NORTH CAROLINA

BUNCOMBE COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
No. 21-CVS-3276

WILLIAM ALAN DAVIS, LORRAINE NASH, ADMINISTRATOR OF THE ESTATE OF RICHARD NASH, WILL OVERFELT, Ed.S BCBA, JONATHAN POWELL, FAITH C. COOK, Psy.D., and KATHERINE BUTTON, on their own behalf and on behalf of all others similarly situated,

***Plaintiffs*,**

v.

HCA HEALTHCARE, INC., HCA MANAGEMENT SERVICES, LP, HCA, INC., MH MASTER HOLDINGS, LLLP, MH HOSPITAL MANAGER, LLC, MH MISSION HOSPITAL, LLLP, ANC HEALTHCARE, INC. f/k/a MISSION HEALTH SYSTEM, INC., and MISSION HOSPITAL, INC.,

Defendants.

FIRST AMENDED CLASS ACTION COMPLAINT

Plaintiffs William Alan Davis, Lorraine Nash, Administrator of the Estate of Richard Nash, Will Overfelt, Ed.S BCBA, Jonathan Powell, Faith C. Cook, Psy.D., and Katherine Button, individually, and on behalf of all others similarly situated, pursuant to N.C.R. Civ. P. 15(a), hereby file their First Amended Complaint against Defendants HCA Healthcare, Inc. and its affiliates (collectively "HCA"), and Mission Health System, Inc. and its affiliate (collectively "Mission"), and state as follows:

Case No.2021CVS3276 ECF No. 61 Filed 10/31/2022 16:20:08 N.C. Business Court

I. NATURE OF THE ACTION

1. This is an action for restraint of trade and unlawful monopolization seeking class-wide damages and injunctive and equitable relief under North Carolina's antitrust and consumer protection statute (N.C.G.S. § 75-1 *et seq.*).

2. Article 1, Section 34 of the North Carolina Constitution states: "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed." However, from 1995 until 2019, Mission operated its hospital system as a monopoly. In January 2019, HCA acquired Mission and to this day continues to operate it as a for-profit monopoly.

3. The original monopoly was created in 1995, when Mission merged with its only significant competitor in the region, St. Joseph's Hospital. As a result of that merger, Mission's flagship Asheville hospital ("Mission Hospital-Asheville") effectively became the only provider of inpatient general acute care ("GAC") hospital services in Buncombe and Madison Counties. From 1995 until 2016, Mission was immunized from antitrust liability by a state statute under which it was issued a Certificate of Public Advantage ("COPA"). COPAs are a form of regulation in which a hospital is permitted to operate as a monopoly in exchange for subjecting itself to state oversight.

4. In 2016, after years of lobbying by Mission executives, the State repealed the COPA, leaving in place an unregulated monopoly. Once that repeal occurred, both Mission and any later purchasers of its assets, including HCA, lost any immunity from suit under the antitrust laws.

5. After the COPA was repealed, and prior to when HCA purchased the assets, Mission engaged in improper restraints on competition by enforcing unlawful terms and arrangements with private payers, including commercial health plans, and third-party

administrators ("TPAs") of self-insured plans. These improper restraints included tying, all-or-nothing arrangements, gag clauses, and, on information and belief, other anticompetitive terms and negotiating devices. Each of Mission's anticompetitive acts, together and individually, increased the prices of hospital services, insurance premiums, copays or deductibles paid by residents of Mission's overall 18-County Western North Carolina service area.

6. In 2019, Mission sold its assets to HCA, the world's largest for-profit hospital chain, and a company that has been subject to approximately 20 prior Federal Trade Commission ("FTC") antitrust proceedings. When HCA purchased Mission's assets effective January 2019, HCA did so precisely because of Mission's outsized ability to dictate prices and other contract terms to its customers.

7. Like Mission before it, HCA has used improper restraints in its agreements and arrangements with commercial health plans and TPAs, including tying, all-or-nothing arrangements, gag clauses, and on information and belief, other anticompetitive terms and negotiating devices. HCA has also refused to fully comply with a rule enacted by President Trump's Administration to increase transparency in healthcare pricing. Were HCA to comply and reveal to consumers and regulators the true prices that it charges, the public would know that HCA/Mission's prices for key services are by far the highest in North Carolina. For instance, according to a large commercial dataset, HCA currently charges ***more than two times the State average for a C-Section without complications***. This price disparity—one matched and exceeded by numerous other procedures—can only exist because of the system's unbridled monopoly power and its status as a "must have" system in Western North Carolina. As a result, individual insurance premiums, which are primarily driven by healthcare costs, are significantly higher in Mission's service area than in surrounding counties and even North Carolina's largest cities.

8. At the same time, to maximize profits, HCA has been cutting costs and staff at an alarming rate, leaving Western North Carolinians with increasingly bad healthcare at an ever-growing price. It has also taken steps to drive business to its more expensive flagship facility in Asheville, reducing access and increasing travel times for citizens in affected areas. As stated in a July 9, 2021, Executive Order by President Biden: "Hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options." HCA/Mission perfectly encapsulates this troubling trend and the harms consolidation inflicts on the population a hospital purports to serve.

9. Within the applicable damages period commencing on August 10, 2017, Defendants' improper conduct has harmed consumers through higher health insurance premiums, copays, deductibles, and coinsurance payments. Consumers have also lost access to preferred physicians and healthcare providers and experienced worsening facility conditions and service.

10. Reduced quality and higher prices are the hallmark effects of an unregulated monopoly. Today, HCA holds ***an approximate 90% market share*** in the market for inpatient GAC hospital care in Buncombe County, the most populous county in Western North Carolina, and in nearby Madison County. Because insurers and consumers in the region have no choice but to use HCA, HCA has free rein to dictate the prices it charges insurers and consumers while at the same time undermining quality to cut costs.

11. In fact, in the Outlying Regions Inpatient Services-Only Market (defined below), HCA has clear monopoly (70%-plus)[1] market power across five Counties, based on multiple

[1] "Generally speaking, a 70% to 75% market share is necessary to sustain a monopolization claim." *Sitelink Software, LLC v. Red Nova Labs, Inc.*, No. 14 CVS 9922, 2016 NCBC 43, 2016 NCBC LEXIS 45, *29 (N.C. Super. Ct., Wake County June 14, 2016).

sources detailing total patient discharge: Yancey – 91-96%; Mitchell – 84-96%; Transylvania – 80-87%; McDowell – 79-88%; and Macon – 76-84%.

12. HCA cannot deny the negative effects that unregulated hospital monopolies inflict on our Nation's healthcare system. Indeed, in 2018—while it was negotiating its takeover of Mission—HCA complained to an agency in Florida about a competitor's "monopolistic dominance," stating that "patients suffer from lack of access to care in their community," they "have little to no healthcare provider choice," and "[t]his type of monopolistic environment within the healthcare market stifles innovation and breeds a culture that negatively impacts the cost and quality of care."

13. HCA's behavior since taking over Mission, and Mission's prior abuse of its monopoly power, exemplify why healthcare in the United States costs so much more than elsewhere.

14. Without this Court's intervention, the future of healthcare in Western North Carolina—traditionally a destination for many, including retirees, in part because of its reputation for high-quality, low-cost healthcare—is at risk. Accordingly, Plaintiffs, who each have commercial or self-funded health coverage and have been and continue to be injured by Defendants' practices, sue for class-wide damages and for equitable relief seeking to enjoin the continuation of Defendants' unlawful abuse of their monopoly power.

II. PARTIES

A. Plaintiffs

15. Plaintiff **William Alan Davis** is a citizen of North Carolina who resides in Clyde, Haywood County. Mr. Davis is a participant in a private group healthcare plan and has had to pay higher amounts due to Defendants' conduct.

16. Plaintiff **Lorraine Nash, Administrator of the Estate of Richard Nash** is the administrator of Mr. Nash's estate after he passed away in September 2021. Mr. Nash was a citizen of North Carolina who resides in Candler, Buncombe County. Mr. Nash was a participant in a private group healthcare plan and had to pay higher amounts due to Defendants' conduct.

17. Plaintiff **Will Overfelt, Ed.S BCBA** is a citizen of North Carolina who resides in Asheville, Buncombe County. Mr. Overfelt holds an individual Affordable Care Act policy through Blue Cross and has had to pay higher amounts due to Defendants' conduct.

18. Plaintiff **Jonathan Powell** is a citizen of North Carolina who resides in Morganton, Burke County. Mr. Powell holds group health insurance with Blue Cross through his place of employment and has had to pay higher amounts due to Defendants' conduct.

19. Plaintiff **Faith C. Cook, Psy.D.** is a citizen of North Carolina who resides in Asheville, Buncombe County. Dr. Cook holds group health insurance with Blue Cross through an Affordable Care Act plan and has had to pay higher amounts due to Defendants' conduct.

20. Plaintiff **Katherine Button** is a citizen of North Carolina who resides in Asheville, Buncombe County. Ms. Button is a member of a self-funded health insurance plan, and has had to pay higher amounts due to Defendants' conduct.

B. Defendants

21. Defendant **HCA Healthcare, Inc.** is a Delaware corporation with a principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203, or through its registered agent, The Corporation Trust Company, at Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

22. HCA Healthcare, Inc. is the ultimate parent company of the HCA enterprise and was directly and materially involved through its officers and directors in making the pertinent

decisions and undertaking the pertinent actions herein. It is publicly held and listed with the Securities and Exchange Commission ("SEC"). HCA Healthcare, Inc. or its predecessors in interest have been named as respondents in prior antitrust proceedings brought by the FTC and/or the U.S. Department of Justice ("DOJ"), including with regard to hospital acquisitions and divestments of improper mergers.

23. HCA is the world's largest for-profit hospital chain. It owns and operates over 180 hospitals in 21 states. HCA's revenues were over $51 billion for 2020.[2] Its net income was over $3.7 billion in 2020.

24. Defendant **HCA Management Services, LP** is a Delaware limited partnership with its principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203, or through its North Carolina registered agent, CT Corporation System, 160 Mine Lake Court Suite 200, Raleigh, NC 27601.

25. HCA Management Services, LP was formed in 1999. It applied for a certificate of authority to do business in North Carolina on December 28, 2005. It is currently registered to do business in North Carolina. It is listed on the HCA Healthcare website[3] as being the entity responsible for that website.

26. HCA Management Services, LP entered into a confidentiality and nondisclosure agreement with Defendant ANC Healthcare, Inc. f/k/a Mission Health System, Inc. in or about July 11, 2017. At that time, MH Master Holdings, LLLP which was only first organized on August 23, 2018 did not yet exist. Pursuant to negotiations conducted under that nondisclosure agreement, various Mission and HCA entities entered into an Asset Purchase Agreement ("APA") dated

[2] By comparison, according to the National Association of State Budget Officers, North Carolina's total expenditures in fiscal year (FY) 2020 were $60.2 billion, including general funds, other state funds, bonds, and federal funds. HCA Healthcare is at number 62 on the Fortune 500.
[3] https://hcahealthcare.com.

August 2018, and an amended Asset Purchase Agreement ("Amended APA") dated January 2019, facilitating the asset sale of relevant Mission system assets to HCA.

27. Defendant **HCA, Inc.** is a Delaware corporation with its principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203.

28. HCA, Inc. is the plan sponsor of a defined contribution plan established January 1, 1983, which provides retirement benefits for all eligible employees of HCA, Inc. or its affiliates. It is the sponsor of the HCA 401(k) Plan, with employer identification number 75-2497104, and a total number of participants of 387,421 as of 2019. On information and belief, HCA, Inc. is the plan sponsor of a retirement benefit plan for numerous employees associated with the North Carolina Division of HCA Healthcare, Inc. It has been a party to prior proceedings challenging various aspects of HCA's business practices. *E.g.,* US DOJ press release dated June 26, 2003.

29. Defendant **MH Master Holdings, LLLP** is a Delaware limited liability limited partnership. HCA has stated in press releases that "Mission Health, an operating division of HCA Healthcare, is based in Asheville, North Carolina, and is the state's sixth largest health system." On information and belief, the "Mission Health" entity to which HCA refers as being "based in Asheville" is MH Master Holdings, LLLP. Accordingly, MH Master Holdings, LLLP has a principal place of business in Asheville, North Carolina. It may be served with process at its registered office address, c/o CT Corporation System, 160 Mine Lake Ct Ste 200, Raleigh, NC 27615, or, at its principal office at 509 Biltmore Avenue, Asheville, NC 28801, or, c/o HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203.

30. MH Master Holdings, LLLP is listed as the buyer in the asset sale documented by the APA and Amended APA. It purchased the Mission system assets via the Amended APA and is the current owner of the former Mission system assets.

31. MH Master Holdings, LLLP applied for a certificate of authority to do business in North Carolina on August 23, 2018. It filed its most recent annual report with the North Carolina Secretary of State, Department of Corporations ("NC SOS"), on or about April 6, 2021, describing itself as being engaged in the "healthcare related business."

32. MH Master Holdings, LLLP's general partner is MH Hospital Manager LLC. MH Master Holdings, LLLP is a 99% limited partner in MH Mission Hospital, LLLP. Under the Amended APA, MH Master Holdings, LLLP is authorized to do business under brand names including "Mission Health," "Mission Health System" and the "HCA" brand.

33. The "corporate bio" used at the end of many HCA NC press releases, opens, under the header "ABOUT MISSION HEALTH," by stating that "Mission Health [is] an operating division of HCA Healthcare [and] is based in Asheville, North Carolina…."

34. On information and belief, MH Master Holdings, LLLP identifies itself as and holds itself out as being a part of the North Carolina Division of HCA Healthcare, Inc. See, e.g., job postings on websites like "Health Careers," listing open positions at "HCA Healthcare -- North Carolina Division."

35. HCA states in public website content that its "North Carolina Division," also known as, "Mission Health," is "based in Asheville, North Carolina."

36. Per HCA press releases, since February 2019, Greg Lowe has been "president of the newly created Asheville-based North Carolina Division, which comprises the recently

purchased Mission Health system of six hospitals in western North Carolina." Upon information and belief, Mr. Lowe resides in North Carolina.

37. Defendant, **MH Hospital Manager, LLC,** is a Delaware limited liability company with a principal place of business in Tennessee or North Carolina. It may be served with process through its registered agent, c/o CT Corporation System, 160 Mine Lake Court Suite 200, Raleigh NC 27615, or, at its office at 509 Biltmore Avenue, Asheville, NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

38. MH Hospital Manager, LLC applied for a certificate of authority to do business in North Carolina on August 22, 2018. Its annual report dated April 6, 2021, describes the nature of its business as "healthcare related business."

39. MH Hospital Manager uses the assumed business name, "North Carolina Division," pursuant to an assumed name certificate dated April 22, 2019, filed with the Buncombe County Register of Deeds. It described the counties where the assumed business name will be used to engage in business as "All 100 North Carolina counties."

