remains unclear whether Kaiser's California members or California taxpayers will subsidize the Geisinger acquisition, which includes $2 to $5 billion of promised investments by Kaiser Foundation Hospitals into Risant Health and Geisinger Health, or future acquisitions.[15] This should be a major concern for OHCA in transactions like the Kaiser-Geisinger merger where significant financial investments in the out-

[13] *See, e.g.,* Leemore D et al. 2019. "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry." *RAND J of Econ* 50(2). https://www.people.fas.harvard.edu/~robinlee/papers/PriceEffects.pdf (finding a 7 to 10% price increase at hospitals involved in cross-market transactions, relative to hospitals that were not between 1996 and 2012).

Lewis MS, Pflum KE. 2017. "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions." *RAND J of Econ* 48(3). https://onlinelibrary.wiley.com/doi/abs/10.1111/1756-2171.12186 (finding that prices at the independent hospitals that were acquired by out-of-market systems between 2000 and 2010 increased by as much as 17% relative to the standalone hospitals that were not acquired).

[14] See Caroline Hudson. Aug 29, 2023. "Risant Health could reshape healthcare: Geisinger CEO." *Modern Health Care.* https://www.modernhealthcare.com/mergers-acquisitions/risant-health-value-based-care-geisinger-jaewon-ryu.

[15] See Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals and Subsidiaries. Combined Financial Statements and Additional Information (For the six months ended June 30, 2023 and 2022) (Unaudited).

of-state entity has been assured by an entity that provides a large share of health care services in California. In that same vein, as large California health care entities like Kaiser Foundation Hospitals seek out-of-state transactions, it is important that OHCA review what state and local California tax breaks the entity is receiving and whether California taxpayers are or should be receiving any benefits.

CNA also agrees that it is equally important that OHCA monitor smaller serial or patterns of transactions that may not be subject to OHCA material change notice. Health care entities should not be able to avoid OHCA material change notice and CMIR by breaking up transactions into smaller agreements that do not trigger notice or review.

It is important for OHCA to monitor whether larger health care entities have engaged in patterns of acquisition of smaller or community clinics within a health care market. In some areas of the country, health care firms have engaged in a pattern of acquiring small competitors and then closing those facilities or parts of those facilities.[16] For example, it is unfortunately a routine strategy of some health care firms to increase their market power by purchasing a full-service acute care facility and then closing all or some of the acquired firm's non-emergency services, often converting the acquired full services acute care facility into a free-standing emergency room.[17] Patients are then forced to travel long distances for non-emergency care, frequently provided by another facility owned by the acquiring firm. In other words, a health care firm can eliminate its competition in acute care services by buying a competing hospital and turning it into a freestanding emergency room. Freestanding emergency rooms often do not provide the same level of care as hospital-based emergency rooms, but regularly charge hospital emergency room prices for their services.[18]

9. OHCA should further specify the information that health care entities must report as part of a CMIR, including additional information on labor market impact and the health care entity's history of and anticipated post-transaction changes in staffing, prices, and location and availability of services.

To evaluate labor market effects and the effects on staffing, prices, and location and availability of services, OHCA should clarify its emergency rule to include additional requirements on reporting by health care entities as part of CMIR. Specifically, CNA urges OHCA to maintain or add the following reporting requirements in §§ 97439(b)(10), (11), or (12) of the CMIR material change notice. CNA proposes additions to §§ 97439(b)(10), (11), or (12), which are included in Appendix below.

[16] For examples of this acquire and close behavior, please see National Nurses United's comments to the Federal Trade Commission's 2022 Request for Information on Merger Enforcement. See National Nurses United. Apr. 27, 2022. "Comment Submitted by National Nurses United." *Regulations.gov*, Docket ID FTC-2022-0003, Comment ID FTC-2022-0003-1831. https://www.regulations.gov/comment/FTC-2022-0003-1831.

[17] *Ibid.*

[18] *See, e.g.*, Byrne E. June 3, 2019. "Texas has more than 200 freestanding ERs. Lawmakers just passed bills to combat patient confusion and price gouging." *Texas Tribune*. https://www.texastribune.org/2019/06/03/freestanding-emergency-centers-bills-legislature/

- **Labor market impact reporting:** The health care entity should be required to report and provide a summary of its historical and expected post-transaction impact on the labor market, including employer concentration, unsafe staffing levels, unsafe occupational safety and health conditions, job loss, exploitative employment contract terms, or other negative impacts on health care worker wages or benefits.
- **Reporting on service reductions, closures, or shifts:** The health care entity should be required to report and provide a summary of its historical and expected post-transaction service reductions, closures, or other shifts in the location, availability, or acuity level of health care services.
- **Financial and administrative barriers to care reporting:** should be required to report and provide a summary of its historical and expected post-transaction impact on premiums, deductibles, provider network, prior authorization, out-of-pocket costs to patients, surprise billing, and other financial and administrative barriers to care for patients.

10. In § 97441(f)(2), OHCA should add provisions on public posting of CMIR reports and allow for OHCA to hold public hearings and receive verbal public comment on CMIRs.

To ensure effective public participation in the CMIR process, OHCA should include a provision in § 97441(f)(2) of the emergency rule that clearly states that OHCA shall publicly post on its website completed factual findings and preliminary reports upon completion of a CMIR. Additionally, while we appreciate that OHCA's emergency rule allows the public to submit written comments in response to the findings in the preliminary CMIR report, OHCA should also add language to § 97441(f)(2) that clearly requires OHCA to take additional measures to ensure public participation in the CMIR process. Specifically, OHCA should include language that permits OHCA to hold public hearings or workshops to take verbal public comment on the factual findings and preliminary reports of a CMIR and public comment on the CMIR.

11. OHCA should lower the patient revenue and asset thresholds for material change notice in § 97435(b)(1) & (2).

CNA supports lowering the patient revenue and asset threshold for material change notice in § 97435(b)(1) & (2). Reviewing HCAI's 2021-2022 annual financial data for hospitals, a significant number of hospitals would not meet the $25 million or $10 million revenue or asset thresholds.[19] There were 68 hospitals that had less than $25 million in net patient revenue and 40 with less than $10 million in net patient revenue. There were 51 hospitals with less than $25 million in total assets and 51 hospitals with less than $10 million in total assets. OHCA's draft patient revenue and asset thresholds also may inadvertently leave out from material change notice requirements some hospitals and health care entities that are a part of larger health care

[19] CNA analyzed data from Department of Health Care Access and Information. "Hospital Annual Financial Data – Selected Data & Pivot Tables, 2021-2022 FY Hospital Annual Selected File." California Health and Human Services Agency. https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.

systems. Because some larger health care systems may use holding companies for assets, a single hospital or facility may not have reportable assets over $10 million or $25 million. For example, while it is not clear from reviewing HCAI annual financial data why precisely this is the case, there were over 30 hospitals that are Kaiser Foundation Hospitals that reported zero net assets for fiscal year 2021-2022.

Additionally, the dual $25 million and $10 million asset and revenue thresholds could be simplified to use only the lower $10 million asset and revenue threshold.

12. In § 97435, OHCA should use total annual revenue rather than net patient revenue and should clarify the definition of California asset.

To ensure that a number of large hospitals and health care facilities are not inadvertently left out of material change notice requirements, OHCA should use total annual revenue thresholds, including non-operating revenue, for CMIR material change notice rather than net patient revenue.

Additionally, it is unclear how OHCA defines ownership or control of California assets. As discussed in Comment #11, some hospitals and health care entities are a part of larger health care systems that use holding companies for assets. This leads to individual hospitals or health care facilities reporting zero net assets to HCAI in their annual financial data. Reviewing HCAI's 2021-2022 annual financial data for hospitals, over 30 hospitals that are Kaiser Foundation Hospitals and 14 other hospitals reported zero net assets for fiscal year 2021-2022. OHCA should clarify that a health care facility's control of California assets for the purposes of the CMIR rule would include assets owned by a holding company but operated by the health care entity.

13. CNA supports the inclusion of the § 97435(b)(3) material notice requirements for health care entities located in or serving health professional shortage areas.

To appropriately monitor for negative impacts of market consolidation and market power on rural and underserved communities, CNA strongly supports the CMIR emergency rule's inclusion of a notice filing requirement if a transaction involves a health care entity that serves a health professional shortage area.

It is precisely because of the interest of large investors, particularly for-profit health care systems, large health systems, and private equity firms, in small and rural health care facilities that OHCA should include, not exclude transactions involving health professional shortage from material change notice requirements. Large investors may be interested in acquiring health care facilities that serve rural or underserved areas because they may be able obtain a market advantage over competitor prices and payer mixes or because they may be able to close a competitor altogether.

First, CNA is greatly concerned about the trend of private equity and large health care systems buying small competitor hospitals and clinics in rural and underserved areas and

subsequently closing or reducing important services at hospitals and clinics. The acquire and close tactic by large health care systems appears to be growing throughout the country.[20] Health care entities should notify OHCA of transactions involving these critical health care providers so that OHCA can review the risk of post-transaction health care service closures or reductions.

Additionally, CNA is concerned about market-dominant health systems leveraging their market power to manipulate their own and competitor payer mixes to the dominant health system's advantage. In the CMIR process, OHCA should be monitoring whether a transaction may result in a health system gaining leverage through increased market dominance to demand favorable contract terms with commercial payers.[21] Exacerbating existing issues of access and affordability of care in health professional shortage areas, firms that dominate a market can cherry pick patients who have insurance plans that will pay higher prices for health care services while leaving patients without health insurance or who are enrolled in public health care programs to public or critical access facilities. In turn, loss of private payers in a critical access hospital or public health care facility's payer mix and attendant financial loss may make these facilities more susceptible to closing or being acquired by the dominant health care operator in the market. Because health care facilities serving rural and underserved areas are particularly vulnerable to changes in payer mix as a result of market consolidation, OHCA must ensure that it is notified when large health systems enter in a transaction with entities that provide services in health professional shortage areas.

14. CNA supports the inclusion of management service organizations and independent physician associations as health care entities in § 97431(g).

Finally, CNA supports the inclusion of management service organizations (MSOs) and independent physician associations (IPAs) as health care entities subject to the material change notice and CMIR requirements. The increasing use of risk-bearing arrangements by providers and vertical integration of providers through managed care arrangements makes the market behavior of MSOs and IPAs, which manage the administrative functions and structures of risk-bearing entities, increasingly important. As risk-bearing entities consolidate in the market, the opportunity to increase financial and insurance barriers and to leverage favorable insurance market arrangements between providers and the risk-bearing entities serviced by MSOs and IPAs also grows. In other words, even though their decision-making is based on financial risk and not based on the clinical judgement, MSOs, and IPAs function as gatekeepers to care and should be regulated as health care entities subject to material change notice requirements and CMIR under the emergency CMIR rule.

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[20] *See supra* note 16.

[21] Some examples of contracts between large health systems and commercial insurers that can alter payer mixes of health care facilities serving rural and underserved communities include agreements where private insurance provider networks include all facilities owned and operated by a health system ("all-or-nothing" agreements), clauses that require insurers to place all system facilities in the most favorable tier ("anti-tiering" clauses), and contracts that prohibits an insurer from steering patients to other health systems ("anti-steering" clauses). See also Gudiksen K et al. 2021 "Mitigating the Price Impacts of Health Care Provider Consolidation." *Issue Brief*, Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf.

CNA again appreciates the opportunity to provide OHCA with comments on the draft CMIR emergency rules. If you have any questions, please contact Carmen Comsti at (510) 206-6083 or ccomsti@calnurses.org.

Sincerely,

Puneet Maharaj
Director of Government Relations
California Nurses Association/National Nurses United

Appendix

CNA's Proposed Amendments to the CMIR Emergency Regulations

Proposed amendments to § 97441(a)(2) with additions underlined and deletions with strikethrough:

(2) The Office may base its decision to conduct a cost and market impact review on any one or more of the following factors:

(A) If the transaction, the market failure, or market power may result in a negative impact on the availability or accessibility of health care services, including the health care entity's ability to offer culturally competent care.

(B) If the transaction, the market failure, or market power may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) If the transaction, the market failure, or market power may lessen competition or tend to create a monopoly in any geographic service areas impacted by the transaction.

(D) If the transaction, the market failure, or market power directly affects a general acute care or specialty hospital.

(E) If the transaction, the market failure, or market power may negatively impact the quality of care.

(F) If the transaction between a health care entity located in this state and out-of-state entity may increase the price of health care services or limit access to health care services in California.

(G) If the transaction, the market failure, or market power may result in a negative labor market impact, including employer concentration, unsafe staffing levels, unsafe occupational safety and health conditions, job loss, exploitative employment contract terms, or other negative impacts on health care worker wages or benefits.

(I) If the transaction, the market failure, or market power may result in health care service reductions, closures, or other shifts in the location, availability, or acuity level of health care services.

(H) The health care entity's history of any of the factors described in subparagraphs (A) to (H).

Proposed amendments to § 97441(e) with additions underlined and deletions with strikethrough:

(e) Factors Considered in a Cost and Market Impact Review

A cost and market impact review shall examine factors relating to a health care entity's business and its relative market position, including, but not limited to:

(1) The effect on the availability or accessibility of health care services to the community affected by the transaction, including the accessibility of culturally competent care and the risk of health care service reductions, closures, or other shifts in the location, availability, or acuity level of health care services.

(2) The effect on the quality of health care services to the community affected by the transaction.

(3) The effect of lessening competition or tending to create a monopoly which could result in raising prices, reducing quality or equity, restricting access, or innovating less.

(4) The effect on any health care entity's ability to meet any health care cost targets established by the Health Care Affordability Board.

(5) Whether the parties to the transaction have been parties to any other transactions in the past ten years that have been below the thresholds set forth in section 97435(b).

(6) Consumer concerns including, but not limited to, complaints or other allegations against any health care entity that is a party to the transaction related to access, care, quality, equity, affordability, or coverage.

(7) The negative effect on the labor market and health care workers, including employer concentration, unsafe staffing levels, unsafe occupational safety and health conditions, potential job loss, exploitative employment contract terms, or other negative impacts on health care worker wages or benefits.

(8) The effect on premiums, deductibles, provider network, prior authorization, out-of-pocket costs to patients, surprise billing, and other financial and administrative barriers to care for patients.

(9) The health care entity's history of any of the factors described in paragraphs (1) to (8), including, but not limited to, citations, complaints or other allegations against any health care entity that is party to the transactions for violations of local, state, or federal worker protection, consumer protection, or antitrust law.

~~(7)~~ (10) Any other factors the Office determines to be in the public interest.

Proposed amendments to §§ 97439(b)(10), (11), and (12) with additions underlined and deletions with strikethrough:

(10) A description of current services provided and expected post-transaction impacts on health care services, which shall include, if applicable:

(A) Physical addresses where services are performed;

(B) Levels and type of health care services offered, including reproductive health care services, labor and delivery services, pediatric services, behavioral health services, cardiac services, ~~and~~ emergency services, and potential service reductions, closures, or other shifts in the location, availability, or acuity level of health care services;

(C) Number and type of patients served, including but not limited to, age, gender, race, ethnicity, preferred language spoken, disability status, and payer category;

(D) Community needs assessments;

(E) Charity care;

(F) Community benefit programs; and

(G) Medi-Cal and Medicare.

a summary of its historical and expected post-transaction.

(11) Description of any other prior transactions that:

(A) Affected or involved the provision of health care services, including service reductions, closures, or other shifts in the location, availability, or acuity level of health care services;

(B) Involved any of the health care entities in the proposed transaction; and

(C) Occurred in the last ten years.

(12) Description of potential post-transaction changes to:

(A) Ownership, governance, or operational structure.

(B) Employee staffing levels, job security or retraining policies, employee wages, benefits, working conditions, ~~and~~ employment protections, labor market concentration, any prior transaction that had a labor market impact, and any labor or employment violation or complaint within the past ten years.

(C) City or county contracts regarding the provision of health care services between the parties to the transaction and cities or counties.

(D) Seismic compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, §§ 129675-130070).

(E) Competition within 20 miles of any physical facility offering comparable patient services.

(F) Billing and insurance administration policies, including any expected post-transaction changes to, as applicable, premiums, deductibles, provider network, prior authorization policies, out-of-pocket consumer costs, or out-of-network billing policies, and including any consumer complaints or other allegations against any health care entity that is a party to the transaction related to access, care, quality, equity, affordability, or coverage within the past ten years.

ATTACHMENT #4

California Nurses Association, Comments to the California Law Revision Commission

Antitrust Law - Study B-750, Mergers and Acquisitions

National Nurses United, "Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care," November 2020.

Fleecing Patients

Hospitals Charge Patients More Than Four Times the Cost of Care

National Nurses United


EDICAL
INVOICE
COUNT SUMMARY
ICES PROVIDED
DESCRIPTION
Office Visit
Lab Work
X-Rays / Abdominal
Surgery
Anesthesia
Pathology
Medical/Surgical Supplies
Post-Op Care
$
125.00
225.00
350.00
7,500.00
1,000.0
531
130
$10,570-

Fleecing Patients

Hospitals Charge Patients More Than Four Times the Cost of Care

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SUMMARY OF FINDINGS

- U.S. hospitals charge on average $417 for every $100 of their total costs, in statistical terms a 417 percent charge-to-cost ratio.
- Hospital charges over costs have been climbing steadily over the past 20 years—in 1999 hospitals charged on average 200 percent of their costs; by 2018, hospital charges equaled 417 percent of their costs. The average charge-to-cost ratio more than doubled over this time period.
- Over the last 20 years, hospital expenditures have grown faster than overall health care expenditures. Hospital expenditures as a percentage of national health expenditures have increased from 30.8 percent in 1999 to 32.7 percent in 2018. In 2018 hospital expenditures alone comprised close to 6 percent of the national GDP.
- Of the 100 hospitals with the highest charges relative to their costs, for-profit corporations own or operate 95 of them. All of the top 100 hospitals are owned by hospital systems, as opposed to being independently operated community hospitals. The top system is HCA Healthcare, which owns 53 of these hospitals, including the hospital with the highest charge-to-cost ratio in the U.S. Community Health Systems was second with 18 hospitals in the top 100.
- For the 100 hospitals with the lowest charge-to-cost ratios, nearly two-thirds do not belong to systems. Only two of the lowest 100 are operated by for-profit corporations, while 60 are owned by government agencies, including four hospitals whose charges do not exceed their costs.
- Higher charge-to-cost ratios tend to be strongly associated with higher hospital profits.
- U.S. hospital profits, pushed upward by high charges, hit a record $88 billion in 2017, and fell slightly in 2018 to $83.5 billion. Since 2013, hospital profits have increased by 21 percent. Over the last 20 years, hospital profits have increased by 411 percent. In total, hospitals have received nearly a trillion dollars in net income.

Hospital charges over costs have been climbing steadily over the past 20 years.

INTRODUCTION

As Covid-19 rages across the United States, the importance of hospitals to the health and well-being of our communities has never been more apparent. Hospitals are a central part of a community's social fabric, providing care and treatment throughout our lifespan and seeing us at our most vulnerable—through the birth of a child, in ill-health, and at death. Life can begin, be saved, and end in a hospital. And, just as importantly, hospitals are a key factor in a community's economic foundation. They are major employers, providing well-paying, meaningful jobs and hiring local workers and contractors. In 2018, hospitals provided just under 5.2 million jobs to Americans, with tens of thousands of new positions added each month.[1] The health care sector is projected to have some of the fastest annual employment growth through 2028.[2] Hospitals also shape the overall economic forces within a community by augmenting the larger local economy through purchases, rentals, and indirect commerce to local businesses. Every dollar spent by hospitals results in $2.81 of economic activity.[3] Moreover, each year, hospitals spend approximately $852 billion on goods and services and generate over $2.8 trillion in economic activity.[4]

Despite their prominence and importance to their communities, hospitals have been shifting away from their role as community anchor institutions and aggressively reinventing themselves as multi-million-dollar corporations focused on building up their financial wealth and assets through market share growth and consolidation. Nationally, hospitals and their executive staff consistently pull in large profits,[5,6,7] with hospitals receiving $1 out every $3 spent on health care.[8] One study revealed that for those with private insurance, spending on hospitals represents approximately 44 percent of personal health care expenses.[9] Yet, Americans are faced with a deteriorating health care system. Health care costs continue to rise out of the reach of millions of Americans to unsustainable levels: health insurance premiums are rising faster than both inflation and wage increases, with the average family paying nearly $20,000 per year in insurance premiums, deductibles, and out-of-pocket expenses for health care.[10] Unsurprisingly, these costs are forcing people to delay or forgo needed care.[11] Indeed, in 2018, an estimated 44 percent of Americans said they didn't go to the doctor when sick because of cost; 40 percent skipped medical testing; and about 30 percent said they had to choose between paying for medical bills and basic necessities like food or housing.[12,13] Under pressure from the effects of the Covid pandemic, the health care delivery system faces further unraveling. There were already millions of uninsured individuals, 27.9 million nonelderly individuals in 2018,[14] and now we are adding to that an estimated 27 million who have lost their insurance due to the Covid-related economic collapse.[15] Even before Covid, approximately 87 million people who had health insurance were underinsured.[16] Despite spending more than any other country on health care, Americans have some of the worst health outcomes among industrialized nations.[17]

Against this backdrop, this paper examines hospitals' charges, in relation to their costs, by looking at their charge-to-cost ratios (CCRs). CCRs as a metric help us better understand hospital pricing strategies and hospital profitability. While few patients end up paying the gross charges referenced in CCRs, they are a crucial variable in the negotiation of reimbursements from major payers, including insurance companies and government programs. The most current data available, through the end of 2018, shows that hospitals are charging on average over $417 for every $100 in their total costs. In addition, hospitals have dramatically increased their charges, in relation to their costs, over the last two decades. Since 1999, the average charge-to-cost ratio for all U.S. hospitals has more than doubled. Over this same period, hospital prices have tripled.

While charges and prices have risen dramatically, hospitals have consolidated at an unprecedented rate, now with more than two-thirds of hospitals belonging to systems. Likewise, profits have exploded, increasing by 411 percent over 20 years, from 1999 to 2018. At the same time, dubious hospital practices—such as surprise billing, charging exorbitant trauma and facility fees, slashing charity care, and filing medical debt lawsuits against patients too poor to pay—have become far too common. This paper demonstrates that instead of creating healthier and more vibrant communities, hospitals are forcing individuals and families to pay larger and larger amounts of their income for hospital services. It is clear that too many hospitals have failed their patients, their health care workers, and their communities. The first part of this report will place health care and hospital spending in the context of the nation's economy. From there, this paper examines hospitals' CCRs, how they have changed over time, and the relation of CCRs to hospital ownership, corporate structure, profits, and geography.

HOSPITAL CHARGES IN THE AGE OF COVID-19

The fact that millions of Americans are struggling to afford the cost of health care is of particular concern right now as we face the global outbreak and deepening spread of a novel virus. Americans are not only worried about contracting Covid-19, but they are also increasingly worried about paying for the testing and unexpected health expenses that may arise as a result. According to a Commonwealth Fund survey, 68 percent of respondents said that "potential out-of-pocket costs would be very or somewhat important in their decision to seek care if they had symptoms of the coronavirus."[18] Unfortunately, experience shows they are right to be worried. Both insured and uninsured patients have been hit with staggering bills connected to Covid treatment and testing, despite government attempts to limit such charges. Examples are numerous. One uninsured patient in New York was billed almost $50,000 after he was admitted to a hospital for three days for Covid treatment.[19] Another uninsured Covid patient in Massachusetts was billed almost $35,000 for medical care received in a hospital emergency room.[20] An insured patient in Kentucky, likely suffering from Covid, racked up $180,000 in hospital and emergency department charges. Though the insurance company paid most of the bill, the patient ended up spending $7,900 in out-of-pocket costs for the treatment.[21]

High hospital charges play a major role in driving up the costs of Covid treatment. According to a study by FAIR Health, a nonprofit that analyzes claims data, average charges for a Covid-19 patient requiring an inpatient stay can range from $42,486 with no or few complications to $74,310 with major complications.[22] Of course, hospital charges can and do go much higher. One Covid patient in Colorado was initially billed over $840,000 after a two-week stay in the ICU at an HCA Healthcare facility. After much publicity the bill was reduced to zero.[23] Other Covid patients with severe symptoms have received hospital bills north of $1 million.[24,25]

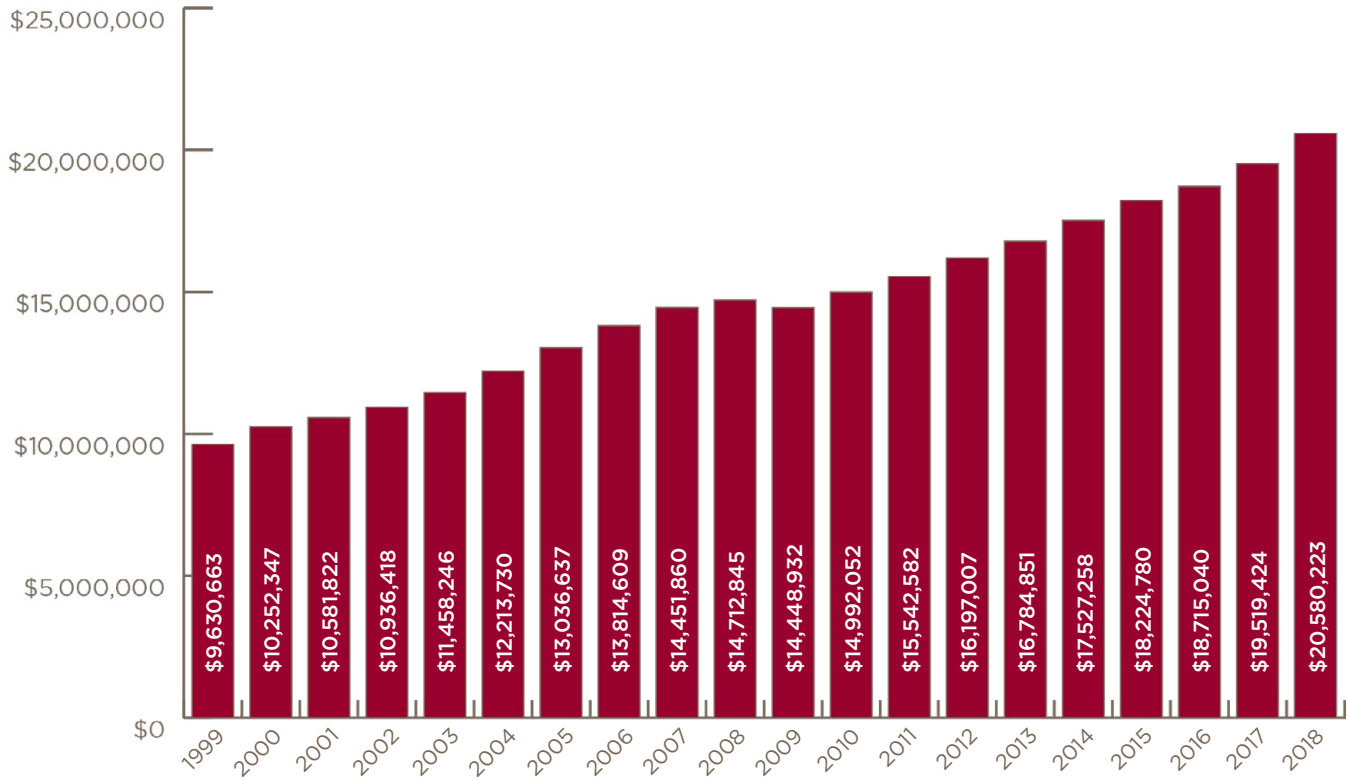
Beyond the high hospital charges for Covid-related treatments, the simple act of getting tested can also be cost prohibitive. Uninsured patients, who are often charged $200 for a test, can be subjected to surprise medical bills. A woman in Alabama received a surprise $1,000 bill from the lab processing her test.[26] Even with insurance, patients simply seeking a Covid diagnosis have ended up paying hundreds and even thousands of dollars in out-of-pocket costs. In one case, an insured patient in West Virginia suspected she was infected with Covid and visited her doctor to get checked, and ended up paying $500 in out-of-pocket costs.[27] Another patient in Pennsylvania received a $1,689 bill after unsuccessfully seeking a coronavirus test and getting a flu test and X-ray instead. In New Jersey, a patient reached out to his doctor because he thought he might have the coronavirus, and ended up paying $1,528 out-of-pocket for a chest X-ray. A patient in Wisconsin visited a hospital triage tent to find out if she was infected with Covid, and was later billed $1,186 for the visit.[28] Another patient in Florida, who visited an emergency room believing he had Covid and received a battery of tests, ended up being stuck with a bill for over $2,700.[29]

Situations like these, which are widespread, raise serious red flags around the ability of our health system to respond to what has become the greatest health care emergency of our time. By failing to remove the cost penalty to Covid-related tests and treatments, our health system is actively discouraging individuals who may be infected from getting tested and treated, undermining our ability to track and contain the virus. This failure will only add to the already substantial damage inflicted on all of us by the current pandemic. As noted by health law scholar Jaime S. King in the *New England Journal of Medicine*: "Failure to receive testing and treatment because of cost harms everyone by prolonging the pandemic, increasing its morbidity and mortality, and exacerbating its economic impact."[30]

As the Covid outbreak deepens, a simple truth remains: increasing hospital charges play a substantial role in our country's skyrocketing health care costs and deteriorating health. Moving away from their focus on patient care and community service, hospitals have become increasingly fixated on profits, leaving millions of patients and families to suffer.

HEALTH EXPENDITURES AND THE U.S. ECONOMY

Figure 1. **U.S. Gross Domestic Product, 1999 – 2018** (in Millions of Dollars)



Before examining health expenditure increases in the United States, it is important to understand the state of the U.S. economy and the important role health expenditures play in the economy. When examined through the lens of the gross domestic product (GDP), it is clear that prior to the economic collapse related to the Covid pandemic, the size of the nation's economy had been steadily growing over the last two decades. As Figure 1 demonstrates, the nation's GDP has more than doubled from $9.6 trillion in 1999 to $20.6 trillion in 2018. As Figure 1 further indicates, each year saw an increase in the GDP, aside from 2008 to 2009 when the GDP dropped slightly (less than 2 percentage change) due to the Great Recession. However, by 2010 it increased again and, overall, the GDP has witnessed a 113.7 percentage change between 1999 and 2018.

Meanwhile, the nation's health expenditures, a component of the nation's overall GDP, increased significantly faster. In 1999 (Figure 2), health expenditures totaled $1.3 trillion. By 2018 they had grown to $3.7 trillion. This is a 185.6 percentage change, meaning that the health expenditures in our country are increasing at a substantially faster rate than the nation's GDP. Notably, health expenditures steadily rose even during the Great Recession (2008–2009), when GDP fell.