40. Defendant, **MH Mission Hospital, LLLP** is a Delaware limited liability limited partnership. According to Defendants, it is "located in Asheville, North Carolina" and has a principal place of business in North Carolina. It may be served with process at its registered office address, c/o CT Corporation System, 160 Mine Lake Ct Ste 200, Raleigh, NC 27615, or, at its principal office at 509 Biltmore Avenue, Asheville NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

41. Effective July 2019, Chad Patrick became the Chief Executive Officer of what HCA describes as "HCA Healthcare's North Carolina Division's flagship 763-bed Mission

Hospital" and resided in Asheville since Summer 2019. On information and belief, the HCA corporate entity employing Mr. Patrick is MH Mission Hospital, LLLP.

42. Defendant **ANC Healthcare, Inc. f/k/a Mission Health System, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. It may be served with process through its registered agent, c/o Corporation Service Company, 2626 Glenwood Avenue Suite 550, Raleigh NC 27608, or at its current office address of 425 West New England Avenue Suite 300, Winter Park, FL 32789.

43. ANC Healthcare, Inc. f/k/a Mission Health System, Inc. was incorporated in 1981 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. See Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

44. As of 2015, it described itself as an "integrated healthcare system" which provided "medical care, hospital care" and "the delivery of health care services to persons resident in Western North Carolina and surrounding areas."

45. During the time period commencing in or about 2010 and continuing through and including January 2019, Ronald Paulus ("Paulus") was the President and Chief Executive Officer of ANC Healthcare, Inc. f/k/a Mission Health System, Inc.

46. Defendant **Mission Hospital, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law. In or about February 2019, its principal office

was moved to Florida. It may be served with process through its registered agent, c/o Corporation Service Company, 2626 Glenwood Avenue Suite 550, Raleigh NC 27608, or at its current office address of 425 West New England Avenue Suite 300, Winter Park, FL 32789.

47. Defendant Mission Hospital, Inc. was incorporated in 1951 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. See Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

48. Defendants ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. are each identified as sellers under the Amended APA. *See* Amended APA, p. 1. Under the Amended APA's terms, ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. remain liable for pre-asset sale ownership or operations of the hospital business. *See* Amended APA, § 2.4 (in which the HCA entities who function as the buyers under the Amended APA purported to exclude from their liability "any Liabilities related to the ownership or operation of the Business or the Purchased Assets prior to the Effective Time").

49. Under the Amended APA, the sellers represented and warranted that they "have operated, and are operating, the Business… and their properties in compliance in all material respects with all applicable Laws," up through the sale date. Amended APA, § 4.11(a)(i). In fact, they did not comply with the laws, as alleged herein.

III. JURISDICTION AND VENUE

50. The Court has subject matter jurisdiction over Plaintiffs' claims under N.C.G.S. § 75-1 *et seq.*

51. The Court has personal jurisdiction over Defendants because they are domiciled in the State or they have transacted business in the State relevant to this antitrust action.

52. Venue is proper in this Court because a substantial part of the events giving rise to Plaintiffs' claims occurred in Buncombe County.

53. The case falls under the local controversy exception to federal jurisdiction under the Class Action Fairness Act. 28 U.S.C. § 1332(d)(4)(A)[4] and (B).[5]

54. The case is properly designated a mandatory complex business case. Under N.C.G.S. § 7A-45.4(a)(3), the case involves disputes under antitrust law, including disputes arising under Chapter 75 of the General Statutes that do not arise solely under G.S. 75-1.1 or Article 2 of Chapter 75 of the General Statutes. Under N.C.G.S. § 7A-45.4(b)(2), the amount in controversy computed in accordance with G.S. 7A-243 is at least five million dollars ($5,000,000) when the claims of the putative class are taken into account.

55. Under the Amended APA, a choice of forum provision specifies the Business Court. Amended APA § 13.2, entitled, Choice of Law and Forum. While Plaintiffs are nonparties to the Amended APA, the Business Court remains the appropriate venue for the instant matter.

56. All Defendants during the pertinent times have participated in significant interstate commerce and the relevant hospital operations have affected interstate commerce.

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[4] "A [federal] district court shall decline to exercise jurisdiction … (A) (i) over a class action in which— (I) greater than two-thirds of the members of all proposed plaintiff classes in the aggregate are citizens of the State in which the action was originally filed; (II) at least 1 defendant is a defendant— (aa) from whom significant relief is sought by members of the plaintiff class; (bb) whose alleged conduct forms a significant basis for the claims asserted by the proposed plaintiff class; and (cc) who is a citizen of the State in which the action was originally filed; and (III) principal injuries resulting from the alleged conduct or any related conduct of each defendant were incurred in the State in which the action was originally filed; and (ii) during the 3-year period preceding the filing of that class action, no other class action has been filed asserting the same or similar factual allegations against any of the defendants on behalf of the same or other persons…." 28 U.S.C. § 1332(d)(4)(A).

[5] A "district court shall decline to exercise jurisdiction" [where] "two-thirds or more of the members of all proposed plaintiff classes in the aggregate, and the primary defendants, are citizens of the State in which the action was originally filed." 28 U.S.C. § 1332(d)(4)(B).

IV. RELEVANT HISTORICAL BACKGROUND

A. <u>Mission acquires monopoly power under the COPA</u>

57. Mission Hospital was originally formed over a century ago as a local Asheville charitable institution. When founded in the 1880s, the Dogwood Mission, also known as the Flower Mission, provided charity care to Asheville's sick and poor.

58. After World War II, Mission Hospital joined with other Buncombe County hospitals to become a major medical center in western North Carolina. In 1951, Mission Hospital was incorporated as a nonprofit. Although it was a nonprofit, it was not under the patronage or the control of the State nor was it a local health authority.

59. As of the early 1990s, the two private acute care hospitals in Asheville were Mission Hospital-Asheville and St. Joseph's Hospital. Mission had 381 beds. St. Joseph's Hospital had 285 beds. The two hospitals sought to partner and lobbied the General Assembly to enact an initial version of the COPA law to facilitate a partnership in 1993.[6]

60. The hospitals claimed that their plans did not call for a merger and that each hospital would maintain its corporate identity, governance structure and assets. Nonetheless, in 1994 the FTC opened an antitrust investigation out of a concern that the combination of St. Joseph's and Mission would result in a single large hospital dominating upwards of 80% or 90% of the market, an undeniable monopoly under the concentration metric the FTC uses.

61. In response, the hospitals lobbied the North Carolina General Assembly to amend the COPA[7] to further immunize them from antitrust scrutiny. The General Assembly did so in December 1995. Mission and St. Joseph's then entered into their partnership.

[6] Hospital Cooperation Act of 1993, Session Law 1993-529.
[7] *See* N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed).

62. Subsequently, in 1998, Mission determined that it desired to buy St. Joseph's, acquire all of its assets, and combine operations under one license as Mission Health System. The COPA was amended in October 1998 to facilitate the merger which then occurred.

63. The COPA statute contemplated that Mission would "limit health care costs" and "control prices of health care services."[8] Effectively, the government and Mission had a deal: If Mission accepted regulation to prevent it from charging monopoly prices or otherwise abusing its monopoly market power, North Carolina would exempt Mission from the antitrust laws.

64. The COPA law acknowledged that the same conduct that may be lawful under the COPA may be unlawful without it, noting that "federal and State antitrust laws may prohibit or discourage" the "cooperative arrangements" that the COPA allowed.[9]

65. When the COPA was amended in 1998 to allow the Mission-St. Joseph's merger, the State accepted the hospitals' representations that the merger "will not likely have an adverse effect on costs or prices of health care."[10]

66. The 1998 amended COPA documented the dominant market share of the merged Mission institution: "The two Hospitals dominate the market share in two counties. 91% of Madison County admissions and 87% of Buncombe County admissions are either Memorial Mission or St. Joseph's Hospital. Memorial Mission and St. Joseph's are located in Buncombe County. Madison County, which has no hospital, is closer to the two Asheville hospitals than to any other acute care hospital."[11]

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[8] *See* former N.C.G.S. §§ 90-21.24, 90-21.28 (enacted by Physician Cooperation Act of 1995, SL 1995-395 (1995)); recodified at N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed by Session Laws 2015-288, s. 4, as amended by Session Laws 2016-94, s. 12G.4(a), effective Sept. 30, 2016).
[9] *See* former N.C.G.S. §§ 90-21.24(5).
[10] 1998 COPA, p. 13. *See also id*. at p. 14 (reciting that merger will "not likely have an adverse impact on … price of health care services").
[11] *Id.*, pp. 7-8.

67. A second amended COPA dated June 2005 stated: "Mission Health dominates the market share in two counties. 93.8% of Madison County admissions and 90.6% of Buncombe County admissions are at Mission Hospitals' facilities, which are located in Buncombe County. Madison County, which has no hospital, is closer to Mission Hospitals in Asheville than to any other acute care hospital."

68. In 2011, a hospital protesting Mission's anticompetitive practices publicized comments by Mission's Communications Director at a conference in which the Director said, "There was a lot of talk about the fact that we are a monopoly, and we are.... We're kinda the 500-pound gorilla in Western North Carolina." The Director was subsequently terminated.

69. As of 2016, Mission continued to have a 93% market share in its primary service area—Buncombe and Madison Counties—for inpatient GAC hospital services. Under modern antitrust law, generally a market share of over 60% constitutes a monopoly. And HCA itself has described a competitor's 85% inpatient market share as a monopoly in another state.

B. Mission engages in anticompetitive conduct under the COPA

70. While the COPA was in effect, it had provisions that sought to limit the ability of Mission to charge supracompetitive monopoly prices for healthcare or otherwise engage in anticompetitive behavior.

71. However, Mission evaded the COPA's substantive restrictions, to the detriment of competition and consumer welfare. Between 1995 and 2016, Mission engaged in anticompetitive conduct by using its monopoly income from Mission Hospital-Asheville to pressure smaller hospitals in the counties surrounding Buncombe and Madison Counties to allow Mission to manage or acquire their businesses. Each time Mission managed to acquire one of the smaller hospitals in the counties surrounding its Buncombe and Madison County primary service area, this

eliminated a potential competitor and expanded the scope of Mission's dominance. Between 1995 and 2016-17, Mission successfully acquired five of the hospitals in those counties.

72. During the same period, Mission acquired and associated with many physician groups and eliminated many of them.

73. From time to time, Mission executives admitted that the purpose of these acquisitions was to reduce competition in those regions. For example, in 2004, when Mission acquired McDowell Hospital, CEO Bob Burgin was quoted as saying that the acquisition would "prevent another provider from entering a local market."

74. In 2004, a group of four large employers in Western North Carolina issued a report on rising medical prices, which noted that Mission refused to cooperate and threatened to sue. The employers expressed their concern that the COPA was "allowing Mission to negotiate reimbursement rates that are higher than in other major counties...." Mission denied that any of this was occurring.

75. In 2011-12, with the COPA coming up for renewal, physicians and other hospitals publicly protested Mission's business practices. One physician described "Mission's abuse of the COPA," which was "a law that was enacted at their request to protect the citizens of [Western North Carolina] from monopolies and high medical prices." He described that by using its Asheville monopoly to charge "higher payments from insurers," Mission was able to "build an unprecedented empire," buying so many practices and other hospitals that competitors, including "those of us in private practice will not be able to survive." This physician described that when he met with Mission executives to try to protect his practice, Mission's response was that they would "crush us."

76. During this period, Mission was publicly claiming that its costs and prices were low. In fact, its prices were high, but they were concealed from regulators and the public due to Mission's use of gag clauses with commercial health plans.

77. A 2011 report by economist Greg Vistnes ("Vistnes Report") commissioned to study the efficacy of the COPA confirmed that a potential for regulatory evasion existed and that "[t]he incentive problems associated with the COPA regulation appear to be consistent with MHS' [Mission Hospital System] observed conduct and complaints about MHS' conduct that have been voiced by certain parties." The report found in part that the COPA created an incentive for Mission to acquire facilities outside of Asheville, because while the COPA limited Mission's ability to raise costs and margins, the cost increase cap was tied *only* to Mission Hospital-Asheville—meaning that if Mission increased costs by acquiring outlying facilities it could raise prices without technically violating the COPA's margin cap. Evidence presented at an FTC workshop in 2019 indicated that this was in fact what Mission appeared to have done.

C. **The COPA is repealed in 2016**

78. In 2010, Paulus became the new President and CEO of Mission. Paulus almost immediately began an effort to reduce or lift the COPA restrictions while retaining its immunity protection.

79. Paulus claimed that the Mission system could not survive unless the COPA restraints were repealed. These representations were false.

80. In a 2012 video, Paulus criticized the anticompetitive effect of "much larger out-of-area health systems that have entered our region." Paulus claimed that the COPA prevented Mission from competing with these predatory for-profit out-of-state multi-market systems.

81. After years of pressure by Paulus and other Mission executives, the Legislature obliged and passed a bill that repealed the COPA, terminating state oversight effective September 30, 2016.

82. While Mission prices had risen under the COPA, after its repeal they grew even more substantially, as described below.

83. On information and belief, within a year of the COPA's repeal, Mission executives had begun meeting with HCA about selling the system to HCA, an out-of-state system. Upon information and belief, Paulus anticipated the sale to a for-profit chain at the time he lobbied to repeal the statute. However, he did not inform Legislators about that fact.

D. <u>Mission assets are sold to HCA</u>

84. By 2017, Mission's executives had entered secret negotiations to sell assets from the Mission system to HCA, a multi-state health system that has been subject to at least 20 antitrust proceedings brought by the FTC. The negotiation process was conducted without any public notice or input, despite both companies' purported commitment to transparency and Mission's status as a charitable nonprofit with a fiduciary duty to the citizens of Western North Carolina. Non-executive doctors and staff were excluded from the negotiation process and the decision to sell to HCA.

85. Upon information and belief, there were inadequate efforts made to solicit other bidders and any other bids submitted were not taken seriously, resulting in an undervaluation of Mission.

86. Mission and HCA announced the deal on March 21, 2018. It was followed by execution of the 2018 APA on August 30, 2018, and the Amended APA in January 2019. The

purchase price was approximately $1.5 billion. Mission's annual income was estimated to be in the same range, at approximately $1.75 billion, reflecting the undervalued nature of the deal.

87. From approximately 2017 through January 2019, HCA and Mission negotiated the terms of the asset purchase which would form the new North Carolina Division of HCA Healthcare. On information and belief, HCA was interested in the transaction primarily because of the built-in monopoly power Mission had as a result of the COPA.

88. The HCA takeover was hugely beneficial to Mission's executives. In his last four months as CEO of Mission—which, at that point, was still technically a nonprofit—Paulus was paid $4 million in compensation from Mission's 501(c)(3) arm (i.e., its charity). He also secured a contract for himself as a consultant with HCA, under terms that have been kept secret and has, on information and belief, secured other lucrative business related to HCA that is ongoing.

E. HCA engages in post-acquisition conduct that adversely affects physicians, staff, consumers, and the community

89. Defendants' monopolistic practices have caused reduced quality of service in HCA/Mission hospitals. After the sale to HCA, there have been numerous news reports, public protests, over 100 citizen complaints sent into the Attorney General, and statements from area politicians protesting declining quality at the system.

90. Because the asset sale involved the sale of a nonprofit to a for-profit business, it was necessary for Defendants to obtain regulatory approval from the North Carolina Attorney General.