Figure 2. **National Health Expenditures, 1999 – 2018** (in Millions of Dollars)

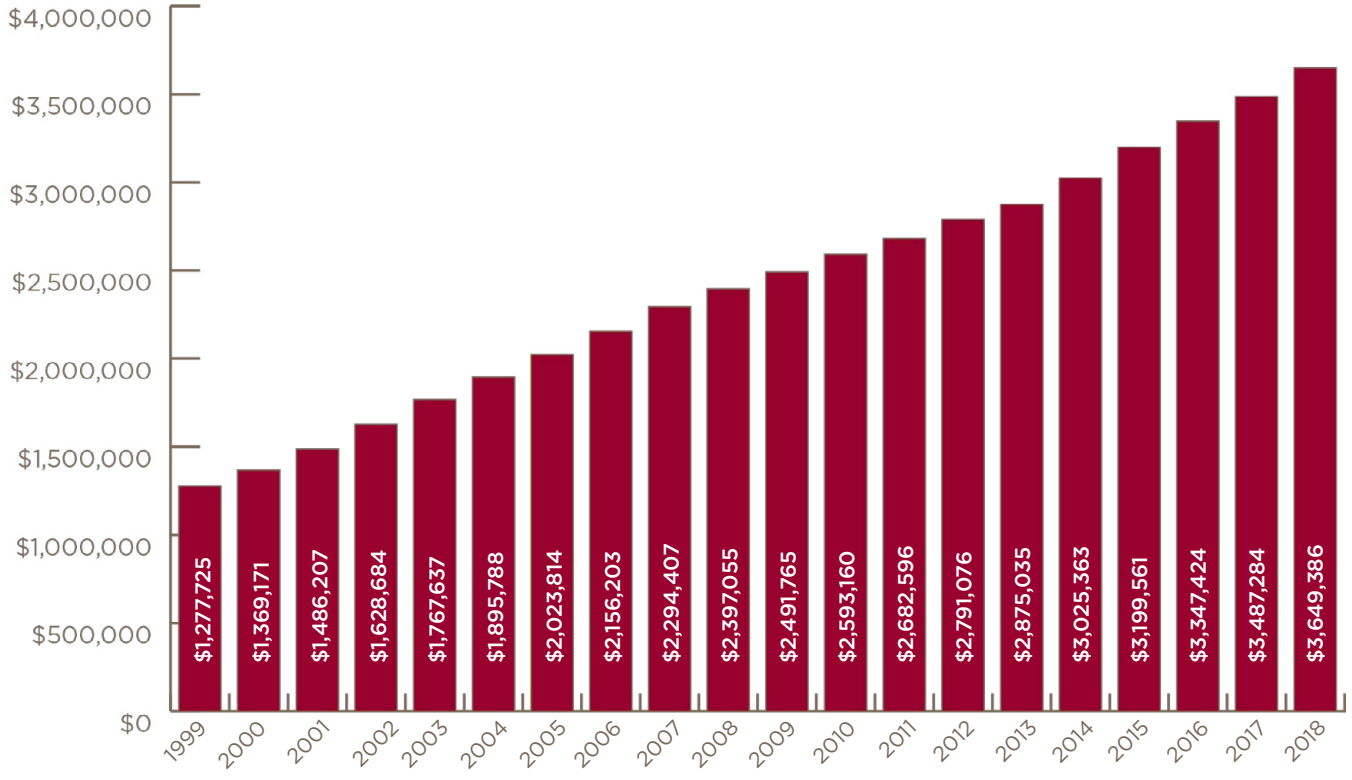


Figure 3. **National Health Expenditure as Percent of National Gross Domestic Product, 1999 – 2018**

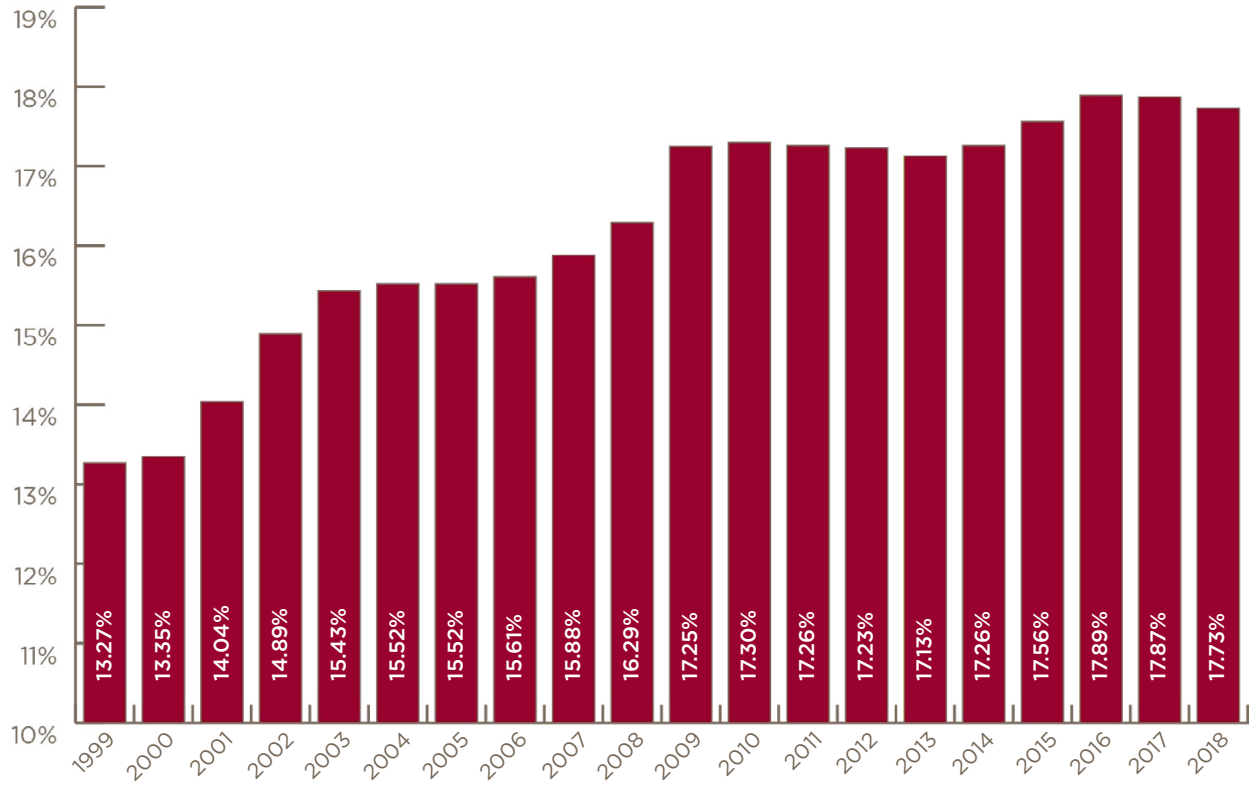


Figure 4. **National Health Expenditures Components, 2018**

	Expenditures in Billions	Percent
Hospital Services	$1,191.80	33%
Physician and Clinical Services	$725.60	20%
Drugs and Other Non-durable Products	$401.40	11%
Other Health Residential and Personal Care	$191.60	5%
Nursing Care Facilities & Continuing Care Retirement Communities	$168.50	5%
Home Health Care	$102.20	3%
Dental Services	$135.60	4%
Other Professional Services	$103.90	3%
Durable Medical Equipment	$54.90	2%
Net Cost of Health Insurance	$258.50	7%
Public Health Activity	$93.50	3%
Government Administration	$47.50	1%
Investment	$174.40	5%
Total Health Expenditures	**$3649.40**	**100%**

Health care constitutes an increasingly larger portion of the nation's economy. As Figure 3 demonstrates, in 1999, national health expenditures as a percentage of GDP were 13.27 percent. By 2018, they had risen to 17.73 percent. No doubt there have been fluctuations, particularly between 2010 through 2015. These were the years of the slow recovery from the Great Recession and the implementation of the Affordable Care Act. While the hangover effects of the economic downturn may have reduced the national health expenditures as a percentage of GDP between 2010 and 2013, these were minor decreases and, by 2014 and moving forward, the percentage has increased. Current projections indicate that this percentage is expected to continue to increase in the coming years, and, at this current pace, health expenditures will account for 20 percent of the nation's economy within several years.[31]

Looking at health care expenditures more closely, hospitals comprise the single largest component of total health care expenditures. As Figure 4 shows, in 2018, expenditures for hospitals totaled close to $1.2 trillion, or 33 percent. Physicians and clinical services constituted the second largest component of national health care expenditures at 20 percent. Together, hospital services and physician/clinical services accounted for over half of all health care expenditures.

A primary reason why hospital expenditures are such a large share of total national health care expenditures is because expenditures on hospital services have been rising dramatically over the last two decades. Figure 5 shows this rapid increase over the past two decades. Indeed, expenditures have increased over 202 percent.

The past 20 years have witnessed national hospital expenditures as a percentage of national health expenditures increase from 30.8 percent in 1999 to 32.7 percent in 2018 (Figure 6). Overall, hospital expenditures have grown more than overall health care expenditures. In 2018 hospital expenditures alone comprised close to 6 percent of the national GDP.

Figure 5. **National Hospital Expenditures, 1999 – 2018** (in Millions of Dollars)

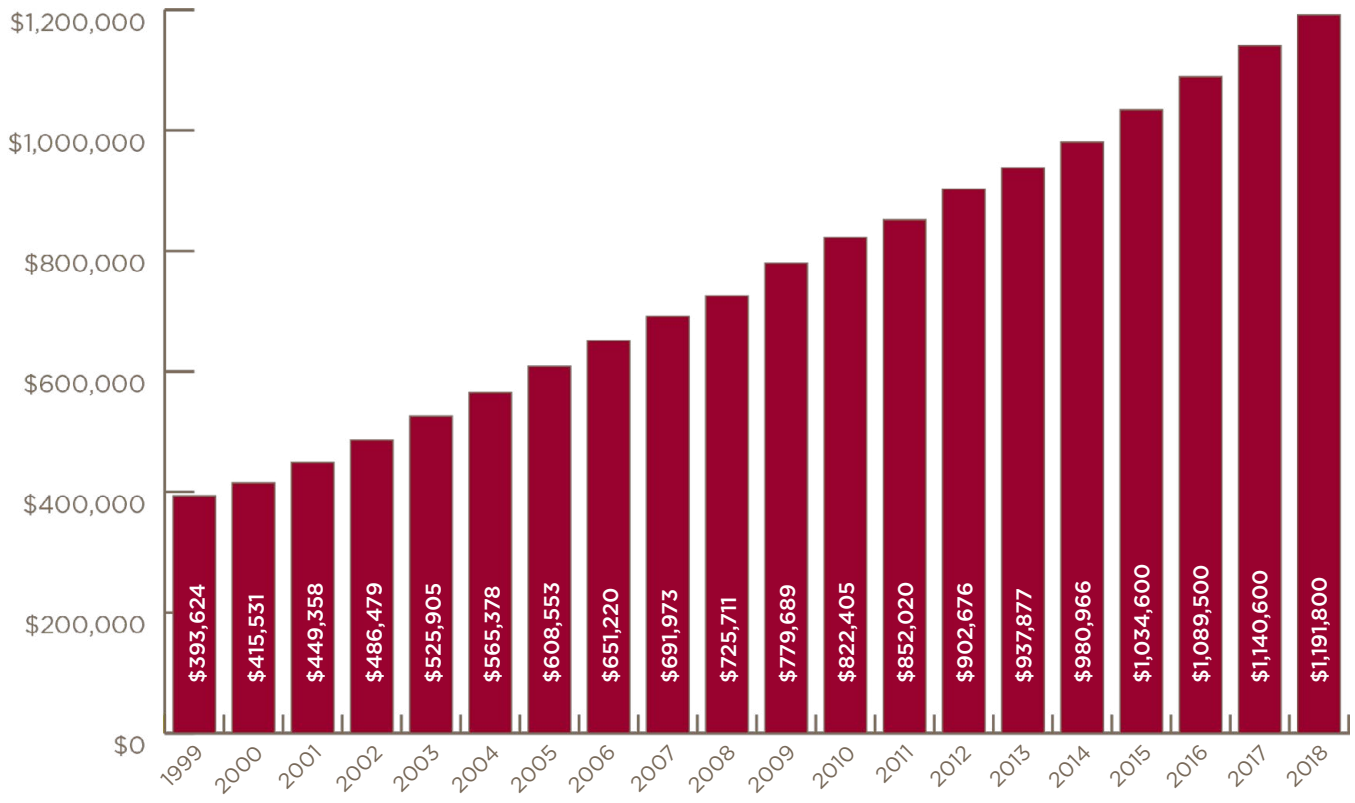
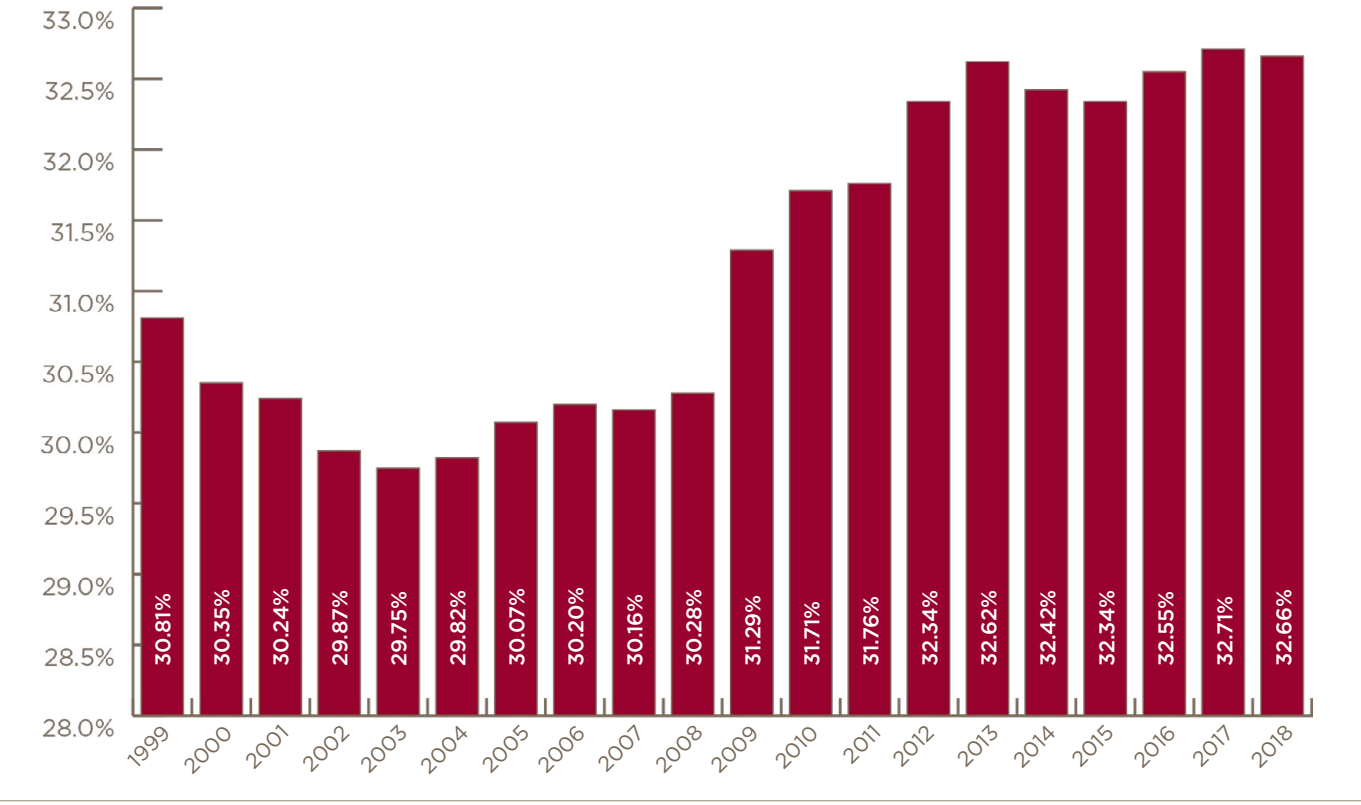


Figure 6. **National Hospital Expenditures as Percent of Health Expenditures, 1999 – 2018**



RISING HOSPITAL PROFITS

Figure 7. **U.S. Hospitals' Net Income, 1999 – 2018 » Total $917,254,684,447**

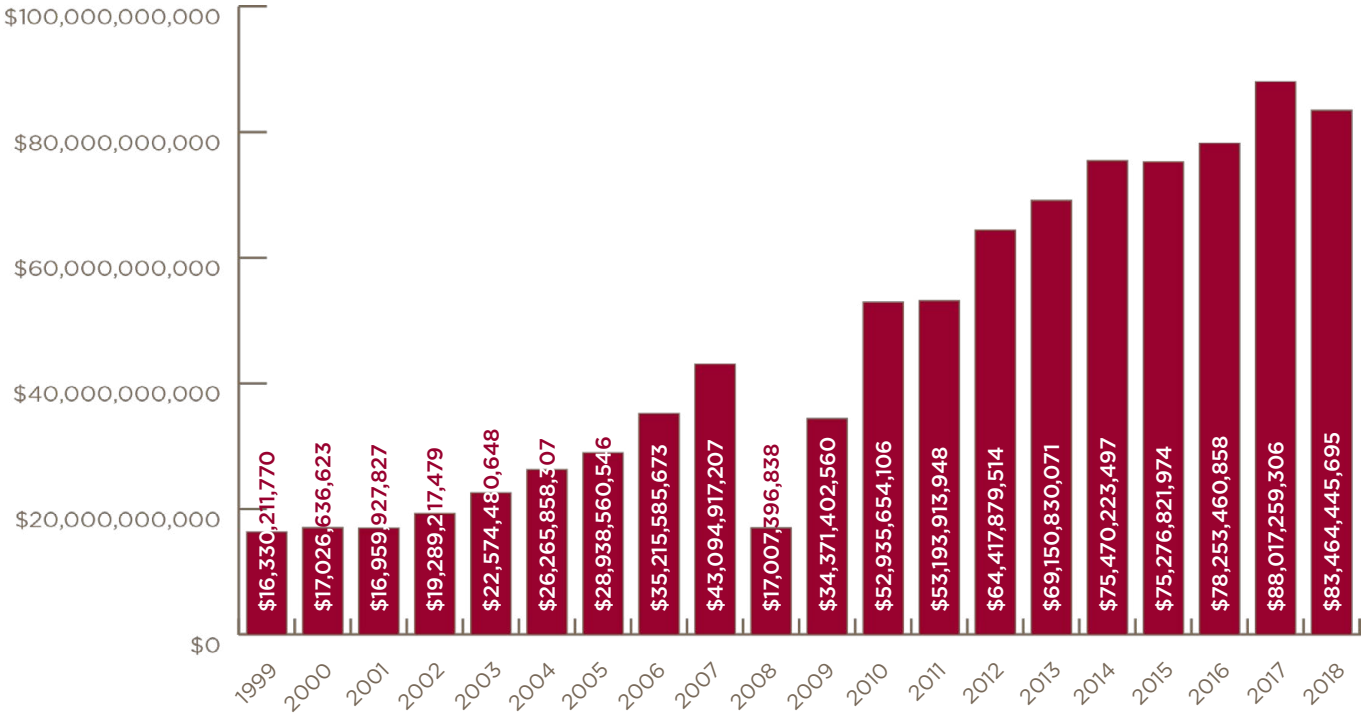


Figure 8. U.S. Hospitals' Net Income, 1999-2018

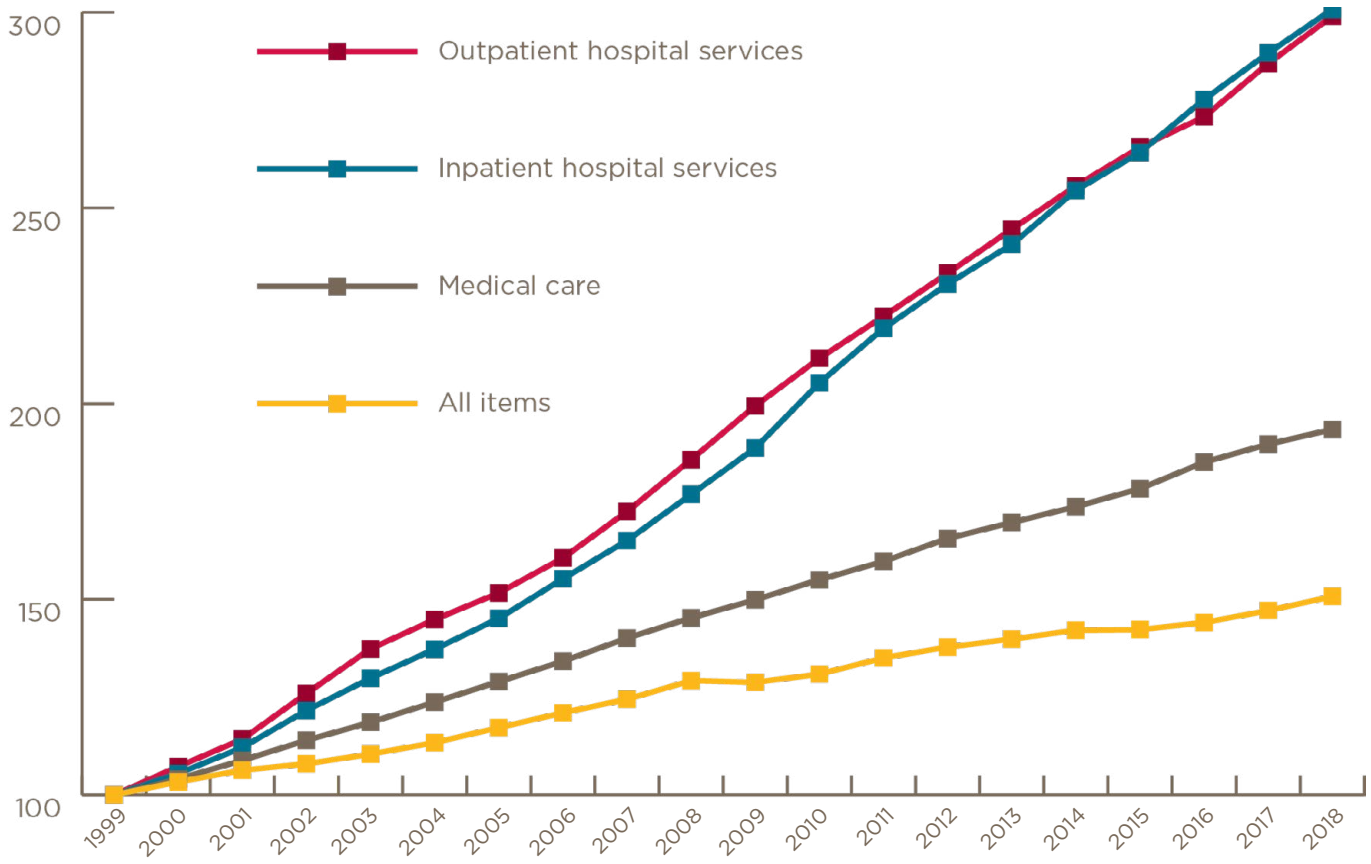
Year	Net Income
1999	$16,330,211,770
2000	$17,026,636,623
2001	$16,959,927,827
2002	$19,289,217,479
2003	$22,574,480,648
2004	$26,265,858,307
2005	$28,938,560,546
2006	$35,215,585,673
2007	$43,094,917,207
2008	$17,007,396,838

Year	Net Income
2009	$34,371,402,560
2010	$52,935,654,106
2011	$53,193,913,948
2012	$64,417,879,514
2013	$69,150,830,071
2014	$75,470,223,497
2015	$75,276,821,974
2016	$78,253,460,858
2017	$88,017,259,306
2018	$83,464,445,695
Total	**$917,254,684,447**

One partial explanation of the rise in hospital expenditures as a share of total health expenditures and the national GDP is that hospital profits have increased in dramatic fashion. U.S. hospital profits, or net income, have increased by an astounding 411 percent since 1999, rising from $16.3 billion in 1999 to $83.5 billion in 2018. Since the implementation of the Affordable Care Act, hospital profits have soared by 21 percent, with hospitals receiving $14.3 billion more in net income in 2018 than they did in 2013. Over the last 20 years, the profit rate for hospitals has increased by 75 percent, with hospitals receiving in aggregate more than $917 billion in net income over the period (Figures 7 and 8).

RISING HOSPITAL PRICES

Figure 9. **Consumer Price Index for Outpatient, Inpatient, and Medical Care, 1999 – 2018 (1999 = 100)**



A key reason for the dramatic increase in health and hospital expenditures, as well as hospital profits, is overall rising hospital prices. Data from the United States Bureau of Labor Statistics reveals a threefold increase in both inpatient and outpatient hospital service prices between 1999 and 2018. This means that if a specific hospital service cost $100 in 1999, that same service cost $300 in 2018 (see blue and orange lines on Figure 9). These increases are particularly galling when compared to the price changes in other health care sectors. As Figure 9 demonstrates, hospital price level increases were the largest among components of health expenditures. From 1999 to 2018 overall medical expense prices (depicted by the yellow line, "All Items") increased by 50 percent, while the health care prices (depicted by the gray line, "Medical Care") nearly doubled. For more details see Appendix 7 for the Consumer Price Index for health care expenditures.

One might argue that these price increases are justified if the costs to provide care are simultaneously increasing at the same rate. The next section discusses the relationship between charges and costs by focusing on the charge-to-cost ratio. While a one-to-one correspondence between the price increases (discussed above) and charges (discussed in the next section) does not exist, both highlight that hospital charges have been rapidly increasing with little justification other than revenue generation.

CHARGE-TO-COST RATIO IN THE UNITED STATES

To better understand rising hospital prices, we now turn to an examination of the charge-to-cost ratio (CCR). Using Medicare cost reports (MCR) for fiscal year 2018 from the Centers for Medicare and Medicaid Services (CMS), this report examines 4,203 acute-care hospital in the United States, including 351 hospital systems. MCRs present information on hospital charges and costs for various inpatient and outpatient services provided by the hospital. These charges are known as the charge master prices. Few patients pay the charge master price. Rather, the importance of the charge master price is that it establishes a baseline for negotiations between hospitals and health insurance companies over reimbursements (Medicare does not enter into these negotiations as it sets its rates administratively). Hospitals' costs include not only the cost of direct labor and supplies provided to patients, but also noncare costs, such as administration, general costs, housekeeping, and nursing administration.[32] These noncare costs are proportionate to patient services. The CCR reveals the relationship between charges and costs: if charges are higher than costs, the CCR will be greater than 100 percent; if the charges are lower than costs, the CCR will be less than 100 percent. Importantly, the CCR demonstrates whether or not charge master prices are increasing faster than costs over time. (If the CCR increases from one year to the next or over time, a hospital is increasing their charges to provide care faster than it is costing them to provide that care.)

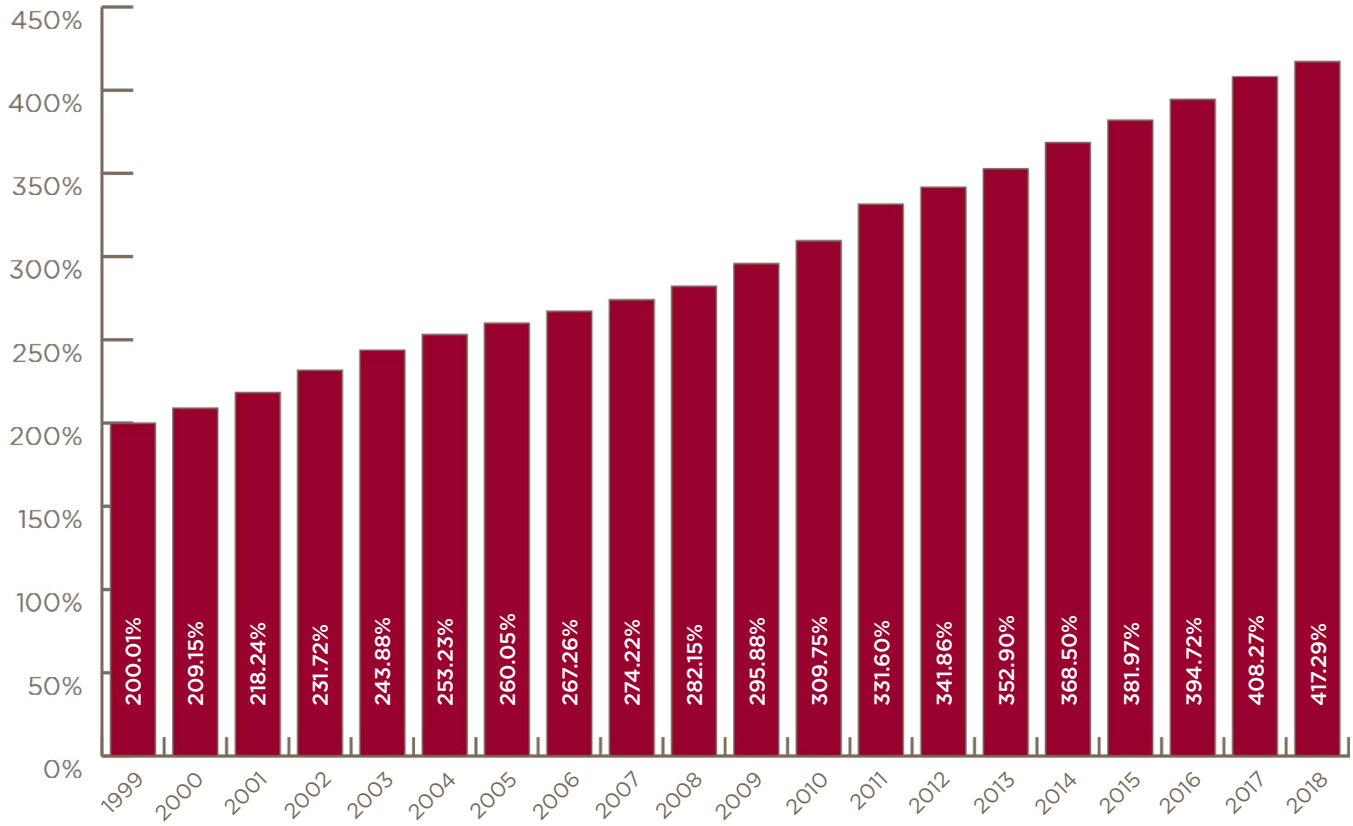
Hospitals often maintain that the charge master price does not matter and does not influence the price paid for services by private insurers. To prove this point, hospitals point out that private insurers usually pay a substantially discounted price from the charge master price.[33] Moreover, because price negotiations between insurers and hospitals are confidential and reimbursement data is often proprietary, neither the charge master price nor the exact price paid by insurers is made public.[34] Nevertheless, the fact remains that prices continue to increase and that, more importantly, CCRs continue to climb. It is also important to acknowledge that some patients are in fact billed the undiscounted charge master price by hospitals. Out-of-network patients are often subjected to the full charge and are forced to pay a large portion of it out-of-pocket. In many cases, the uninsured are also billed the full price, creating an absurd dynamic where those with the least ability to pay are forced to pay most.[35]

Several studies have shown the relationship between charge master price and hospital revenue, specifically that higher charge master markups result in higher profits.[36,37,38,39] A 2017 study found a striking relationship between the charge master prices and higher prices paid by private insurers: for each additional dollar increase in a list price, private insurers paid an additional 15 cents in payment to hospitals. It thus appears that hospitals employ a strategy of increasing charge master prices to generate additional revenue.[40] Testimony from hospital executives reveals that the outright goal of charge master prices is to ensure profitability.[41] If that is in fact the goal, then it appears that increasing charge master prices has been wildly successful, as the rate of profit received by hospitals has increased 75 percent since 1999.[42]

Charge-to-cost ratios across hospitals in the United States have increased dramatically over the past two decades. In 1999, the average CCR was 200.01 percent; by 2018 that number had climbed to 417.29 percent. Overall, as Figure 10 shows, hospital charge-to-cost ratios have more than doubled in 20 years (see Appendix 2 for table).

While the chart in Figure 10 shows average CCRs for all U.S. hospitals, there is wide variation in CCRs for individual hospitals. As Appendix 3 highlights, among the 100 hospitals with the highest CCRs in 2018, cases range from a high of 1,808 percent for Poinciana Medical Center in Kissimmee, FL (owned by HCA Healthcare, the largest for-profit hospital system in the U.S.), to a low of 1,129 percent for Tristar Hendersonville Medical Center in Hendersonville, TN (also owned by HCA). No doubt this is a huge discrepancy, but even more startling is the discrepancy between the hospital with the highest CCR (Poinciana at 1,808 percent) and the hospitals with the lowest CCRs. The lowest CCR hospitals—Harlem Hospital Center, Elmhurst Hospital Center, Metropolitan Health Center, and NYC + Hospital/Coney Island—all have CCRs of 100 percent, meaning for each $100 in costs to provide care, hospitals charged $100. Notably, these are all part of the same hospital system, NYC Health + Hospitals. Meanwhile, the top 100 hospitals all have CCRs over 1,000 percent. Hospitals with high CCRs have never provided any rationale for such high charges other than generating revenue. (See Appendices 3 and 4 for a full list of top 100 and bottom 100 hospitals ranked by their CCRs).

Figure 10. **U.S. Hospitals' Average Charge-to-Cost Ratio, 1999 – 2018**



Hospitals with the Highest Charge-to-Cost Ratios

As mentioned above, the 100 hospitals with the highest charges relative to their costs, listed in Appendix 3, have CCRs that range from 1,808 percent at the high end to 1,129 percent at the low end. Of these 100 hospitals, for-profit corporations owned or operated 95 percent of them (as compared to only 20.6 percent of hospitals overall). All of the top 100 hospitals belong to hospital systems and are not independently operated. The top system is HCA Healthcare, which owns or operates 53 of the 100 hospitals with the highest CCRs (Figure 11). Community Health Systems had the second most with 18 hospitals. Most of the top 100 hospitals are located in states in the west and south. Florida had the highest number, with 40 hospitals. Other top states included Texas with 14 hospitals, Alabama with eight, Nevada with seven, and California with six (see Appendix 5).

Out of the 10 hospitals with the highest charge-to-cost ratios, HCA was again the largest system with six. Community Health Systems had two hospitals, and Capital Health and Quorum Health each had one.

Perhaps unsurprisingly, it is for-profit hospitals that tend to have the highest CCRs. As Figure 12 shows, these hospitals have an average CCR of 671.08 percent, the highest on the chart. The for-profit hospitals' CCRs are 78 percent higher than nonprofit facilities' average CCR, and 143 percent higher than governmental or public hospitals' average CCR.