91. Between August 2018 and January 2019, the Attorney General required Mission and HCA to include certain provisions in the Amended APA to secure his approval. Under these provisions, Defendants promised to uphold certain commitments set forth in the Amended APA.

The Amended APA affords the Attorney General the authority to enforce the commitments in the Business Court.

92. The scope of the Amended APA commitments is narrow and is not coextensive with this lawsuit. The Amended APA agreement with the negotiated HCA commitments did not cover quality of care or pricing. However, some of the commitments do cover relevant ground and have been the subject of multiple public complaints:

- HCA promised that until January 2029 it would maintain the same level of charity care coverage for poor patients as before. However, HCA has a) reduced coverage for non-emergency services, b) implemented a threshold such that out-of-pocket expenses must exceed $1,500 to qualify for charity care coverage, and c) ended pre-approval for charity care coverage such that patients are forced to risk taking on substantial debt or forgo needed care.

- Section 7.13(a) and Schedule 7.13(a) require HCA to provide until January 2029 numerous defined services at Mission Hospital-Asheville. However, patients and staff have publicly noted that HCA has reduced budgets and staffing, making it more difficult for medical staff to provide the same quality of service as before.

- Section 7.13(b) and Schedule 7.13(b) required HCA to provide until January 2029 numerous services at its five smaller regional hospitals. HCA has cut budgets, staffing and quality there too. Nurses were so outspoken about their concerns that they voted to unionize, a drastic and effectively unprecedented step.

- Under Section 7.13(j), Defendants asserted they had "no present intent to discontinue any of the community activities, programs or services provided" prior to the buyout. Less than a year later in October 2019, however, HCA closed outpatient rehabilitation clinics in Candler and Asheville. In 2020, it closed primary care practices in Candler and Biltmore Park, and ended chemotherapy services at Mission Medical Oncology locations in Franklin, Brevard, Marion, and Spruce Pine.

93. These cutbacks and profit-driven decisions drew criticism from regulators. Among other things, the Attorney General wrote in February 2020 that the Defendants' "decision to focus on emergent care appears inconsistent with the Asset Purchase Agreement" and that the Defendants' website incorrectly claimed its charity care policy covered "non-elective" services. The Attorney General's office also said they had received a "surge" of complaints after the HCA

sale, including "harrowing" complaints about quality of care and staffing cuts. Other officials, such as the Mayor of Asheville and Buncombe County officials, also publicly expressed "deep concern" about HCA's dramatic cuts and the pressure put on doctors and nurses. Doctors, nurses, and patients have also called the situation created by HCA's cost cutting "dangerous," and have noted that HCA's policies force doctors and nurses to see more patients to maximize profit at the expense of patient care.

94. After the HCA purchase, leading national agencies that assess quality of care factors such as safety, accidents, injuries, infections, and readmissions lowered their ratings for the hospital system. The Leapfrog Group, an independent agency, downgraded Mission Hospital-Asheville to a "B" from an "A." According to Leapfrog, the hospital fell short in various measures, including infections, high-risk baby deliveries, some cancer treatment procedures, and the patient experience regarding elective surgeries.

95. The Centers for Medicare & Medicaid Services ("CMS") also downgraded Mission. CMS uses surveys of patients' experiences, including how responsive hospital staff were to their needs and the cleanliness of the hospital environment. In 2020, CMS even threatened to terminate its contract with HCA/Mission over patient safety concerns, a rare and particularly serious step given Mission's large share of Medicare and Medicaid patients.

96. The Mission Health System HCA now controls has quickly gone from one of the most respected hospitals in the Nation and a "crown jewel" of North Carolina's healthcare system to a facility known for declining, dangerous conditions. Amid the decline, HCA's profits are at an all-time high, driven by the new addition of Mission Hospital-Asheville as the HCA chain's second highest revenue hospital out of all 100-plus ones in the chain.

V. HOSPITAL/INSURANCE MARKETS AND EFFECTS OF CONSOLIDATION

A. <u>Hospital/insurance negotiations in a competitive market</u>

97. The market for hospital services is different from other product/services markets because the person consuming the hospital services (the patient) does not negotiate—and in many cases, does not even know beforehand—the costs of the services they are consuming.

98. Instead, commercial health plans, such as Blue Cross and Aetna, purchase medical services for the benefit of their insured members, the consumers. Commercial health plans negotiate with hospitals for the price the plans will pay for medical services, known as the "allowed amount," before services are consumed by members.

99. Commercial health plans generally do not negotiate with hospitals on a service-by-service basis; rather, commercial health plans negotiate with hospitals for bundles of services that the health plan will offer to members as "in-network" benefits. If the commercial health plan and hospital reach a deal for a bundle of services (for instance, all acute inpatient hospital services), the hospital will be considered in-network for every service in that bundle. This means that for any service in that bundle, if a commercial health plan's member receives that service from the hospital, the commercial health plan will pay the hospital the allowed amount those two parties negotiated for that service.

100. In competitive markets—markets with multiple hospitals—commercial health plans will enter into a contract with a hospital for a bundle of services when the hospital offers competitively priced and sufficiently high-quality services. In competitive markets, commercial health plans may choose to include as in-network some bundles of services at a hospital but not others; for instance, the commercial health plan may choose to have one hospital be in-network for all acute inpatient hospital services, but the plan may choose not to include that hospital in-

network for some acute outpatient hospital services (visits not requiring an overnight stay) because the plan could purchase higher quality versions of those outpatient services from a nearby competing hospital or other outpatient provider at a lower price. Similarly, in a competitive market, a commercial health plan may decline to purchase any services from a hospital if that hospital's price or quality of care are not competitive with other nearby providers.

101. If a commercial health plan wishes to be a viable product that consumers wish to purchase for themselves (or employers wish to purchase for their employees), the plan must include a comprehensive bundle of services that members can access in their region. A commercial health plan that does not offer in-network services that individuals commonly desire or that individuals may need in the case of unforeseen health problems will not be a viable insurance plan. Similarly, if a commercial health plan only offers certain services (such as acute inpatient hospital services) in-network at a hospital that is a long distance from many individuals' residences, that plan will not be viable, because individuals may not be able or willing to travel so far to receive those services.

102. The costs that commercial health plans pay hospitals for the in-network services they offer members are ultimately passed onto their members, such as the Plaintiffs, in the form of commercial health insurance premiums. Thus, the insurance premiums paid by commercial health plan members increase when the plans are forced to purchase services from hospitals at higher rates. Health plan members also pay directly for the costs of medical services provided by hospitals in the form of co-insurance payments and other out of pocket payments, such as co-pays.

103. In a competitive market, hospitals compete to be selected for inclusion in commercial health plans. Then, commercial health plans compete to be selected by employers to offer to their workers, or they compete to be selected by individuals.

B. Hospital/insurance negotiations in the absence of competition

104. The unique mechanics of the healthcare market described above provide an opportunity for hospital conglomerates with significant market power to illegally restrain trade through unduly restrictive negotiations and agreements with commercial health plans that limit competition and allow the system to thereby extract supracompetitive prices. Supracompetitive prices are rates that are higher than what would be found in the context of normal competition. In the market for hospital services, supracompetitive prices come in the form of inflated allowed amounts, which directly lead to higher insurance premiums and coinsurance payments. Importantly, while a dominant firm is permitted to charge a higher price by virtue of its monopoly power, it is not permitted to impose anticompetitive restraints that further inhibit price and quality competition and to charge a price even higher than the monopoly price.

105. When a commercial health plan seeks to offer a plan in a region where a significant area is controlled by a single hospital, that hospital is in effect a "must have" hospital for that health plan: Individuals and employers seeking insurance will not choose any health plan that does not include necessary services provided by that hospital.

106. If a "must have" hospital decides to engage in anticompetitive behavior, it can cause significant financial harm to both commercial health plans as well as employers and individuals purchasing such plans. First, a "must have" hospital can demand from commercial health plans allowed amounts that are grossly above what the hospital could obtain if it faced competition. This is true both by virtue of the hospital's extant market power, as well as the enormously high barriers to entry when it comes to many services hospitals provide. These barriers to entry, which include the costs of building facilities and hiring skilled staff (such as surgeons and anesthesiologists) as well as regulatory hurdles such as obtaining a certificate of need from the State before opening a

new facility, prevent new entrants from entering the market and reining in the price the "must have" hospital can charge. Second, if the "must have" hospital is part of a system that has other facilities that *do* face competition, the hospital system can refuse to offer medical services at the "must have" facility unless commercial health plans also agree to purchase medical services from the system's other facilities at high prices dictated by the hospital system.

107. These factors and others have led to a consensus in the field of healthcare economics that monopolization of hospital markets significantly increases prices for hospital services paid by commercial health plans and by employers and individuals, in the form of higher direct payments to hospitals and higher insurance premiums. And the economic literature strongly suggests that there are no concomitant improvements in quality from such monopolization. HCA itself stated in a regulatory filing in Florida, "there is documented empirical evidence of the negative aspects of lack of competition in a healthcare market on charges, costs, and quality of care" and that "economic studies consistently demonstrate that a reduction in hospital competition leads to higher prices for hospital care."

C. Effect of supracompetitive hospital prices on insurance premiums and wages

108. When hospitals use anticompetitive restraints to extract higher prices from insurers for hospital services—or use anti-steering provisions to artificially inflate the number of patients paying the dominant hospitals' supracompetitive prices—the higher amounts that commercial health plans pay hospitals for in-network services are ultimately passed on to their members, such as Plaintiffs, in the form of higher commercial health insurance premiums and/or, for workers who have employer-provided healthcare, reduced wages. A significant body of academic research has demonstrated that "the effects of [hospitals'] higher prices are not limited to the patients at these hospitals because insurers pass on these increased prices to *all* enrollees and their employers

through increased premiums. Furthermore, workers bear the burden of these increased premiums as employers depress wages to pay more for health insurance coverage."[12] Similarly, the FTC noted in a recent complaint against a hospital that "[w]hen hospital rates increase, commercial insurers generally pass on a significant portion of those increased rates to their customers—employers, their employees, and individuals—in the form of higher premiums, co-pays, and deductibles."[13] Other research also demonstrates a direct correlation between hospital consolidation and higher insurance premiums.[14] Part of this is due to regulations on insurance companies tying premium levels to the medical costs insurers pay for members. The Affordable Care Act, for example, requires "insurance companies to spend at least 80% or 85% of premium dollars on medical care,"[15] which is another reason hospital prices and insurance premiums are so directly linked.

109. With respect to how employers in turn pass on such higher premiums to employees, in a report published earlier this year about the relationship between hospital prices and insurance expenses, the Congressional Budget Office noted that "[i]n general, insurers' greater spending would be passed on to employers that purchase coverage on behalf of their employees. Employers' spending on health insurance represents a large part of their employees' nonwage compensation, so employers generally take actions to offset increases in health insurance spending in order to

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[12] Katherine L. Gudiksen, Amy Y. Gu, and Jaime S. King, *Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California* at 2, Calif. Health Care Found. (Dec. 2021) (emphasis added), *available at* https://www.chcf.org/wp-content/uploads/2021/11/MarketsMonopoliesHCConsolidation.pdf.

[13] Administrative Complaint, *In the Matter of HCA Healthcare, Inc.* at 12, FTC (June 2, 2022*), available at* https://www.ftc.gov/system/files/ftc_gov/pdf/D9410HCAStewardPart3ComplaintPublic.pdf.

[14] *See, e.g.*, Richard Scheffler, et al., *Consolidation Trends in California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*, Health Affairs, vol. 37, no. 9: 1409-16 (September 1, 2018), *available at* https://doi.org/10.1377/hlthaff.2018.0472 (finding that an increase in share of physicians in practices owned by a hospital was associated with 12% increase in premiums for commercial health plans).

[15] *Medical Loss Ratio*, U.S. Centers for Medicare and Medicaid Servs. (last visited Oct. 24, 2022), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio#:~:text=The%20Affordable%20Care%20Act%20requires%20insurance%20companies%20to%20spend%20at,on%20health%20insurance%20rate%20increases.

maintain their profits."[16] The CBO also cited a "recent study [finding] that price increases for hospitals' services were associated with a rise in employees' out-of-pocket costs, an increase in the use of high-deductible health plans, and slower wage growth for employees."[17]

110. UC Berkeley researchers summarized recent academic research on this topic: "Increases in health care costs are coming out of workers' pockets one way or another. . . . When health care costs rise, employers can respond in a variety of ways, such as by increasing worker premium contributions, increasing deductibles or copayment amounts, reducing employment, or increasing their own premium contributions while reducing or limiting wage growth accordingly."[18]

D. Relevant markets

111. Judgment may be entered against Defendants for the illegal conduct described in this complaint without defining the particular economic markets that Defendants' conduct has harmed. Defendants' ability to impose anticompetitive contract terms in all, or nearly all, of its agreements with commercial insurers and their ability to persistently charge supracompetitive prices are direct evidence of Defendants' market power that obviates any need for further analysis of competitive effects in particular defined markets. Moreover, market definitions are unnecessary because Defendants' anticompetitive behavior is a per se violation of N.C.G.S. § 75-1 *et seq*.

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[16] *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* at 9, U.S. Cong. Budget Office (Jan. 2022), *available at* https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf.

[17] *Id.* at 12 & n.2 (citing Zack Cooper *et al*, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, Quarterly J. of Economics, vol. 134, no. 1 (Feb. 2019), pp. 51–107, *available at* https://doi.org/10.1093/qje/qjy020).

[18] Laurel Lucia and Ken Jacobs, *Increases in health care costs are coming out of workers' pockets one way or another: The tradeoff between employer premium contributions and wages*, University of California Berkeley Labor Center, (Jan. 29, 2020), *available at* https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/; See, e.g., *Rising health care costs mean lower wages*, Harvard School of Public Health (Oct. 2011), *available at* https://www.hsph.harvard.edu/news/hsph-in-the-news/baicker-health-care-costs-wages/.

112. Notwithstanding the foregoing, the relevant markets at issue in this case are defined herein. For each, the product market includes only the purchase of medical services by commercial health plans, including individual, group, fully insured, and self-funded health plans, as well as related payments by patients directly to providers through coinsurance or otherwise. The relevant product markets do not include sales of such services to government payers, e.g., Medicare, Medicaid, and TRICARE (covering military families), because a healthcare providers' negotiations with commercial health plans are separate from the process used to determine the rates paid by government payers.

113. The three markets that are relevant to the illegal conduct described in this complaint are properly defined as follows:

1. Primary Relevant Market: Asheville Region Inpatient Services

114. A relevant market in which Defendants have unlawfully maintained and abused their monopoly power and unlawfully restrained trade is the sale of inpatient general acute care (previously defined as GAC) hospital services to insurers (or self-funded TPAs) in Buncombe and Madison Counties (the "Asheville Region Inpatient Services Market"). Defendants participate in the Asheville Region Inpatient Services Market predominately through their flagship facility, Mission Hospital-Asheville.