Figure 11. **System Owners of the Top 100 Hospitals by CCR**

System Name	Hospitals within the Top 100 by Charge-to-Cost Ratio
HCA Healthcare	53
Community Health Systems, Inc.	18
Tenet Healthcare Corporation	7
Universal Health Services, Inc.	6
CarePoint Health	3
LifePoint Health	3
Capital Health	2
Quorum Health	2
AdventHealth	1
Emerus	1
Regional Medical Center	1
Temple University Health System	1
UPMC	1
West Tennessee Healthcare	1

Figure 12. **Charge-to-Cost Ratio by Provider Control Type, 2018**

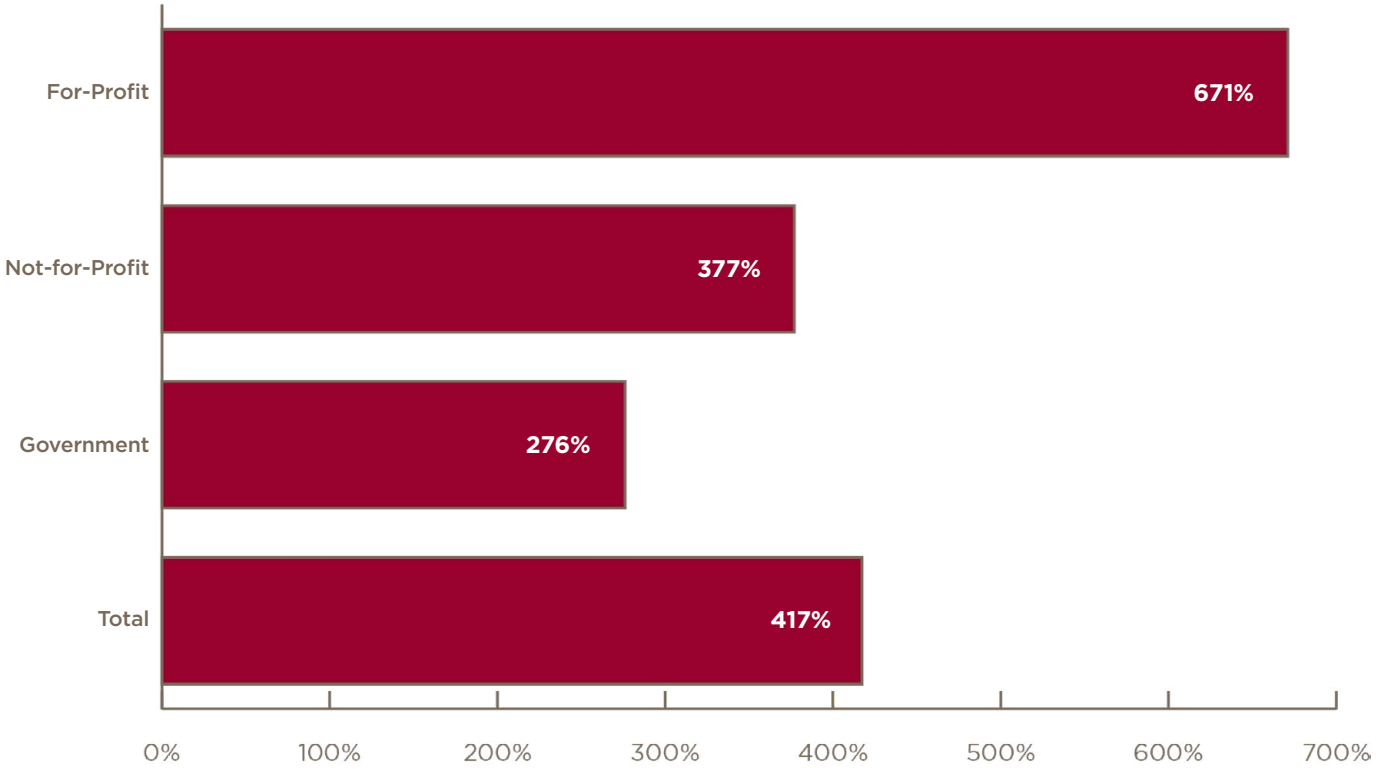
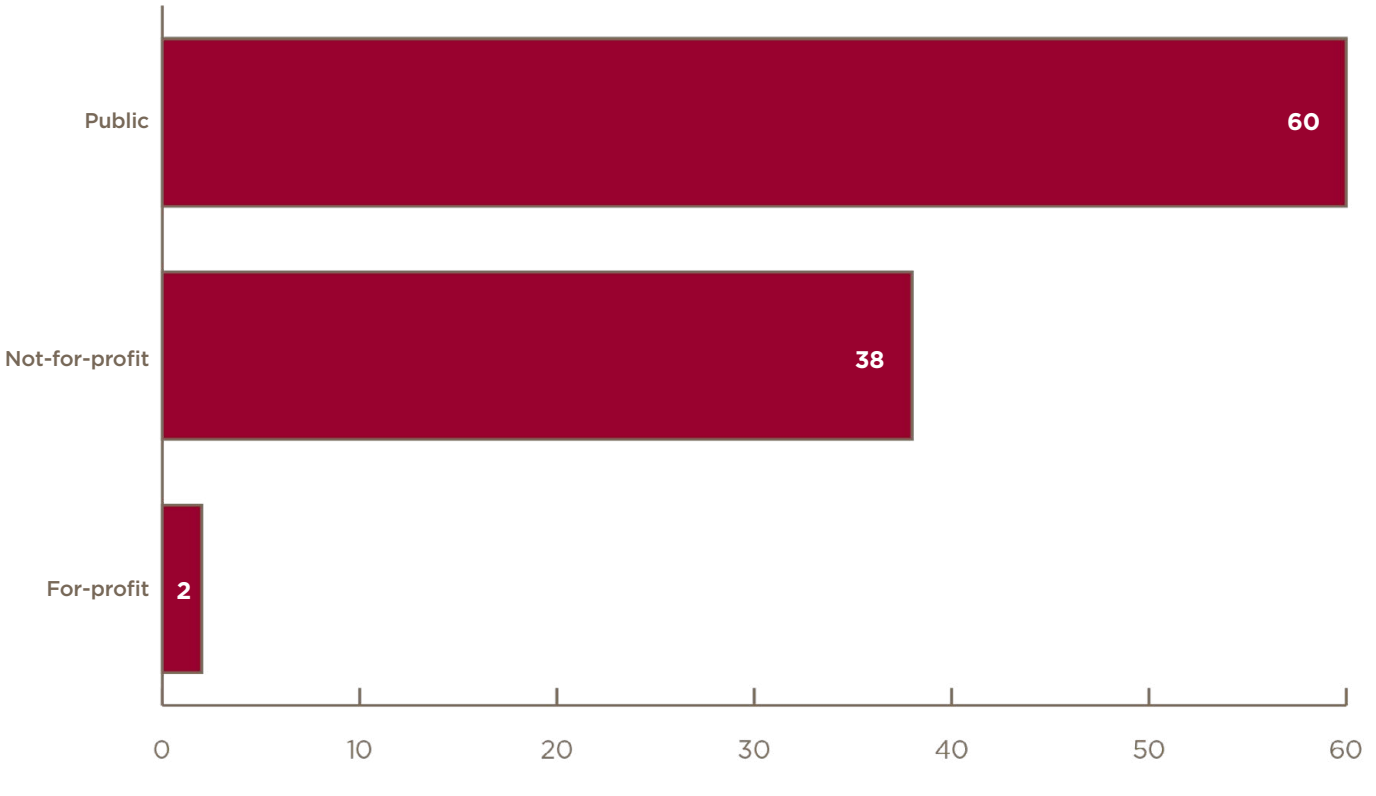


Figure 13. **Provider Control Type » Hospitals with the 100 Lowest CCRs**



Hospitals with the Lowest Charge-to-Cost Ratios

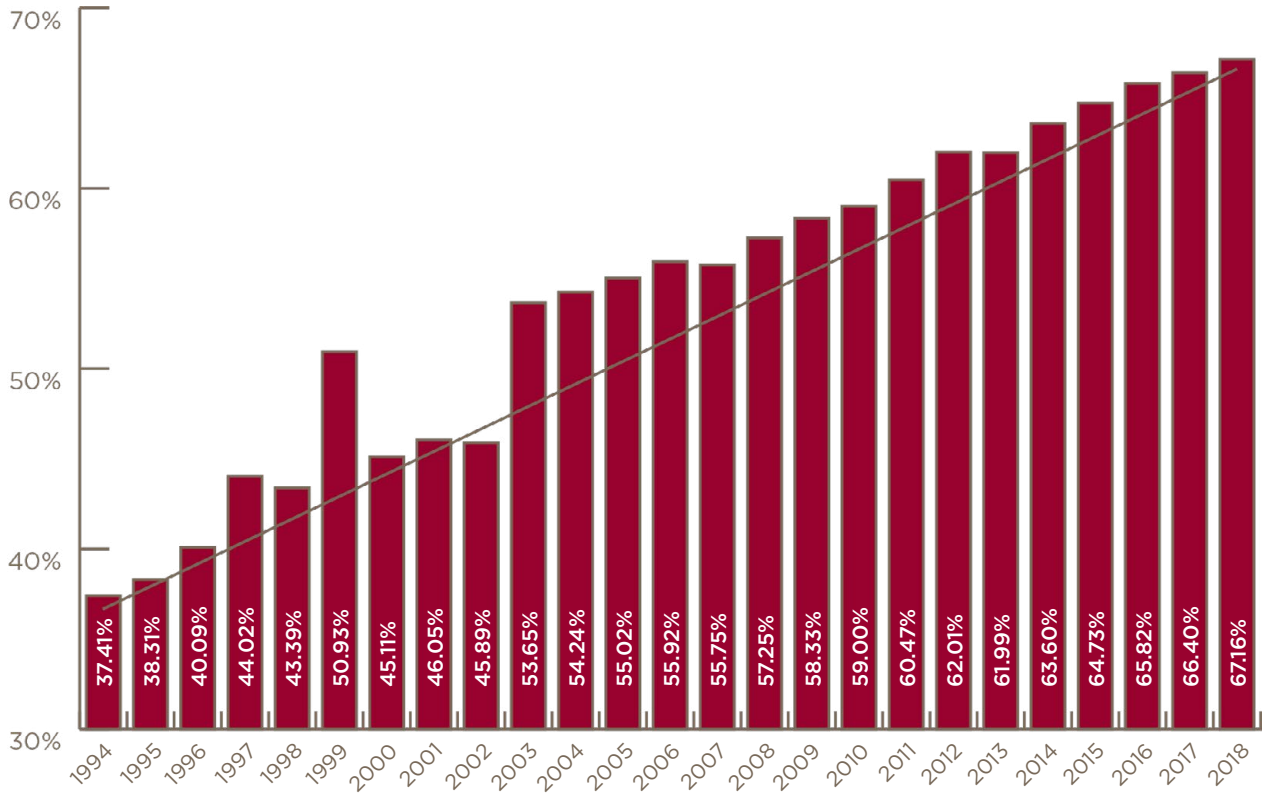
The hospitals with the 100 lowest charge-to-cost ratios are listed in in Appendix 4. CCRs for this group range from a low of 100 percent for four hospitals that are a part of NYC Health + Hospitals, to a high of 128 percent for Fort Washington Medical Center in Fort Washington, MD. These hospitals, in contrast to those with the 100 highest CCRs, are mostly owned by public agencies or not-for-profits (Figure 13). In fact, only two hospitals in this group are operated by for-profit firms, as compared to 95 among those with the 100 highest CCRs. Likewise, 64 of the 100 hospitals with the lowest CCRs are independently operated, and only 36 belong to systems (Figure 14). This contrasts starkly with the 100 hospitals with the highest CCRs, which are owned or operated entirely by systems.

Figure 14. **System Owners of the 100 Hospitals with the Lowest CCRs**

System Name	Hospitals Within the Lowest 100 by Charge-to-Cost Ratio
Independent Community Hospitals (no system)	64
NYC Health + Hospitals	9
Great Plains Health Alliance, Inc.	3
CommonSpirit Health	2
MercyOne	2
QHR	2
UnityPoint Health	2
Ascension Healthcare	1
Bryan Health	1
Faith Regional Health Services	1
Hawaii Health Systems Corporation	1
Intermountain Healthcare, Inc.	1
Mayo Clinic	1
Mercy	1
Mosaic Life Care	1
Northern Light Health	1
Preferred Management Corporation	1
Providence St. Joseph Health	1
Puerto Rico Department of Health	1
Regional Health	1
Sisters of Mary of the Presentation Health System	1
Southwest Health Systems	1
Trinity Health	1

CHARGE-TO-COST RATIOS AMONG HOSPITAL SYSTEMS

Figure 15. **Percentage of Hospitals as Part of Hospital System, 1994 – 2018**

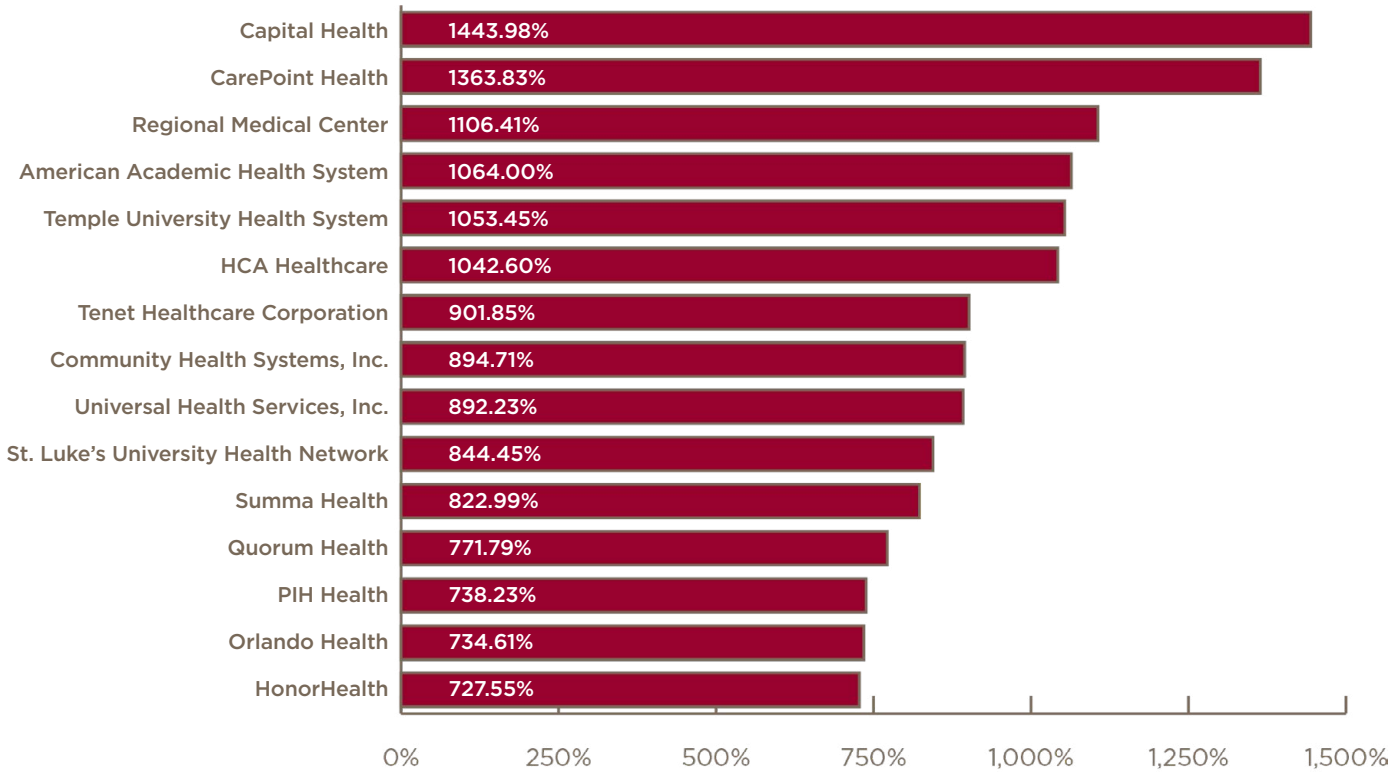


Over the last 25 years, hospitals have increasingly consolidated into multihospital systems, resulting in more concentrated and less competitive hospital markets in the United States. In 1994, a bit over one-third of hospitals (37.41 percent) belonged to a system, while the remainder were independent. By 2018, that number jumped to over two-thirds (67.16 percent) of hospitals belonging to systems (Figure 16). The ever-increasing dominance of multihospital systems represents a transformative restructuring of the industry, as independent community hospitals slowly disappear from the health care landscape.

It is important to note that all the hospitals in the top 100 by CCRs are part of health care systems (see Appendices 3 and 6). A small number of systems own the vast majority of these hospitals. Of the top 100 by CCR, 71 are owned by just two for-profit firms: HCA and Community Health Systems.

When looking at all hospitals owned by systems, the charge-to-cost ratios vary widely (see Appendix 10 for system CCR averages), from a low of 100.77 percent to an astronomical high of 1,443.98 percent. Figure 16 shows the top 15 highest CCR hospital systems in the country. Notably, all 15 hospital systems have significantly higher CCRs than the national average CCR of 417.29 percent. HCA Healthcare, the largest system in the country, has the sixth highest CCR at 1,042.6 percent.

Figure 16. **Top 15 U.S. Hospital Systems by Charge-to-Cost Ratios, 2018**



Mergers and acquisitions of hospitals have led to highly concentrated hospital markets. A study found that in 2016, 90 percent of all U.S. metropolitan statistical areas had highly concentrated hospital markets.[43] Such markets allow hospitals and systems to gain negotiating power relative to health insurance companies over hospital charges and reimbursements. The justification put forth by hospitals for consolidation is that doing so will lead to reduced costs. Yet, studies have found that mergers result in small cost savings.[44,45] There is no evidence that any savings are passed along to patients in lower charges. Rather, numerous studies have found mergers and acquisitions result in higher reimbursements for hospitals after a merger.[46] This is true for both consolidation within hospital markets[47] and across hospital markets.[48,49]

The overall impact has been that in highly concentrated markets, hospital charges and reimbursements are higher than in less concentrated markets. In a recent study comparing a more concentrated area (Northern California) to a less concentrated area (Southern California), prices in the more concentrated area were 70 percent higher for inpatient prices and 17 to 55 percent higher for outpatient prices.[50] There is little doubt that consolidation has contributed to hospitals' ability to increase their power relative to health insurance companies. Hospitals that belong to larger systems are able to manipulate their pricing strategies through the CCRs for their own benefit at the expense of patients.

HIGHER CCRs CORRESPOND TO HIGHER NET INCOME

While the charge-to-cost ratios do not tell us how much hospitals are reimbursed beyond their costs, higher CCRs tend to be strongly associated with higher hospital profits, or net income. In Figures 17 and 18, we divided the hospitals into deciles based on their CCRs, from lowest to highest. For each decile, we include the average CCR and the average net income for the group. Though there is some variation in the lower deciles, there is a clear trend showing that the deciles with higher average CCRs are associated with higher net incomes. The more the hospital charges, the more the hospital makes in profits.

Figure 18. **Hospital Deciles » CCRs Levels and Net Income**

Hospital Deciles by CCR	Average Charge-to-Cost Ratio	Average 2018 Net Income
1	138.75%	$3,636,777
2	185.90%	$789,544
3	236.45%	$5,318,052
4	286.01%	$8,953,434
5	337.18%	$16,078,914
6	388.40%	$20,753,769
7	447.97%	$20,876,950
8	523.95%	$26,349,590
9	640.85%	$27,024,535
10	987.66%	$29,164,837
Total	**417.29%**	**$15,901,881**

Figure 17. **Hospital Deciles » CCRs Levels and Net Income**

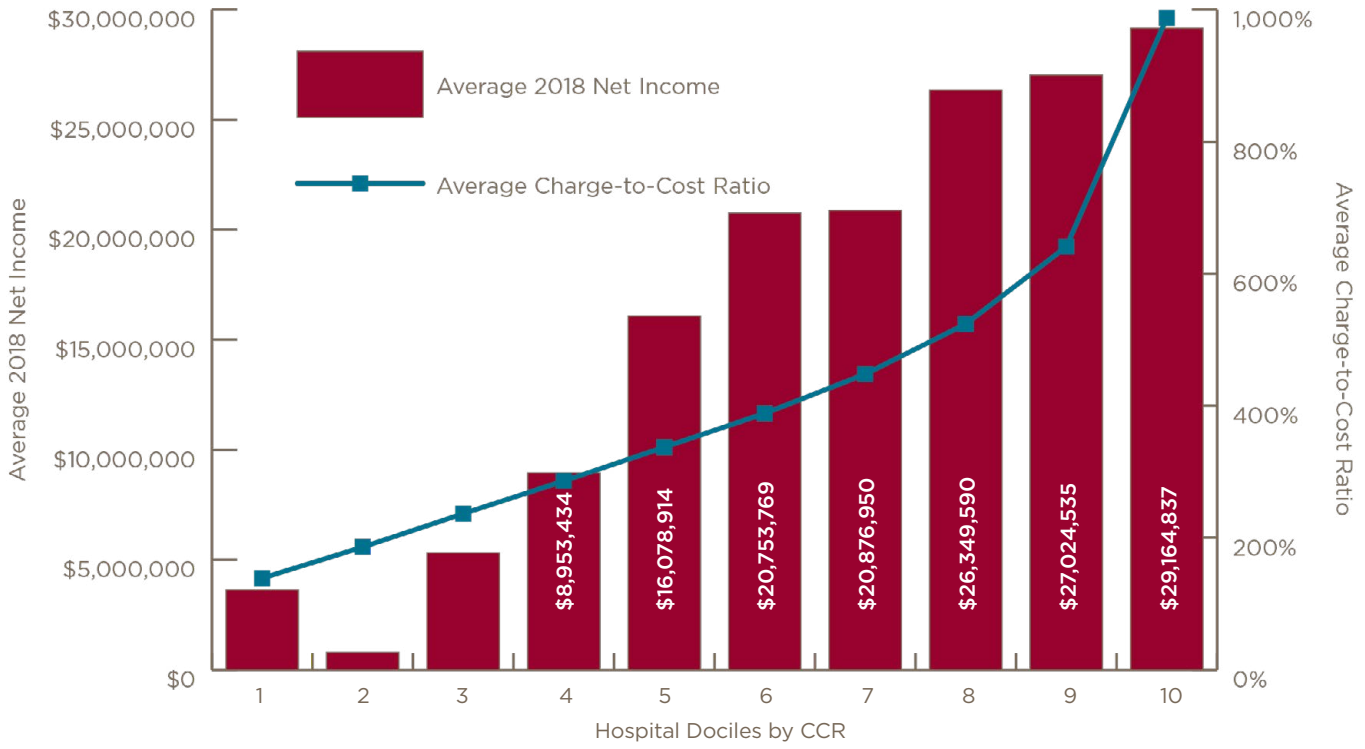
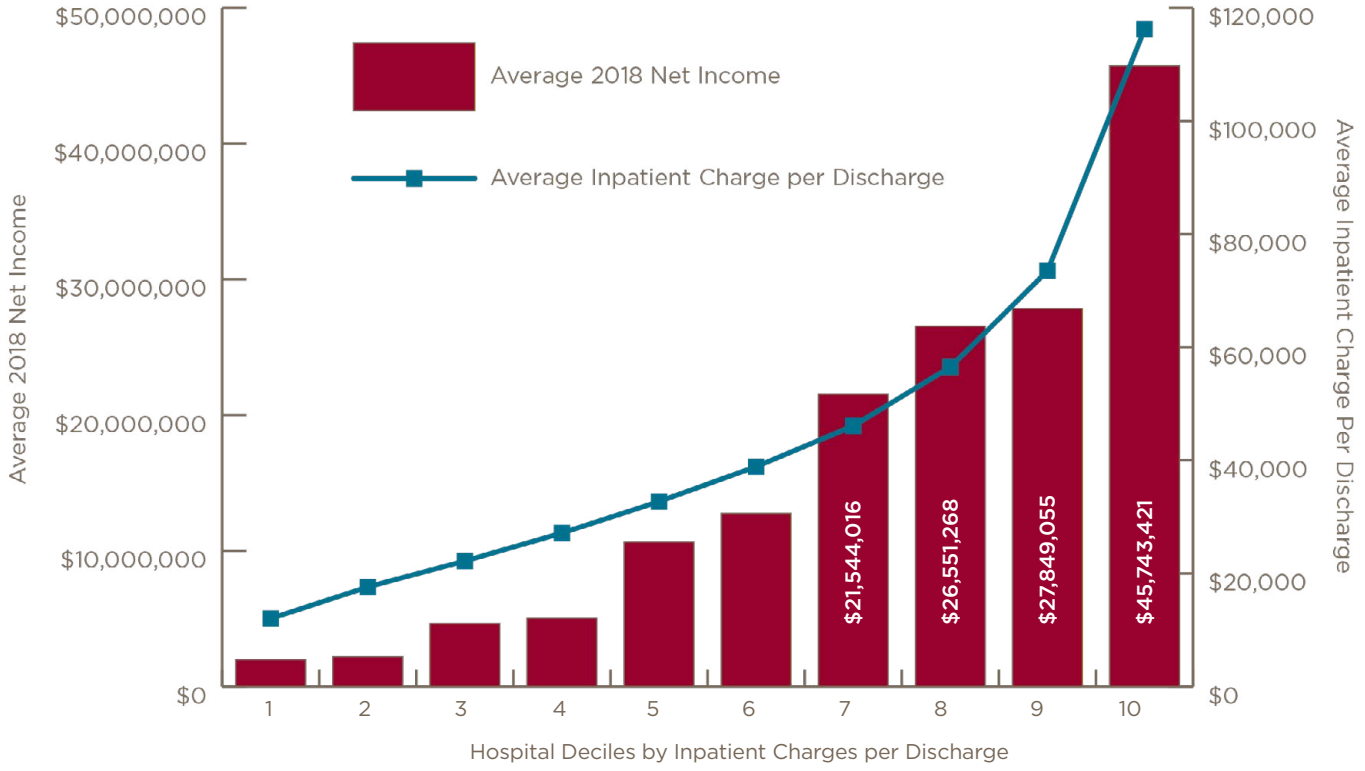


Figure 19. **Hospital Deciles » Inpatient Charges Per Discharge and Net Income**



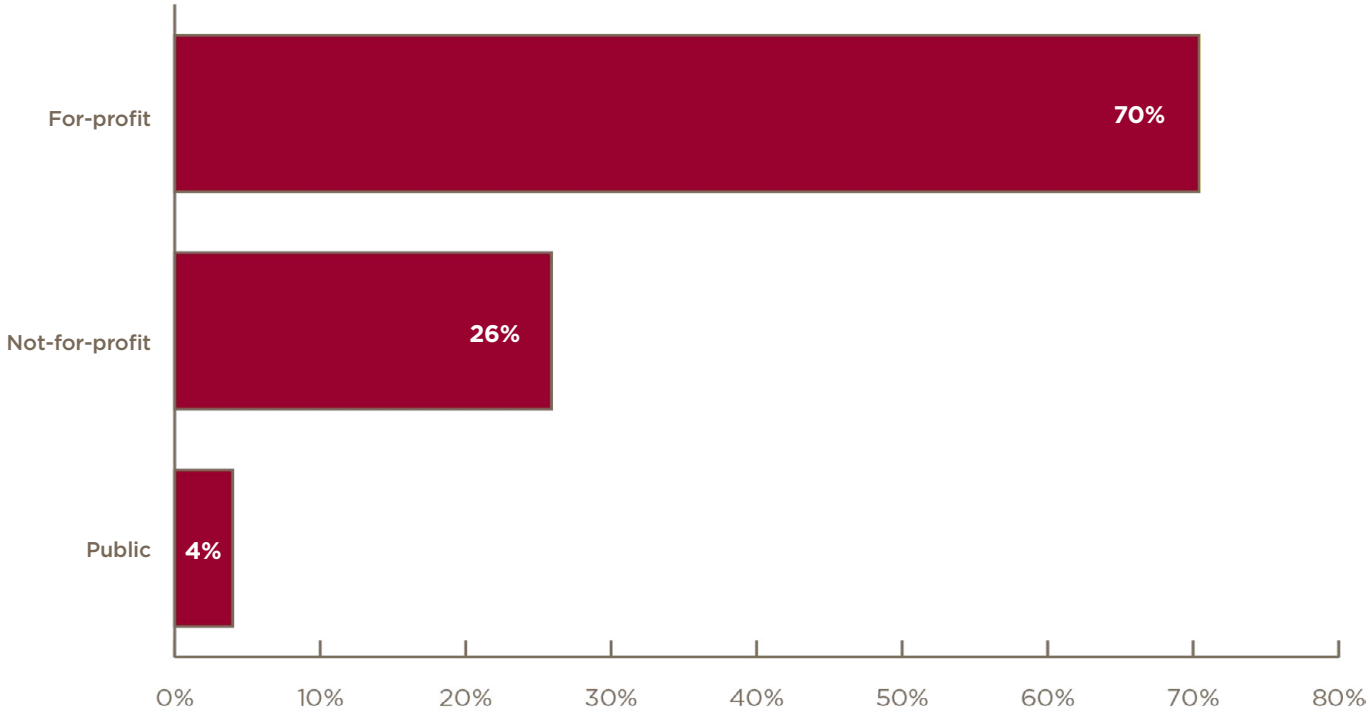
Similarly, higher charges per inpatient discharge are also strongly associated with higher hospital profits. Dividing the hospitals again into deciles in Figures 19 and 20, this time based on their average inpatient charges per discharge, we find that higher charges per discharge are directly correlated with higher net income. This relationship is especially pronounced for the hospitals in the decile with the highest charges per discharges—this group's average net income was 64.3 percent larger than the next highest decile group, while its charges per discharge were 58.1 percent higher. The span between the decile group with the highest charges and those in the middle and those with the lowest charges per discharge was also substantial: the average net income for the highest decile group was 329 percent higher than that of the fifth decile group, and 2,207.8 percent higher than that of the group with the lowest charges per discharge.

Figure 20. **Hospital Deciles » Inpatient Charges Per Discharge and Net Income**

	Average Inpatient Charge per Discharge	Average 2018 Net Income
1	$12,017	$1,982,099
2	$17,605	$2,183,691
3	$22,198	$4,648,843
4	$27,143	$5,041,294
5	$32,710	$10,663,236
6	$38,883	$12,759,992
7	$46,077	$21,544,016
8	$56,478	$26,551,268
9	$73,494	$27,849,055
10	$116,212	$45,743,421
Total	**$44,277**	**$15,901,881**

HIGHEST CCRs BY STATE AND REGION

Figure 21. **Provider Control Type for Hospitals with Highest CCR in Each State**



In Appendix 11 we provide a list of the 10 hospitals with the highest charge-to-cost ratio for each state and territory. Of the hospitals with the highest charge-to-cost ratios in their respective geographic area, 70.4 percent were owned or operated by for-profit companies, while 25.9 percent were owned by not-for-profits (Figure 21). More than four out of five of the top hospitals belonged to systems. Just five for-profit systems own or operate over half of the hospitals with the highest CCRs in their states. These systems include HCA (which owned 22.2 percent of the top-ranked hospitals by state), Community Health Systems (which owned 14.8 percent), LifePoint Health (7.4 percent), Quorum Health (5.6 percent), and Universal Health Services (3.7 percent).

For-profit companies also control most of the hospitals that made the top 10 list by CCR in each state, making up 51.8 percent of the total. Hospital systems account for 79.1 percent of the facilities that made the top 10 list in their respective states, with the for-profit firms HCA, Community Health Systems, and LifePoint topping the list. In the 19 states in which HCA operates, it owned the hospital with the highest CCR in 12 states, it owned one or more in the top three in 16 states, and had hospitals in the top 10 in all the states in which it operates.

Drilling down further, if we look at hospital regional markets, as defined by the Dartmouth Healthcare Atlas's Health Referral Regions, the facilities run by for-profit firms and hospital systems routinely have the highest charges in relation to their costs (see Appendix 12 for the full list of Health Referral Regions and the top hospital by CCR for each region). Of the hospitals with the highest charge-to-cost ratios within each of the 307 Health Referral Regions, 49.8 percent were owned or operated by for-profit businesses. Likewise, hospital systems controlled 85.3 percent of these hospitals, with the top five hospital systems accounting for 36.2 percent of the total. Not surprisingly, the top five systems are all operated as for-profit enterprises. Again, HCA tops the list, controlling more hospitals with the highest regional CCRs than any other system, with a total of 49 facilities. According to the American Hospital Association, HCA operates hospitals in 58 Health Referral Regions. That means HCA facilities have the highest charge-to-cost ratio in 86.0 percent of the regional markets in which they operate.

BEYOND CHARGES: OTHER HOSPITAL PRACTICES TO MAXIMIZE PROFIT

The rise in charge-to-cost ratios is unfortunately only one of many tactics hospitals use to extract more revenue from their patients. One particularly noxious example is the increasingly common practice of surprise billing—when patients with health insurance find themselves liable for hundreds or even thousands of dollars in unforeseen medical bills, due to receiving health care from an out-of-network provider. This often occurs even when patients seek care at a hospital that is "in-network," meaning it is a part of the approved provider network of the patient's insurance company, but the doctors or other technicians providing care in the hospital are employed by a staffing firm that is not included within that network. Hospitals have by and large given the corporate staffing firms they contract with a green light to engage in surprise billing practices, which can result in windfall profits for those firms, because they are able to charge exorbitant rates to out-of-network patients. The practice has become commonplace, with studies indicating that four out of every 10 trips to the ER result in surprise medical bills. While the prime beneficiaries of this practice are the corporate physician staffing firms, hospitals are sharing in the profits as well. In one case, HCA formed a joint venture with EmCare (subsidiary of Envision Physician Services), in which EmCare would provide ER physicians for HCA hospitals and bill patients directly. In exchange, EmCare would split profits with HCA 50%–50%, once a certain margin was reached.[51]

Hospitals have also increased their revenues by elevating routine fees to exorbitant levels. According to a 2014 report by the Trauma Center Association of America, hospitals had increased "trauma fees" (charged on top of services, supplies, and facility fees) by 87 percent over six years. In Florida, trauma fees were reported to reach as high as $33,000 and have showed no sign of slowing.[52] In another example, "facility fees," which are extra charges tacked onto medical bills for care from emergency departments, nearly doubled on average from 2009 to 2016, according to the Health Care Cost Institute. In Colorado, a patient who had gone to the emergency room for dehydration, a visit lasting only 45 minutes and only requiring minimal treatment, said he was charged a facility fee of $7,644—an amount characterized as "obscene" by a health care consumer rights group.[53] In California, Zuckerberg San Francisco General Hospital has nearly doubled its facility fees over the last 10 years. In 2010, the emergency room fees at the hospital ranged from $287 to $6,118, depending on the severity. By 2019, those fees ranged from $525 to $11,958, more than double the average amount charged by other San Francisco hospitals.[54] Zuckerberg General has also taken advantage of excessively high trauma fees. In 2016, the hospital charged a couple $15,666 in trauma fees for an ER visit that included no tests beyond a basic examination by a physician, which found the patient to be in good health. The national average for trauma fees, which usually involve actual physical trauma, was $3,968 at the time (the hospital agreed to waive the $15,666 trauma fee after it became the subject of numerous articles).[55]

Hospital systems have also sought higher revenues through market concentration. When systems are able to dominate local hospital markets—through mergers and acquisitions—their ability to demand higher prices from health insurance companies and other payers is greatly enhanced. Numerous studies have shown that hospital consolidation results in increased reimbursements for hospitals (see Endnotes 52–55). Recognizing this, hospital systems have been pursuing mergers and acquisitions with gusto: since 2004 there have been more than 2,000 instances of individual hospitals changing ownership.[56] Furthermore, as mentioned above, hospital systems have expanded from operating just 37.41 percent of hospitals in 1994 to 67.16 percent of hospitals in 2018.[57] In some cases, hospital systems have used their market power to raise prices to a degree that violates antitrust laws. In 2019, for example, Sutter Health in Northern California agreed to a settlement to a lawsuit brought by the state attorney general for illegally using its market dominance to stifle competition and drive up prices for its medical services. In the end, the hospital system agreed to end its most anticompetitive practices and paid $575 million to settle the case.[58]

As the charges, fees, and profits of hospitals have surged in recent years, the burden of health care costs for patients is becoming much heavier. As many as 137.1 million Americans have reported struggling with medical debt over the last year.[59] Even as medical debt and medical bankruptcies become more common, hospitals have reduced the amount of financial assistance and charity care offered to patients around the country.[60,61,62] As more and more patients lack the resources to pay their medical debts, hospitals have resorted to

extraordinary collection practices, including suing their patients by the thousands. In Maryland, for example, hospitals have filed over 145,000 medical debt lawsuits over the last 10 years, seeking $268.7 million in payments from patients, whose median debt was only $944. The Johns Hopkins Health System alone filed nearly 22,000 cases over that time, seeking $45.3 million in medical debt.[63] Media reports have exposed numerous other examples of hospitals suing patients who are too poor to pay medical debts: studies and articles have been published discussing this practice in Connecticut,[64] Virginia,[65,66,67,68] Oklahoma,[69] New Mexico,[70] and Tennessee.[71,72,73] These studies find that hospitals are suing thousands, if not tens of thousands of poor and low-income patients who need medical care, but are unable to pay due to being uninsured or underinsured. Once the hospitals receive a favorable judgment, they are able then to ensure payment through filing liens against patients' homes and garnishing the bank accounts or wages of their patients.

Though hospitals have been increasing their revenue through higher charges, fees, and aggressive collections, they do not seem to be reinvesting this money in patient care. As one example of this, hospitals have been abandoning rural America at alarming rates: 174 rural hospitals have closed since 2005,[74] and one in four currently in operation are at risk of closing.[75] Nearly 80 percent of rural America is designated by the federal government as medically underserved, putting patients in those areas at heightened risk due to lack of access to care.[76] Urban areas, especially serving the poor and communities of color, have also experienced a number of hospital closures in recent years. Examples from 2019 include the closings of Hahnemann University Hospital in downtown Philadelphia and Providence Hospital in eastern Washington, DC, both of which primarily served neighborhoods with high poverty rates and large Black communities.[77] More closures are likely, as the financial pressures faced by safety-net hospitals have been made significantly worse by the Covid pandemic. One recent casualty is Mercy Hospital & Medical Center, located on the South Side of Chicago, which announced that it will be closing in the coming months. Mercy's service area includes 55 percent of the city's impoverished residents and 62 percent of its Black residents.[78] The disappearance of hospitals such as these are increasingly leaving the poor and communities of color with limited access to health services. In fact, a recent study published in the *Journal of the American Medical Association* found that Black communities are now experiencing consistent disparities in geographic access to trauma centers.[79]

In addition, across the country, hospitals have failed to invest in maintaining adequate stockpiles of personal protective equipment (PPE), leading to shortages and rationing throughout the Covid crisis. In a survey conducted by National Nurses United, 87 percent of nurses working in hospitals reported being required to reuse single-use PPE, an unsafe practice in the midst of a pandemic that puts both nurses and patients at risk.[80] Seventeen HCA hospitals are the subject of an OSHA complaint filed by the union highlighting lack of PPE and other unsafe practices.[81] The needs for adequate supplies of PPE were well understood before the pandemic hit, yet hospitals chose to put the safety of their staff and patients at risk in order to minimize the expense of maintaining a stockpile.

CONCLUSION

Hospitals have largely abandoned their once traditional roles as community-centered charitable organizations focused on patient care, transforming themselves into powerful corporations focused on maximizing profits. With little or no community accountability or stakeholder representation, hospitals effectively use their economic power to take advantage of their social importance and distort pricing systems. As this report has shown, charges, in relation to costs, have dramatically increased across hospitals over the last two decades. During this period, multihospital systems have dramatically expanded and increased their market power, hospital prices have tripled, and profits have skyrocketed. All the while, the public has been left with increasingly unaffordable health care, as millions of Americans forego needed medical treatment due to cost and millions more struggle with medical debt. This dynamic, intolerable under normal circumstances, has grown to crisis proportions as our nation faces the continuing health crisis of Covid-19.

This report illustrates the failure of the U.S. health care system to slow the ever-increasing charges for hospital services, and by extension, the increasing costs of health care in general. Our system for purchasing medical care—a fractured web of employer-provided insurance plans, government plans, and individual market plans—is incapable of addressing this problem. Our largely profit-driven health care industry remains the most expensive in the world. Attempts to rationalize the provision of health care in this country have been going on for decades. Rising health costs have been recognized as a problem since at least the 1970s, and have been the target of numerous reform efforts. These reforms, from the Health Maintenance Organization Act of 1973 to the Affordable Care Act of 2010, sought to use market mechanisms to slow cost growth. Nevertheless, health expenditures have continued to increase dramatically through the decades, rising from 8.9 percent of GDP in 1980, to 12.1 percent in 1990, to 17.7 percent in 2018, and they are projected to rise to 19.7 percent of GDP by 2028.[82] Market-based reforms, though they have in some cases reduced the amount of care Americans receive, have never slowed for any length of time the continual increase in health spending as a proportion of overall economic activity. If we are not able to alter this trajectory, one-fifth of the U.S. economy will be devoted to health care in less than 10 years. Last year, average health spending as a share of GDP for other industrialized nations was only 8.8 percent.[83]

The most viable solution to slowing the growth in hospital charges and the continued inflation of hospital prices is to bring all health care purchasers together under a public, nationwide single-payer plan. The straightforward way to achieve this goal is to expand Medicare to all Americans, regardless of age, creating a unified, equitable system for paying for health care. This simple, yet extraordinarily profound reform would dramatically inhibit the ability of hospitals and other providers to continue to increase their charges relative to their costs, and slow the ever-increasing portion of our national income going toward hospital profits and the enrichment of health care executives. It would also expand care to the millions of Americans who cannot afford it, eliminate the cost penalty for seeking care, and eradicate the national blight of medical debt and medical bankruptcies. We have seen single-payer health systems succeed at reducing costs and expanding care in nearly every other wealthy nation on the planet. The alternative, if we fail to take steps to slow the rising price of health care, will mean the costs of hospital care and other medical services will continue to grow to even more unsustainable and unaffordable levels, exacerbating the suffering and financial burdens of the millions who are already buckling under the weight of our overpriced health care system.

APPENDICES

Appendix 1. **Sources and Methods**

All charge-to-cost data is based on Medicare hospital cost report filings, current as of March 31, 2020. The Medicare hospital cost reports are also the basis for individual hospital net income figures, ownership type, total discharges, and city and state location.

Charge-to-cost ratios, as expressed as percentages, are calculated by dividing total facility charges by total facility costs and multiplying by 100. Both the total charges and costs are found in Worksheet C of the Medicare hospital cost reports.

Charges per inpatient discharge are calculated by dividing total inpatient charges for each hospital by total discharges.

For the purposes of calculating total charge-to-cost ratios, we included only short-term general acute care hospitals, and only those hospitals that had total charges equal to or greater than their total costs, net patient revenues greater than 0, and at least 100 patient discharges.

All hospital system data and Health Referral Region data come from the American Hospital Association Annual Survey. Aggregate hospital net income figures and total percentage of hospitals belonging to systems are based on the American Hospital Association's Hospital Statistics.

Sources for each table are listed below.

- Figure 1: U.S. Gross Domestic Product, 1999–2018. Source: Bureau of Economic Analysis
- Figure 2: National Health Expenditures, 1999–2018. Source: National Health Expenditures Data, provided by the Centers for Medicare and Medicaid Services
- Figure 3: National Health Expenditure as Percentage of National Gross Domestic Product, 1999–2018. Source: National Health Expenditures Data, provided by the Centers for Medicare and Medicaid Services and Bureau of Economic Analysis
- Figure 4: National Health Expenditures Components, 2018. Source: National Health Expenditures Data, provided by the Centers for Medicare and Medicaid Services
- Figure 5: National Hospital Expenditures, 1999–2018. Source: National Health Expenditures Data, provided by the Centers for Medicare and Medicaid Services
- Figure 6: National Hospital Expenditures as Percentage of Health Expenditures, 1999–2018. Source: National Health Expenditures Data, provided by the Centers for Medicare and Medicaid Services
- Figure 7: U.S. Hospitals' Net Income, 1999–2018. Source: American Hospital Association's Hospital Statistics
- Figure 8: U.S. Hospitals' Net Income, 1999–2018 (table). Source: American Hospital Association's Hospital Statistics
- Figure 9: Consumer Price Index for Outpatient, Inpatient, and Medical Care, 1999–2018. Source: Bureau of Labor Statistics
- Figure 10: U.S. Hospitals' Average Charge-to-Cost Ratio, 1999–2018. Source: Medicare cost reports
- Figure 11: System Owners of the Top 100 Hospitals by CCR. Source: Medicare cost reports and AHA Annual Survey
- Figure 12: Charge-to-Cost Ratio by Provider Control Type, 2018. Source: Medicare cost reports
- Figure 13: Provider Control Type: Hospitals with the 100 Lowest CCRs. Source: Medicare cost reports
- Figure 14: System Owners of the 100 Hospitals with the Lowest CCRs. Source: Medicare cost reports and AHA Annual Survey
- Figure 15: Percentage of Hospitals as Part of Hospital System, 1994–2018. Source: AHA Hospital Statistics
- Figure 16: Top 15 U.S. Hospital Systems by Charge-to-Cost Ratios for 2018. Source: Medicare cost reports and AHA Annual Survey
- Figure 17: Hospital Deciles: CCR Levels and Net Income. Source: Medicare cost reports

- Figure 18: Hospital Deciles: CCR Levels and Net Income (table). Source: Medicare cost reports
- Figure 19: Hospital Deciles: Inpatient Charges per Discharge and Net Income. Source: Medicare cost reports
- Figure 20: Hospital Deciles: Inpatient Charges per Discharge and Net Income (table). Source: Medicare cost reports
- Figure 21: Ownership Type for Hospitals with Highest CCR in Each State. Source: Medicare cost reports
- Appendix 2: Average Charge-to-Cost Ratios, 1999–2018 (table). Source: Medicare cost reports
- Appendix 3: 2018 Top 100 Hospitals—Charge-to-Cost Ratio. Source: Medicare cost reports and AHA Annual Survey
- Appendix 4: 2018 Bottom 100 Hospitals—Charge-to-Cost Ratio. Source: Medicare cost reports AHA Annual Survey
- Appendix 5. The States of the Hospitals with the 100 Highest CCRs. Source: Medicare cost reports
- Appendix 6: System Affiliation of the Hospitals with the 100 Highest CCRs. Source: Medicare cost reports and AHA Survey
- Appendix 7: Consumer Price Index for Medical Care, 1999–2018. Source: Bureau of Labor Statistics
- Appendix 8: Average Hospital Charge-to-Cost Ratio by State. Source: Medicare cost reports
- Appendix 9: Average Hospital Charge-to-Cost Ratio by State (table). Source: Medicare cost reports
- Appendix 10: Average Charge-to-Cost Ratio by System. Source: Medicare cost reports and AHA Annual Survey
- Appendix 11: Top 10 Hospitals by Charge-to-Cost Ratio for Each State. Source: Medicare cost reports and AHA Annual Survey
- Appendix 12: Hospitals with the Highest Charge-to-Cost Ratios for Each Health Referral Region. Source: Medicare cost reports and AHA Annual Survey

Appendix 2. Average Charge-to-Cost Ratios 1999-2018

Year	Average Charge-to-Cost Ratio
1999	200.01%
2000	209.15%
2001	218.24%
2002	231.72%
2003	243.88%
2004	253.23%
2005	260.05%
2006	267.26%
2007	274.22%
2008	282.15%
2009	295.88%
2010	309.75%
2011	331.60%
2012	341.86%
2013	352.90%
2014	368.50%
2015	381.97%
2016	394.72%
2017	408.27%
2018	417.29%

Appendix 3. **2018 Top 100 Hospitals — Charge-to-Cost Ratios**

Rank by CCR (highest to lowest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
1	Poinciana Medical Center	HCA Healthcare	Kissimmee	FL	1,808%	$7,266,981
2	North Okaloosa Medical Center	Community Health Systems, Inc.	Crestview	FL	1,761%	$34,729,984
3	Oak Hill Hospital	HCA Healthcare	Spring Hill	FL	1,633%	$68,933,194
4	Western Arizona Regional Medical Center	Community Health Systems, Inc.	Bullhead City	AZ	1,621%	$46,303,852
5	Capital Health Regional Medical Center	Capital Health	Trenton	NJ	1,602%	($7,194,845)
6	Orange Park Medical Center	HCA Healthcare	Orange Park	FL	1,580%	$76,021,057
7	Paul B. Hall Regional Medical Center	Quorum Health	Paintsville	KY	1,556%	$4,040,640
8	St. Petersburg General Hospital	HCA Healthcare	St. Petersburg	FL	1,546%	$18,392,779
9	Fort Walton Beach Medical Center	HCA Healthcare	Fort Walton Beach	FL	1,538%	$98,136,146
10	Twin Cities Hospital	HCA Healthcare	Niceville	FL	1,538%	$16,568,776
11	Gadsden Regional Medical Center	Community Health Systems, Inc.	Gadsden	AL	1,509%	($9,438,192)
12	AllianceHealth Durant	Community Health Systems, Inc.	Durant	OK	1,488%	$16,243,624
13	Bayfront Health Brooksville	Community Health Systems, Inc.	Brooksville	FL	1,467%	($6,987,387)
14	Fawcett Memorial Hospital	HCA Healthcare	Port Charlotte	FL	1,448%	$25,225,121
15	Medical Center Enterprise	Community Health Systems, Inc.	Enterprise	AL	1,446%	$3,680,302
16	Citrus Memorial Health System	HCA Healthcare	Inverness	FL	1,418%	($976,765)
17	Osceola Regional Medical Center	HCA Healthcare	Kissimmee	FL	1,417%	$84,125,153 *
18	Crestwood Medical Center	Community Health Systems, Inc.	Huntsville	AL	1,406%	$25,969,832
19	Regional Medical Center Bayonet Point	HCA Healthcare	Hudson	FL	1,397%	$81,602,710

** Because of a likely error, the 2017 net income figure was used for this hospital.*

Rank by CCR (highest to lowest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
20	Brandon Regional Hospital	HCA Healthcare	Brandon	FL	1,387%	$148,765,775
21	RMC-Stringfellow Memorial Hospital	Regional Medical Center	Anniston	AL	1,375%	($1,158,815)
22	CarePoint Health Christ Hospital	CarePoint Health	Jersey City	NJ	1,372%	($10,940,450)
23	CarePoint Health Bayonne Medical Center	CarePoint Health	Bayonne	NJ	1,364%	($582,612)
24	Englewood Community Hospital	HCA Healthcare	Englewood	FL	1,349%	$5,815,061
25	North Florida Regional Medical Center	HCA Healthcare	Gainesville	FL	1,347%	$126,173,087
26	Grandview Medical Center	Community Health Systems, Inc.	Birmingham	AL	1,345%	$61,167,397
27	Baptist Emergency Hospital	Emerus	San Antonio	TX	1,341%	$21,495,457
28	DeTar Healthcare System	Community Health Systems, Inc.	Victoria	TX	1,336%	$35,981,881
29	National Park Medical Center	LifePoint Health	Hot Springs	AR	1,332%	$13,299,474
30	South Baldwin Regional Medical Center	Community Health Systems, Inc.	Foley	AL	1,324%	$38,199,431
31	Kendall Regional Medical Center	HCA Healthcare	Miami	FL	1,316%	$174,272,728
32	Chippenham Hospital	HCA Healthcare	Richmond	VA	1,313%	$133,004,748
33	North Suburban Medical Center	HCA Healthcare	Thornton	CO	1,302%	$37,469,312
34	South Texas Health System	Universal Health Services, Inc.	Edinburg	TX	1,297%	$14,551,259
35	Santa Rosa Medical Center	Community Health Systems, Inc.	Milton	FL	1,289%	$13,827,075
36	Capital Health Medical Center—Hopewell	Capital Health	Hopewell	NJ	1,286%	($2,289,385)
37	Northside Hospital	HCA Healthcare	St. Petersburg	FL	1,280%	$8,030,586
38	MUSC Health Florence Medical Center	Community Health Systems, Inc.	Florence	SC	1,279%	($82,296,613)
39	Memorial Hospital Jacksonville	HCA Healthcare	Jacksonville	FL	1,276%	$83,276,271

Rank by CCR (highest to lowest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
40	West Tennessee Healthcare Dyersburg Hospital	West Tennessee Healthcare	Dyersburg	TN	1,275%	($3,602,872)
41	MUSC Health Lancaster Medical Center	Community Health Systems, Inc.	Lancaster	SC	1,271%	($47,075,668)
42	Bayfront Health Port Charlotte	Community Health Systems, Inc.	Port Charlotte	FL	1,268%	$18,258,558
43	Northwest Medical Center	HCA Healthcare	Margate	FL	1,266%	$49,125,110
44	Las Palmas Medical Center	HCA Healthcare	El Paso	TX	1,262%	$133,719,656
45	South Bay Hospital	HCA Healthcare	Sun City Center	FL	1,256%	($5,306,031)
46	Lawnwood Regional Medical Center & Heart Institute	HCA Healthcare	Ft. Pierce	FL	1,252%	$68,649,457
47	Ocala Regional Medical Center	HCA Healthcare	Ocala	FL	1,250%	$105,746,687
48	Medical Center of Trinity	HCA Healthcare	Trinity	FL	1,246%	$6,499,433
49	Palms of Pasadena Hospital	HCA Healthcare	St. Petersburg	FL	1,245%	($4,179,268)
50	Centennial Hills Hospital Medical Center	Universal Health Services, Inc.	Las Vegas	NV	1,235%	$51,370,315
51	Medical City Arlington	HCA Healthcare	Arlington	TX	1,233%	$53,177,075
52	Valley Regional Medical Center	HCA Healthcare	Brownsville	TX	1,232%	$35,824,250
53	Riverside Community Hospital	HCA Healthcare	Riverside	CA	1,229%	$104,558,592
54	Westside Regional Medical Center	HCA Healthcare	Plantation	FL	1,223%	$86,912,104
55	Valley Baptist Medical Center—Harlingen	Tenet Healthcare Corporation	Harlingen	TX	1,217%	$39,168,387
56	Valley Baptist Medical Center—Brownsville	Tenet Healthcare Corporation	Brownsville	TX	1,213%	$4,598,397
57	University Hospital and Medical Center	HCA Healthcare	Tamarac	FL	1,211%	$28,169,064
58	Good Samaritan Medical Center	Tenet Healthcare Corporation	West Palm Beach	FL	1,210%	$19,438,334
59	Plantation General Hospital	HCA Healthcare	Plantation	FL	1,210%	$24,167,072

Rank by CCR (highest to lowest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
60	St. Lucie Medical Center	HCA Healthcare	Port St. Lucie	FL	1,210%	$72,411,461
61	Vaughan Regional Medical Center	LifePoint Health	Selma	AL	1,208%	$1,958,252
62	CarePoint Health Hoboken University Medical Center	CarePoint Health	Hoboken	NJ	1,205%	$21,697,979
63	Sunrise Hospital and Medical Center	HCA Healthcare	Las Vegas	NV	1,202%	$8,742,318
64	Largo Medical Center	HCA Healthcare	Largo	FL	1,200%	$57,577,479
65	Medical City Denton	HCA Healthcare	Denton	TX	1,199%	$12,282,024
66	Tennova Healthcare—Cleveland	Community Health Systems, Inc.	Cleveland	TN	1,199%	$9,800,809
67	Flowers Hospital	Community Health Systems, Inc.	Dothan	AL	1,193%	$23,840,374
68	UPMC Presbyterian	UPMC	Pittsburgh	PA	1,188%	($171,613,931)
69	JFK Medical Center	HCA Healthcare	Atlantis	FL	1,188%	$79,248,004
70	Trident Medical Center	HCA Healthcare	Charleston	SC	1,185%	$107,952,289
71	Corpus Christi Medical Center	HCA Healthcare	Corpus Christi	TX	1,185%	$22,667,939
72	Sky Ridge Medical Center	HCA Healthcare	Lone Tree	CO	1,185%	$285,232,454
73	Doctors Medical Center of Modesto	Tenet Healthcare Corporation	Modesto	CA	1,181%	$112,482,606
74	Lake City Medical Center	HCA Healthcare	Lake City	FL	1,181%	$25,477,114
75	Palms West Hospital	HCA Healthcare	Loxahatchee	FL	1,176%	$57,282,249
76	Regional Medical Center of San Jose	HCA Healthcare	San Jose	CA	1,175%	($46,194,508)
77	Bayshore Medical Center	HCA Healthcare	Pasadena	TX	1,175%	$3,822,429
78	Southside Regional Medical Center	Community Health Systems, Inc.	Petersburg	VA	1,175%	$4,035,873
79	Longview Regional Medical Center	Community Health Systems, Inc.	Longview	TX	1,173%	$18,248,077
80	West Florida Hospital	HCA Healthcare	Pensacola	FL	1,171%	$77,917,847
81	Capital Regional Medical Center	HCA Healthcare	Tallahassee	FL	1,166%	$69,004,669

Rank by CCR (highest to lowest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
82	Barstow Community Hospital	Quorum Health	Barstow	CA	1,163%	$14,313,137
83	HCA Houston Healthcare Conroe	HCA Healthcare	Conroe	TX	1,162%	$2,538,826
84	Henderson Hospital	Universal Health Services, Inc.	Henderson	NV	1,162%	$24,907,600
85	Jeanes Hospital	Temple University Health System	Philadelphia	PA	1,161%	($2,971,293)
86	Desert Springs Hospital Medical Center	Universal Health Services, Inc.	Las Vegas	NV	1,160%	$29,745,499
87	AdventHealth Heart of Florida	AdventHealth	Davenport	FL	1,158%	$5,231,408
88	Spring Valley Hospital Medical Center	Universal Health Services, Inc.	Las Vegas	NV	1,156%	$56,658,823
89	Valley View Medical Center	LifePoint Health	Fort Mohave	AZ	1,153%	($938,514)
90	Cartersville Medical Center	HCA Healthcare	Cartersville	GA	1,152%	$47,818,504
91	Gulf Coast Regional Medical Center	HCA Healthcare	Panama City	FL	1,151%	$18,844,259
92	Kingwood Medical Center	HCA Healthcare	Kingwood	TX	1,146%	$10,438,809
93	Doctors Hospital	HCA Healthcare	Augusta	GA	1,144%	$212,076,661
94	Doctors Hospital of Manteca	Tenet Healthcare Corporation	Manteca	CA	1,143%	($10,384,127)
95	Emanuel Medical Center	Tenet Healthcare Corporation	Turlock	CA	1,142%	$46,776,728
96	Grand Strand Regional Medical Center	HCA Healthcare	Myrtle Beach	SC	1,141%	$108,304,465
97	Summerlin Hospital Medical Center	Universal Health Services, Inc.	Las Vegas	NV	1,139%	$91,629,414
98	MountainView Hospital	HCA Healthcare	Las Vegas	NV	1,139%	$36,634,265
99	Hialeah Hospital	Tenet Healthcare Corporation	Hialeah	FL	1,137%	($7,537,580)
100	TriStar Hendersonville Medical Center	HCA Healthcare	Hendersonville	TN	1,129%	$48,854,176

Appendix 4. **2018 Bottom 100 Hospitals — Charge-to-Cost Ratios**

Rank by CCR (lowest to highest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
4203	NYC Health + Hospitals / Elmhurst	NYC Health + Hospitals	Elmhurst	NY	100%	$8,781,973
4202	NYC Health + Hospitals / Harlem	NYC Health + Hospitals	New York	NY	100%	$3,571,807
4201	NYC Health + Hospitals / Metropolitan	NYC Health + Hospitals	New York	NY	100%	($18,625,230)
4200	NYC Health + Hospitals / Coney Island	NYC Health + Hospitals	Brooklyn	NY	100%	($35,774,010)
4199	Northern Light CA Dean Hospital	Northern Light Health	Greenville	ME	101%	$2,126,719
4198	NYC Health + Hospitals / Woodhull	NYC Health + Hospitals	Brooklyn	NY	101%	$66,900,359
4197	NYC Health + Hospitals / Queens	NYC Health + Hospitals	Jamaica	NY	101%	$57,060,279
4196	NYC Health + Hospitals / Bellevue	NYC Health + Hospitals	New York	NY	102%	($52,009,008)
4195	NYC Health + Hospitals / Kings County	NYC Health + Hospitals	Brooklyn	NY	102%	$589,597,904
4194	Kane County Hospital		Kanab	UT	103%	$2,520,604
4193	Gundersen Palmer Lutheran Hospital and Clinics		West Union	IA	103%	($520,710)
4192	Haskell Memorial Hospital		Haskell	TX	103%	($283,030)
4191	Graham County Hospital		Hill City	KS	105%	$505,918
4190	Jacobson Memorial Hospital Care Center		Elgin	ND	105%	$53,058
4189	Newman Memorial Hospital		Shattuck	OK	105%	($3,048,197)
4188	Republic County Hospital	Great Plains Health Alliance, Inc.	Belleville	KS	105%	($1,224,665)
4187	Annie Jeffrey Memorial County Health Center		Osceola	NE	106%	($48,179)
4186	NYC Health + Hospitals / Jacobi	NYC Health + Hospitals	Bronx	NY	106%	($15,895,894)
4185	CHI St. Alexius Health Garrison	CommonSpirit Health	Garrison	ND	106%	$575,485
4184	Hospital District No 1 of Rice County		Lyons	KS	106%	($67,039)
4183	Ness County Hospital District No. 2		Ness City	KS	107%	$81,596

Rank by CCR (lowest to highest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
4182	Smith County Memorial Hospital	Great Plains Health Alliance, Inc.	Smith Center	KS	107%	($986,068)
4181	Phillips County Health Systems		Phillipsburg	KS	107%	$229,434
4180	Petersburg Medical Center		Petersburg	AK	108%	($249,872)
4179	Northern Rockies Medical Center	QHR	Cut Bank	MT	109%	($851,174)
4178	Mosaic Medical Center—Albany	Mosaic Life Care	Albany	MO	109%	($2,175,000)
4177	Hodgeman County Health Center		Jetmore	KS	109%	($1,518,946)
4176	Lindsay Municipal Hospital		Lindsay	OK	110%	$346,685
4175	Pioneers Medical Center	QHR	Meeker	CO	110%	($144,348)
4174	Martin County Hospital District		Stanton	TX	110%	$4,812,796
4173	Laurel Regional Hospital				111%	$3,262,916
4172	Ryder Memorial Hospital		Humacao	PR	111%	($7,804,106)
4171	St. Aloisius Medical Center	Sisters of Mary of the Presentation Health System	Harvey	ND	111%	$75,994
4170	Thayer County Health Services		Hebron	NE	111%	$153,538
4169	Sedan City Hospital		Sedan	KS	112%	($571,957)
4168	Callaway District Hospital		Callaway	NE	112%	$356,351
4167	Rush County Memorial Hospital		La Crosse	KS	113%	($230,803)
4166	Morton County Health System		Elkhart	KS	113%	($1,166,741)
4165	Hospital Cuidado Agudo Especializado En Pacientes Politraumatizados		San Juan	PR	114%	$42,821,435
4164	Weston County Health Services	Regional Health	Newcastle	WY	114%	$377,675
4163	Providence Valdez Medical Center	Providence St. Joseph Health	Valdez	AK	114%	$1,341,043
4162	Stevens County Hospital		Hugoton	KS	114%	($643,796)
4161	Memorial Hospital		Seminole	TX	114%	$5,311,765

Rank by CCR (lowest to highest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
4160	Mercy Hospital		Moundridge	KS	115%	($430,971)
4159	Ringgold County Hospital	MercyOne	Mount Ayr	IA	115%	($390,249)
4158	Mineral Community Hospital		Superior	MT	115%	$1,817,990
4157	Sitka Community Hospital		Sitka	AK	115%	($1,977,312)
4156	Sheridan Memorial Hospital		Plentywood	MT	115%	($720,468)
4155	Miami Jewish Home and Hospital for Aged		Miami	FL	116%	($23,994,078)
4154	Caribou Memorial Hospital and Living Center		Soda Springs	ID	116%	($4,683,205)
4153	Bath Community Hospital		Hot Springs	VA	116%	($405,454)
4152	South Lincoln Medical Center		Kemmerer	WY	116%	($2,121,280)
4151	Stonewall Memorial Hospital		Aspermont	TX	116%	$719,945
4150	Osborne County Memorial Hospital	Great Plains Health Alliance, Inc.	Osborne	KS	116%	$184,446
4149	Appleton Area Health Services		Appleton	MN	116%	$100,803
4148	Rawlins County Health Center		Atwood	KS	117%	$339,685
4147	Linton Hospital		Linton	ND	117%	$491,536
4146	Phillips County Hospital		Malta	MT	118%	($309,007)
4145	University Hospital	Puerto Rico Department of Health	San Juan	PR	118%	$2,725,836
4144	Muleshoe Area Medical Center	Preferred Management Corporation	Muleshoe	TX	118%	$100,890
4143	Yoakum County Hospital		Denver City	TX	118%	($1,639,974)
4142	Rice Medical Center		Eagle Lake	TX	118%	$1,705,324
4141	Ellsworth County Medical Center		Ellsworth	KS	119%	($259,956)
4140	Holy Cross Germantown Hospital	Trinity Health	Germantown	MD	119%	($4,958,057)
4139	Columbia Basin Hospital		Ephrata	WA	119%	$435,644
4138	Unity Medical Center		Grafton	ND	119%	$1,276,912