115. The sale of GAC hospital services is a relevant product market. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (e.g., orthopedic surgery is not a substitute for gastroenterology), commercial health plans typically contract for various individual acute inpatient hospital services as a cluster in a single negotiation with a hospital system. That is how

Defendants negotiate with insurers with respect to acute inpatient hospital services at Mission Hospital-Asheville. Moreover, non-hospital facilities, such as outpatient facilities, specialty facilities (such nursing homes), and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services are not viable substitutes for acute inpatient hospital services. Consequently, commercial health plans' and consumers' demand for acute inpatient hospital services is generally inelastic because such services are often necessary to prevent death or long-term harm to health. Thus, such services can be treated analytically as a single product market.

116. The relevant geographic market for this product market is Buncombe and Madison Counties (the "Asheville Region"). Defendants themselves have specified Mission Hospital-Asheville's service area to include Buncombe and Madison Counties.[19] The Dartmouth Atlas of Health Care—a well-established industry authority that defines geographic hospital markets—defines the "Health Referral Region" for all of the Mission System hospitals as "NC-ASHEVILLE."[20] The 2010 census reported the population of Buncombe County was 238,318 and the population of Madison County was 20,764.

117. Commercial health plans contract to purchase acute inpatient hospital services from hospitals within the geographic area where their enrollees are likely to seek medical care. Such hospitals are typically close to their enrollees' homes or workplaces. Insurers who seek to sell commercial health plans to individuals and employers in the Asheville Region must include hospitals in that region in their provider networks, because people who live and work in the

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[19] *E.g.*, Mission Hospital Implementation Strategy, 2013-15, p. 1 ("Our community, defined for the purposes of community health needs assessment and this related implementation strategy, is comprised of Buncombe and Madison Counties."), https://missionhealth.org/wp-content/uploads/2018/04/2013-Mission-Hospital-Implementation-Strategy.pdf (accessed June 2, 2021). *See also* IRS Form 990 for period ending September 2019, Schedule H, supplemental information ("Mission Hospital primarily serves Buncombe and Madison Counties").

[20] Dartmouth Atlas of Health Care, https://www.dartmouthatlas.org/about/ (accessed July 12, 2021).

Asheville Region strongly prefer to obtain acute inpatient hospital services in that area and it could be medically inappropriate and unfeasible to require them to travel farther. Consumers in the Asheville Region have little or no willingness or practical ability to enroll in a commercial health plan that provides no network access to acute inpatient hospital services located in the Asheville Region.

118. For these reasons, there are no reasonable substitutes or alternatives to acute inpatient hospital services in the Asheville Region for insurers wishing to offer commercial health plans in that area. Nor is it viable for many patients living in the Asheville Region to seek acute inpatient hospital services elsewhere. Consequently, competition from providers of acute inpatient hospital services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of acute hospital services located in the Asheville Region from profitably imposing small but significant price increases for those services over a sustained period of time. Defendants have, in fact, imposed such price increases on acute inpatient services, demonstrating that the Asheville Region is a properly defined geographic market.

119. Defendants have a market share of approximately 80% to 90% for acute inpatient hospital services in Buncombe County and Madison County, primarily due to the regional dominance of Mission Hospital-Asheville. Defendants' market share in this market is significant enough to stifle competition and restrict freedom of commerce, and, during the relevant period, Defendants have had the ability to control the price for this market.

2. Other Relevant Markets

a. Asheville Region Outpatient Services

120. A second relevant market is the sale of outpatient medical services to insurers in Buncombe and Madison Counties ("Asheville Region Outpatient Services Market"). In general,

outpatient medical services encompass all the medical services a hospital provides that are not inpatient medical services (i.e., services that do not require an overnight stay). Defendants participate in this market through their flagship facility, Mission Hospital-Asheville, and other HCA/Mission outpatient facilities in Buncombe and Madison counties.

121. The sale of outpatient medical services is a relevant product market. Outpatient medical services consist of a broad group of medical, diagnostic, and treatment services that do not include a patient's overnight stay in the hospital. Although individual outpatient medical services are not substitutes for each other (e.g., a CT scan is not a substitute for an annual physical), commercial health plans typically contract for various individual outpatient medical services as a cluster in a single negotiation with a hospital system, and that is how Defendants negotiate with insurers with respect to outpatient hospital services at Mission Hospital-Asheville.

122. Unlike for acute inpatient hospital services, non-hospital facilities—such as independent primary care providers, specialty facilities, ambulatory surgical centers, nursing homes and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services—can be substitutes for outpatient medical services provided at a hospital. Consequently, insurers' and consumers' demand for outpatient medical services *from a hospital* is generally more elastic because, if given the opportunity, they could obtain some of these services from non-hospital providers. But demand for outpatient medical services *in general* is inelastic because such services are often necessary to prevent illness, loss of physical mobility, or long-term harm to health. Thus, outpatient medical services can be treated analytically as a single product market.

123. As with the primary relevant market described above, Asheville Region Inpatient Services, the relevant geographic market for this market is the Asheville Region.

124. Insurers contract to purchase outpatient medical services from hospitals and non-hospital providers within the geographic area where their enrollees are likely to seek medical care. Such providers are typically close to their enrollees' homes or workplaces. Insurers who seek to sell insurance plans to individuals and employers in the Asheville Region must include providers in that Region in their provider networks, because people who live and work in the Asheville Region strongly prefer to obtain outpatient medical services in that area, and it could be medically inappropriate to require them to travel farther. Consumers in the Asheville Region have little or no willingness or practical ability to enroll in an insurance plan that provides no network access to outpatient medical services located in the Asheville Region.

125. For these reasons, there are no reasonable substitutes or alternatives to outpatient medical services in the Asheville Region for insurers wishing to offer insurance plans in that area. Nor is it viable for patients to seek outpatient medical services elsewhere. Consequently, competition from providers of outpatient medical services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of outpatient medical services located in the Asheville area from profitably imposing small but significant price increases for those services over a sustained period of time.

126. The Asheville Region Outpatient Services Market is a separate market from the Asheville Region Inpatient Services Market because they are not interchangeable and can be sold separately. Commercial health plans can and often do purchase outpatient services from different providers (i.e., non-hospital providers) than they purchase acute inpatient hospital services, which can only be purchased from hospitals. The existence of non-hospital competitors would, in a competitive market absent any anticompetitive behavior, reduce the price commercial health plans would pay a hospital for outpatient medical services, but those competitors would not affect the

price a hospital could charge for acute inpatient hospital services. The markets are therefore distinct.

b. Outlying Regions Inpatient and Outpatient Services

127. Other relevant markets at issue in this case involve the markets for (a) acute inpatient hospital services, and (b) outpatient medical services, in Outlying Regions in Western North Carolina in which or near where Defendants operate five Outlying Facilities ("Outlying Regions Inpatient and Outpatient Services Markets").

128. The Outlying Regions Inpatient and Outpatient Services Markets involve two separate product markets (inpatient services and outpatient services), and therefore they can be considered as separate from each other for purposes of assessing monopoly power. For purposes of Plaintiffs' restraint of trade claim, however, they can effectively be considered together, because Defendants' all-or-nothing contracting ties Asheville Region Inpatient Services to both inpatient and outpatient services in the Outlying Regions.

129. The relevant products in these markets—acute inpatient hospital services and outpatient medical services—are defined the same as for the Asheville Region, and those definitions in the preceding paragraphs are realleged here.

130. The relevant geographic market is the area encompassed by the following counties in or near where Defendants' hospitals operate: Macon, McDowell, Mitchell, Transylvania and Yancey Counties (the "Outlying Regions"). In the alternative, each of these counties in the Outlying Regions constitutes its own separate relevant geographic market.

131. In the Outlying Regions, Defendants operate five facilities (collectively, the "Outlying Facilities"):

- **Transylvania Regional Hospital**, Transylvania County
- **Angel Medical Center,** Macon County

- **Highlands-Cashiers Hospital**, Macon County
- **Mission Hospital McDowell,** McDowell County
- **Blue Ridge Regional Hospital,** Mitchell County

132. Unlike Mission Hospital-Asheville, several of these Outlying Facilities face some competition for acute inpatient hospital services and compared to Mission Hospital-Asheville they face more competition for outpatient medical services, from other hospitals and non-hospital providers in the geographic regions in which they operate. Thus, due to this heightened level of competition, commercial health plans seeking to build a viable insurance network may not, absent Defendants' anticompetitive conduct, be required to include all these facilities in-network in order to be viable. Or commercial health plans would be able to negotiate a lower price for acute inpatient hospital services or outpatient medical services at these facilities, or they would be able to steer patients to competing hospitals that have lower prices and higher quality.

133. In the Outlying Regions, Defendants are able to impose—and have imposed—on insurers a significant, non-transitory increase in price for both inpatient and outpatient services. The existence of some competition in the Outlying Regions has not prevented Defendants from maintaining these significant price increases.

134. The fact that Defendants still face some competition for both inpatient and outpatient services in the Outlying Regions does not mean Defendants do not have monopoly power in this geographic market. Contrary to the colloquial use of "monopoly" to mean a single firm with no competitors, under antitrust law monopoly power means, according to the U.S. Department of Justice, "the power to control prices or exclude competition," *i.e.*, a "dominant market share." A market share above 70% is almost always treated as "dominant," and any

market share above 50% can be "dominant" depending on the particular market characteristics.[21] Thus, a firm may be considered a "monopoly" even though it faces some competition.

135. The Outlying Regions Inpatient and Outpatient Markets are separate markets from the Asheville Region Inpatient Services Market because they are not interchangeable and can be sold separately. Despite some geographic overlap, the markets involve different facilities, operating primarily in different regions, and they offer different types of service. For instance, in the Asheville Region, Defendants offer acute trauma care, whereas this service is not offered by any of the Outlying Facilities. Moreover, some of Defendants' Outlying Facilities face more competition from other providers than Defendants' facility at Mission Hospital-Asheville faces, particularly for acute inpatient hospital services. Commercial health plans can and often do purchase outpatient services from different providers (i.e., non-hospital providers) than they purchase acute inpatient hospital services from, which can only be purchased from hospitals. The competition the Outlying Facilities face from both other hospitals and non-hospital facilities would, in a competitive market absent any anticompetitive behavior, reduce the price commercial health plans would pay the Outlying Facilities for inpatient and outpatient services, or the overall level of spending at those facilities (through steering), but those competitors would not have an effect on the price a hospital could charge for acute inpatient hospital services in the Asheville Region. The markets are therefore distinct.

E. <u>Defendants' market power</u>

136. Since the repeal of the COPA in 2016, Defendants have operated an unregulated monopoly in the Asheville Region, particularly with respect to acute inpatient hospital services.

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[21] *Competition and Monopoly: Single-Firm Conduct Under Section 2 of the Sherman Act: Chapter 2 ("Monopoly Power")*, U.S. Dep't of Justice (citations omitted), https://www.justice.gov/archives/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-2 (last visited Oct. 31, 2022).

Defendants have likewise, through the anticompetitive restraints described herein, expanded and abused their monopolistic market power to increase their dominance and pricing in the markets for Asheville Region Outpatient Services and the Outlying Regions Inpatient and Outpatient Services Markets. This has resulted in a situation where, both within the Asheville Region and its surrounding areas, Defendants are able to control the prices paid by commercial health plans and patients.

137. Defendants have a market share of 80 to 90% for acute inpatient hospital services in both Buncombe County and Madison County, i.e., the Asheville Region Inpatient Services Market. The Medicare Hospital Market Service Area File for the calendar year ending December 31, 2019, reflects that, with regard to inpatient origin for the top three zip codes, Mission Hospital-Asheville's market share was as follows: market share of 88.9% for zip code of residence 28806; market share of 86.5% for zip code of residence 28803; and market share of 87% for zip code of residence 28715.[22]

138. While sometimes not as high as in Asheville, Defendants also have significant market share in certain surrounding geographic regions, in part because they can exert control over referrals in those regions through their dominance at Mission Hospital-Asheville. Outside of Asheville, Defendants' market share often exceeds 75% in areas where Defendants have only a small hospital with less than 30 beds but where a large portion of patients are also directed to the more distant Mission Hospital-Asheville. Defendants have used their monopoly in acute inpatient hospital services in the Asheville Region to monopolize inpatient and outpatient services in the Outlying Regions. Alternatively, Defendants have attempted to establish additional monopolies in each of these counties where they hold well over a 70% market share (See Counts I & II below).

[22] See American Hospital Directory, available at https://www.ahd.com/free_profile/340002/Mission_Hospital_-_Memorial_Campus/Asheville/North_Carolina/ (accessed June 26, 2021).

139. Defendants have maintained and grown this market share since the COPA's repeal because of the anticompetitive negotiating and contracting practices at issue in this suit. These anticompetitive practices, described in more detail hereafter, have led directly to significant price increases at all of Defendants' facilities, for both inpatient and outpatient care, and these higher prices have led directly to severely increased premiums paid by Plaintiffs and the putative class.

VI. DEFENDANTS' ANTICOMPETITIVE PRACTICES HAVE HARMED COMPETITION, RESULTING IN HIGHER PRICES AND WORSE QUALITY

140. During the pertinent times and within the last four years, Defendants have engaged in anticompetitive negotiating tactics with commercial health plans and/or have insisted on contract terms including one or more anticompetitive provisions with insurers. These negotiating tactics and contract clauses have included: tying arrangements and all-or-nothing arrangements, gag clauses, and, on information and belief, non-participating provider rate clauses and anti-tiering or anti-steering arrangements. The use of anticompetitive provisions and arrangements is consistent with the areas of regulatory evasion identified in the Vistnes Report and with HCA's documented use of similar provisions and negotiating tactics in other states.

141. Individually and in combination, these contract provisions are designed to suppress competition and transparency in the market for the sale of acute hospital services and increase the prices Defendants can charge commercial health plans. Defendants use their market power to force insurers to accept these restrictions which have the following anticompetitive effects:

- protecting Defendants' market power and enabling Defendants to raise prices and reduce quality of acute inpatient hospital services substantially beyond what would be tolerated in a competitive market, to the detriment of consumer welfare;
- substantially lessening competition among providers in their sale of acute inpatient hospital services;
- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that bar them from sharing competitive pricing information;

- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that bar them from directing consumers to lower cost providers;
- restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services;
- reducing consumers' incentives and ability to seek or even be aware of acute inpatient hospital services from more cost-effective providers; and
- depriving consumers of the benefits of a competitive market for their purchase of inpatient hospital services.

142. These types of arrangements and agreements have been found to be illegal even in markets with more robust provider competition than exists here, due to their inherent harm to consumer welfare and competition. However, because Defendants have an unregulated monopoly (instead of built-out market power in a free market), the illegal anticompetitive impacts on consumers are much more severe. Most obviously, healthcare costs in the Western North Carolina market area that Defendants control are now dramatically higher than the North Carolina average and still rising while quality is declining.

143. Anticompetitive contract provisions and negotiating tactics are particularly problematic when a provider controls a "must have" hospital, as HCA acquired here when it acquired Mission Hospital-Asheville. It is not practically possible to assemble a commercially viable insurance plan in Western North Carolina that excludes Mission Hospital-Asheville. In a market with a "must have" hospital, even the limited use of these contract provisions or negotiating tactics causes much greater harm to consumers and potential competitors than the use of such practices and provisions in a competitive market.

144. On information and belief, HCA/Mission has been among the most intransigent of all systems in North Carolina during contract renewals and other negotiations with insurers.