Rank by CCR (lowest to highest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
4137	Lake District Hospital		Lakeview	OR	119%	$758,647
4136	Saint Elizabeth's Medical Center	Ascension Healthcare	Wabasha	MN	120%	($9,723,826)
4135	West Holt Medical Services	Faith Regional Health Services	Atkinson	NE	120%	($53,132)
4134	HIMA San Pablo Cupey				120%	($5,181,731)
4133	Norton Sound Regional Hospital		Nome	AK	120%	$34,880,318
4132	Okeene Municipal Hospital		Okeene	OK	120%	($722,620)
4131	Columbia County Health System		Dayton	WA	121%	$18,838
4130	Kauai Veterans Memorial Hospital	Hawaii Health Systems Corporation	Waimea	HI	121%	($4,644,786)
4129	Roger Mills Memorial Hospital		Cheyenne	OK	121%	($256,921)
4128	Mercy Health Love County	Mercy	Marietta	OK	122%	($360,366)
4127	I. Gonzalez Martinez Oncologic Hospital		Hato Rey	PR	122%	$5,831,146
4126	Audubon County Memorial Hospital and Clinics		Audubon	IA	122%	$338,268
4125	Wishek Community Hospital and Clinics		Wishek	ND	123%	$38,457
4124	Lincoln Community Hospital and Nursing Home		Hugo	CO	123%	($812,937)
4123	Humboldt County Memorial Hospital	UnityPoint Health	Humboldt	IA	124%	$332,633
4122	Lawrence County Hospital	Southwest Health Systems	Monticello	MS	124%	($604,838)
4121	Lexington Regional Health Center		Lexington	NE	124%	$462,332
4120	North Valley Health Center		Warren	MN	124%	($680,047)
4119	Johnson County Healthcare Center		Buffalo	WY	124%	($1,736,948)
4118	Garfield Memorial Hospital	Intermountain Healthcare, Inc.	Panguitch	UT	125%	($384,438)
4117	West River Regional Medical Center		Hettinger	ND	125%	$191,030

Rank by CCR (lowest to highest)	Hospital Name	System Name	City	State	Charge-to-Cost Ratio	Net Income for 2018
4116	Lincoln Hospital		Davenport	WA	125%	$142,220
4115	Sakakawea Medical Center		Hazen	ND	126%	($491,583)
4114	Clarke County Hospital	UnityPoint Health	Osceola	IA	126%	$5,629,256
4113	Mayo Clinic Health System in Springfield	Mayo Clinic	Springfield	MN	126%	($1,135,170)
4112	Chadron Community Hospital and Health Services		Chadron	NE	126%	$584,469
4111	Henderson Health Care Services		Henderson	NE	126%	$1,482,326
4110	CHI Health Plainview	CommonSpirit Health	Plainview	NE	126%	$1,410,669
4109	Manning Regional Healthcare Center	MercyOne	Manning	IA	126%	($1,915,334)
4108	Pioneer Medical Center		Big Timber	MT	127%	$245,495
4107	Saunders Medical Center	Bryan Health	Wahoo	NE	127%	$2,113,120
4106	Minnie Hamilton HealthCare Center		Grantsville	WV	127%	($514,338)
4105	Jackson County Hospital District		Edna	TX	127%	$207,711
4104	Fort Washington Medical Center		Oxen Hill	MD	128%	$1,389,938

Appendix 5. **The States of the Hospitals with the 100 Highest CCRs**

State	Top 100 Hospitals by CCR
Florida	40
Texas	14
Alabama	8
Nevada	7
California	6
New Jersey	5
South Carolina	4
Tennessee	3
Arizona	2
Colorado	2
Georgia	2
Pennsylvania	2
Virginia	2
Arkansas	1
Kentucky	1
Oklahoma	1

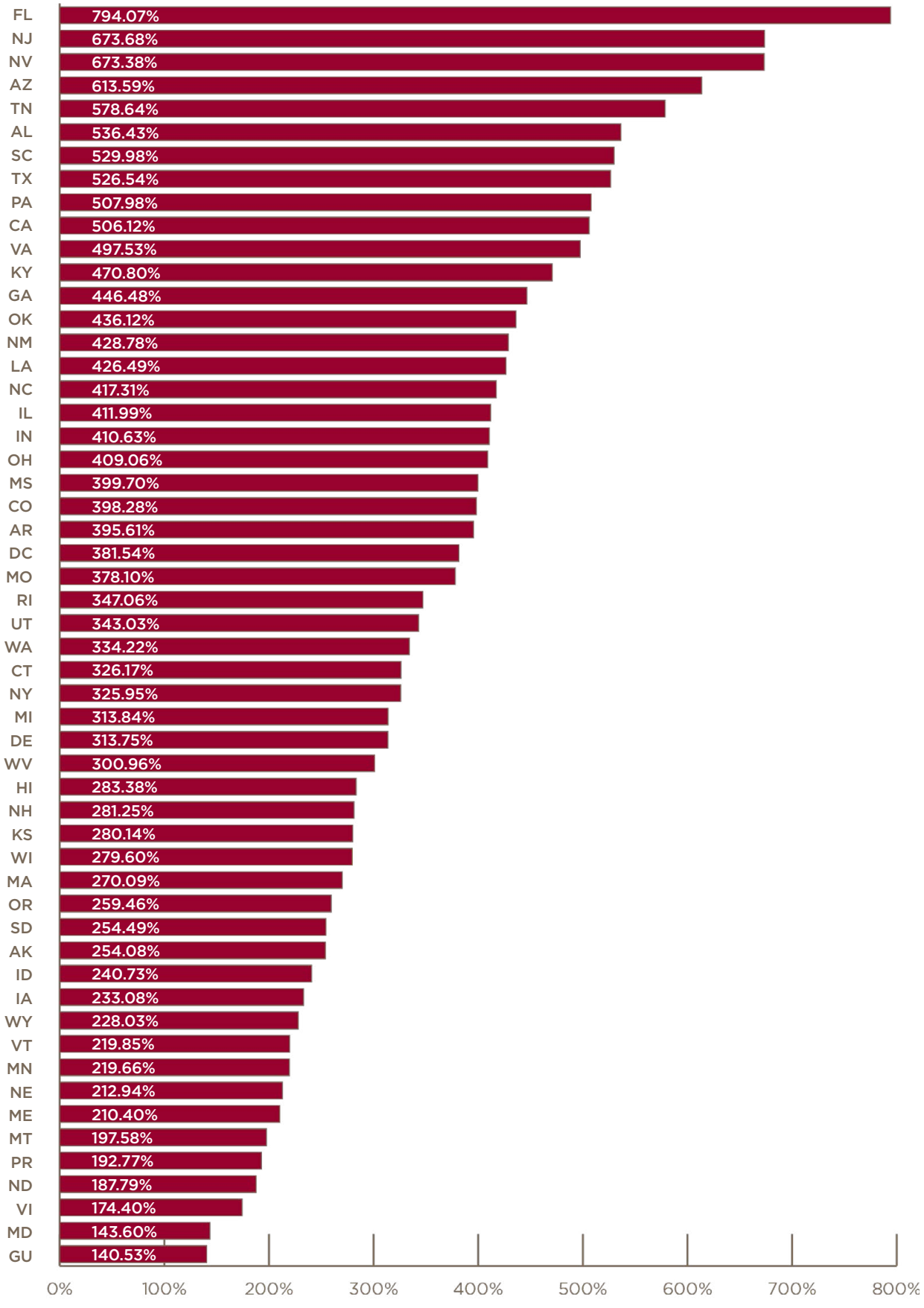
Appendix 6. **System Affiliation of the Hospitals with the 100 Highest CCRs**

System Name	Top 100 Hospitals by CCR
HCA Healthcare	53
Community Health Systems, Inc.	18
Tenet Healthcare Corporation	7
Universal Health Services, Inc.	6
CarePoint Health	3
LifePoint Health	3
Capital Health	2
Quorum Health	2
AdventHealth	1
Emerus	1
Regional Medical Center	1
Temple University Health System	1
UPMC	1
West Tennessee Healthcare	1

Appendix 7. **Consumer Price Index for Medical Care, 1999-2018 (1999=100)**

Year	All Items	Medical Care	Inpatient Hospital Services	Out-patient Hospital Services	Physi-cians' Services	Prescrip-tion Drugs	Dental Services	Eye-glasses and Eye Care	Nursing Homes and Adult Day Services
1999	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
2000	103.36	104.07	105.47	107.24	103.69	104.39	104.57	102.89	104.84
2001	106.30	108.86	112.14	114.27	107.46	110.06	108.82	106.19	109.14
2002	107.98	113.97	121.59	125.93	110.42	115.76	113.67	106.87	114.61
2003	110.44	118.56	129.84	137.36	113.43	119.35	118.33	107.15	121.15
2004	113.39	123.74	137.26	144.84	117.92	123.30	124.15	109.48	125.81
2005	117.23	128.97	145.13	151.63	121.82	127.65	131.07	112.16	129.93
2006	121.01	134.16	155.24	160.57	123.69	133.10	137.90	115.53	135.30
2007	124.45	140.09	165.02	172.45	128.49	135.02	144.99	117.95	143.00
2008	129.23	145.28	176.82	185.71	131.92	138.36	152.45	119.66	148.16
2009	128.77	149.89	188.66	199.44	135.95	143.03	157.01	120.60	153.79
2010	130.89	155.00	205.31	211.61	140.39	149.17	161.31	121.41	158.60
2011	135.02	159.72	219.25	222.30	144.20	155.44	165.06	122.51	163.25
2012	137.81	165.57	230.58	233.34	147.16	160.99	168.88	123.61	169.18
2013	139.83	169.65	240.71	244.58	150.07	161.88	174.66	124.24	174.26
2014	142.10	173.70	254.50	255.66	152.16	167.65	178.40	126.41	179.28
2015	142.27	178.27	264.20	265.52	155.12	175.32	182.92	126.43	184.95
2016	144.06	185.03	277.76	273.32	160.20	183.80	188.12	128.50	191.47
2017	147.13	189.67	289.61	286.92	161.05	190.06	191.17	128.73	197.36
2018	150.72	193.42	300.77	299.04	161.21	193.13	196.41	130.32	204.14

Appendix 8. **Average Hospital Charge-to-Cost Ratio by State**



Appendix 9. **Average Hospital Charge-to-Cost Ratio by State**

State/ Territory	Number of Hospitals	Average Hospital Charge-to-Cost Ratio by State
Florida	174	794.07%
New Jersey	63	673.68%
Nevada	32	673.38%
Arizona	64	613.59%
Tennessee	99	578.64%
Alabama	87	536.43%
South Carolina	57	529.98%
Texas	341	526.54%
Pennsylvania	156	507.98%
California	279	506.12%
Virginia	78	497.53%
Kentucky	85	470.80%
Georgia	123	446.48%
Oklahoma	99	436.12%
New Mexico	34	428.78%
Louisiana	104	426.49%
North Carolina	103	417.31%
Illinois	172	411.99%
Indiana	120	410.63%
Ohio	155	409.06%
Mississippi	82	399.70%
Colorado	74	398.28%
Arkansas	71	395.61%
District of Columbia	7	381.54%
Missouri	102	378.10%
Rhode Island	10	347.06%
Utah	41	343.03%
Washington	79	334.22%
Connecticut	27	326.17%
New York	151	325.95%
Michigan	124	313.84%
Delaware	6	313.75%
West Virginia	46	300.96%
Hawaii	12	283.38%
New Hampshire	26	281.25%
Kansas	100	280.14%
Wisconsin	121	279.60%
Massachusetts	57	270.09%
Oregon	54	259.46%
South Dakota	38	254.49%
Alaska	13	254.08%
Idaho	37	240.73%
Iowa	99	233.08%
Wyoming	21	228.03%
Vermont	13	219.85%
Minnesota	107	219.66%
Nebraska	68	212.94%
Maine	32	210.40%
Montana	36	197.58%
Puerto Rico	46	192.77%
North Dakota	27	187.79%
Virgin Islands	2	174.40%
Maryland	47	143.60%
Guam	2	140.53%
Total	4,203	417.29%

Appendix 10. **Average Charge-to-Cost Ratio by System**

System Name	CCR Average
Capital Health	1,443.98%
CarePoint Health	1,313.60%
Regional Medical Center	1,106.41%
American Academic Health System	1,064.00%
Temple University Health System	1,053.45%
HCA Healthcare	1,008.78%
Tenet Healthcare Corporation	879.25%
Community Health Systems, Inc.	876.12%
Universal Health Services, Inc.	870.38%
St. Luke's University Health Network	836.76%
Summa Health	822.99%
Quorum Health	779.44%
PIH Health	771.79%
Orlando Health	766.57%
HonorHealth	750.29%
Avanti Hospitals	745.80%
AHMC & Healthcare, Inc.	737.47%
Memorial Healthcare System	729.69%
North Oaks Health System	726.80%
Vanderbilt Health	717.92%
Emerus	707.08%
Tower Health	684.14%
Virtua Health	678.53%
NYU Langone Health	676.23%
Cedars-Sinai Health System	667.89%
Atlantic Health System	661.28%
Curae Health	657.60%
Geisinger	653.31%
Kettering Health Network	652.04%
Houston Methodist	632.43%

System Name	CCR Average
Edward-Elmhurst Healthcare	627.09%
RWJBarnabas Health	618.91%
INTEGRIS Health	616.55%
McLeod Health	613.94%
LifePoint Health	613.54%
Stanford Health Care	612.53%
Legent Hospital of El Paso	604.81%
Prime Healthcare Services	601.36%
John Muir Health	600.63%
West Tennessee Healthcare	600.34%
Ardent Health Services	598.46%
Ballad Health	592.97%
Piedmont Healthcare	586.30%
Main Line Health	585.30%
Saint Luke's Health System	584.30%
AdventHealth	584.23%
CHRISTUS Health	583.26%
Inspira Health Network	583.02%
Lehigh Valley Health Network	575.16%
Loma Linda University Adventist Health Sciences Center	573.76%
UPMC	572.25%
MultiCare Health System	568.76%
Baptist Health	568.32%
Scripps Health	565.63%
WellStar Health System	564.43%
Lee Health	563.38%
Baptist Health Care Corporation	562.62%
Hackensack Meridian Health	562.22%
Community Medical Centers	559.70%

System Name	CCR Average
Methodist Le Bonheur Healthcare	558.17%
Norton Healthcare	555.97%
Palomar Health	555.41%
Sharp HealthCare	549.75%
WMCHealth	546.66%
University of Pennsylvania Health System	542.28%
Morton Plant Mease Health Care	538.36%
University of Chicago Medicine	537.05%
Memorial Hermann Health System	529.41%
Mercy Health	529.29%
Jefferson Health	527.51%
AnMed Health	526.93%
Einstein Healthcare Network	526.85%
Spartanburg Regional Healthcare System	526.00%
Steward Health Care System, LLC	523.37%
Verity Health System	523.11%
Health First, Inc.	522.01%
Sinai Health System	521.91%
MemorialCare	519.34%
Duke LifePoint Healthcare	515.17%
Prospect Medical Holdings	514.76%
Atrium Health	513.80%
Northside Healthcare System	511.45%
Catholic Health Services of Long Island	506.93%
Physicians for Healthy Hospitals	502.86%
Baptist Health South Florida	499.95%
Northwestern Memorial HealthCare	498.53%
UPMC Susquehanna	493.79%
Saint Francis Health System	489.98%

System Name	CCR Average
Allegiance Health Management	488.13%
Duncan Regional Hospital	485.98%
WakeMed Health & Hospitals	485.43%
Northeast Georgia Health System	484.70%
Bon Secours Mercy Health	481.77%
Ohio State University Health System	481.00%
UF Health Shands	479.53%
Banner Health	478.36%
Renown Health	477.42%
Allegheny Health Network	477.41%
Premier Health	476.55%
Southern Illinois Healthcare	475.95%
American Province of Little Company of Mary Sisters	474.62%
Alecto Healthcare	474.08%
LCMC Health	469.71%
Parkview Health	469.53%
Methodist Health System	469.23%
UC Health	468.16%
OSF Healthcare	465.92%
ProMedica Health System	464.58%
Floyd Healthcare Management	464.00%
Rush University Medical Center	462.14%
Community Health Network	461.29%
Community Healthcare System	458.67%
Duke University Health System	458.47%
UAB Health System	458.45%
Astria Health	455.74%
Ascension Healthcare	453.80%
Adventist Health	447.51%
KPC Healthcare, Inc.	447.21%
Sentara Healthcare	446.54%

System Name	CCR Average
North Mississippi Health Services, Inc.	446.37%
Baylor Scott & White Health	443.95%
Central Florida Health	443.18%
Broward Health	441.57%
CommonSpirit Health	440.38%
Northern Arizona Healthcare	439.19%
Freeman Health System	437.96%
Penn State Hershey Health System	436.12%
Texas Health Resources	435.93%
Wake Forest Baptist Health	434.98%
Beaumont Health	434.06%
United Surgical Partners International	433.97%
Cleveland Clinic Health System	433.80%
SCL Health	428.51%
Northwell Health	425.07%
University Hospitals	423.52%
Huntsville Hospital Health System	422.27%
Montefiore Health System	420.46%
Advocate Aurora Health	419.59%
Ochsner Health System	419.51%
Swedish Health Services	418.01%
UCHealth	417.86%
Appalachian Regional Healthcare, Inc.	417.55%
Franciscan Health	416.74%
Prisma Health—Midlands	414.75%
University Health Care System	411.70%
Cape Fear Valley Health System	411.49%
Franciscan Missionaries of Our Lady Health System, Inc.	410.36%
Baptist Memorial Health Care Corporation	409.41%
UVA Health System	408.91%

System Name	CCR Average
Lafayette General Health	408.81%
FirstHealth of the Carolinas	408.50%
Carilion Clinic	407.03%
Providence St. Joseph Health	405.21%
University of California Systemwide Administration	404.29%
University of Kansas Health System	404.22%
VCU Health System	404.08%
National Surgical Healthcare	401.88%
Skagit Regional Health	401.10%
Guthrie Clinic	400.78%
Emory Healthcare	399.66%
Riverside Health System	397.90%
Sutter Health	397.14%
Indiana University Health	394.64%
Novant Health	393.26%
New York—Presbyterian	391.99%
Keck Medicine of USC	391.16%
Roper St. Francis Healthcare	390.44%
Hunt Regional Healthcare	386.48%
SSM Health	384.81%
Mercy Health System	384.57%
BJC HealthCare	382.27%
Citrus Valley Health Partners	381.93%
Erlanger Health System	381.78%
ProHealth Care, Inc.	380.11%
University of Missouri Health Care	374.98%
Alameda Health System	373.26%
Mount Sinai Health System	370.98%
Trinity Health	370.93%
Prisma Health—Upstate	370.28%
Community Hospital Corporation	369.55%

System Name	CCR Average
Acadia Healthcare Company, Inc.	369.29%
Sisters of Charity Health System	367.26%
CoxHealth	367.00%
Queen's Health Systems	366.77%
Covenant Health	366.40%
Marshall Health System	363.75%
Beacon Health System	363.54%
UW Health System	363.34%
Greater Hudson Valley Health System	361.71%
SoutheastHEALTH	361.20%
DCH Health System	360.70%
Houston Healthcare System	359.29%
UW Medicine	358.83%
Infirmary Health System	358.79%
Tift Regional Health System	358.41%
WellSpan Health	355.15%
Carle Foundation	354.83%
Benefis Health System	354.20%
UNC Health Care	353.92%
Adena Health System	352.84%
Asante Health System	352.04%
Navicent Health	351.01%
Yale New Haven Health	349.91%
OhioHealth	349.29%
Lifespan Corporation	349.10%
Memorial Health System	348.57%
HSHS Hospital Sisters Health System	348.04%
Mary Washington Healthcare	346.67%
CRC Health Group, Inc.	346.06%
UMass Memorial Health Care, Inc.	344.24%
White River Health System	342.08%

System Name	CCR Average
Excela Health	341.52%
Cone Health	341.21%
Holzer Health System	339.43%
Arnot Health	339.03%
Owensboro Health	338.61%
Mountain Health Network	338.50%
Nuvance Health	338.47%
Froedtert Health	338.38%
Cottage Health	338.24%
Thomas Health System, Inc.	337.67%
Nebraska Methodist Health System, Inc.	336.64%
St. Elizabeth Healthcare	335.49%
USMD Health System	334.76%
Centra Health, Inc.	334.11%
Tanner Health System	332.66%
Maury Regional Health System	331.10%
Med Center Health	328.51%
Hawaii Pacific Health	326.46%
Partners HealthCare System, Inc.	326.38%
Meadville Medical Center	325.45%
Fairview Health Services	324.86%
Mission Health System	324.48%
Mercy	324.26%
Phoebe Putney Health System	322.83%
Washington Health System	321.03%
Southeast Georgia Health System	320.88%
New Hanover Regional Medical Center	320.70%
McLaren Health Care Corporation	320.21%
Archbold Medical Center	319.08%
SolutionHealth	314.77%

System Name	CCR Average
Health Quest Systems, Inc.	314.26%
Care New England Health System	313.24%
Vidant Health	312.76%
Deaconess Health System	310.91%
Willis-Knighton Health System	308.01%
Sparrow Health System	306.49%
University Hospitals and Health System	304.72%
Henry Ford Health System	301.90%
Alliant Management Services	301.07%
North Memorial Health Care	300.29%
Legacy Health	298.44%
University of Texas System	297.43%
Ephraim McDowell Health	296.47%
Community Memorial Health System	294.50%
HealthTech Management Services	294.23%
Kaiser Foundation Hospitals	291.83%
Virginia Mason Health System	290.02%
Success Healthcare	290.01%
MidMichigan Health	289.77%
Appalachian Regional Healthcare System	287.90%
United Health Services	287.90%
Gilliard Health Services	286.67%
Inova Health System	285.88%
Spectrum Health	284.59%
Bronson Healthcare Group	283.91%
Aultman Health Foundation	283.36%
Intermountain Healthcare, Inc.	282.93%
Allina Health	281.83%
Heritage Valley Health System	281.78%
Presbyterian Healthcare Services	278.83%

System Name	CCR Average
University Health System	277.13%
West Virginia University Health System	275.72%
PeaceHealth	275.16%
Cape Cod Healthcare, Inc.	275.14%
Franciscan Sisters of Christian Charity Sponsored Ministries, Inc.	274.56%
Hartford HealthCare	274.40%
Rochester Regional Health	273.05%
UnityPoint Health	272.96%
College Health Enterprises	270.82%
University of Rochester Medical Center	270.61%
Heywood Healthcare	267.42%
St. Lawrence Health System	266.23%
Salem Health	265.61%
Davis Health System	265.13%
Genesis Health System	264.84%
Avita Health System	260.85%
Baystate Health, Inc.	259.80%
Munson Healthcare	257.49%
LRGHealthcare	257.32%
Upper Allegheny Health System	257.17%
QHR	253.39%
Mon Health System	250.18%
USA Health	248.72%
Catholic Health System	246.73%
Salina Regional Health Center	244.98%
University of New Mexico Hospitals	244.45%
HealthPartners	243.89%
Christiana Care Health System	243.68%
ThedaCare, Inc.	240.21%
Avera Health	239.77%

System Name	CCR Average
Southwest Healthcare System	239.32%
Finger Lakes Health	238.60%
Rush Health Systems	237.81%
Beth Israel Lahey Health	237.02%
LifeBrite Hospital Group, LLC	236.56%
Blanchard Valley Health System	235.91%
Aspirus, Inc.	234.50%
Southwest Health Systems	234.42%
St. Charles Health System, Inc.	229.98%
South Georgia Medical Center	227.97%
MediSys Health Network	226.13%
Union General Hospital, Inc.	225.19%
Valley Health System	222.01%
Central Maine Healthcare	221.21%
Tahoe Forest Health System	217.63%
United Medical Corporation	216.78%
Faith Regional Health Services	215.91%
Mayo Clinic	215.36%
Bassett Healthcare Network	214.09%
San Luis Valley Health	213.98%
Sanford Health	213.56%
Samaritan Health Services	211.98%
Berkshire Health Systems, Inc.	211.81%
MedStar Health	210.81%
St. Luke's Health System	208.82%
CentraCare Health	207.79%
Iowa Specialty Hospitals	206.90%
Regional Health	201.44%
Mosaic Life Care	200.62%
Essentia Health	198.96%
Cayuga Health System	198.31%

System Name	CCR Average
MercyOne	198.10%
Marshfield Clinic Health System	197.73%
MaineHealth	196.44%
Bryan Health	189.97%
Northern Light Health	189.77%
Hawaii Health Systems Corporation	187.34%
Rural Health Group	186.59%
Ridgeview Medical Center	184.21%
Sisters of Mary of the Presentation Health System	183.48%
Truman Medical Centers	182.32%
Rural Community Hospitals of America	180.37%
Johns Hopkins Health System	166.34%
Preferred Management Corporation	153.30%
University of Maryland Medical System	145.57%
LifeBridge Health	143.02%
Cook County Health and Hospitals System	142.03%
Adventist HealthCare	140.33%
Puerto Rico Department of Health	128.51%
Great Plains Health Alliance, Inc.	123.29%
NYC Health + Hospitals	101.35%
Total	417.29%

Appendix 11. **Top 10 Hospitals by Charge-to-Cost Ratio for Each State**

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Alaska						
1	Alaska Regional Hospital	HCA Healthcare	593%	Anchorage	AK	$62,828,656
2	Mat-Su Regional Medical Center	Community Health Systems, Inc.	584%	Palmer	AK	$56,890,637
3	Providence Alaska Medical Center	Providence St. Joseph Health	469%	Anchorage	AK	$109,915,625
4	Central Peninsula Hospital		256%	Soldotna	AK	$8,132,565
5	Fairbanks Memorial Hospital		239%	Fairbanks	AK	$19,012,586
6	Providence Kodiak Island Medical Center	Providence St. Joseph Health	192%	Kodiak	AK	$3,206,294
7	Bartlett Regional Hospital		188%	Juneau	AK	$4,512,697
8	South Peninsula Hospital		165%	Homer	AK	$11,457,359
9	PeaceHealth Ketchikan Medical Center	PeaceHealth	158%	Ketchikan	AK	$1,394,744
10	Norton Sound Regional Hospital		120%	Nome	AK	$34,880,318
Alabama						
1	Gadsden Regional Medical Center	Community Health Systems, Inc.	1,509%	Gadsden	AL	-$9,438,192
2	Medical Center Enterprise	Community Health Systems, Inc.	1,446%	Enterprise	AL	$3,680,302
3	Crestwood Medical Center	Community Health Systems, Inc.	1,406%	Huntsville	AL	$25,969,832
4	RMC-Stringfellow Memorial Hospital	Regional Medical Center	1,375%	Anniston	AL	-$1,158,815
5	Grandview Medical Center	Community Health Systems, Inc.	1,345%	Birmingham	AL	$61,167,397
6	South Baldwin Regional Medical Center	Community Health Systems, Inc.	1,324%	Foley	AL	$38,199,431
7	Vaughan Regional Medical Center	LifePoint Health	1,208%	Selma	AL	$1,958,252
8	Flowers Hospital	Community Health Systems, Inc.	1,193%	Dothan	AL	$23,840,374
9	Riverview Regional Medical Center	Prime Healthcare Services	1,115%	Gadsden	AL	-$897,270
10	Brookwood Baptist Medical Center	Tenet Healthcare Corporation	1,031%	Birmingham	AL	-$16,105,823

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Arkansas						
1	National Park Medical Center	LifePoint Health	1,332%	Hot Springs	AR	$13,299,474
2	Saint Mary's Regional Medical Center	LifePoint Health	1,051%	Russellville	AR	$14,337,858
3	Baptist Health—Van Buren	Baptist Health	1,046%	Van Buren	AR	-$83,664
4	Northwest Medical Center—Springdale	Community Health Systems, Inc.	973%	Springdale	AR	$33,508,393
5	Medical Center of South Arkansas	Community Health Systems, Inc.	833%	El Dorado	AR	$3,104,989
6	Baptist Health—Fort Smith	Baptist Health	782%	Fort Smith	AR	$4,205,018
7	Siloam Springs Regional Hospital	Community Health Systems, Inc.	746%	Siloam Springs	AR	$5,448,401
8	Forrest City Medical Center	Quorum Health	723%	Forrest City	AR	$2,200,213
9	Helena Regional Medical Center	Quorum Health	678%	Helena	AR	-$4,137,711
10	CHI St. Vincent Medical Center—North	CommonSpirit Health	648%	Sherwood	AR	-$1,884,745
Arizona						
1	Western Arizona Regional Medical Center	Community Health Systems, Inc.	1,621%	Bullhead City	AZ	$46,303,852
2	Valley View Medical Center	LifePoint Health	1,153%	Fort Mohave	AZ	-$938,514
3	Abrazo West Campus	Tenet Healthcare Corporation	1,081%	Goodyear	AZ	$34,364,512
4	Oro Valley Hospital	Community Health Systems, Inc.	930%	Oro Valley	AZ	$13,525,618
5	Northwest Medical Center	Community Health Systems, Inc.	923%	Tucson	AZ	$38,974,847
6	Abrazo Central Campus	Tenet Healthcare Corporation	920%	Phoenix	AZ	$3,214,151
7	Abrazo Arrowhead Campus	Tenet Healthcare Corporation	916%	Glendale	AZ	$29,110,473
8	HonorHealth Deer Valley Medical Center	HonorHealth	849%	Phoenix	AZ	$90,859,576
9	Banner Goldfield Medical Center	Banner Health	835%	Apache Junction	AZ	-$2,143,375
10	Havasu Regional Medical Center	LifePoint Health	802%	Lake Havasu City	AZ	$40,199,327

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
California						
1	Riverside Community Hospital	HCA Healthcare	1,229%	Riverside	CA	$104,558,592
2	Doctors Medical Center of Modesto	Tenet Healthcare Corporation	1,181%	Modesto	CA	$112,482,606
3	Regional Medical Center of San Jose	HCA Healthcare	1,175%	San Jose	CA	-$46,194,508
4	Barstow Community Hospital	Quorum Health	1,163%	Barstow	CA	$14,313,137
5	Doctors Hospital of Manteca	Tenet Healthcare Corporation	1,143%	Manteca	CA	-$10,384,127
6	Emanuel Medical Center	Tenet Healthcare Corporation	1,142%	Turlock	CA	$46,776,728
7	Placentia-Linda Hospital	Tenet Healthcare Corporation	1,076%	Placentia	CA	$14,430,309
8	West Hills Hospital and Medical Center	HCA Healthcare	990%	West Hills	CA	$15,526,979
9	John F. Kennedy Memorial Hospital	Tenet Healthcare Corporation	970%	Indio	CA	-$3,305,361
10	Good Samaritan Hospital	HCA Healthcare	966%	San Jose	CA	$173,876,816
Colorado						
1	North Suburban Medical Center	HCA Healthcare	1,302%	Thornton	CO	$37,469,312
2	Sky Ridge Medical Center	HCA Healthcare	1,185%	Lone Tree	CO	$285,232,454
3	Swedish Medical Center	HCA Healthcare	1,072%	Englewood	CO	$333,728,635
4	Medical Center of Aurora	HCA Healthcare	1,059%	Aurora	CO	$143,865,983
5	Rose Medical Center	HCA Healthcare	1,024%	Denver	CO	$143,096,313
6	Presbyterian-St. Luke's Medical Center	HCA Healthcare	908%	Denver	CO	$284,856,928
7	Littleton Adventist Hospital	AdventHealth	660%	Littleton	CO	$33,612,104
8	University of Colorado Hospital	UCHealth	633%	Aurora	CO	$462,531,057
9	St. Anthony North Health Campus	CommonSpirit Health	631%	Westminster	CO	$11,243,800
10	UCHealth Memorial Hospital	UCHealth	598%	Colorado Springs	CO	$170,942,488

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Connecticut						
1	Stamford Hospital		487%	Stamford	CT	-$13,769,300
2	Waterbury Hospital	Prospect Medical Holdings	471%	Waterbury	CT	-$5,072,091
3	Bridgeport Hospital	Yale New Haven Health	402%	Bridgeport	CT	$72,797,140
4	Griffin Hospital		393%	Derby	CT	$19,206,726
5	Manchester Memorial Hospital	Prospect Medical Holdings	390%	Manchester	CT	-$20,103,272
6	Bristol Hospital		389%	Bristol	CT	$5,163,483
7	Yale-New Haven Hospital	Yale New Haven Health	369%	New Haven	CT	$246,502,001
8	Greenwich Hospital	Yale New Haven Health	369%	Greenwich	CT	$19,811,032
9	Middlesex Hospital		362%	Middletown	CT	-$41,348,000
10	Saint Mary's Hospital	Trinity Health	356%	Waterbury	CT	$28,430,181
District of Columbia						
1	George Washington University Hospital	Universal Health Services, Inc.	693%	Washington	DC	$60,583,102
2	MedStar Georgetown University Hospital	MedStar Health	459%	Washington	DC	$105,872,615
3	MedStar Washington Hospital Center	MedStar Health	430%	Washington	DC	$58,830,338
4	Howard University Hospital		340%	Washington	DC	-$18,581,585
5	Sibley Memorial Hospital	Johns Hopkins Health System	313%	Washington	DC	$86,138,926
6	United Medical Center		275%	Washington	DC	-$10,896,861
7	Providence Hospital	Ascension Healthcare	160%	Washington	DC	-$48,605,848
Delaware						
1	St. Francis Hospital	Trinity Health	373%	Wilmington	DE	$2,936,064
2	Beebe Healthcare		364%	Lewes	DE	$45,964,484
3	Bayhealth Medical Center		326%	Dover	DE	$52,461,544
4	Bayhealth Hospital Sussex Campus		305%	Milford	DE	$512,637
5	Nanticoke Memorial Hospital		271%	Seaford	DE	$3,480,795
6	Christiana Care Health System	Christiana Care Health System	244%	Newark	DE	$214,328,906