Defendants have continued to insist on higher prices for declining quality of service because they are aware of their "must have" status for commercial health plans and TPAs.

145. An insurance official summed up the problem with HCA/Mission in two words: "their price." The excessive price increases being billed directly and indirectly to Plaintiffs and other patients would have been unlawful under the COPA, unsustainable in a competitive market that operated free from the restraints described herein, and unrealistic before the HCA takeover.

A. Defendants willfully and unlawfully acquired, maintained, and/or abused monopoly power in each of the relevant markets

146. Neither Mission nor HCA acquired monopoly power by outcompeting rivals on price and quality as our antitrust laws envision. Instead, Mission became a monopoly solely by virtue of a merger that would have been unlawful under the antitrust law but that was shielded from suit by the protection the COPA gave from antitrust scrutiny.

147. Once Mission became so large as to be both indispensable to commercial health plans and insulated from any meaningful competition, particularly for acute inpatient hospital services, Mission's executives sought and obtained the COPA's repeal, freeing it from any relevant government restrictions. HCA then purchased the monopoly in a cross-market merger and has further exploited the system's market dominance by raising prices and cutting costs in ways that have harmed quality of care. Now and for the last several years, neither Mission nor HCA has immunity from antitrust liability, meaning their unlawful acquisition and maintenance of this monopoly is properly the subject of this lawsuit.

1. While the COPA was in effect, Mission circumvented its restrictions to gain additional market power and raise prices

148. The COPA did not directly regulate the prices Mission could charge for services, but it sought to do so indirectly through several limitations on the way Mission could do business.

Most notably, the COPA imposed three purported caps on Mission's operations: a margin cap, a cost cap, and an employed-physician cap.

149. The COPA's margin cap on Mission was systemwide—Mission as a whole was not allowed to raise its profit margin by more than a certain amount compared to comparable hospitals. But the cost cap was specific only to Mission Hospital-Asheville: That facility could only increase its costs at the same rate as a national index, but there was no limit on how much Mission could increase its costs at other facilities.

150. In 2011, the Vistnes Report concluded that this structure gave Mission an incentive to increase spending on Outlying Facilities—including by purchasing new ones—so as to push its overall costs up, thereby allowing it raise prices to earn a higher profit while still meeting the percentage margin cap.

151. Under the COPA, Mission grew its market share in Western North Carolina. It did so by acquiring the five smaller Outlying Facilities, each time eliminating a competitor in the process. In doing so, Mission could increase its costs without affecting the cost cap, thereby allowing it to increase prices at all of its facilities without violating the COPA's margin cap.

152. Thus, while the COPA was designed to ensure Mission's recognized monopoly power in the market for acute inpatient hospital services did not harm consumers in the region, Mission grew substantially more dominant by acquiring competing practices, expanding its geographic reach, and moving costs from Mission Hospital-Asheville to its Outlying Facilities. This caused Mission's prices to raise across the board, including for acute inpatient hospital services.

153. In 2019, after the COPA was repealed, two FTC economists, Lien Tran and Rena Schwarz, concluded that the COPA's margin and caps did not prevent Mission from raising prices

20 percent more than similarly situated hospitals: "The evidence suggests that, despite the margin/cost regulations, the COPA oversight did not prevent [Mission] from raising prices."

154. As a result of these findings, the FTC in 2020 held up the example of the Mission Hospital COPA as a reason why a COPA proposed for another State, Texas, should not be allowed:

> In 2015, the North Carolina legislature repealed the state's COPA statute as a result of lobbying efforts by Mission Health, and the Mission Health COPA was terminated as of September 2016 – leaving no meaningful competitive or regulatory constraint on Mission Health's monopoly market power. In February 2019, Mission Health was acquired by HCA Healthcare.
>
> At the FTC COPA Workshop, empirical research was presented on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008. The study showed that Mission Health increased its prices by at least 20% more than the control hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices….
>
> Kip Sturgis, from the North Carolina Attorney General's office, was responsible for overseeing the Mission Health COPA for nearly 20 years. Mr. Sturgis explained that in hindsight, he would have implemented more quality metrics and financial incentives for the hospital to control costs. He does not recommend that states use COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.

2. HCA purchased Mission in order to acquire a monopoly system and exploit that market power

155. After the COPA was repealed, HCA acquired Mission precisely because of its (now unregulated) monopoly power, and with the knowledge that, as a larger national for-profit chain, it would be better positioned to exploit Mission Health's monopoly power in Western North Carolina. As noted at the time:

- A former HCA executive remarked: "[I]t is a high growth market *where they have no competition* and their margins are already strong" and "HCA is parachuting into Asheville and getting the benefit of a COPA *without any restrictions*." (Emphases added).

- A leading healthcare finance reporter observed that the Mission acquisition "fits with HCA's longstanding strategy of scooping up facilities that dominate their markets, which helps the company negotiate better rates with health insurers."

- HCA in communicating with Wall Street analysts has called Mission a "market maker" that "need[ed] to be a part of something bigger," citing the acquisition as a "model" for acquiring market power. Shortly after the acquisition, HCA executives told Wall Street analysts that the company's "market share has reached an all-time high using the most recently available data. *But we are pushing for more***.**" (Emphasis added).

156. Prior to the HCA acquisition of the Mission system, HCA owned hospitals in a variety of important markets across the country, but not in North Carolina. Thus, when HCA acquired Mission, it was not the case of one competitor in the same town or region acquiring another. Rather, a dominant hospital owner in many other markets (HCA) acquired the dominant hospital system in the Western North Carolina market (Mission).

157. According to peer-reviewed published studies, one effect of a cross-market or multi-market merger is to cause an increase in healthcare prices.

158. On information and belief, HCA uses its market power via its ownership of hospitals in other markets to leverage insurance companies to agree to higher prices at HCA/Mission hospitals, and vice versa.

159. The FTC has on multiple occasions challenged in-market mergers due to the anticompetitive effect of such mergers.

160. A cross-market merger of the type that has occurred here likewise has an anticompetitive effect.

161. In 2019, 61 percent of US workers with employer-sponsored health coverage were enrolled in self-insured plans, including 17 percent in small firms and 80 percent in large firms.[23]

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[23] Kaiser Family Foundation, 2019 Employer Health Benefits Survey (Sept. 25, 2019), *available at* https://www.kff.org/report-section/ehbs-2019-summary-of-findings/.

162. Large firms likely have territories extending beyond the 18-county scope of the Western North Carolina region identified by HCA as Mission's extended service area.

163. When large self-funded employers negotiate with HCA, it becomes relevant to the negotiation that HCA not only owns hospitals in NC but also in many other states.

164. Large self-funded employers are currently unable to restrain increases in healthcare prices caused by the concentration of market power into large for-profit hospital chains like HCA.[24]

165. Allowing HCA to join into its national network the monopoly in Western North Carolina increases the anticompetitive effect of the monopoly far beyond where it was when only local nonprofit Mission owned it.

166. Large self-funded employers and their TPAs pay more for access to the Mission hospital monopoly as part of HCA's Western North Carolina region than they would pay for that access if Mission was only part of a western North Carolina hospital network.

167. The antitrust law restrains mergers to the extent that such combinations may tend to lessen competition.

168. The asset sale of the Mission Hospital monopoly from old owner Mission to new owner HCA was an unlawful merger or acquisition because it resulted in a lessening of competition.

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[24] Matthew D. Eisenberg, Mark K. Meiselbach, Ge Bai, Aditi P. Sen, Gerard Anderson, *Large Self-insured Employers Lack Power to Effectively Negotiate Hospital Prices*, Am. J. of Managed Care, vol. 27, Issue 7 (July 13, 2021), *available at* https://www.ajmc.com/view/large-self-insured-employers-lack-power-to-effectively-negotiate-hospital-prices.

3. Through the restraints described herein, Defendants unlawfully abused and maintained their monopoly over the Asheville inpatient market

169. Even if Defendants' monopoly power over the Asheville inpatient market was lawfully obtained, they have used the restraints described herein to unlawfully abuse and maintain that monopoly.

170. As noted above, Defendants' market share in the inpatient services market in the Asheville region is between 80 and 90 percent, as measured by patient discharges. While this level is far above the 70 percent threshold that courts deem sufficient to constitute monopoly power, Defendants' flagship facility at Mission Hospital-Asheville does still face some competition in this market. For instance, according to data published by the North Carolina Hospital Association ("NCHA") for patient discharges, by county of residence, Mission Hospital-Asheville competes for patients in Buncombe County with AdventHealth Hendersonville and Pardee UNC Health Care.[25] According to this data, Mission Hospital-Asheville has an 88.6% market share, while AdventHealth Hendersonville and Pardee UNC Health Care have 4.2% and 2.5% respectively. Similarly, in Madison County, Mission Hospital-Asheville has a 90.6% market share, while AdventHealth Hendersonville and Pardee UNC Health Care have 2.4% and 1.7% respectively. Thus, for at least some number of patients who reside in Buncombe and Madison Counties, there are viable competitors that, absent Defendants' restrictions, insurers could steer patients to in order to receive lower-cost, higher quality care. Defendants' anticompetitive anti-steering provisions, therefore, have exacerbated the ill effects of their market power when it comes to patients who live in Buncombe and Madison counties.

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[25] *See North Carolina Hospital Discharge Data, Fiscal Year 2020*, North Carolina Hospital Association, *available at* https://www.shepscenter.unc.edu/wp-content/uploads/2022/05/ptorg_hosp_by_pt_res_2020.pdf. This data includes all discharges, and is not limited to Medicare discharges.

171. Moreover, patients who receive care at Mission Hospital-Asheville do not all reside in Buncombe and Madison Counties. Thus, it would be incorrect to assume that Mission Hospital-Asheville's monopoly power is limited to those two counties, and that its restraints only affect counties outside of Buncombe and Madison.

172. Through the use of anti-steering provisions, Mission Hospital-Asheville has prevented insurers from steering patients to competing hospitals in nearby counties. That is, it has artificially (and unlawfully) inflated the number of patients that receive care at Mission Hospital-Asheville, who could receive care at one or more cheaper, higher-quality facilities if insurers were able to incentivize patients to seek care there. This is most evident by examining hospital discharge data by patient county of residence.

173. Mission Hospital-Asheville also competes with other hospitals for patients from other counties. For example, for patients who reside in Henderson County, Mission Hospital-Asheville has a 29.7% market share, while Pardee UNC Health Care has a 47.1% market share, and AdventHealth Hendersonville has an 18.6% market share. For patients who reside in Haywood County, Mission Hospital-Asheville has a 40.9% market share and competes with at least three other hospitals (one of which, Haywood Regional Medical Center, operated by Duke, has a 51.5% market share). For patients from Graham County, Mission Hospital-Asheville has a 38.3% market share, and competes with several other hospitals. For patients who reside in Transylvania County, Mission Hospital-Asheville has 47.1% market share, while Pardee UNC Health Care has 10.2% and AdventHealth Hendersonville has 5.1%. (According to NCHA's dataset, Defendants' total market share in the Transylvania County market is 80.7%, because HCA's Transylvania Regional Hospital has a 33.6% market share in this market.)

174. Thus, patients who reside in these and other counties that Mission Hospital-Asheville serves have multiple other, less expensive hospitals from which they could receive care.

175. But because of Defendants' restrictive anti-steering provisions—which they are able to impose on insurers, because every insurer must include the "must have" Mission Hospital-Asheville in their networks—insurers cannot take measures, such as by providing financial incentives, to encourage patients who reside in these counties to seek higher quality, lower-cost care from competing hospitals. This has resulted in Defendants' anticompetitively increasing the number of patients who receive care at Mission Hospital-Asheville, and preventing competitors from cutting into Defendants' dominance in Western North Carolina. In this way, Defendants' have unlawfully abused and maintained their monopoly over the Asheville Region inpatient care market, and this has foreclosed competition and had anticompetitive effects within Mission Hospital-Asheville's service area.

4. Through the restraints described herein, Defendants have monopolized the Outlying Regions and the Asheville outpatient market

176. At the time of the 1995 COPA, Mission had a monopoly-level market share only in the Buncombe and Madison County inpatient markets.

177. By contrast, the HCA system in North Carolina now has a monopoly (well above 70%) commercial insurance inpatient market share both in Buncombe and Madison Counties, as well as in other Counties. Defendants were able to obtain this monopoly power because they required insurers to include all of their hospitals in-network through their all-or-nothing contracting, and they prevented insurers from steering patients to competitors in the Outlying Regions through the use of anti-steering provisions. Absent these restraints, Defendants would not have monopolized these markets.

178. Because of the restraints Defendants have imposed, each of the HCA hospitals in the Outlying Regions now has a monopoly-level market share (*i.e.*, above 70%) in inpatient services in the county in which it is located or other relevant county.[26] The following table lists total inpatient market share—including all commercial discharges—as calculated by four different sources of data (including from HCA itself), and compares them to Medicare market share numbers at those same facilities:

	County	All Patients	All Patients	All Patients	All Patients	All Patients	Medicare
		IBM Watson Analysis - 2019[27]	North Carolina Hospital Association (NCHA) - 2020[28]	Mission Inpatient Market Share 2020 (From HCA CON Application Filed June 2022)	Mission Inpatient Market Share 2021 (From HCA CON Application Filed June 2022)	Hospital License Renewal Applications (FY 2021)	CMS - Medicare Discharges (2019)
Asheville Region	Buncombe	87%	89%	90%	89%	94%	92%
Asheville Region	Madison	89%	91%	90%	89%	95%	97%
"Outlying Market"	Yancey	93%	93%	91%	88%	96%	96%
"Outlying Market"	Mitchell	84%	90%	HCA Did Not Provide	HCA Did Not Provide	96%	91%
"Outlying Market"	Transylvania	80%	81%	HCA Did Not Provide	HCA Did Not Provide	85%	87%
"Outlying Market"	McDowell	80%	79%	HCA Did Not Provide	HCA Did Not Provide	88%	86%
"Outlying Market"	Macon	80%	76%	HCA Did Not Provide	HCA Did Not Provide	76%	84%

[26] As per paragraphs 130-131 *infra*, two of the outlying hospitals are in Macon County and none are in Yancey County.
[27] *North Carolina Hospital Discharge Data, Fiscal Year 2019*, IBM Watson Health, *available at* https://www.shepscenter.unc.edu/wp-content/uploads/2021/12/ptorg_hosp_by_pt_res_2019.pdf (last visited Oct. 31, 2022).
[28] *North Carolina Hospital Discharge Data, Fiscal Year 2020*, North Carolina Hospital Association, *available at* https://www.shepscenter.unc.edu/wp-content/uploads/2022/05/ptorg_hosp_by_pt_res_2020.pdf (last visited Oct. 31, 2022).

179. Notably, the market share data provided by CMS Medicare discharge data (shown in the rightmost column) are highly similar to the total patient discharge data from these sources, all of which include all commercial discharges. This is not anomalous—Medicare discharges nearly always track very closely with commercial patient discharges—which is why CMS has stated that Medicare discharge data "may be a useful proxy for researchers or providers in [commercial insurance] markets."[29]

180. Separately, for thousands of residents in need of emergent care in the Outlying Regions, an HCA inpatient facility is the only viable option within driving distance. Because a commercial health plan that does not offer emergent care within close driving distance will not be viable, this dynamic separately gives HCA inpatient monopoly market power in the Outlying Regions.

181. As to the outpatient services market in the Outlying Regions, HCA controls a dominant market share, and its market power is separately evidenced both by its ability to control prices and its control of all of certain outpatient specialties in the relevant counties. An analysis of HCA's control of outpatient physicians in five prominent outpatient specialties available through a commercial health plan shows that HCA controls about 80% of those physicians in Macon, McDowell, Mitchell, Transylvania, and Yancey Counties. The overall analysis understates HCA's market power in the outpatient services market in the Outlying Regions: HCA controls all or virtually all neurologists in Macon, McDowell, and Mitchell County and over 80% of neurologists available through commercial health plans in Macon, Mitchell, McDowell, and

[29] The CFO of HCA's North Carolina Division submitted this inpatient data to a North Carolina government regulator in June 2022, a mere five months after five months after HCA stated in a brief to the Court that Medicare market share data is "completely irrelevant" to determining commercial market shares. And one month after HCA submitted this data to the North Carolina government, HCA argued to the Court that Medicare data is "so distinct" from commercial market data as to be effectively useless.

Transylvania counties. As for urologists, HCA controls all or virtually all urologists in McDowell, Mitchell, and Transylvania counties and overall, controls well over 80% of urologists available through a commercial health plan across the five counties of the Outlying Regions. As for cardiologists, HCA controls all or virtually all cardiologists in McDowell, Mitchell, and Transylvania counties and overall, controls over 80% of cardiologists available through a commercial health plan across the five counties of the outlying markets. As for radiologists (a key component of outpatient profit for health systems and a key requirement for diagnosis of a variety of health problems), HCA controls more than 75% of radiologists available through a commercial health plan in each of the five counties of the Outlying Regions and about 90% of radiologists in the five counties overall. And HCA controls all or virtually all radiologists available through a commercial health plan in Mitchell, McDowell, and Transylvania counties. Defendants' dominance in each of these important outpatient specialties demonstrates its monopoly power over outpatient services.

182. Indeed, these market share numbers understate HCA's outpatient market power in the Outlying Regions because a commercial health plan that lacks *any* providers of several commonly used specialist outpatient providers in a region will not be viable. Therefore, HCA's control of all or virtually all cardiologists, gastroenterologists, radiologists, and urologists in Transylvania County means that a commercial health plan could not offer a viable plan available in Transylvania County without including HCA, giving HCA enormous leverage with commercial health plans. Similarly, HCA controls all or virtually all cardiologists, radiologists, urologists, and neurologists available in Mitchell County, giving it enormous market power and leverage over commercial health plans.

183. As to the Asheville Region Outpatient Services market: HCA's monopoly market power is demonstrated by its market share, ability to control prices, and ability to impose anticompetitive restrictions on insurers. For example, HCA owns approximately 79% of outpatient ambulatory surgical centers in Buncombe County, a key source of outpatient revenue and market share and controls most large specialty practices in Asheville. HCA also controls the only emergency room in the Asheville Region, and emergency rooms are an important source of outpatient visits. These overall market share numbers likely understate HCA's outpatient monopoly power because, for some outpatient services, HCA is the *only* provider available. For example, HCA owns the only PET scanner in the Asheville PSA. A PET scanner is used for a variety of outpatient procedures and is critical to diagnosis and treatment of a variety of cancers, as well as neurological and cardiovascular conditions, and a commercial health plan that excluded the only PET scanner available would not be viable in the Asheville PSA. Mission has also touted that, in Asheville, it employs "the only pediatric subspecialists in the region" and operates "the only Cyberknife" (a device that performs outpatient cancer treatments). As of 2019, Defendants controlled the sole cardiology practice in Asheville and most of the pulmonologists in Asheville.

184. Overall, Defendants control the contracting and negotiating for the vast majority of outpatient providers in Asheville. A 2019 Georgetown University report stated that Defendants have used their overall dominance to gain market power in the outpatient market: "In other cases, hospitals appear to use their market power to build more market power. For example, Asheville's Mission hospital reportedly used its dominance to pressure physician groups to join their accountable care organization (ACO)."[30]

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[30] Sabrina Corlette, Jack Hoadley, Katie Keith, and Olivia Hoppe, *Assessing Responses to Increased Provider Consolidation in Six Markets: Final Report*, Georgetown University Health Policy Institute (Oct. 2019), *available at* https://chirblog.org/wp-content/uploads/2020/02/GtownCHIR_Provider-Consolidation_Final-Report_Oct2019.pdf.

B. <u>Defendants abuse their monopoly power by unreasonably negotiating with commercial health plans and charging supracompetitive prices</u>

1. Mission unreasonably withheld essential services from commercial health plans and raised prices to supracompetitive levels after the COPA's repeal

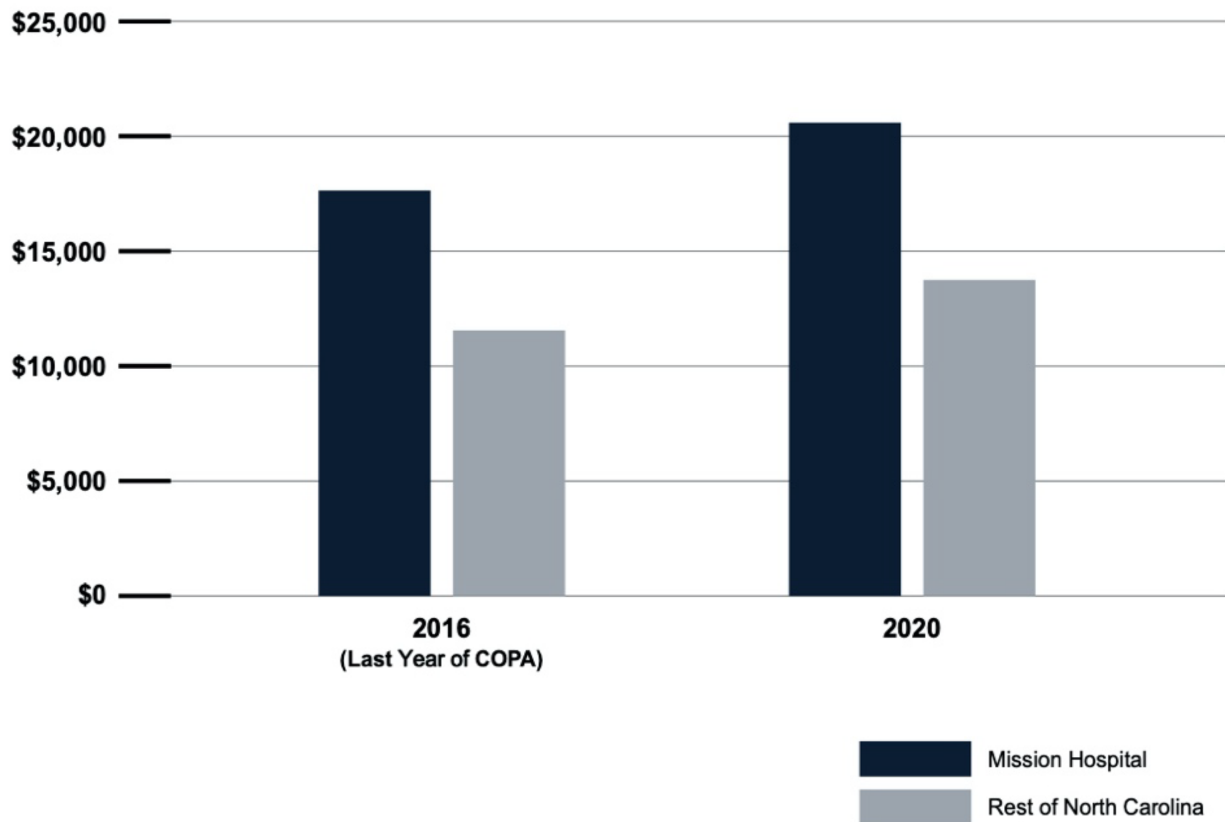
185. As noted above, Mission raised prices much more than regulators anticipated—or were even aware about—while the COPA was in effect. These high prices were the result of regulatory evasion by Mission and they were concealed by gag clauses. Mission's public statements regarding its costs and prices were inaccurate, unfair, and deceptive.

186. But the situation got worse after the COPA was repealed and Mission was freed from any semblance of State oversight. Specifically, after the COPA was repealed, two things relevant to healthcare cost and quality in Western North Carolina happened almost immediately: (1) Mission negotiated with insurers for price increases in aggressive ways the COPA would have prevented, and (2) Mission executives began secretly negotiating a sale to HCA.

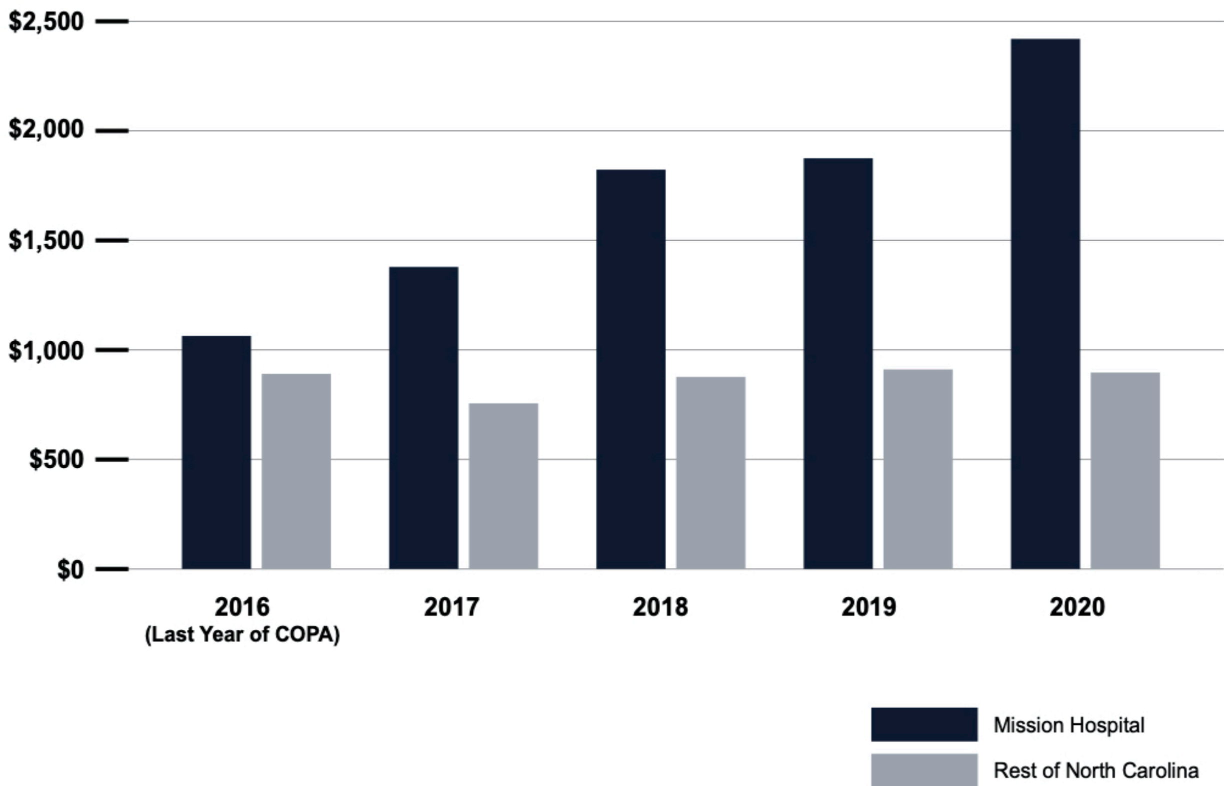
187. In 2017, Mission engaged in its first major post-COPA negotiation with Blue Cross, the State's largest health plan, over reimbursement rates. While details of the negotiations were kept secret, on information and belief Mission asked for exorbitant increases in the prices Blue Cross and its members were paying. When Blue Cross did not agree, Mission took its entire system "out of network," meaning that the 260,000 people in Western North Carolina insured by Blue Cross could not seek care at Mission facilities unless they paid much higher prices out of their own pocket. While hospital systems and insurers regularly negotiate over rates, a hospital system taking an insurer out of network is considered "go[ing] nuclear." This disrupted the administration of healthcare in the region, requiring Blue Cross members to switch doctors, forgo medical care, or drive long distances to receive care at a non-Mission facility. Mission remained out of network for Blue Cross for two months, until the two parties reached an agreement in which on information

and belief Mission still received a rate increase but not as high as originally demanded. On information and belief, Mission's aggressive and unreasonable stance in these negotiations would not have occurred under the COPA.

188. While the resolution of that dispute was kept secret, available data confirms that Mission got much of what it wanted: significantly higher prices for GAC services. After the COPA was repealed, the allowed amount Mission received from commercial health plans increased substantially, beyond what would be found in a competitive market. For example, within a large commercial claims dataset, the average allowed amount paid by most commercial insurers to Mission, and later HCA, for knee replacements, was higher than for the rest of North Carolina, and stayed higher, with the gap the same or growing over time:



189. For a shoulder arthroscopy, the rest of North Carolina's costs have stayed relatively stable with allowed amounts averaging just under $1,000 from 2016 to 2020. However, Mission's average allowed amount in the same dataset went up from about $1,000 in the last year of the COPA to about $2,400 in 2020—an increase of close to 150% in four years:



190. According to the same large claims commercial dataset, these allowed amount increases were consistent across most services lines, particularly (but not exclusively) at Mission Hospital-Asheville and for acute inpatient hospital services. Thus, while Mission could move costs around under the COPA and increase prices, the data show that once freed from the COPA's restrictions Mission could effectively dictate the prices it charged in a manner that no other system in North Carolina could.

2. HCA increased prices substantially after acquiring the hospital from Mission while cutting staff and reducing quality

191. Once the nonprofit Mission became the for-profit HCA, prices rose at an even higher rate than the State average, while at the same time HCA cut staffing to dangerously low levels to further increase its profit. This resulted in more expensive and lower quality care for Plaintiffs and other members of the putative class.

192. HCA/Mission is currently one of the most expensive hospitals in the State, and for many procedures—including "plausibly undifferentiated" procedures for which quality does not meaningfully vary by provider—it is *the* most expensive provider in the State.

193. A recent RAND analysis of nationwide hospital pricing data compared the prices negotiated between hospitals and commercial health plans to the fee schedule set by Medicare, with the Medicare price acting as a relative baseline (given the federal government's regulatory power). RAND reported this data analysis at the hospital systemwide level, without revealing the prices charged for specific procedures.

194. According to RAND data, at Mission Hospital-Asheville Defendants charged commercial insurers 372% above the Medicare price, on average, for inpatient and outpatient services, and 393% above the Medicare price, on average, for inpatient services alone. That compares with a mean of 262% and a median of 277% above Medicare for all hospitals in North Carolina for which RAND released metrics (including Mission).