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Florida						
1	Poinciana Medical Center	HCA Healthcare	1,808%	Kissimmee	FL	$7,266,981
2	North Okaloosa Medical Center	Community Health Systems, Inc.	1,761%	Crestview	FL	$34,729,984
3	Oak Hill Hospital	HCA Healthcare	1,633%	Brooksville	FL	$68,933,194
4	Orange Park Medical Center	HCA Healthcare	1,580%	Orange Park	FL	$76,021,057
5	St. Petersburg General Hospital	HCA Healthcare	1,546%	Saint Petersburg	FL	$18,392,779
6	Fort Walton Beach Medical Center	HCA Healthcare	1,538%	Fort Walton Beach	FL	$98,136,146
7	Twin Cities Hospital	HCA Healthcare	1,538%	Niceville	FL	$16,568,776
8	Bayfront Health Brooksville	Community Health Systems, Inc.	1,467%	Brooksville	FL	-$6,987,387
9	Fawcett Memorial Hospital	HCA Healthcare	1,448%	Port Charlotte	FL	$25,225,121
10	Citrus Memorial Health System	HCA Healthcare	1,418%	Inverness	FL	-$976,765
Georgia						
1	Cartersville Medical Center	HCA Healthcare	1,152%	Cartersville	GA	$47,818,504
2	Doctors Hospital	HCA Healthcare	1,144%	Augusta	GA	$212,076,661
3	Fairview Park Hospital	HCA Healthcare	1,073%	Dublin	GA	$19,618,175
4	East Georgia Regional Medical Center	Community Health Systems, Inc.	947%	Statesboro	GA	$38,146,898
5	Redmond Regional Medical Center	HCA Healthcare	924%	Rome	GA	$28,153,596
6	Optim Medical Center—Tattnall	National Surgical Healthcare	908%	Reidsville	GA	$42,685,849
7	Eastside Medical Center	HCA Healthcare	875%	Snellville	GA	$10,301,376
8	Coliseum Medical Centers	HCA Healthcare	841%	Macon	GA	$18,163,196
9	Coliseum Northside Hospital	HCA Healthcare	828%	Macon	GA	$7,288,144
10	Fannin Regional Hospital	Quorum Health	779%	Blue Ridge	GA	-$202,292
Guam						
1	Guam Regional Medical City		142%	Dededo	GU	$5,494,728
2	Guam Memorial Hospital Authority		139%	Tamuning	GU	-$1,597,893

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Hawaii						
1	The Queen's Medical Center	Queen's Health Systems	378%	Honolulu	HI	$101,011,708
2	North Hawaii Community Hospital	Queen's Health Systems	356%	Kamuela	HI	$5,815,505
3	Adventist Health Castle	Adventist Health	342%	Kailua	HI	$7,459,607
4	Pali Momi Medical Center	Hawaii Pacific Health	341%	Aiea	HI	$17,627,820
5	Wilcox Medical Center	Hawaii Pacific Health	331%	Lihue	HI	$10,135,686
6	Straub Medical Center	Hawaii Pacific Health	308%	Honolulu	HI	-$4,294,746
7	Maui Memorial Medical Center	Kaiser Foundation Hospitals	292%	Wailuku	HI	$24,596,939
8	Kuakini Medical Center		248%	Honolulu	HI	$2,574,195
9	Wahiawa General Hospital		244%	Wahiawa	HI	$9,616,589
10	Hilo Medical Center	Hawaii Health Systems Corporation	232%	Hilo	HI	$11,534,002
Iowa						
1	UnityPoint Health–Iowa Methodist Medical Center	UnityPoint Health	531%	Des Moines	IA	$176,987,856
2	Mercy Medical Center—Cedar Rapids		501%	Cedar Rapids	IA	-$4,398,000
3	Mercy Medical Center—Des Moines	CommonSpirit Health	499%	Des Moines	IA	$9,769,207
4	CHI Health Mercy Council Bluffs	CommonSpirit Health	498%	Council Bluffs	IA	$1,816,398
5	UnityPoint Health–Iowa Lutheran Hospital	UnityPoint Health	465%	Des Moines	IA	$30,907,627
6	Ottumwa Regional Health Center	LifePoint Health	461%	Ottumwa	IA	$4,023,570
7	MercyOne Iowa City Medical Center	MercyOne	418%	Iowa City	IA	$1,106,756
8	University of Iowa Hospitals and Clinics		398%	Iowa City	IA	$130,409,539
9	MercyOne Cedar Falls Medical Center	Trinity Health	394%	Cedar Falls	IA	$41,430
10	Genesis Medical Center, Davenport	Genesis Health System	392%	Davenport	IA	$7,204,197

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Idaho						
1	Eastern Idaho Regional Medical Center	HCA Healthcare	609%	Idaho Falls	ID	$132,321,443
2	West Valley Medical Center	HCA Healthcare	584%	Caldwell	ID	$30,701,561
3	Portneuf Medical Center	Ardent Health Services	426%	Pocatello	ID	$44,621,148
4	Treasure Valley Hospital		411%	Boise	ID	$23,702,246
5	Saint Alphonsus Regional Medical Center	Trinity Health	345%	Boise	ID	$29,240,678
6	Saint Alphonsus Medical Center—Nampa	Trinity Health	340%	Nampa	ID	$18,350,161
7	Saint Alphonsus Neighborhood Hospital		323%	Nampa	ID	-$494,118
8	St. Joseph Regional Medical Center	LifePoint Health	321%	Lewiston	ID	-$7,076,248
9	Kootenai Health		297%	Coeur D'Alene	ID	$26,979,657
10	Northwest Specialty Hospital	National Surgical Healthcare	293%	Post Falls	ID	$5,103,475
Illinois						
1	Gateway Regional Medical Center	Quorum Health	1,123%	Granite City	IL	$1,660,076
2	Vista Health	Quorum Health	1,022%	Waukegan	IL	$8,279,781
3	Heartland Regional Medical Center	Quorum Health	949%	Marion	IL	$26,431,475
4	Galesburg Cottage Hospital	Quorum Health	884%	Galesburg	IL	-$2,402,879
5	MacNeal Hospital	Trinity Health	881%	Berwyn	IL	-$1,592,274
6	West Suburban Medical Center		751%	Oak Park	IL	-$10,393,899
7	MetroSouth Medical Center	Quorum Health	743%	Blue Island	IL	-$12,631,235
8	Crossroads Community Hospital	Quorum Health	717%	Mount Vernon	IL	$4,556,837
9	SwedishAmerican—A Division of UW Health	UW Health	715%	Rockford	IL	$33,660,157
10	AMITA Health St. Mary's Hospital	Ascension Healthcare	692%	Kankakee	IL	$5,754,646

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Indiana						
1	Orthopaedic Hospital of Lutheran Health Network	Community Health Systems, Inc.	886%	Fort Wayne	IN	$23,894,596
2	Kosciusko Community Hospital	Community Health Systems, Inc.	880%	Warsaw	IN	$30,558,152
3	Porter Regional Hospital	Community Health Systems, Inc.	821%	Valparaiso	IN	$38,567,301
4	Lutheran Hospital of Indiana	Community Health Systems, Inc.	748%	Fort Wayne	IN	$71,958,357
5	Terre Haute Regional Hospital	HCA Healthcare	717%	Terre Haute	IN	$16,820,206
6	Dupont Hospital	Community Health Systems, Inc.	674%	Fort Wayne	IN	$30,444,732
7	Bluffton Regional Medical Center	Community Health Systems, Inc.	665%	Bluffton	IN	-$606,532
8	Parkview Ortho Hospital	Parkview Health	623%	Fort Wayne	IN	$89,963,512
9	Indiana University Health West Hospital	Indiana University Health	612%	Avon	IN	$58,441,839
10	Franciscan Health Mooresville	Franciscan Health	592%	Mooresville	IN	$53,795,939
Kansas						
1	Wesley Healthcare Center	HCA Healthcare	1,064%	Wichita	KS	$125,590,514
2	Overland Park Regional Medical Center	HCA Healthcare	896%	Overland Park	KS	$95,405,067
3	Menorah Medical Center	HCA Healthcare	652%	Overland Park	KS	$28,584,601
4	AdventHealth Shawnee Mission	AdventHealth	634%	Shawnee Mission	KS	$11,873,084
5	The University of Kansas Hospital	University of Kansas Health System	578%	Kansas City	KS	$106,753,587
6	Saint Luke's South Hospital	Saint Luke's Health System	562%	Overland Park	KS	$8,637,839
7	Ascension Via Christi Hospital on St. Teresa	Ascension Healthcare	559%	Wichita	KS	$6,256,871
8	Saint Luke's Cushing Hospital	Saint Luke's Health System	559%	Leavenworth	KS	-$7,025,890
9	Doctor's Hospital		546%	Leawood	KS	$2,831,859
10	Providence Medical Center	Prime Healthcare Services	533%	Kansas City	KS	$14,874,737

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Kentucky						
1	Paul B. Hall Regional Medical Center	Quorum Health	1,556%	Paintsville	KY	$4,040,640
2	Three Rivers Medical Center	Quorum Health	1,000%	Louisa	KY	$5,036,001
3	Baptist Health La Grange	Baptist Health	928%	La Grange	KY	$26,281,179
4	Meadowview Regional Medical Center	LifePoint Health	920%	Maysville	KY	$13,291,228
5	Lake Cumberland Regional Hospital	LifePoint Health	905%	Somerset	KY	$27,117,654
6	Kentucky River Medical Center	Quorum Health	856%	Jackson	KY	-$2,263,377
7	Georgetown Community Hospital	LifePoint Health	829%	Georgetown	KY	$14,720,731
8	TriStar Greenview Regional Hospital	HCA Healthcare	801%	Bowling Green	KY	$18,235,070
9	Jackson Purchase Medical Center	LifePoint Health	772%	Mayfield	KY	$7,650,382
10	Clark Regional Medical Center	LifePoint Health	767%	Winchester	KY	$20,011,082
Louisiana						
1	Rapides Regional Medical Center	HCA Healthcare	1,117%	Alexandria	LA	$2,554,253
2	Byrd Regional Hospital	Allegiance Health Management	948%	Leesville	LA	$3,935,456
3	Tulane Health System	HCA Healthcare	943%	New Orleans	LA	-$22,086,121
4	Women's and Children's Hospital	HCA Healthcare	895%	Lafayette	LA	$223,272
5	Slidell Memorial Hospital	Ochsner Health System	860%	Slidell	LA	$7,756,990
6	Northern Louisiana Medical Center	Community Health Systems, Inc.	844%	Ruston	LA	-$6,124,670
7	CHRISTUS Ochsner Lake Area Hospital	CHRISTUS Health	823%	Lake Charles	LA	-$3,975,511
8	Mercy Regional Medical Center	Allegiance Health Management	786%	Ville Platte	LA	-$2,414,198
9	Central Louisiana Surgical Hospital		742%	Alexandria	LA	$3,309,119
10	Glenwood Regional Medical Center	Steward Health Care System, LLC	741%	West Monroe	LA	$1,054,979

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Massachusetts						
1	Saint Vincent Hospital	Tenet Healthcare Corporation	576%	Worcester	MA	$74,028,830
2	MetroWest Medical Center	Tenet Healthcare Corporation	464%	Framingham	MA	$2,886,607
3	Massachusetts General Hospital	Partners HealthCare System, Inc.	407%	Boston	MA	$252,252,623
4	Brigham and Women's Hospital	Partners HealthCare System, Inc.	404%	Boston	MA	$171,875,257
5	Brigham and Women's Faulkner Hospital	Partners HealthCare System, Inc.	379%	Boston	MA	$1,862,000
6	UMass Memorial–Marlborough Hospital	UMass Memorial Health Care, Inc.	366%	Marlborough	MA	-$131,589
7	UMass Memorial HealthAlliance–Clinton Hospital	UMass Memorial Health Care, Inc.	340%	Leominster	MA	-$15,261,322
8	North Shore Medical Center	Partners HealthCare System, Inc.	329%	Salem	MA	-$32,534,000
9	UMass Memorial Medical Center	UMass Memorial Health Care, Inc.	327%	Worcester	MA	$1,689,506
10	Harrington Hospital		323%	Southbridge	MA	$12,128,434
Maryland						
1	Bon Secours Baltimore Health System	Bon Secours Mercy Health	201%	Baltimore	MD	-$7,145,907
2	Atlantic General Hospital		186%	Berlin	MD	-$7,036,892
3	Saint Agnes Healthcare	Ascension Healthcare	171%	Baltimore	MD	$4,131,828
4	University of Maryland Shore Medical Center at Easton	University of Maryland Medical System	167%	Easton	MD	$34,824,313
5	University of Maryland Shore Medical Center at Chestertown	University of Maryland Medical System	162%	Chestertown	MD	-$11,697,939
6	Peninsula Regional Medical Center		162%	Salisbury	MD	$41,957,444
7	MedStar Harbor Hospital	MedStar Health	159%	Baltimore	MD	$297,308
8	McCready Health		158%	Crisfield	MD	-$927,489
9	Garrett Regional Medical Center		151%	Oakland	MD	-$417,313
10	MedStar Union Memorial Hospital	MedStar Health	150%	Baltimore	MD	-$8,956,085

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Maine						
1	Cary Medical Center	QHR	295%	Caribou	ME	$856,596
2	Maine Medical Center	MaineHealth	278%	Portland	ME	$168,707,211
3	MaineGeneral Medical Center		277%	Augusta	ME	$1,738,081
4	St. Mary's Regional Medical Center	Covenant Health	275%	Lewiston	ME	-$25,894,109
5	Mid Coast Hospital		272%	Brunswick	ME	$3,973,283
6	Central Maine Medical Center	Central Maine Healthcare	266%	Lewiston	ME	-$15,851,540
7	St. Joseph Hospital	Covenant Health	257%	Bangor	ME	-$13,390,110
8	Northern Light Eastern Maine Medical Center	Northern Light Health	251%	Bangor	ME	$9,675,020
9	York Hospital		250%	York	ME	-$5,116,314
10	Northern Light Mercy Hospital	Northern Light Health	248%	Portland	ME	$1,624,887
Michigan						
1	Pontiac General Hospital		688%	Pontiac	MI	-$3,687,993
2	Lake Huron Medical Center	Prime Healthcare Services	640%	Port Huron	MI	$850,972
3	Garden City Hospital	Prime Healthcare Services	608%	Garden City	MI	$32,516,766
4	ProMedica Bixby Hospital	ProMedica Health System	560%	Adrian	MI	-$12,999,166
5	Beaumont Hospital—Trenton	Beaumont Health	523%	Trenton	MI	$22,698,671
6	DMC–Detroit Receiving Hospital	Tenet Healthcare Corporation	510%	Detroit	MI	$36,644,021
7	UP Health System—Marquette	Duke LifePoint Healthcare	495%	Marquette	MI	$9,724,513
8	Covenant Healthcare		492%	Saginaw	MI	$32,332,615
9	DMC Huron Valley-Sinai Hospital	Tenet Healthcare Corporation	480%	Commerce Township	MI	$20,895,638
10	DMC–Sinai-Grace Hospital	Tenet Healthcare Corporation	467%	Detroit	MI	$29,823,787

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Minnesota						
1	St. John's Hospital	Fairview Health Services	400%	Maplewood	MN	$7,981,725
2	Woodwinds Health Campus	Fairview Health Services	397%	Woodbury	MN	$15,421,857
3	Abbott Northwestern Hospital	Allina Health	378%	Minneapolis	MN	$80,750,336
4	St. Joseph's Hospital	Fairview Health Services	360%	Saint Paul	MN	-$45,223,346
5	United Hospital	Allina Health	353%	Saint Paul	MN	$65,763,753
6	Regions Hospital	HealthPartners	350%	Saint Paul	MN	$26,294,072
7	Mercy Hospital	Allina Health	348%	Coon Rapids	MN	$50,546,344
8	Fairview Southdale Hospital	Fairview Health Services	326%	Edina	MN	$49,570,192
9	Fairview Ridges Hospital	Fairview Health Services	325%	Burnsville	MN	$32,071,127
10	University of Minnesota Medical Center, Fairview	Fairview Health Services	323%	Minneapolis	MN	$35,522,855
Missouri						
1	Poplar Bluff Regional Medical Center	Community Health Systems, Inc.	979%	Poplar Bluff	MO	$28,572,709
2	Centerpoint Medical Center	HCA Healthcare	925%	Independence	MO	$36,424,166
3	Belton Regional Medical Center	HCA Healthcare	895%	Belton	MO	$11,300,464
4	Research Medical Center	HCA Healthcare	822%	Kansas City	MO	-$21,438,343
5	St. Mary's Medical Center	Prime Healthcare Services	743%	Blue Springs	MO	$13,545,718
6	Lee's Summit Medical Center	HCA Healthcare	719%	Lee's Summit	MO	$9,449,360
7	Saint Luke's East Hospital	Saint Luke's Health System	708%	Lee's Summit	MO	$41,301,637
8	Twin Rivers Regional Medical Center		698%	Kennett	MO	-$4,523,148
9	Northeast Regional Medical Center	Community Health Systems, Inc.	681%	Kirksville	MO	$24,821,791
10	Moberly Regional Medical Center	Community Health Systems, Inc.	653%	Moberly	MO	$3,661,013

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Mississippi						
1	Garden Park Medical Center	HCA Healthcare	1,082%	Gulfport	MS	-$2,039,169
2	Merit Health Biloxi	Community Health Systems, Inc.	1,079%	Biloxi	MS	-$5,855,428
3	Merit Health River Oaks	Community Health Systems, Inc.	1,075%	Flowood	MS	$23,398,403
4	Merit Health Central	Community Health Systems, Inc.	1,056%	Jackson	MS	-$7,096,474
5	Merit Health River Region	Community Health Systems, Inc.	1,044%	Vicksburg	MS	$11,274,526
6	Merit Health Wesley	Community Health Systems, Inc.	1,016%	Hattiesburg	MS	$1,144,041
7	Memorial Hospital at Gulfport		913%	Gulfport	MS	$19,769,846
8	Bolivar Medical Center	LifePoint Health	907%	Cleveland	MS	$1,352,850
9	Merit Health Natchez	Community Health Systems, Inc.	892%	Natchez	MS	-$4,282,824
10	Northwest Mississippi Medical Center	Curae Health	780%	Clarksdale	MS	-$1,767,613
Montana						
1	St. Vincent Healthcare	SCL Health	377%	Billings	MT	$59,860,334
2	St. James Healthcare	SCL Health	372%	Butte	MT	$759,986
3	Benefis Health System	Benefis Health System	354%	Great Falls	MT	$34,100,312
4	Great Falls Clinic Hospital		325%	Great Falls	MT	$5,561,186
5	Providence St. Patrick Hospital	Providence St. Joseph Health	301%	Missoula	MT	$19,964,134
6	Community Medical Center	LifePoint Health	290%	Missoula	MT	$26,271,477
7	The HealthCenter	QHR	273%	Kalispell	MT	$20,575,388
8	Kalispell Regional Healthcare	QHR	259%	Kalispell	MT	$28,439,669
9	Billings Clinic		246%	Billings	MT	$93,913,192
10	Northern Montana Health Care		243%	Havre	MT	$6,823,028

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
North Carolina						
1	Lake Norman Regional Medical Center	Community Health Systems, Inc.	842%	Mooresville	NC	$30,934,589
2	Martin General Hospital	Quorum Health	792%	Williamston	NC	-$2,952,819
3	Davis Regional Medical Center	Community Health Systems, Inc.	750%	Statesville	NC	-$1,473,294
4	Rutherford Regional Health System	Duke LifePoint Healthcare	693%	Rutherfordton	NC	$2,362,736
5	Frye Regional Medical Center	Duke LifePoint Healthcare	666%	Hickory	NC	-$2,129,273
6	Atrium Health University City	Atrium Health	651%	Charlotte	NC	$69,302,214
7	Carolinas HealthCare System Blue Ridge	Atrium Health	625%	Morganton	NC	$10,022,651
8	Central Carolina Hospital	Duke LifePoint Healthcare	605%	Sanford	NC	-$3,412,762
9	Wilson Medical Center	Duke LifePoint Healthcare	598%	Wilson	NC	$5,530,427
10	Atrium Health Lincoln	Atrium Health	597%	Lincolnton	NC	$32,202,730
North Dakota						
1	CHI St. Alexius Health Devils Lake Hospital	CommonSpirit Health	338%	Devils Lake	ND	$11,936,886
2	Trinity Health		334%	Minot	ND	$22,045,888
3	Altru Health System		320%	Grand Forks	ND	-$12,346,660
4	Sanford Medical Center Fargo	Sanford Health	302%	Fargo	ND	$51,005,295
5	Sanford Bismarck	Sanford Health	276%	Bismarck	ND	$32,636,990
6	CHI St. Alexius Health	CommonSpirit Health	268%	Bismarck	ND	-$75,003,459
7	CHI St. Alexius Health–Williston Medical Center	CommonSpirit Health	263%	Williston	ND	$6,320,852
8	Essentia Health Fargo	Essentia Health	228%	Fargo	ND	-$6,138,518
9	Jamestown Regional Medical Center		206%	Jamestown	ND	$1,192,043
10	CHI St Alexius Health Carrington Medical Center	CommonSpirit Health	200%	Carrington	ND	$1,779,346

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Nebraska						
1	Nebraska Spine Hospital		549%	Omaha	NE	$19,942,302
2	CHI Health Lakeside	CommonSpirit Health	489%	Omaha	NE	$45,649,923
3	Midwest Surgical Hospital		465%	Omaha	NE	$21,566,392
4	CHI Health Immanuel	CommonSpirit Health	439%	Omaha	NE	$1,508,779
5	CHI Health Creighton University Medical Center—Bergan Mercy	CommonSpirit Health	415%	Omaha	NE	$23,143,903
6	CHI Health Midlands	CommonSpirit Health	394%	Papillion	NE	$11,898
7	CHI Health Saint Francis	CommonSpirit Health	392%	Grand Island	NE	$52,906,798
8	Nebraska Medicine–Nebraska Medical Center		378%	Omaha	NE	$35,625,937
9	Bryan Medical Center	Bryan Health	351%	Lincoln	NE	$57,999,904
10	Great Plains Health		346%	North Platte	NE	$7,831,402
New Hampshire						
1	Portsmouth Regional Hospital	HCA Healthcare	673%	Portsmouth	NH	$92,633,329
2	Parkland Medical Center	HCA Healthcare	645%	Derry	NH	$37,058,362
3	Wentworth-Douglass Hospital	Partners HealthCare System, Inc.	375%	Dover	NH	$27,311,641
4	Catholic Medical Center		346%	Manchester	NH	$5,858,539
5	Southern New Hampshire Medical Center	SolutionHealth	326%	Nashua	NH	$57,260,558
6	Cheshire Medical Center		324%	Keene	NH	$5,880,042
7	Dartmouth-Hitchcock Medical Center		314%	Lebanon	NH	$84,916,461
8	Exeter Hospital		306%	Exeter	NH	$34,037,993
9	Elliot Hospital	SolutionHealth	303%	Manchester	NH	$76,077,876
10	Concord Hospital		298%	Concord	NH	$17,031,216

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
New Jersey						
1	Capital Health Regional Medical Center	Capital Health	1,602%	Trenton	NJ	-$7,194,845
2	CarePoint Health Christ Hospital	CarePoint Health	1,372%	Jersey City	NJ	-$10,940,450
3	CarePoint Health Bayonne Medical Center	CarePoint Health	1,364%	Bayonne	NJ	-$582,612
4	Capital Health Medical Center-Hopewell	Capital Health	1,286%	Pennington	NJ	-$2,289,385
5	CarePoint Health Hoboken University Medical Center	CarePoint Health	1,205%	Hoboken	NJ	$21,697,979
6	St. Luke's Hospital—Warren Campus	St. Luke's University Health Network	1,001%	Phillipsburg	NJ	$14,715,635
7	Salem Medical Center		957%	Salem	NJ	-$25,309,845
8	Hudson Regional Hospital		927%	Secaucus	NJ	$6,464,539
9	Newton Medical Center	Atlantic Health System	925%	Newton	NJ	-$6,788,216
10	Saint Peter's University Hospital		896%	New Brunswick	NJ	$20,319,203
New Mexico						
1	Eastern New Mexico Medical Center	Community Health Systems, Inc.	910%	Roswell	NM	$70,942,789
2	Lovelace Women's Hospital	Ardent Health Services	779%	Albuquerque	NM	$34,577,464
3	Lovelace Westside Hospital	Ardent Health Services	744%	Albuquerque	NM	$9,932,801
4	Alta Vista Regional Hospital	Quorum Health	728%	Las Vegas	NM	$3,957,865
5	MountainView Regional Medical Center	Community Health Systems, Inc.	714%	Las Cruces	NM	$67,854,047
6	Lovelace Medical Center	Ardent Health Services	713%	Albuquerque	NM	$13,243,260
7	Carlsbad Medical Center	Community Health Systems, Inc.	706%	Carlsbad	NM	$31,405,824
8	Memorial Medical Center	LifePoint Health	619%	Las Cruces	NM	$35,930,851
9	Lovelace Regional Hospital—Roswell	Ardent Health Services	585%	Roswell	NM	$1,112,035
10	Gerald Champion Regional Medical Center		580%	Alamogordo	NM	$26,808,515

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Nevada						
1	Centennial Hills Hospital Medical Center	Universal Health Services, Inc.	1,235%	Las Vegas	NV	$51,370,315
2	Sunrise Hospital and Medical Center	HCA Healthcare	1,202%	Las Vegas	NV	$8,742,318
3	Henderson Hospital	Universal Health Services, Inc.	1,162%	Henderson	NV	$24,907,600
4	Desert Springs Hospital Medical Center	Universal Health Services, Inc.	1,160%	Las Vegas	NV	$29,745,499
5	Spring Valley Hospital Medical Center	Universal Health Services, Inc.	1,156%	Las Vegas	NV	$56,658,823
6	Summerlin Hospital Medical Center	Universal Health Services, Inc.	1,139%	Las Vegas	NV	$91,629,414
7	MountainView Hospital	HCA Healthcare	1,139%	Las Vegas	NV	$36,634,265
8	Valley Hospital Medical Center	Universal Health Services, Inc.	1,106%	Las Vegas	NV	$18,880,423
9	Dignity Health St Rose Dominican	CommonSpirit Health	1,010%	North Las Vegas	NV	$4,894,809
10	Northern Nevada Medical Center	Universal Health Services, Inc.	985%	Sparks	NV	$12,367,997
New York						
1	NYU Winthrop Hospital	NYU Langone Health	810%	Mineola	NY	$78,176,907
2	St. Anthony Community Hospital	WMCHealth	747%	Warwick	NY	-$557,132
3	Bon Secours Community Hospital	WMCHealth	675%	Port Jervis	NY	$1,900,210
4	Good Samaritan Regional Medical Center	WMCHealth	662%	Suffern	NY	$5,525,218
5	St. Francis Hospital, The Heart Center	Catholic Health Services of Long Island	612%	Roslyn	NY	$83,505,000
6	Health Alliance Hospital—Broadway Campus	WMCHealth	605%	Kingston	NY	-$10,340,049
7	Westchester Medical Center	WMCHealth	594%	Valhalla	NY	$50,636,088
8	South Nassau Communities Hospital		588%	Oceanside	NY	-$46,135,702
9	Long Island Community Hospital		576%	Patchogue	NY	$1,153,964
10	Good Samaritan Hospital Medical Center	Catholic Health Services of Long Island	549%	West Islip	NY	$116,660,000

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Ohio						
1	Western Reserve Hospital		881%	Cuyahoga Falls	OH	$5,818,219
2	Summa Health System	Summa Health	823%	Akron	OH	$89,494,297
3	Mercy St. Anne Hospital	Mercy Health	790%	Toledo	OH	$10,965,952
4	Grandview Medical Center	Kettering Health Network	703%	Dayton	OH	$59,751,595
5	Mercy St. Vincent Medical Center	Mercy Health	702%	Toledo	OH	$28,798,134
6	Trumbull Memorial Hospital	Steward Health Care System, LLC	698%	Warren	OH	$5,800,115
7	Sycamore Medical Center	Kettering Health Network	684%	Miamisburg	OH	$14,609,266
8	Institute for Orthopaedic Surgery	Mercy Health	672%	Lima	OH	$26,659,732
9	Kettering Medical Center	Kettering Health Network	655%	Kettering	OH	$97,457,386
10	Soin Medical Center	Kettering Health Network	645%	Beavercreek	OH	$15,544,507
Oklahoma						
1	AllianceHealth Durant	Community Health Systems, Inc.	1,488%	Durant	OK	$16,243,624
2	AllianceHealth Midwest	Community Health Systems, Inc.	1,118%	Midwest City	OK	-$7,735,657
3	Summit Medical Center		1,076%	Edmond	OK	$3,048,236
4	INTEGRIS Deaconess	INTEGRIS Health	817%	Oklahoma City	OK	-$12,825,034
5	INTEGRIS Canadian Valley Hospital	INTEGRIS Health	724%	Yukon	OK	$12,400,915
6	Hillcrest Hospital Claremore	Ardent Health Services	721%	Claremore	OK	$6,897,814
7	OU Medical Center		720%	Oklahoma City	OK	$26,198,498
8	Tulsa Spine and Specialty Hospital	Ardent Health Services	711%	Tulsa	OK	$1,705,427
9	OneCore Health		709%	Oklahoma City	OK	$2,677,678
10	Hillcrest Medical Center	Ardent Health Services	704%	Tulsa	OK	$20,447,116

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Oregon						
1	McKenzie-Willamette Medical Center	Quorum Health	542%	Springfield	OR	$26,430,161
2	Willamette Valley Medical Center	LifePoint Health	536%	McMinnville	OR	$8,723,584
3	Adventist Health Portland	Adventist Health	416%	Portland	OR	$547,414
4	Asante Three Rivers Medical Center	Asante Health System	398%	Grants Pass	OR	$9,767,925
5	Mercy Medical Center	CommonSpirit Health	386%	Roseburg	OR	$30,072,313
6	PeaceHealth Sacred Heart Medical Center at RiverBend	PeaceHealth	367%	Springfield	OR	$40,023,186
7	Asante Rogue Regional Medical Center	Asante Health System	348%	Medford	OR	$44,155,247
8	Legacy Mount Hood Medical Center	Legacy Health	326%	Gresham	OR	$17,067,378
9	Providence Medford Medical Center	Providence St. Joseph Health	326%	Medford	OR	-$49,760,981
10	Sky Lakes Medical Center		315%	Klamath Falls	OR	$16,634,231
Pennsylvania						
1	UPMC Presbyterian	UPMC	1,188%	Pittsburgh	PA	-$171,613,931
2	Jeanes Hospital	Temple University Health System	1,161%	Philadelphia	PA	-$2,971,293
3	Hahnemann University Hospital	American Academic Health System	1,064%	Philadelphia	PA	-$77,562,793
4	Chestnut Hill Hospital	Tower Health	1,062%	Philadelphia	PA	-$27,615,538
5	Geisinger Wyoming Valley Medical Center	Geisinger	1,023%	Wilkes Barre	PA	$125,848,015
6	St. Luke's Hospital—Quakertown Campus	St. Luke's University Health Network	1,005%	Quakertown	PA	$12,892,317
7	Moses Taylor Hospital	Community Health Systems, Inc.	997%	Scranton	PA	$2,830,578
8	Temple University Hospital	Temple University Health System	946%	Philadelphia	PA	$49,936,371
9	St. Luke's Hospital—Anderson Campus	St. Luke's University Health Network	943%	Easton	PA	$63,053,279
10	UPMC Hamot	UPMC	943%	Erie	PA	$27,499,852

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Puerto Rico						
1	Dr. Ramon E. Betances Hospital—Mayaguez Medical Center Branch		292%	Mayaguez	PR	-$58,540
2	Caribbean Medical Center		285%	Fajardo	PR	$4,801,630
3	Hospital Manati Medical Center		275%	Manati	PR	-$1,736,031
4	Hospital Pavia-Santurce	United Medical Corporation	265%	San Juan	PR	$2,772,548
5	Wilma N. Vazquez Medical Center		256%	Vega Baja	PR	
6	Hospital de la Universidad de Puerto Rico/Dr. Federico Trilla		253%	Carolina	PR	$4,248,416
7	Doctors Center		253%	Manati	PR	$8,408,480
8	Hospital Pavia Arecibo		250%	Arecibo	PR	$7,505,227
9	Hospital Metropolitano Dr. Susoni		241%	Arecibo	PR	$7,842,590
10	Hospital Pavia Yauco		231%	Yauco	PR	$2,576,814
Rhode Island						
1	Landmark Medical Center	Prime Healthcare Services	589%	Woonsocket	RI	$7,191,590
2	St. Joseph Health Services of Rhode Island	Prospect Medical Holdings	383%	North Providence	RI	-$4,091,216
3	Miriam Hospital	Lifespan Corporation	383%	Providence	RI	-$6,067,471
4	Kent County Memorial Hospital	Care New England Health System	363%	Warwick	RI	$6,701,126
5	Rhode Island Hospital	Lifespan Corporation	350%	Providence	RI	$1,477,314
6	Westerly Hospital	Yale New Haven Health	337%	Westerly	RI	-$3,009,365
7	South County Hospital		315%	Wakefield	RI	$11,844,235
8	Newport Hospital	Lifespan Corporation	315%	Newport	RI	$1,434,000
9	Women & Infants Hospital of Rhode Island	Care New England Health System	263%	Providence	RI	$21,860,224
10	Memorial Hospital of Rhode Island		172%	Pawtucket	RI	$53,461,974

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
South Carolina						
1	MUSC Health Florence Medical Center	Community Health Systems, Inc.	1,279%	Florence	SC	-$82,296,613
2	MUSC Health Lancaster Medical Center	Community Health Systems, Inc.	1,271%	Lancaster	SC	-$47,075,668
3	Trident Medical Center	HCA Healthcare	1,185%	Charleston	SC	$107,952,289
4	Grand Strand Regional Medical Center	HCA Healthcare	1,141%	Myrtle Beach	SC	$108,304,465
5	Spartanburg Medical Center—Mary Black	Spartanburg Regional Healthcare System	825%	Spartanburg	SC	$533,553
6	Coastal Carolina Hospital	Tenet Healthcare Corporation	810%	Hardeeville	SC	$9,735,912
7	Piedmont Medical Center	Tenet Healthcare Corporation	767%	Rock Hill	SC	$54,006,190
8	Aiken Regional Medical Centers	Universal Health Services, Inc.	754%	Aiken	SC	$24,168,972
9	McLeod Medical Center Dillon	McLeod Health	725%	Dillon	SC	$11,816,017
10	Carolina Pines Regional Medical Center	LifePoint Health	700%	Hartsville	SC	$4,169,127
South Dakota						
1	Dunes Surgical Hospital		582%	Dakota Dunes	SD	$38,227,372
2	Sioux Falls Specialty Hospital		550%	Sioux Falls	SD	$36,982,681
3	Sanford USD Medical Center	Sanford Health	459%	Sioux Falls	SD	$77,808,024
4	Avera Heart Hospital of South Dakota	Avera Health	446%	Sioux Falls	SD	$16,213,309
5	Black Hills Surgical Hospital		407%	Rapid City	SD	$24,529,185
6	Avera McKennan Hospital and University Health Center	Avera Health	393%	Sioux Falls	SD	$30,214,053
7	Avera Sacred Heart Hospital	Avera Health	360%	Yankton	SD	$14,389,194
8	Avera St. Mary's Hospital	Avera Health	350%	Pierre	SD	$10,080,405
9	Rapid City Regional Hospital	Regional Health	349%	Rapid City	SD	$43,493,455
10	Avera Queen of Peace Hospital	Avera Health	342%	Mitchell	SD	-$887,956

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Tennessee						
1	West Tennessee Healthcare Dyersburg Hospital	West Tennessee Healthcare	1,275%	Dyersburg	TN	-$3,602,872
2	Tennova Healthcare—Cleveland	Community Health Systems, Inc.	1,199%	Cleveland	TN	$9,800,809
3	TriStar Hendersonville Medical Center	HCA Healthcare	1,129%	Hendersonville	TN	$48,854,176
4	TriStar Skyline Medical Center	HCA Healthcare	1,071%	Nashville	TN	$45,994,265
5	Regional Hospital of Jackson		1,067%	Jackson	TN	-$9,731,138
6	TriStar Summit Medical Center	HCA Healthcare	1,037%	Hermitage	TN	$91,490,639
7	Saint Francis Hospital—Bartlett	Tenet Healthcare Corporation	986%	Bartlett	TN	$19,892,203
8	Vanderbilt Wilson County Hospital	Vanderbilt Health	935%	Lebanon	TN	-$3,362,774
9	TriStar Horizon Medical Center	HCA Healthcare	914%	Dickson	TN	-$3,136,402
10	Tennova Healthcare—Harton	Community Health Systems, Inc.	904%	Tullahoma	TN	-$1,334,753
Texas						
1	Baptist Emergency Hospital	Emerus	1,341%	San Antonio	TX	$21,495,457
2	DeTar Healthcare System	Community Health Systems, Inc.	1,336%	Victoria	TX	$35,981,881
3	South Texas Health System	Universal Health Services, Inc.	1,297%	Edinburg	TX	$14,551,259
4	Las Palmas Medical Center	HCA Healthcare	1,262%	El Paso	TX	$133,719,656
5	Medical City Arlington	HCA Healthcare	1,233%	Arlington	TX	$53,177,075
6	Valley Regional Medical Center	HCA Healthcare	1,232%	Brownsville	TX	$35,824,250
7	Valley Baptist Medical Center—Harlingen	Tenet Healthcare Corporation	1,217%	Harlingen	TX	$39,168,387
8	Valley Baptist Medical Center—Brownsville	Tenet Healthcare Corporation	1,213%	Rio Hondo	TX	$4,598,397
9	Medical City Denton	HCA Healthcare	1,199%	Denton	TX	$12,282,024
10	Corpus Christi Medical Center	HCA Healthcare	1,185%	Corpus Christi	TX	$22,667,939

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Utah						
1	St. Mark's Hospital	HCA Healthcare	689%	Salt Lake City	UT	$133,048,765
2	Ogden Regional Medical Center	HCA Healthcare	682%	Ogden	UT	$78,908,776
3	Lakeview Hospital	HCA Healthcare	566%	Bountiful	UT	$21,374,179
4	Lone Peak Hospital	HCA Healthcare	527%	Draper	UT	$13,146,638
5	Brigham City Community Hospital	HCA Healthcare	495%	Brigham City	UT	$12,747,251
6	Mountain View Hospital	HCA Healthcare	485%	Payson	UT	$16,033,219
7	Timpanogos Regional Hospital	HCA Healthcare	483%	Orem	UT	$30,081,995
8	Ashley Regional Medical Center	LifePoint Health	481%	Vernal	UT	$10,855,837
9	Mountain West Medical Center	Quorum Health	460%	Tooele	UT	$24,252,989
10	Castleview Hospital	LifePoint Health	451%	Price	UT	$13,616,128
Virginia						
1	Chippenham Hospital	HCA Healthcare	1,313%	Richmond	VA	$133,004,748
2	Southside Regional Medical Center	Community Health Systems, Inc.	1,175%	Petersburg	VA	$4,035,873
3	Henrico Doctors' Hospital	HCA Healthcare	1,106%	Richmond	VA	$119,280,074
4	John Randolph Medical Center	HCA Healthcare	1,053%	Hopewell	VA	$554,332
5	Southern Virginia Regional Medical Center	Community Health Systems, Inc.	963%	Emporia	VA	-$11,232,843
6	Clinch Valley Medical Center	LifePoint Health	912%	Richlands	VA	$4,496,428
7	Johnston Memorial Hospital	Ballad Health	814%	Abingdon	VA	$36,245,273
8	LewisGale Hospital Montgomery	HCA Healthcare	800%	Blacksburg	VA	$27,076,675
9	LewisGale Hospital Pulaski	HCA Healthcare	794%	Pulaski	VA	-$3,803,542
10	Bon Secours–Richmond Community Hospital	Bon Secours Mercy Health	794%	Richmond	VA	$75,798,764
U.S. Virgin Islands						
1	Governor Juan F. Luis Hospital		183%	Christiansted	VI	-$17,439,406
2	Schneider Regional Medical Center		166%	Saint Thomas	VI	-$3,285,407

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Vermont						
1	North Country Hospital and Health Center		264%	Newport	VT	$1,000,145
2	University of Vermont Medical Center		257%	Burlington	VT	$68,916,000
3	Southwestern Vermont Medical Center		253%	Bennington	VT	$9,698,196
4	Springfield Hospital		250%	Springfield	VT	-$5,920,215
5	Gifford Medical Center		239%	Randolph	VT	$998,829
6	The University of Vermont Health Network Central Vermont Medical Center		222%	Berlin	VT	$2,423,294
7	Rutland Regional Medical Center		222%	Rutland	VT	$1,297,260
8	Brattleboro Memorial Hospital		221%	Brattleboro	VT	$760,889
9	Porter Medical Center		218%	Middlebury	VT	$5,261,457
10	Northeastern Vermont Regional Hospital		212%	Saint Johnsbury	VT	$1,885,564
Washington						
1	Capital Medical Center	LifePoint Health	692%	Olympia	WA	-$1,849,923
2	MultiCare Valley Hospital	MultiCare Health System	638%	Spokane Valley	WA	$7,525,542
3	St. Clare Hospital	CommonSpirit Health	633%	Lakewood	WA	-$588,649
4	St. Francis Hospital	CommonSpirit Health	627%	Federal Way	WA	$44,681,323
5	MultiCare Deaconess Hospital	MultiCare Health System	584%	Spokane	WA	-$25,890,539
6	MultiCare Tacoma General Hospital	MultiCare Health System	583%	Tacoma	WA	$288,336,619
7	St. Anthony Hospital	CommonSpirit Health	580%	Gig Harbor	WA	$14,971,794
8	Astria Regional Medical Center	Astria Health	573%	Yakima	WA	-$17,001,310
9	MultiCare Good Samaritan Hospital	MultiCare Health System	533%	Puyallup	WA	$59,911,656
10	Harrison Medical Center	CommonSpirit Health	528%	Bremerton	WA	$126,635,861

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Wisconsin						
1	Aurora Medical Center Kenosha	Advocate Aurora Health	507%	Kenosha	WI	$79,961,973
2	Aurora West Allis Medical Center	Advocate Aurora Health	505%	West Allis	WI	$71,988,029
3	Aurora St. Luke's Medical Center	Advocate Aurora Health	502%	Milwaukee	WI	$164,327,597
4	Aurora Medical Center Grafton	Advocate Aurora Health	463%	Grafton	WI	$55,667,776
5	HSHS St. Mary's Hospital Medical Center	HSHS Hospital Sisters Health System	460%	Green Bay	WI	-$8,694,110
6	Aurora Medical Center Burlington	Advocate Aurora Health	456%	Burlington	WI	$16,850,243
7	Orthopaedic Hospital of Wisconsin		448%	Glendale	WI	$31,253,432
8	Aurora Sheboygan Memorial Medical Center	Advocate Aurora Health	432%	Sheboygan	WI	$35,812,263
9	Aurora Medical Center in Washington County	Advocate Aurora Health	431%	Hartford	WI	$11,088,285
10	Beloit Health System		431%	Beloit	WI	$9,614,538
West Virginia						
1	Raleigh General Hospital	LifePoint Health	562%	Beckley	WV	$14,249,947
2	Logan Regional Medical Center	LifePoint Health	543%	Logan	WV	$2,095,486
3	Plateau Medical Center	Community Health Systems, Inc.	505%	Oak Hill	WV	$11,463,231
4	Greenbrier Valley Medical Center	Community Health Systems, Inc.	504%	Ronceverte	WV	$13,734,668
5	Weirton Medical Center		419%	Weirton	WV	-$5,815,055
6	Bluefield Regional Medical Center	Community Health Systems, Inc.	414%	Bluefield	WV	-$44,058,415
7	Williamson Memorial Hospital		396%	Williamson	WV	-$2,915,465
8	Princeton Community Hospital		382%	Princeton	WV	$2,490,036
9	Charleston Area Medical Center		378%	Charleston	WV	$9,191,000
10	Wetzel County Hospital		368%	New Martinsville	WV	$698,171

State Rank by CCR	Hospital Name	System Name	Charge-to-Cost Ratio	City	State	Net Income for 2018
Wyoming						
1	SageWest Health Care at Riverton	LifePoint Health	564%	Riverton	WY	$5,931,507
2	Evanston Regional Hospital	Quorum Health	400%	Evanston	WY	$9,362,804
3	Wyoming Medical Center		337%	Casper	WY	$10,725,051
4	Cheyenne Regional Medical Center		327%	Cheyenne	WY	$28,499,352
5	Ivinson Memorial Hospital		251%	Laramie	WY	$18,119,207
6	Mountain View Regional Hospital	National Surgical Healthcare	249%	Casper	WY	$10,301,215
7	Sheridan Memorial Hospital		247%	Sheridan	WY	$249,175
8	Memorial Hospital of Sweetwater County		240%	Rock Springs	WY	$1,068,159
9	West Park Hospital	QHR	231%	Cody	WY	$670,108
10	Campbell County Health		216%	Gillette	WY	-$1,090,837

Appendix 12. **Hospitals with the Highest Charge-to-Cost Ratios for Each Health Referral Region**

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Anchorage, AK	AK	Alaska Regional Hospital	HCA Healthcare	Anchorage	593.19%
Birmingham, AL	AL	Gadsden Regional Medical Center	Community Health Systems, Inc.	Gadsden	1,509.36%
Dothan, AL	AL	Medical Center Enterprise	Community Health Systems, Inc.	Enterprise	1,446.02%
Huntsville, AL	AL	Crestwood Medical Center	Community Health Systems, Inc.	Huntsville	1,405.59%
Mobile, AL	AL	South Baldwin Regional Medical Center	Community Health Systems, Inc.	Foley	1,324.24%
Montgomery, AL	AL	Jackson Hospital and Clinic		Montgomery	612.83%
Tuscaloosa, AL	AL	DCH Regional Medical Center	DCH Health System	Tuscaloosa	419.70%
Fort Smith, AR	AR	Baptist Health—Van Buren	Baptist Health	Van Buren	1,046.48%
Jonesboro, AR	AR	NEA Baptist Memorial Hospital	Baptist Memorial Health Care Corporation	Jonesboro	551.71%
Little Rock, AR	AR	National Park Medical Center	LifePoint Health	Hot Springs	1,331.70%
Springdale, AR	AR	Northwest Medical Center—Springdale	Community Health Systems, Inc.	Springdale	972.86%
Las Vegas, NV	AZ	Western Arizona Regional Medical Center	Community Health Systems, Inc.	Bullhead City	1,621.30%
Mesa, AZ	AZ	Banner Goldfield Medical Center	Banner Health	Apache Junction	835.39%
Phoenix, AZ	AZ	Abrazo West Campus	Tenet Healthcare Corporation	Goodyear	1,081.47%
Sun City, AZ	AZ	Banner Del E. Webb Medical Center	Banner Health	Sun City West	687.75%
Tucson, AZ	AZ	Oro Valley Hospital	Community Health Systems, Inc.	Oro Valley	930.35%
Alameda County, CA	CA	Stanford Health Care–ValleyCare	Stanford Health Care	Livermore	559.16%
Bakersfield, CA	CA	Bakersfield Heart Hospital		Bakersfield	709.37%
Chico, CA	CA	Enloe Medical Center		Chico	585.68%
Contra Costa County, CA	CA	NorthBay Medical Center		Fairfield	851.16%
Fresno, CA	CA	Clovis Community Medical Center	Community Medical Centers	Clovis	565.34%
Los Angeles, CA	CA	West Hills Hospital and Medical Center	HCA Healthcare	West Hills	989.70%
Modesto, CA	CA	Doctors Medical Center of Modesto	Tenet Healthcare Corporation	Modesto	1,181.49%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Napa, CA	CA	Queen of the Valley Medical Center	Providence St. Joseph Health	Napa	694.18%
Orange County, CA	CA	Placentia-Linda Hospital	Tenet Healthcare Corporation	Placentia	1,076.10%
Palm Springs/Rancho Mira, CA	CA	Desert Regional Medical Center	Tenet Healthcare Corporation	Palm Springs	956.63%
Redding, CA	CA	Shasta Regional Medical Center	Prime Healthcare Services	Redding	651.44%
Sacramento, CA	CA	Adventist Health Lodi Memorial	Adventist Health	Lodi	713.01%
Salinas, CA	CA	Salinas Valley Memorial Healthcare System		Salinas	508.70%
San Bernardino, CA	CA	Riverside Community Hospital	HCA Healthcare	Riverside	1229.01%
San Diego, CA	CA	John F. Kennedy Memorial Hospital	Tenet Healthcare Corporation	Indio	969.95%
San Francisco, CA	CA	MarinHealth Medical Center		Greenbrae	605.45%
San Jose, CA	CA	Regional Medical Center of San Jose	HCA Healthcare	San Jose	1,175.30%
San Luis Obispo, CA	CA	Twin Cities Community Hospital	Tenet Healthcare Corporation	Templeton	877.21%
San Mateo County, CA	CA	Stanford Health Care	Stanford Health Care	Stanford	665.89%
Santa Barbara, CA	CA	Marian Regional Medical Center	CommonSpirit Health	Santa Maria	506.68%
Santa Cruz, CA	CA	Watsonville Community Hospital	Quorum Health	Watsonville	946.66%
Santa Rosa, CA	CA	Petaluma Valley Hospital	Providence St. Joseph Health	Petaluma	764.76%
Stockton, CA	CA	Doctors Hospital of Manteca	Tenet Healthcare Corporation	Manteca	1,142.53%
Ventura, CA	CA	Los Robles Hospital and Medical Center	HCA Healthcare	Thousand Oaks	890.51%
Boulder, CO	CO	Good Samaritan Medical Center	SCL Health	Lafayette	590.83%
Colorado Springs, CO	CO	UCHealth Memorial Hospital	UCHealth	Colorado Springs	598.34%
Denver, CO	CO	North Suburban Medical Center	HCA Healthcare	Thornton	1,301.91%
Fort Collins, CO	CO	UCHealth Poudre Valley Hospital	UCHealth	Ft. Collins	420.20%
Grand Junction, CO	CO	Community Hospital	QHR	Grand Junction	385.09%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Greeley, CO	CO	UCHealth Medical Center of the Rockies	UCHealth	Loveland	502.56%
Pueblo, CO	CO	St. Mary-Corwin Medical Center	CommonSpirit Health	Pueblo	534.51%
Bridgeport, CT	CT	Stamford Hospital		Stamford	487.18%
Hartford, CT	CT	Manchester Memorial Hospital	Prospect Medical Holdings	Manchester	389.50%
New Haven, CT	CT	Waterbury Hospital	Prospect Medical Holdings	Waterbury	471.02%
Washington, DC	DC	George Washington University Hospital	Universal Health Services, Inc.	Washington	693.32%
Salisbury, MD	DE	Beebe Healthcare		Lewes	364.11%
Tampa, FL	FL	Tampa Community Hospital		Tampa	1,092.86%
Bradenton, FL	FL	Blake Medical Center	HCA Healthcare	Bradenton	1,038.52%
Clearwater, FL	FL	Largo Medical Center	HCA Healthcare	Largo	1,200.34%
Fort Lauderdale, FL	FL	Northwest Medical Center	HCA Healthcare	Margate	1,266.18%
Fort Myers, FL	FL	Fawcett Memorial Hospital	HCA Healthcare	Port Charlotte	1,447.53%
Gainesville, FL	FL	North Florida Regional Medical Center	HCA Healthcare	Gainesville	1,346.60%
Hudson, FL	FL	Oak Hill Hospital	HCA Healthcare	Spring Hill	1,633.16%
Jacksonville, FL	FL	Orange Park Medical Center	HCA Healthcare	Orange Park	1,579.70%
Lakeland, FL	FL	Bartow Regional Medical Center	Trinity Health	Bartow	674.56%
Miami, FL	FL	Kendall Regional Medical Center	HCA Healthcare	Miami	1,316.36%
Ocala, FL	FL	Citrus Memorial Health System	HCA Healthcare	Inverness	1,418.19%
Orlando, FL	FL	Poinciana Medical Center	HCA Healthcare	Kissimmee	1,807.60%
Ormond Beach, FL	FL	AdventHealth Daytona Beach	AdventHealth	Daytona	598.16%
Panama City, FL	FL	Gulf Coast Regional Medical Center	HCA Healthcare	Panama City	1,150.74%
Pensacola, FL	FL	North Okaloosa Medical Center	Community Health Systems, Inc.	Crestview	1,761.42%
Sarasota, FL	FL	Englewood Community Hospital	HCA Healthcare	Englewood	1,349.17%
St. Petersburg, FL	FL	St. Petersburg General Hospital	HCA Healthcare	Saint Petersburg	1,545.57%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Tallahassee, FL	FL	Capital Regional Medical Center	HCA Healthcare	Tallahassee	1,166.17%
Tampa, FL	FL	Brandon Regional Hospital	HCA Healthcare	Brandon	1,386.85%
Albany, GA	GA	Phoebe Putney Memorial Hospital	Phoebe Putney Health System	Albany	425.02%
Atlanta, GA	GA	Cartersville Medical Center	HCA Healthcare	Cartersville	1,152.22%
Augusta, GA	GA	Doctors Hospital	HCA Healthcare	Augusta	1,144.06%
Columbus, GA	GA	Piedmont Columbus Regional Northside	Piedmont Healthcare	Columbus	428.85%
Macon, GA	GA	Fairview Park Hospital	HCA Healthcare	Dublin	1,073.32%
Rome, GA	GA	Redmond Regional Medical Center	HCA Healthcare	Redmond	923.81%
Savannah, GA	GA	East Georgia Regional Medical Center	Community Health Systems, Inc.	Statesboro	946.89%
Honolulu, HI	HI	The Queen's Medical Center	Queen's Health Systems	Honolulu	377.89%
Cedar Rapids, IA	IA	Mercy Medical Center—Cedar Rapids		Cedar Rapids	500.59%
Davenport, IA	IA	Genesis Medical Center, Davenport	Genesis Health System	Davenport	391.51%
Des Moines, IA	IA	UnityPoint Health–Iowa Methodist Medical Center	UnityPoint Health	Des Moines	531.15%
Dubuque, IA	IA	Mercy Medical Center—Dubuque	Trinity Health	Dubuque	368.73%
Iowa City, IA	IA	Ottumwa Regional Health Center	LifePoint Health	Ottumwa	461.04%
Mason City, IA	IA	MercyOne North Iowa Medical Center	Trinity Health	Mason City	373.72%
Waterloo, IA	IA	MercyOne Cedar Falls Medical Center	Trinity Health	Cedar Falls	393.87%
Boise, ID	ID	West Valley Medical Center	HCA Healthcare	Caldwell	584.14%
Idaho Falls, ID	ID	Eastern Idaho Regional Medical Center	HCA Healthcare	Idaho Falls	609.45%
Aurora, IL	IL	AMITA Health Mercy Medical Center	Ascension Healthcare	Aurora	663.91%
Bloomington, IL	IL	OSF St. Joseph Medical Center	OSF Healthcare	Bloomington	570.82%
Blue Island, IL	IL	MetroSouth Medical Center	Quorum Health	Blue Island	743.46%
Chicago, IL	IL	Louis A. Weiss Memorial Hospital		Chicago	674.33%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Elgin, IL	IL	AMITA Health Saint Joseph Hospital	Ascension Healthcare	Elgin	672.27%
Evanston, IL	IL	AMITA Health Saint Francis Hospital Evanston	Ascension Healthcare	Evanston	652.86%
Hinsdale, IL	IL	Edward Hospital	Edward-Elmhurst Healthcare	Naperville	621.57%
Joliet, IL	IL	AMITA Health St. Mary's Hospital	Ascension Healthcare	Kankakee	691.82%
Melrose Park, IL	IL	MacNeal Hospital	Trinity Health	Berwyn	880.54%
Milwaukee, WI	IL	Vista Health	Quorum Health	Waukegan	1,022.11%
Paducah, KY	IL	Heartland Regional Medical Center	Quorum Health	Marion	949.34%
Peoria, IL	IL	Galesburg Cottage Hospital	Quorum Health	Galesburg	884.16%
Rockford, IL	IL	SwedishAmerican—A Division of UW Health	UW Health	Rockford	714.51%
Springfield, IL	IL	Blessing Hospital		Quincy	508.24%
St. Louis, MO	IL	Gateway Regional Medical Center	Quorum Health	Granite City	1,123.36%
Urbana, IL	IL	OSF Sacred Heart Medical Center	OSF Healthcare	Danville	600.55%
Fort Wayne, IN	IN	Orthopaedic Hospital of Lutheran Health Network	Community Health Systems, Inc.	Fort Wayne	885.62%
Gary, IN	IN	Porter Regional Hospital	Community Health Systems, Inc.	Valparaiso	821.30%
Indianapolis, IN	IN	Indiana University Health West Hospital	Indiana University Health	Avon	611.82%
Lafayette, IN	IN	Franciscan Health Lafayette East	Franciscan Health	Lafayette	495.47%
Muncie, IN	IN	Indiana University Health Ball Memorial Hospital	Indiana University Health	Muncie	543.51%
Munster, IN	IN	Community Hospital	Community Healthcare System	Munster	442.21%
South Bend, IN	IN	Unity Medical & Surgical Hospital		Mishawaka	472.22%
Terre Haute, IN	IN	Terre Haute Regional Hospital	HCA Healthcare	Terre Haute	716.80%
Topeka, KS	KS	Manhattan Surgical		Manhattan	514.68%
Wichita, KS	KS	Wesley Healthcare Center	HCA Healthcare	Wichita	1,064.11%
Covington, KY	KY	St. Elizabeth Edgewood	St. Elizabeth Healthcare	Edgewood	376.35%
Evansville, IN	KY	Methodist Hospital		Henderson	508.92%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Huntington, WV	KY	Three Rivers Medical Center	Quorum Health	Louisa	999.53%
Lexington, KY	KY	Paul B. Hall Regional Medical Center	Quorum Health	Paintsville	1,555.93%
Louisville, KY	KY	Baptist Health La Grange	Baptist Health	Lagrange	928.39%
Owensboro, KY	KY	Owensboro Health Regional Hospital	Owensboro Health	Owensboro	357.50%
Alexandria, LA	LA	Rapides Regional Medical Center	HCA Healthcare	Alexandria	1,117.32%
Baton Rouge, LA	LA	North Oaks Medical Center	North Oaks Health System	Hammond	726.80%
Houma, LA	LA	Teche Regional Medical Center	LifePoint Health	Morgan City	733.07%
Lafayette, LA	LA	Women's and Children's Hospital	HCA Healthcare	Lafayette	894.68%
Lake Charles, LA	LA	CHRISTUS Ochsner Lake Area Hospital	CHRISTUS Health	Lake Charles	823.19%
Metairie, LA	LA	Avala		Covington	655.29%
Monroe, LA	LA	Glenwood Regional Medical Center	Steward Health Care System, LLC	West Monroe	740.99%
New Orleans, LA	LA	Tulane Health System	HCA Healthcare	New Orleans	942.76%
Shreveport, LA	LA	Northern Louisiana Medical Center	Community Health Systems, Inc.	Ruston	844.45%
Slidell, LA	LA	Slidell Memorial Hospital	Ochsner Health System	Slidell	859.81%
Boston, MA	MA	MetroWest Medical Center	Tenet Healthcare Corporation	Natick	464.04%
Springfield, MA	MA	Baystate Noble Hospital	Baystate Health, Inc.	Westfield	284.33%
Worcester, MA	MA	Saint Vincent Hospital	Tenet Healthcare Corporation	Worcester	575.86%
Baltimore, MD	MD	Bon Secours Baltimore Health System	Bon Secours Mercy Health	Baltimore	201.03%
Takoma Park, MD	MD	Holy Cross Hospital	Trinity Health	Silver Spring	141.28%
Bangor, ME	ME	Cary Medical Center	QHR	Caribou	294.71%
Ann Arbor, MI	MI	ProMedica Bixby Hospital	ProMedica Health System	Adrian	560.04%
Dearborn, MI	MI	Garden City Hospital	Prime Healthcare Services	Garden City	608.00%
Detroit, MI	MI	Lake Huron Medical Center	Prime Healthcare Services	Port Huron	640.46%
Flint, MI	MI	McLaren Lapeer Region	McLaren Health Care Corporation	Lapeer	462.95%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Grand Rapids, MI	MI	Holland Hospital		Holland	317.24%
Kalamazoo, MI	MI	Ascension Borgess Hospital	Ascension Healthcare	Kalamazoo	432.90%
Lansing, MI	MI	Memorial Healthcare		Owosso	425.53%
Marquette, MI	MI	UP Health System—Marquette	Duke LifePoint Healthcare	Marquette	495.48%
Muskegon, MI	MI	North Ottawa Community Hospital		Grand Haven	269.18%
Petoskey, MI	MI	McLaren Northern Michigan	McLaren Health Care Corporation	Petoskey	297.06%
Pontiac, MI	MI	Pontiac General Hospital		Pontiac	688.47%
Royal Oak, MI	MI	Beaumont Hospital—Troy	Beaumont Health	Troy	389.20%
Saginaw, MI	MI	Covenant Healthcare		Saginaw	492.29%
St. Joseph, MI	MI	Spectrum Health Lakeland	Spectrum Health	St. Joseph	290.43%
Traverse City, MI	MI	Munson Medical Center	Munson Healthcare	Traverse City	333.19%
Duluth, MN	MN	St. Luke's Hospital		Duluth	297.41%
Minneapolis, MN	MN	Abbott Northwestern Hospital	Allina Health	Minneapolis	377.71%
Rochester, MN	MN	Mayo Clinic Hospital—Rochester	Mayo Clinic	Rochester	291.56%
St. Cloud, MN	MN	St. Cloud Hospital	CentraCare Health	St. Cloud	318.95%
St. Paul, MN	MN	St. John's Hospital	Fairview Health Services	Maplewood	399.79%
Cape Girardeau, MO	MO	Saint Francis Medical Center		Cape Girardeau	650.50%
Columbia, MO	MO	Northeast Regional Medical Center	Community Health Systems, Inc.	Kirksville	680.51%
Joplin, MO	MO	Freeman Health System	Freeman Health System	Joplin	544.73%
Kansas City, MO	MO	Centerpoint Medical Center	HCA Healthcare	Independence	924.97%
Springfield, MO	MO	Cox Medical Center Branson	CoxHealth	Branson	500.08%
Gulfport, MS	MS	Garden Park Medical Center	HCA Healthcare	Gulfport	1,081.57%
Hattiesburg, MS	MS	Merit Health Wesley	Community Health Systems, Inc.	Hattiesburg	1,016.12%
Jackson, MS	MS	Merit Health River Oaks	Community Health Systems, Inc.	Flowood	1,075.22%
Meridian, MS	MS	Anderson Regional Health System		Meridian	440.93%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Oxford, MS	MS	Baptist Memorial Hospital-North Mississippi	Baptist Memorial Health Care Corporation	Oxford	444.02%
Tupelo, MS	MS	North Mississippi Medical Center Gilmore-Amory	North Mississippi Health Services, Inc.	Amory	637.38%
Billings, MT	MT	St. Vincent Healthcare	SCL Health	Billings	376.77%
Great Falls, MT	MT	Benefis Health System	Benefis Health System	Great Falls	354.20%
Missoula, MT	MT	St. James Healthcare	SCL Health	Butte	371.53%
Asheville, NC	NC	Harris Regional Hospital	Duke LifePoint Healthcare	Sylva	552.65%
Greensboro, NC	NC	FirstHealth Montgomery Memorial Hospital	FirstHealth of the Carolinas	Troy	360.89%
Greenville, NC	NC	Martin General Hospital	Quorum Health	Williamston	792.03%
Hickory, NC	NC	Frye Regional Medical Center	Duke LifePoint Healthcare	Hickory	665.89%
Raleigh, NC	NC	Wilson Medical Center	Duke LifePoint Healthcare	Wilson	597.84%
Wilmington, NC	NC	Novant Health Brunswick Medical Center	Novant Health	Bolivia	499.76%
Winston-Salem, NC	NC	Davis Regional Medical Center	Community Health Systems, Inc.	Statesville	750.08%
Bismarck, ND	ND	Sanford Bismarck	Sanford Health	Bismarck	275.82%
Fargo/Moorhead MN, ND	ND	CHI St. Alexius Health Devils Lake Hospital	CommonSpirit Health	Devils Lake	337.56%
Grand Forks, ND	ND	Altru Health System		Grand Forks	320.49%
Minot, ND	ND	Trinity Health		Minot	333.89%
Lincoln, NE	NE	Bryan Medical Center	Bryan Health	Lincoln	351.07%
Omaha, NE	NE	Nebraska Spine Hospital		Omaha	549.20%
Lebanon, NH	NH	Cheshire Medical Center		Keene	324.08%
Manchester, NH	NH	Portsmouth Regional Hospital	HCA Healthcare	Portsmouth	673.06%
Portland, ME	NH	Wentworth-Douglass Hospital	Partners HealthCare System, Inc.	Dover	374.86%
Camden, NJ	NJ	Lourdes Medical Center of Burlington County	Virtua Health	Willingboro	737.49%
Hackensack, NJ	NJ	CarePoint Health Hoboken University Medical Center	CarePoint Health	Hoboken	1,204.95%
Morristown, NJ	NJ	Newton Medical Center	Atlantic Health System	Newton	924.60%
New Brunswick, NJ	NJ	Saint Peter's University Hospital		New Brunswick	895.87%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Newark, NJ	NJ	CarePoint Health Christ Hospital	CarePoint Health	Jersey City	1,372.03%
Paterson, NJ	NJ	St. Joseph's University Medical Center		Paterson	633.20%
Philadelphia, PA	NJ	Capital Health Regional Medical Center	Capital Health	Trenton	1,601.65%
Wilmington, DE	NJ	Salem Medical Center		Salem	956.72%
Albuquerque, NM	NM	Eastern New Mexico Medical Center	Community Health Systems, Inc.	Roswell	909.64%
Reno, NV	NV	Northern Nevada Medical Center	Universal Health Services, Inc.	Sparks	984.50%
Albany, NY	NY	Health Alliance Hospital—Broadway Campus	WMCHealth	Kingston	605.07%
Binghamton, NY	NY	Our Lady of Lourdes Memorial Hospital, Inc.	Ascension Healthcare	Binghamton	317.97%
Bronx, NY	NY	Montefiore Medical Center	Montefiore Health System	Bronx	536.12%
Buffalo, NY	NY	Eastern Niagara Hospital		Lockport	340.13%
Burlington, VT	NY	The University of Vermont Health Network–Champlain Valley Physicians Hospital		Plattsburgh	316.17%
East Long Island, NY	NY	NYU Winthrop Hospital	NYU Langone Health	Mineola	810.21%
Elmira, NY	NY	Arnot Ogden Medical Center	Arnot Health	Elmira	379.47%
Manhattan, NY	NY	NYU Langone Hospitals	NYU Langone Health	New York	542.24%
Ridgewood, NJ	NY	St. Anthony Community Hospital	WMCHealth	Warwick	746.67%
Rochester, NY	NY	Ira Davenport Memorial Hospital	Arnot Health	Bath	313.76%
Syracuse, NY	NY	Rome Memorial Hospital		Rome	378.13%
White Plains, NY	NY	Westchester Medical Center	WMCHealth	Valhalla	593.56%
Akron, OH	OH	Western Reserve Hospital		Cuyahoga Falls	881.38%
Canton, OH	OH	Mercy Medical Center	Sisters of Charity Health System	Canton	356.86%
Cincinnati, OH	OH	Fort Hamilton Hospital	Kettering Health Network	Hamilton	612.44%
Cleveland, OH	OH	University Hospitals Ahuja Medical Center	University Hospitals	Beachwood	465.34%
Columbus, OH	OH	Diley Ridge Medical Center		Canal Winchester	613.45%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Dayton, OH	OH	Grandview Medical Center	Kettering Health Network	Dayton	702.79%
Elyria, OH	OH	Mercy Regional Medical Center	Mercy Health	Lorain	505.84%
Kettering, OH	OH	Sycamore Medical Center	Kettering Health Network	Miamisburg	684.29%
Toledo, OH	OH	Mercy St. Anne Hospital	Mercy Health	Toledo	789.69%
Youngstown, OH	OH	Trumbull Memorial Hospital	Steward Health Care System, LLC	Warren	698.47%
Dallas, TX	OK	AllianceHealth Durant	Community Health Systems, Inc.	Durant	1,487.88%
Lawton, OK	OK	Southwestern Medical Center	LifePoint Health	Lawton	621.60%
Oklahoma City, OK	OK	AllianceHealth Midwest	Community Health Systems, Inc.	Midwest City	1,118.03%
Tulsa, OK	OK	Hillcrest Hospital Claremore	Ardent Health Services	Claremore	721.15%
Bend, OR	OR	St. Charles Bend	St. Charles Health System, Inc.	Bend	280.89%
Eugene, OR	OR	McKenzie-Willamette Medical Center	Quorum Health	Springfield	541.60%
Medford, OR	OR	Asante Three Rivers Medical Center	Asante Health System	Grants Pass	397.80%
Portland, OR	OR	Willamette Valley Medical Center	LifePoint Health	McMinnville	535.69%
Salem, OR	OR	Salem Hospital	Salem Health	Salem	294.61%
Allentown, PA	PA	St. Luke's Hospital—Quakertown Campus	St. Luke's University Health Network	Quakertown	1,004.70%
Altoona, PA	PA	UPMC Altoona	UPMC	Altoona	516.35%
Danville, PA	PA	Geisinger Medical Center	Geisinger	Danville	883.19%
Erie, PA	PA	UPMC Hamot	UPMC	Erie	942.72%
Harrisburg, PA	PA	UPMC Carlisle	UPMC	Carlisle	681.61%
Johnstown, PA	PA	Conemaugh Memorial Medical Center	Duke LifePoint Healthcare	Johnstown	389.05%
Lancaster, PA	PA	Brandywine Hospital	Tower Health	Coatsville	717.20%
Pittsburgh, PA	PA	UPMC Presbyterian	UPMC	Pittsburgh	1,188.26%
Reading, PA	PA	Pottstown Hospital	Tower Health	Pottstown	677.18%
Sayre, PA	PA	Tyler Memorial Hospital	Community Health Systems, Inc.	Tunkhannock	536.68%
Scranton, PA	PA	Moses Taylor Hospital	Community Health Systems, Inc.	Scranton	997.48%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Wilkes-Barre, PA	PA	Geisinger Wyoming Valley Medical Center	Geisinger	Wilkes Barre	1,023.38%
York, PA	PA	UPMC Memorial	UPMC	York	461.35%
Providence, RI	RI	Landmark Medical Center	Prime Healthcare Services	Woonsocket	589.43%
Charleston, SC	SC	Trident Medical Center	HCA Healthcare	Charleston	1,185.28%
Charlotte, NC	SC	MUSC Health Lancaster Medical Center	Community Health Systems, Inc.	Lancaster	1,270.91%
Columbia, SC	SC	Carolina Pines Regional Medical Center	LifePoint Health	Hartsville	699.85%
Florence, SC	SC	MUSC Health Florence Medical Center	Community Health Systems, Inc.	Florence	1,279.49%
Greenville, SC	SC	Bon Secours St. Francis Health System	Bon Secours Mercy Health	Greenville	679.88%
Spartanburg, SC	SC	Spartanburg Medical Center—Mary Black	Spartanburg Regional Healthcare System	Spartanburg	824.72%
Rapid City, SD	SD	Black Hills Surgical Hospital		Rapid City	407.38%
Sioux City, IA	SD	Dunes Surgical Hospital		Dakota Dunes	581.89%
Sioux Falls, SD	SD	Sioux Falls Specialty Hospital		Sioux Falls	549.52%
Chattanooga, TN	TN	Tennova Healthcare—Cleveland	Community Health Systems, Inc.	Cleveland	1,199.39%
Jackson, TN	TN	Henderson County Community Hospital	Quorum Health	Lexington	733.00%
Johnson City, TN	TN	Sycamore Shoals Hospital	Ballad Health	Elizabethton	834.97%
Knoxville, TN	TN	Starr Regional Medical Center	LifePoint Health	Athens	817.72%
Memphis, TN	TN	West Tennessee Healthcare Dyersburg Hospital	West Tennessee Healthcare	Dyersburg	1,274.99%
Nashville, TN	TN	TriStar Hendersonville Medical Center	HCA Healthcare	Hendersonville	1,128.66%
Abilene, TX	TX	Abilene Regional Medical Center	Community Health Systems, Inc.	Abilene	1,001.36%
Amarillo, TX	TX	Northwest Texas Healthcare System	Universal Health Services, Inc.	Amarillo	773.56%
Austin, TX	TX	St. David's South Austin Medical Center	HCA Healthcare	Austin	952.87%
Beaumont, TX	TX	The Medical Center of Southeast Texas	Steward Health Care System, LLC	Port Arthur	870.94%
Bryan, TX	TX	College Station Medical Center	Community Health Systems, Inc.	College Station	979.27%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Corpus Christi, TX	TX	Corpus Christi Medical Center	HCA Healthcare	Corpus Christi	1,185.24%
El Paso, TX	TX	Las Palmas Medical Center	HCA Healthcare	El Paso	1,261.52%
Fort Worth, TX	TX	Medical City Arlington	HCA Healthcare	Arlington	1,233.36%
Harlingen, TX	TX	Valley Regional Medical Center	HCA Healthcare	Brownsville	1,232.25%
Houston, TX	TX	Bayshore Medical Center	HCA Healthcare	Pasadena	1,175.18%
Longview, TX	TX	Longview Regional Medical Center	Community Health Systems, Inc.	Longview	1,172.51%
Lubbock, TX	TX	Covenant Medical Center	Providence St. Joseph Health	Lubbock	923.00%
McAllen, TX	TX	South Texas Health System	Universal Health Services, Inc.	Edinburg	1,297.19%
Odessa, TX	TX	Odessa Regional Medical Center	Steward Health Care System, LLC	Odessa	726.56%
San Angelo, TX	TX	San Angelo Community Medical Center	Community Health Systems, Inc.	San Angelo	945.30%
San Antonio, TX	TX	Baptist Emergency Hospital	Emerus	San Antonio	1,341.15%
Temple, TX	TX	AdventHealth Central Texas	AdventHealth	Killeen	551.18%
Texarkana, AR	TX	CHRISTUS St. Michael Health System	CHRISTUS Health	Texarkana	602.78%
Tyler, TX	TX	UT Health Tyler	Ardent Health Services	Tyler	1,001.33%
Victoria, TX	TX	DeTar Healthcare System	Community Health Systems, Inc.	Victoria	1,335.53%
Waco, TX	TX	Baylor Scott & White Medical Center—Hillcrest	Baylor Scott & White Health	Waco	608.40%
Wichita Falls, TX	TX	United Regional Health Care System		Wichita Falls	433.65%
Ogden, UT	UT	Ogden Regional Medical Center	HCA Healthcare	Ogden	681.63%
Provo, UT	UT	Mountain View Hospital	HCA Healthcare	Payson	484.93%
Salt Lake City, UT	UT	St. Mark's Hospital	HCA Healthcare	Salt Lake City	688.73%
Arlington, VA	VA	Reston Hospital Center	HCA Healthcare	Reston	625.15%
Charlottesville, VA	VA	Augusta Health		Fishersville	409.33%
Durham, NC	VA	SOVAH Health—Danville	LifePoint Health	Danville	785.52%
Kingsport, TN	VA	Clinch Valley Medical Center	LifePoint Health	Richlands	912.42%