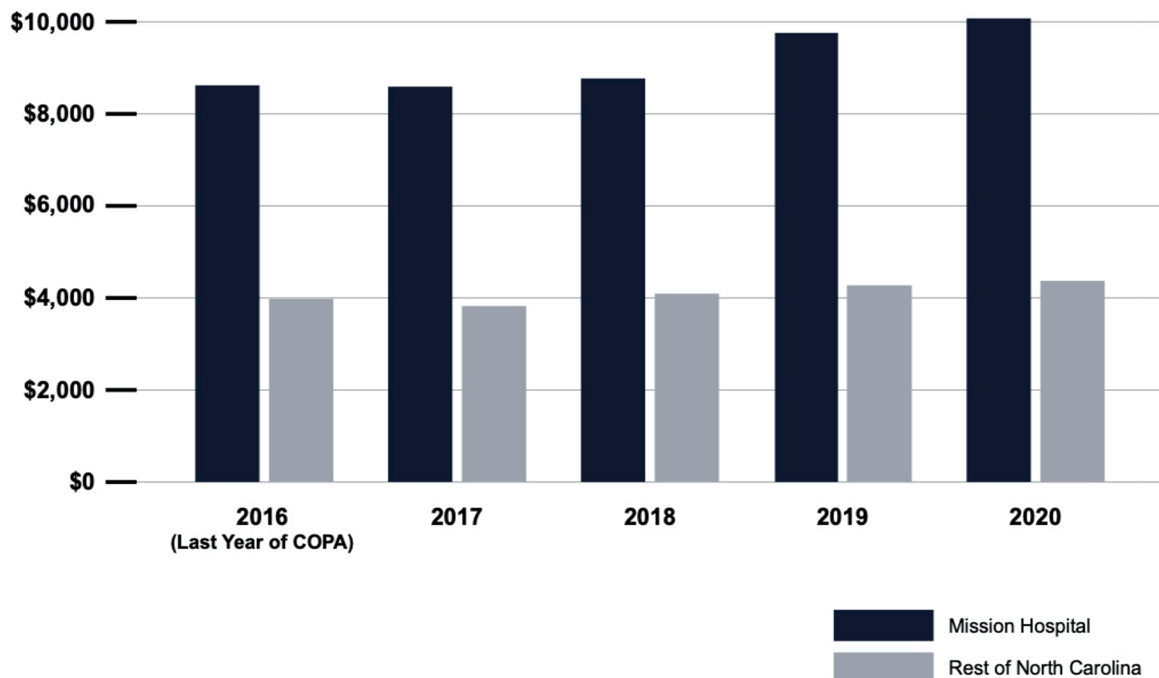
195. Defendants could not charge this much more than other North Carolina hospitals if they were not (1) unlawfully leveraging monopoly power to force insurers to accept rates they would not accept in a competitive market and (2) using anticompetitive means to prevent new entrants from competing.

196. In much the same way that Mission in 2017 took Blue Cross out of network as part of a price dispute, a similar fight unfolded two years later, this time with HCA in control. In 2019, HCA used aggressive contract negotiating tactics to attempt to force Cigna, another major insurer, to accept significant price increases. Cigna said that HCA/Mission's "excessively high rates they are demanding from our clients and customers" would "put affordable healthcare at risk." HCA/Mission's price demands were so excessive that, once again, there was the risk of all customers of a large insurer losing access to the only hospital in their area. Two contract disputes of this level within two years are rare for almost any hospital system and would have been barred by the COPA.

197. HCA itself stated in recent regulatory filings in Florida that, in a county with a monopoly hospital system, insurers have "limited ability" to "negotiate market-driven rates for hospital services" and that, "A large and growing body of literature suggests that health care providers with significant market power can (and do) negotiate higher-than-competitive payment rates."

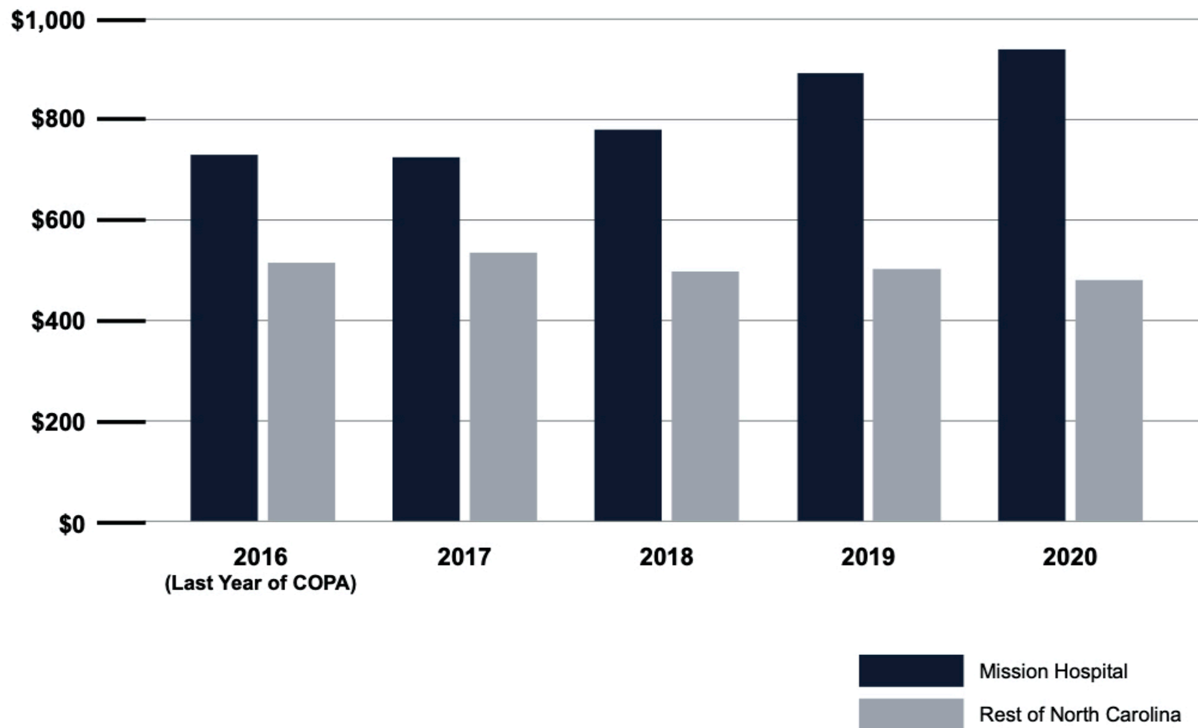
198. Data analysis of specific procedures comports with the systemwide RAND results. For example, within a large commercial claims dataset, HCA's average allowed amount earned from commercial health plans for C-sections without complications at Mission Hospital-Asheville was approximately $9,764 in 2019 and $10,077 in 2020. By contrast, the average allowed amount at all other North Carolina hospitals was $4,287 in 2019 and $4,373 in 2020. The HCA price is over 2.2 times greater than the rest of North Carolina. And while the price of C-sections at all other North Carolina hospitals was relatively stable from 2016 to 2020 near $4,000, the prices at Mission/HCA rose from $8,621 to over $10,000 for service at the Asheville hospital. The data may be visualized as follows:

C-Section Birth

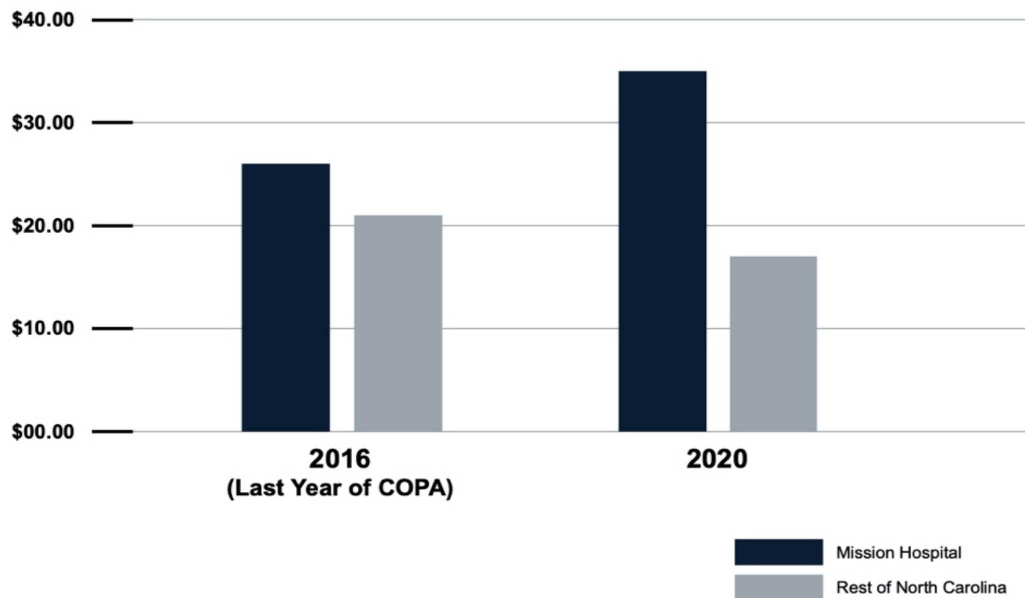


199. Similarly, within that same claims data, HCA's average allowed amount for a coronary bypass is nearly *double* the North Carolina average and, after the repeal of the COPA, Mission Hospital-Asheville has been the most expensive major hospital in the entire State for coronary bypasses.

200. Likewise, with regard to cardiovascular stress tests, an average allowed amount for this procedure at HCA was roughly double that of the average allowed amount in the rest of North Carolina in 2020. While the cost for this procedure slightly declined in the rest of North Carolina from 2016 to 2020, the cost at Mission increased about 30% from the last year of the COPA to 2020:



201. Even low cost but high-volume procedures like a lipid panel have seen significant price increases after the repeal of the COPA. Within a large commercial insurance claims dataset, Mission's average allowed amount for lipid panels increased by about a third while the allowed amount in the rest of the state declined:



202. As prices for these services and others have risen, HCA has reduced the quality of its care by aggressively cutting staff and budgets and by encouraging those doctors who have stayed to focus on maximizing the volume of patients they see so as to maximize profits. The ability of HCA to raise its already supracompetitive prices for procedures common in an outpatient setting – like lipid panels, cardiovascular stress tests, and shoulder arthroscopies – at the same time its quality is declining indicates HCA's ability to control prices in the Asheville outpatient market.

203. As of March 2021, at least 79 doctors had left or planned to leave the system since HCA's takeover. Other doctors describe new employment contracts with HCA in which the compensation equations remove quality of care metrics and focus almost entirely on the number of patients seen and amount billed. As one departing doctor explained, "The change in ownership has shifted this system's priority away from the health of Western North Carolina to the health of the stockholders." A significant number of patients have lost their preferred family doctors either due to doctors leaving the system or from HCA's clinic restructurings and closures.

204. Similarly, nurses working at HCA have described their units as "inhumanely understaffed," with conditions so bad that even travel nurses hired to fill in gaps were leaving before their contracts expired. Patients and families describe situations where, for example, their nurse told them, "… she cries every single night because she knows she is not giving appropriate, competent patient care."

205. Were Defendants operating in a competitive market for acute care services, they would not have been able to take these anticompetitive actions. However, commercial health plans and patients have no choice but to endure the worsening quality of service.

206. As noted, on February 10, 2020, the Chairman of the Buncombe County Commissioners Brownie Newman, Asheville Mayor Esther Manheimer, and most of the delegation of Buncombe County's elected officials in the North Carolina statehouse lambasted these conditions, finding that "numerous, aggressive staff cuts over the past year, put[] patient safety at risk" and that "HCA has aggressively pursued contract renegotiations with multiple physician practices, resulting in unfortunate outcomes."

207. Both anecdotal reports and expert watchdogs have confirmed that these actions have led directly to a decrease in the quality of care. As noted, the Leapfrog Group dropped Mission Hospital's patient safety rating from an "A" to a "B" after HCA's takeover, and CMS also downgraded Mission per surveys of patients' experiences regarding, among other things, responsiveness of hospital staff and the cleanliness of the hospital.

3. HCA abuses its market power by charging for costly, unnecessary procedures

208. After the repeal of the COPA, Defendants began more frequently billing for procedures that academic literature has determined are ineffective and are nearly always considered overuse. In fact, Mission Hospital-Asheville now ranks 88 out of 89 hospitals in North

Carolina for unnecessary procedures and is in the highest 2% of all hospitals nationwide for billing for unnecessary procedures.[31] It has a "Value of Care" rating of "D-minus."

209. But at the same time, Mission Hospital-Asheville is one of HCA's most profitable in the country, and in fact has immediately become the second largest revenue hospital in the entire HCA chain.[32] HCA revenues from Mission Hospital-Asheville were recently reported to be over $1.2 billion, ahead of all but one of the other 100-plus hospitals in the HCA chain and second only to HCA's Methodist Hospital (Texas), which has over twice as many beds.

210. In a competitive market, insurers contracting with a hospital can discipline such behavior by threatening in their next negotiation not to cover certain services, to negotiate for caps on particular procedures likely to be unnecessary, or to threaten to take the hospital out of network and purchase services from a competitor. But because of Defendants' unregulated monopoly status, the all-or-nothing tying schemes described herein, and the lack of any significant competitor for inpatient hospital services in the Asheville Region, insurance plans and consumers are forced to pay for some of the highest rates of unnecessary procedures anywhere in the country.

211. Because HCA controls the only hospital in the Asheville market and because consumers generally do not question provider recommendations while in the hospital, HCA's practice of adding costly and unnecessary procedures to a consumer's bill represents a clear abuse of market power.

212. For example, routine blood tests are a frequent source of price disparities and overbilling by providers with both the volume of tests per patient and the cost of tests per patients

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[31] https://lownhospitalsindex.org/hospital/memorial-mission-hospital-and-asheville-surgery-center/.
[32] Top 50 HCA Hospitals by Net Patient Revenue, https://www.definitivehc.com/blog/top-hca-hospitals-nationwide (accessed Aug. 4, 2021) (reflecting that Mission Hospital-Asheville has the second-highest revenues of all of the HCA hospitals, at $1,209,452,518).

varying dramatically by provider. However, in competitive markets, insurers can incentivize providers who do not overuse or overcharge for tests.

213. On information and belief, Defendants have exploited the lack of competition in the market to charge a substantially higher price than both the North Carolina average and the price that would be tolerated in a hypothetically competitive Asheville market. Defendants have increased prices for routine blood tests, despite no evidence that the actual cost of providing such tests has increased at all. In fact, based on available data, for one routine blood test, Defendants have increased the allowed amount charged to many insurers for the test by about 20% since they acquired Mission Hospital. This leads directly to Plaintiffs and other putative class members paying higher co-insurance for these unnecessary procedures, and it leads to their paying higher insurance premiums because commercial health plans are also liable for their share of the payments for the unnecessarily costly procedures as well.

214. In a competitive market, such overpricing would be aggressively policed by insurers, patients, and competing providers. In this case, since the COPA's repeal left the system unregulated, Defendants have increased prices for often overbilled procedures knowing that commercial health plans and patients have no meaningful choice but to accept these practices. These practices have led directly to the increased costs of commercial insurance for affected consumers.