Health Referral Region	State	Hospital Name	System Name	City	Charge-to-Cost Ratio
Lynchburg, VA	VA	Centra Lynchburg General Hospital	Centra Health, Inc.	Lynchburg	379.96%
Newport News, VA	VA	Sentara CarePlex Hospital	Sentara Healthcare	Hampton	519.46%
Norfolk, VA	VA	Southampton Memorial Hospital	Community Health Systems, Inc.	Franklin	570.46%
Richmond, VA	VA	Chippenham Hospital	HCA Healthcare	Richmond	1,312.62%
Roanoke, VA	VA	LewisGale Hospital Montgomery	HCA Healthcare	Blacksburg	800.49%
Winchester, VA	VA	Winchester Medical Center	Valley Health System	Winchester	315.47%
Everett, WA	WA	Skagit Regional Health	Skagit Regional Health	Mount Vernon	426.66%
Olympia, WA	WA	Capital Medical Center	LifePoint Health	Olympia	692.20%
Seattle, WA	WA	St. Francis Hospital	CommonSpirit Health	Federal Way	627.42%
Spokane, WA	WA	MultiCare Valley Hospital	MultiCare Health System	Spokane	637.76%
Tacoma, WA	WA	St. Clare Hospital	CommonSpirit Health	Lakewood	633.37%
Yakima, WA	WA	Astria Regional Medical Center	Astria Health	Yakima	573.09%
Appleton, WI	WI	Ascension Northeast Wisconsin St. Elizabeth Hospital	Ascension Healthcare	Appleton	306.40%
Green Bay, WI	WI	HSHS St. Mary's Hospital Medical Center	HSHS Hospital Sisters Health System	Green Bay	459.86%
La Crosse, WI	WI	Gundersen Lutheran Medical Center		La Crosse	251.91%
Madison, WI	WI	Beloit Health System		Beloit	430.77%
Marshfield, WI	WI	Howard Young Medical Center	Ascension Healthcare	Woodruff	314.68%
Neenah, WI	WI	Aurora Medical Center of Oshkosh	Advocate Aurora Health	Oshkosh	386.52%
Wausau, WI	WI	Aspirus Wausau Hospital, Inc.	Aspirus, Inc.	Wausau	356.47%
Charleston, WV	WV	Raleigh General Hospital	LifePoint Health	Beckley	562.13%
Morgantown, WV	WV	Fairmont Regional Medical Center	Alecto Healthcare	Fairmont	361.49%
Casper, WY	WY	SageWest Health Care at Riverton	LifePoint Health	Riverton	564.18%

ENDNOTES

1 Data USA. 2020. "Hospitals." Accessed March 4, 2020. https://datausa.io/profile/naics/hospitals

2 U.S. Bureau of Labor Statistics. 2019. "Employment Projections: 2018–2028 Summary." Accessed March 4, 2020. https://www.bls.gov/news.release/ecopro.nr0.htm

3 IMPLAN Group LLC. IMPLAN System, data for 2015. www.IMPLAN.com

4 American Hospital Association. 2017. "Hospitals Are Economic Anchors in Their Communities." Accessed March 4, 2020. https://www.aha.org/statistics/2018-03-29-hospitals-are-economic-anchors-their-communities

5 Andrezejewski, Adam. 2019. "Top U.S. 'Non-Profit' Hospitals & CEOs Are Racking Up Huge Profits." Forbes. Accessed March 4, 2020. https://www.forbes.com/sites/adamandrzejewski/2019/06/26/top-u-s-non-profit-hospitals-ceos-are-racking-up-huge-profits/#-1fa29dc19dfb

6 Herman, Bob. 2019. "Health Care Profits Explode." Axios. Accessed March 4, 2020. https://www.axios.com/health-care-pharma-hospitals-q2-2019-7c20729d-ab9b-460b-9ea8-b08902491eec.html

7 Gee, Emily. 2019. "The High Price of Hospital Care." Center for American Progress. Accessed March 4, 2020. https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/

8 Sisko, Andrea M., Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Sheila D. Smith, Andrew J. Madison, Kathryn E. Rennie, and James C. Hardesty. 2019. "National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth." *Health Affairs*, 38(3):491–501.

9 White, Chapin, and Christopher Whaley. 2019. "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely." RAND. Accessed March 3, 2020. https://www.rand.org/pubs/research_reports/RR3033.html

10 Kaiser Family Foundation. "Employer Health Benefits: 2019 Annual Survey." Accessed March 4, 2020. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019

11 Hamel, Liz, Cailey Munana, and Mollyann Brodie. 2019. "Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored Health Insurance." Accessed March 4, 2020. http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance

12 Karlis, Nicole. February 27, 2020. "America's Patchwork, For-Profit Healthcare System Poised to Worsen Coronavirus Outbreak." *Salon*. Accessed March 9, 2020. https://www.salon.com/2020/02/26/americas-patchwork-for-profit-healthcare-system-poised-to-worsen-coronavirus-outbreak/

13 West Health Institute and NORC. 2018. "Americans' Views of Healthcare Costs, Coverage, and Policy." West Health Institute and NORC. Accessed March 10, 2020. https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf

14 Tolbert, Jennifer, Kendal Orgera, Natalie Singer, and Anthony Damico. 2019. "Key Facts about the Uninsured Population." Kaiser Family Foundation. Accessed March 4, 2020. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

15 Garfield, Rachel, Gary Claxton, Anthony Damico, and Larry Levitt. May 13, 2020. "Eligibility for ACA Health Coverage Following Job Loss. Kaiser Family Foundation." Accessed August 2020. https://www.kff.org/coronavirus-Covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/

16 Collins, Sara R., Herman K. Bhupal, and Michelle M. Doty. 2019. "Health Insurance Coverage Eight Years After the ACA." The Commonwealth Fund. Accessed March 4, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca

17 Tikkanen, Roosa and Melinda K. Abrams. 2020. "U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?" The Commonwealth Fund. Accessed March 4, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

18 Collins, Sara R., Munira Z. Gunja, David Blumenthal, M.D., Christopher Hollander, and Jennifer Wilson. March 20, 2020. "What Are Americans' Views on the Coronavirus Pandemic?" NBC News/Commonwealth Fund Health Care Poll. Accessed August 2020. https://www.commonwealthfund.org/publications/surveys/2020/mar/what-are-americans-views-coronavirus-pandemic

19 Leonard, Kimberly. May 21, 2020. "Trump and Congress Tried to Make Coronavirus Testing and Treatment Free, but People Are Still Getting Big Bills When They Go to the Hospital." *Business Insider*. Accessed August 2020. https://www.businessinsider.com/coronavirus-patients-medical-bills-hospitals-doctors-insurance-2020-5

20 Goodyear, Sheena. March 25, 2020. "Uninsured U.S. Cancer Patient with COVID-19 Says $50K Hospital Bill Might Bankrupt Her." CBC Radio. Accessed August 2020 https://www.cbc.ca/radio/asithappens/as-it-happens-the-wednesday-edition-1.5509566/uninsured-u-s-cancer-patient-with-Covid-19-says-50k-hospital-bill-might-bankrupt-her-1.5509569

21 Williams, Austin and Stephanie Weaver. July 8, 2020. "The Cost of COVID-19: Amid Illness, Americans Face Heavy Financial Burden in Testing and Treatment." Fox 10 Phoenix. Accessed August 2020. https://www.fox10phoenix.com/news/the-cost-of-Covid-19-amid-illness-americans-face-heavy-financial-burden-in-testing-and-treatment

22 FAIR Health Brief, March 25, 2020. "The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System." FAIR Health, Inc. Accessed August 2020. https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/COVID-19%20-%20The%20Projected%20Economic%20Impact%20of%20the%20COVID-19%20Pandemic%20on%20the%20US%20Healthcare%20System.pdf

23 Gruenauer, Jason. May 29, 2020. "COVID Survivor Receives $840,000 Statement for Treatment, with More on the Way." Denver ABC 7. Accessed August 2020. https://www.thedenverchannel.com/news/local-news/Covid-survivor-receives-840-000-statement-for-treatment-with-more-on-the-way

24 Rodriguez, Eddy. July 2, 2020. "Family of Man Who Died of Coronavirus Hit With $1 Million Hospital Bill." Newsweek. Accessed August 2020. https://www.newsweek.com/family-man-who-died-coronavirus-hit-1-million-hospital-bill-1515074

25 Westneat, Danny. June 12, 2020. "Coronavirus Survival Comes with a $1.1 Million, 181-Page Price Tag." Seattle Times. Accessed August 2020. https://www.seattletimes.com/seattle-news/inspiring-story-of-seattle-mans-coronavirus-survival-comes-with-a-1-1-million-dollar-hospital-bill/

26 CNN Newsource. April 15, 2020. "Woman Billed over $1K for Coronavirus Test." WFLA Tampa News Channel 8. Accessed August 2020. https://www.wfla.com/community/health/coronavirus/woman-billed-over-1k-for-coronavirus-test/

27 Rodriguez, Carmen Heredia. April 29, 2020. "COVID Tests Are Free, Except When They're Not." Kaiser Health News. Accessed 2020. https://khn.org/news/bill-of-the-month-Covid19-tests-are-free-except-when-theyre-not/

28 Leonard, Kimberly. May 21, 2020. "Trump and Congress Tried to Make Coronavirus Testing and Treatment Free, but People Are Still Getting Big Bills When They Go to the Hospital." *Business Insider*. Accessed August 2020. https://www.businessinsider.com/coronavirus-patients-medical-bills-hospitals-doctors-insurance-2020-5

29 Appleby, Julie. July 7, 2020. "COVID Catch-22: They Got a Big ER Bill Because Hospitals Couldn't Test for Virus." Kaiser Health News. Accessed August 2020. https://khn.org/news/Covid-catch-22-they-got-a-bigger-bill-because-hospitals-couldnt-test-for-virus/

30 King, Jaime S., JD, PhD. June 25, 2020. "Covid-19 and the Need for Health Care Reform." *New England Journal of Medicine*, 382:e104. Accessed August 2020. https://www.nejm.org/doi/full/10.1056/NEJMp2000821

31 "NHE Projection 2019–2028, National Health Expenditures." CMS. Accessed August 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

32 For full list see Chapter 40 –(T16) Hospital & Hospital Health Care (Form CMS-2552-10) Worksheet A. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935

33 Bai, Ge and Gerard F. Anderson. 2016. "U.S. Hospitals Are Still Using Chargemaster Markups to Maximize Revenues." *Health Affairs*, 35(9), Appendix Exhibit A1: Example Arguments on Irrelevant Chargemaster Price. Accessed March 2020. https://www.healthaffairs.org/doi/suppl/10.1377/hlthaff.2016.0093/suppl_file/2016-0093_bai_appendix.pdf

34 Batty, Michael and Benedic Ippolito. April 2017. "Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay." *Health Affairs*, 36(4):689–696. Accessed August 2020. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0986

35 Ibid.

36 Institute for Health and Socio-Economic Policy (IHSP). 2005. "IHSP Hospital 200: The Nation's Most—and Least—Expensive Hospitals." Accessed August 2020. https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/research/ihsp-hospital-200-2005.pdf

37 Institute for Health and Socio-Economic Policy (IHSP). 2004. "IHSP Hospital 200: Hospitals, Big Pharma, HMOs & the Healthcare War Economy." Accessed August 2020. https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/research/ihsp-hospital-200.pdf

38 Bai, Ge and Gerard F. Anderson. 2016. "A More Detailed Understanding of Factors Associated with Hospital Profitability." *Health Affairs*, 35(5):889–97. Accessed August 2020. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1193

39 Batty, Michael and Benedic Ippolito. 2017. "Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay." *Health Affairs*, 36(4):689-696. Accessed August 2020. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0986

40 Ibid.

41 Dobson, Allen, Joan DeVanzo, Julia Doherty, and Myra Tanamor. 2005. "A Study of Hospital Charge Setting Practices: A Study Conducted by the Lewin Group for the Medicare Payment Advisory Commission." MedPAC, 05-04, 1–18.

42 American Hospital Association Hospital Statistics.

43 Fulton, Brent D. 2017. "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses." *Health Affairs*, 36(9):1530–1538.

44 Craig, Stuart, Matthew Grennan, and Ashley Swanson. 2016. "Mergers and Marginal Costs: New Evidence on Hospital Buyer Power." Working Paper No. 24926, National Bureau of Economic Research.

45 Schmitt, Matt. 2017. "Do Hospital Mergers Reduce Costs?" *Journal of Health Economics*, 52:74–94.

46 Gaynor, Martin and Robert Town. 2012. "The Impact of Hospital Consolidation: Update." The Synthesis Project, Policy Brief No. 9, The Robert Wood Johnson Foundation, Princeton, NJ.

47 Cooper, Zack, Stuart Craig, Martin Gaynor, and John Van Reenen. 2015. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." Working Paper 21815, National Bureau of Economic Research. Cambridge, MA.

48 Lewis, Matthew S. and Kevin E. Pflum. 2017. "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions." *RAND Journal of Economics*, 48(3):579-610.

49 It has been suggested that merger studies are underestimating the effects of the consolidation, since not only are merged hospitals increasing their prices, but nonmerging rivals in the same market are also increasing their prices. See Dafney, Leemore. 2009. "Estimation and Identification of Merger Effects: An Application to Hospital Mergers." *Journal of Law and Economics*, 52(3):523–550.

50 Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. 2018. "Consolidation in California's Health Care Market 2010–2016: Impact on Prices and ACA Premiums." University of California, Berkeley. Accessed March 2020. http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

51 Appelbaum, Eileen and Rosemary Batt. September 4, 2019. "Private Equity and Surprise Medical Billing." Institute for New Economic Thinking. Accessed August 2020. https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing

52 Times Staff Writer. November 23, 2014. "Trauma Fees Growing Across the Nation at 'Absurd' Rate." *Tampa Bay Times*. Accessed September 2020. https://www.tampabay.com/news/health/trauma-fees-growing-across-the-nation-at-absurd-rate/2207461/

53 Hawryluk, Markian. September 19, 2020. "Which Was Worse: This Colorado Man's Bachelor Party Hangover or the Hangover from His ER Bill?" Kaiser Health News. Accessed September 2020. https://khn.org/news/surprise-medical-bill-emergency-hangover-bachelor-party-colorado/

54 Kliff, Sarah. January 22, 2019. "Prices at Zuckerberg Hospital's Emergency Room Are Higher Than Anywhere Else in San Francisco." *Vox*. Accessed September 2020. https://www.vox.com/2019/1/22/18183534/zuckerberg-san-francisco-general-hospital-er-prices

55 Gold, Jenny and Sarah Kliff. July 20, 2018. "A baby Was Treated with a Nap and a Bottle of Formula. His Parents Received an $18,000 bill." *Vox*. Accessed September 2020. https://www.vox.com/2018/6/28/17506232/emergency-room-bill-fees-health-insurance-baby

56 NNU analysis of hospital merger data from Irving Levin Associates, Inc.

57 AHA Hospital Statistics.

58 Attorney General Xavier Becerra. December 20, 2019. "State, Unions, Employers, and Workers Reach Settlement to Address Alleged Anticompetitive Practices by Sutter Health That Increased Healthcare Costs for Californians." Office of the Attorney General of California. Accessed September 2020. https://oag.ca.gov/news/press-releases/attorney-general-becerra-state-unions-employers-and-workers-reach-settlement

59 Yabroff, K. Robin, PhD, Jingxuan Zhao, MPH, Xuesong Han, PhD, and Zhiyuan Zheng, PhD. 2019. "Prevalence and Correlates of Medical Financial Hardship in the USA." Journal of *General Internal Medicine*, 34:1494–1502. Accessed August 2020. https://link.springer.com/article/10.1007/s11606-019-05002-w#citeas

60 National Nurses United and AFL-CIO. December 2018. "Breaking the Promise of Patient Care: How Johns Hopkins Hospital Management Shortchanges Baltimore and Puts Patients and the Community at Risk." Accessed September 2020. https://act.nationalnursesunited.org/page/-/files/graphics/1118_JHH_Charity-Care_Report_web.pdf

61 Cosgrove, Jaclyn. June 12, 2018. "Nonprofit Hospitals Are Being Less Charitable. They Say That Shows Obamacare Is Working." *Los Angeles Times*. Accessed September 2020. https://www.latimes.com/business/la-fi-hospitals-charity-care-20180612-story.html

62 Rowan, Harriet Blair. August 13, 2019. "Charity Care Spending by Hospitals Plunges." Kaiser Health News. Accessed September 2020. https://khn.org/news/charity-care-spending-by-hospitals-plunges/

63 National Nurses United, AFL-CIO, Coalition for a Humane Hopkins, and Maryland Consumer Rights Coalition. "Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits." February 2020. Accessed September 2020. https://www.nationalnursesunited.org/preying-on-patients

64 Villagra, Victor G., et al. June 18, 2019. "When Hospitals and Doctors Sue Their Patients: The Medical Debt Crisis Through a New Lens." UConn Health Disparities Institute. Accessed January 2020. https://health.uconn.edu/health-disparities/wp-content/uploads/sites/53/2019/06/HDI-Issue-Brief_When-Hospitals-and-Doctors-Sue-Their-Patients.pdf.

65 Bruhn, William E., et al. 2019. "Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills." *JAMA*, 322(7):691–692. doi:10.1001/jama.2019.9144

66 Armour, Stephanie. June 25, 2019. "When Patients Can't Pay, Many Hospitals Are Suing." *The Wall Street Journal*. Accessed June 25, 2019. https://www.wsj.com/articles/nonprofit-hospitals-criticized-for-debt-collection-tactics-11561467600

67 Simmons-Duffin, Selena. June 25, 2019. "When Hospitals Sue for Unpaid Bills, It Can Be 'Ruinous' for Patients." NPR. Accessed June 25, 2019. https://www.npr.org/sections/health-shots/2019/06/25/735385283/hospitals-earn-little-from-suing-for-unpaid-bills-for-patients-it-can-be-ruinous

68 Hancock, Jay and Elizabeth Lucas. September 9, 2019. "'UVA Has Ruined Us': Health System Sues Thousands of Patients, Seizing Paychecks and Putting Liens on Homes." *The Washington Post*. Accessed September 9, 2019. https://www.washingtonpost.com/health/uva-has-ruined-us-health-system-sues-thousands-of-patients-seizing-paychecks-and-putting-liens-on-homes/2019/09/09/5eb23306-c807-11e9-be05-f76ac4ec618c_story.html

69 Brown, Trevor. August 13, 2019. "Oklahoma Hospitals Sue Thousands Each Year over Unpaid Medical Bills." *The Oklahoman*. Accessed December 27, 2019. https://oklahoman.com/article/5638456/oklahoma-hospitals-sue-thousands-each-year-over-unpaid-medical-bills

70 Beil, Laura. September 3, 2019. "As Patients Struggle with Bills, Hospital Sues Thousands." *The New York Times*. Accessed September 3, 2019. https://www.nytimes.com/2019/09/03/health/carlsbad-hospital-lawsuits-medical-debt.html?action=click&module=Top%20Stories&pgtype=Homepage

71 Thomas, Wendi C. June 27, 2019. "The Nonprofit Hospital That Makes Millions, Owns a Collection Agency and Relentlessly Sues the Poor." ProPublica. Accessed December 2019. https://www.propublica.org/article/methodist-le-bonheur-healthcare-sues-poor-medical-debt

72 Thomas, Wendi C. June 28, 2019. "Low-Wage Workers Are Being Sued for Unpaid Medical Bills by a Nonprofit Christian Hospital That Employs Them." *ProPublica*. Accessed December 2019. https://www.propublica.org/article/methodist-hospital-sues-low-wage-workers-medical-debt

73 Thomas, Wendi C. July 1, 2019. "Millionaire CEO of Nonprofit Hospital That Sues the Poor Promises Review of Policies." *ProPublica*. Accessed December 2019. https://www.propublica.org/article/methodist-le-bonheur-healthcare-ceo-promises-review-of-policies

74 The Cecil G. Sheps Center for Health Services Research. 2020. "174 Rural Hospital Closures: January 2005–Present (132 since 2010)." The University of North Carolina at Chapel Hill. Accessed September 2020. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

75 Estes, Clary. February 24, 2020. "1 In 4 Rural Hospitals Are at Risk of Closure and the Problem Is Getting Worse." *Forbes*. Accessed September 2020. https://www.forbes.com/sites/claryestes/2020/02/24/1-4-rural-hospitals-are-at-risk-of-closure-and-the-problem-is-getting-worse/#7ddbbcd11bc0

76 "Health Care Deserts: Nearly 80 Percent of Rural U.S. Designated as 'Medically Underserved.'" September 30, 2019. Kaiser Health News. Accessed September 2020. https://khn.org/morning-breakout/health-care-deserts-nearly-80-percent-of-rural-u-s-designated-as-medically-underserved/

77 Williams, Joseph P. July 10, 2019. "Code Red: The Grim State of Urban Hospitals; Closures of Inner-City Hospitals Disproportionately Hurt the Poor and Minority Patients." *US News and World Report*. Accessed September 2020. https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close

78 Rau, Jordan and Emmarie Huetteman. September 17, 2020. "Urban Hospitals of Last Resort Cling to Life in Time of COVID." Kaiser Health News. Accessed September 2020. https://khn.org/news/urban-hospitals-of-last-resort-cling-to-life-in-time-of-Covid/

79 Tung, Elizabeth L., MD, MS, David A. Hampton, MD, Meng, Marynia Kolak, PhD, MS, et al. March 8, 2019. "Race/Ethnicity and Geographic Access to Urban Trauma Care." *JAMA*, 2019;2(3):e190138.

80 "National Nurse Survey Reveals Devastating Impact of Reopening Too Soon." July 28, 2020. National Nurses United. Accessed September 2020. https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-devastating-impact-reopening-too-soon

81 "Nurses Seek OSHA Sanctions on HCA." August 24, 2020. National Nurses United. Accessed September 2020. https://www.nationalnursesunited.org/press/nurses-seek-osha-sanctions-hca

82 "National Health Expenditures Data, Centers for Medicare & Medicaid Services." CMS. Accessed August 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

83 OECD Health Statistics 2020. Accessed September 2020. https://www.oecd.org/health/health-data.htm

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