215. Finally, HCA has charged exorbitant rates for forensic exams such as rape kits, which should be free. Assistant Director of victim advocacy organization REACH of Macon County, Jennifer Turner-Lynn explained that "prior to the [HCA-Mission] merger, we never had an issue with rape victims being charged for the use of the emergency room.... The last victim that I took over received a bill for $1,000. The only services that she received in the emergency room

was to have the rape kit performed." Billing a sexual assault victim for a forensic exam is prohibited under state and federal law. Under N.C.G.S. § 143B-1200, a medical facility cannot bill a sexual assault victim or commercial health plan for a forensic medical exam. Additionally, the Violence Against Women Act mandates that states must cover the "full out-of-pocket costs of forensic medical examinations for victims of sexual assault" to maintain eligibility for funding. The full cost is defined as "any expense that may be charged to a victim in connection with a forensic medical examination for the purpose of gathering evidence of a sexual assault."[33]

4. HCA abuses its trauma center monopoly

216. HCA has shown a pattern of using emergency care, and especially trauma centers, to saddle patients with unnecessary, exorbitant charges. Trauma centers employ specialists equipped to deal with major traumatic injuries and receive substantially higher reimbursements for the theoretically complex care. However, in what appears to be a business practice across the nation documented by investigative reporting,[34] HCA has been shown to be significantly more likely than other providers to admit patients with only mild injuries to trauma centers in order to obtain higher reimbursement rates.

217. In competitive markets, this costly practice can be policed by competitor providers or by insurers who can pressure providers to reduce deceptive trauma center admissions with the threat of taking a provider out-of-network for non-compliance. In a monopoly market with a "must have" hospital and one monopoly trauma center, like the one HCA intentionally acquired from Mission, such policing effectively cannot take place. Absent HCA's unlawful monopoly power, it would not be able to carry on this practice.

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[33] 28 C.F.R. § 90.13(b).

[34] Jay Hancock, *In alleged health care 'money grab,' nation's largest hospital chain cashes in on trauma centers*, Kaiser Health News (June 14, 2021), *available at* https://khn.org/news/article/in-alleged-health-care-money-grab-nations-largest-hospital-chain-cashes-in-on-trauma-centers/.

218. As the only state-designated trauma center in Western North Carolina, HCA can set prices far above the market rate. In Asheville, HCA's trauma center "activation fees"—the charges applied automatically when a patient is routed to the trauma center—are about twice as high as the North Carolina average, costing consumers over $9,000 for every unnecessary admission, before they even incur procedure charges.

219. Similarly, Defendants have a history of pushing patients into more expensive Emergency Department ("ED") care. Nationally, a recent study sponsored by shareholders of HCA found that HCA's Medicare ED admissions were "well-above the national average, growing over time, and not explained by patient case mix," which resulted in excess Medicare payments of $1.1 billion over five years.[35]

220. On information and belief, HCA engages in this practice in North Carolina, regularly running patients, including those with commercial health plans, through the ED for tests that do not require such an admission and thus charging commercial health plans and patients significantly more. In North Carolina specifically, HCA's ability to push patients into more expensive ED care is even more unrestrained due to Mission Hospital-Asheville's effective total control over the market.

221. In a competitive market, a provider that pushed individuals towards higher cost ED care would face strong pressure from commercial health plans and local governments to reduce the practice. In a market with only one hospital, HCA is able to push individuals towards higher cost ED care while simultaneously reducing the quality of the ED. Because of HCA's market

[35] Notice of exempt solicitation, CtW investment group, April 1, 2021, https://www.sec.gov/Archives/edgar/data/860730/000137773921000007/hca21shletter.htm; Oct. 16, 2020 letter from CtW to Charles O. Holliday, Chairman, audit & compliance committee, HCA Healthcare, Inc., https://s3-prod.modernhealthcare.com/2021-03/CtW%20to%20HCA.pdf.

power and use of anti-competitive contract clauses, insurers are less able to push back and may even be contractually blocked from informing consumers about the full extent of the ED practices.

C. **<u>Defendants have engaged in illegal tying of services through all-or-nothing contracting practices and other anticompetitive contracting terms</u>**

222. Both Mission and HCA have engaged in unlawful tying agreements, through which they have used their monopoly in one market—acute inpatient hospital services in Buncombe and Madison Counties—to extract profits in other markets.

223. Under antitrust law, tying occurs when an entity that has market power in one market leverages that market power in order to reap profits in another market. The market in which the defendant has an existing monopoly is called the "tying" market, and the separate market in which the defendant extracts profits is called the "tied" market. Under a tying arrangement, the entity will sell one product (the tying product) only under the condition that the purchaser buy a second product (the tied product). Where the defendant has significant market power or a monopoly in the tying market, such tying arrangements are considered anticompetitive and unlawful under the antitrust laws.

224. One way tying occurs in hospital markets is through a dominant hospital's use of "all-or-nothing" practices in their negotiations with insurers. When a hospital system is the only entity in a given region to offer a product or service that commercial health plans must include in their network to be viable, that hospital system can refuse to sell that product or service to insurers unless insurers also agree to purchase other services from the hospital system, including services that the insurer would otherwise purchase from a different hospital system for a lower price. Either orally during negotiations or in the contracts themselves, the hospital system gives the insurer an "all-or-nothing" choice: Take everything the hospital wants to sell at the price the hospital dictates, or get nothing at all. This paradigm was apparent in Mission's 2017 contract dispute with Blue

Cross, where it responded to Blue Cross' specific concern about proposed price increases at Mission Hospital-Asheville by making the entire Mission system unavailable to Blue Cross—across multiple geographic markets and both inpatient and outpatient markets.

225. Here, Defendants offer a product that any commercial insurer operating in Western North Carolina needs: the only acute inpatient hospital services in Buncombe and Madison Counties. Due to Mission Hospital-Asheville's dominant market share for acute inpatient hospital care in Buncombe and Madison Counties, a commercial health plan could not offer a plan that does not include these services and remain commercially viable. Thus, insurers functionally do not have a choice: They must purchase from Defendants acute inpatient hospital care at Mission Hospital-Asheville. Thus, this is the "tying" product. And Mission and HCA have tied it to two different products over which they have less market power: (1) outpatient medical care at Mission Hospital-Asheville and the rest of Buncombe and Madison Counties, and (2) inpatient and outpatient care at Mission's and HCA's Outlying Facilities.

1. Tying inpatient services at Mission Hospital-Asheville to outpatient services at Mission Hospital-Asheville

226. One way in which Defendants engage in anticompetitive tying is by only offering acute inpatient hospital services at Mission Hospital-Asheville to commercial health plans if those insurers will also contract to purchase outpatient medical services at Mission Hospital-Asheville from Defendants at supracompetitive rates (the "Inpatient/Outpatient Tying Scheme"). When Defendants engage in all-or-nothing contracting in this manner, acute inpatient hospital services at Mission Hospital-Asheville is the "tying" product, and outpatient services at Mission Hospital-Asheville are the "tied" product.

227. While Defendants' Mission Hospital-Asheville has a 80 to 90 percent market share in the market for acute inpatient hospital services in Buncombe and Madison Counties, Defendants

face somewhat more competition for outpatient medical services in those markets. This competition comes from, for example, ambulatory service centers, rehabilitation facilities, and independent physicians. On information and belief, insurers negotiating with Defendants would, absent Defendants' Inpatient/Outpatient Tying Scheme, choose either not to contract for certain outpatient hospital services from HCA at Mission Hospital-Asheville and its other facilities in Buncombe and Madison Counties, or those insurers would negotiate a lower price for those services, given the competition from other outpatient providers in the region. But because Defendants can threaten to withhold their must-have acute inpatient hospital services as part of the same negotiation, commercial health plans must acquiesce to Defendants' demands related to outpatient care.

228. Defendants' Inpatient/Outpatient Tying Scheme has resulted directly in higher costs, both in terms of allowed amounts paid for services at that facility and increased co-pays, premiums, and deductibles for Plaintiffs and the putative class. The Scheme has also harmed competition for outpatient medical services in Buncombe and Madison Counties, because independent providers of outpatient services are unable to fairly compete with Defendants on price or quality. When independent providers cannot compete, they eventually go out of business, which leads to even less competition. On information and belief, because of Defendants' Inpatient/Outpatient Tying Scheme, outpatient facilities have closed or relocated to more competitive markets and would-be competitors for outpatient care have declined to operate in Buncombe and Madison Counties, which has decreased the quantity of outpatient care and increased prices paid by insurers, ultimately, patients for outpatient care.

2. Tying inpatient services at Mission Hospital-Asheville to inpatient and outpatient services at HCA/Mission's five outlying hospitals

229. A second tying scheme Defendants have engaged in is the tying of acute inpatient hospital services in Buncombe and Madison Counties to inpatient and outpatient care at the Outlying Facilities ("Asheville/Outlying Facilities Tying Scheme"). Because any insurer offering a network that includes Western North Carolina must include in that network acute inpatient hospital services at Mission Hospital-Asheville, Defendants are able to force those insurers to also include inpatient and outpatient services at Defendants' Outlying Facilities in network, at supracompetitive prices. As in the Inpatient/Outpatient Tying Scheme, the "tying" market in the Asheville/Outlying Facilities Tying Scheme is the same: acute inpatient hospital care in Buncombe and Madison Counties. The "tied" markets are both acute inpatient hospital services and outpatient medical services at Defendants' five Outlying Facilities.

230. As a direct and proximate result of Defendants' Asheville/Outlying Facilities Tying Scheme, a substantial amount of competition is foreclosed.

231. On information and belief, for each of the Outlying Facilities, Defendants in their negotiations with commercial health plans generally condition the inclusion of Mission Hospital-Asheville's acute inpatient hospital services on those insurers also offering both inpatient and outpatient services at the Outlying Facilities. Defendants generally insist on the Outlying Facilities' inclusion even if insurers would otherwise choose to put a different, competing hospital in network, or even if insurers would not otherwise be willing to pay the allowed amounts Defendants insist on for inpatient and outpatient care at the Outlying Facilities.

232. One example of how the Asheville/Outlying Facilities Tying Scheme works in practice is Defendants' hospital in McDowell County, Mission Hospital-McDowell. It is located at 430 Rankin Drive, Marion, NC 28752, about 45 minutes driving time to the east of Asheville.

233. Mission Hospital-McDowell has significant market power in its region. Data from the Medicare Hospital Market Service Area File for 2019 for inpatient origin reflects that Mission Hospital-McDowell has the following approximate market shares in the three most proximate zip codes: in zip code 28752, 37.4%; in code 28761, 36.1%; and in code 28762, 35.3%. NCHA commercial inpatient data show that when Mission Hospital-McDowell's market share is combined with the approximately 47% share of this geographic market that is controlled by Mission Hospital-Asheville, Defendants collectively control over 75% of this geographic market.[36]

234. A rival hospital, Carolinas HealthCare System Blue Ridge Morganton, is located less than 30 minutes away to the east of Mission Hospital-McDowell. It is located at 2201 S Sterling St, Morganton, NC 28655.

235. Mission Hospital-McDowell has approximately 30 beds. Carolinas HealthCare System Blue Ridge Morganton has approximately 184 beds. Mission Hospital-McDowell and Carolinas HealthCare System Blue Ridge Morganton are competitors.

236. Cost data available in a large commercial dataset for Mission Hospital-McDowell reflects that for a variety of procedures where there is a significant volume of those procedures for each year, such as CT scans, Mission Hospital-McDowell is not only consistently one of the most expensive in the State but is more than triple the average cost for some routine procedures.

237. For example, available price data reflects that the average allowed amount for a CT scan of the abdomen and pelvis (CPT 74176) is about $2,000 at Mission Hospital-McDowell, whereas the average in the State is just under $500. This divergence is particularly stark because

[36] *See, e.g.*, *North Carolina Hospital Discharge Data, Fiscal Year 2020*, North Carolina Hospital Association (noting HCA has combined market share of 78.5% for McDowell County, with 47.4% for Mission Hospital-Asheville, and 31.1% for Mission Hospital-McDowell, for total hospital discharges), https://www.shepscenter.unc.edu/wp-content/uploads/2022/05/ptorg_hosp_by_pt_res_2020.pdf (last visited Oct. 31, 2022).

it is unable to be explained by a quality difference, as CT scans are relatively standard. Instead, the cost differences are explained by contract negotiations between insurers and hospitals and HCA's market power in McDowell County.

238. When the COPA was in effect, Mission Hospital-McDowell was well below the State average with respect to prices for outpatient care. Today, Mission Hospital-McDowell charges approximately 50% above the State average for outpatient care—corresponding with the period in which HCA/Mission were free to engage in unregulated price increases and anticompetitive contracting practices. Using an overall analysis of outpatient procedure costs, Mission Hospital-McDowell has gone from being less expensive than 60% of facilities in the State for outpatient medical service in 2016 to among the top 3% most expensive facilities in the entire State now. This dramatic pricing shift coincides with the removal of COPA regulations in late 2016 that prevented excessive price increases or abusive contracting practices.

239. Mission Hospital-McDowell is not only significantly more expensive than the State average for outpatient care—it is also significantly costlier than its only significant competitor, Carolinas HealthCare System Blue Ridge Morganton, which is less than a 30-minute drive away, indicating its ability to control prices in McDowell County. Moreover, on information and belief, commercial health plans do not consider either hospital to be of significantly higher quality than the other, particularly for "plausibly undifferentiated procedures" such as a CT scan.

240. In a competitive market, commercial health plans would encourage members to seek lower cost care just minutes away. However, on information and belief, because of the Asheville/Outlying Facility Tying Scheme, Defendants have foreclosed real competition on price or quality in other markets that appear competitive on paper. Furthermore, on information and belief, Defendants use contracting provisions to prevent commercial health plans from fully

informing consumers of price differences or from directing consumers to the lower cost option. Defendants are thereby using, or leveraging, their monopoly market power over acute inpatient hospital services in the Asheville Region to anticompetitive effect in the Marion NC-area market.

241. Mission has similarly used its monopoly dominance in inpatient acute care at Mission Hospital-Asheville in Buncombe and Madison County to attempt to monopolize several outlying inpatient and outpatient markets where its other small regional hospitals are located, namely, Angel Medical Center and Highlands-Cashiers Hospital (Macon County), Blue Ridge Regional Hospital (Mitchell County), and Transylvania Regional Hospital (Transylvania County).

242. For example, according to the Medicare Hospital Market Service Area File for 2019 for inpatient origin, HCA has an 85.3% market share in zip code 28712 in Brevard, NC, the top inpatient zip code for HCA's Transylvania Regional Hospital in Brevard, Transylvania County. This total HCA market share comes from Transylvania Regional Hospital's 44.8% market share in the zip code and Mission Hospital-Asheville's 40.5% market share in the zip code.[37] Pardee UNC Hospital only holds 10.4% market share, despite being about half the driving distance from Brevard and substantially lower cost than Mission Hospital-Asheville. This monopolization cannot be explained in a competitive market without tying and/or contracting provisions that prevent insurers from encouraging members to seek care at a closer and lower cost facility. And HCA has shown an ability to control prices in this outlying market: The standardized price per inpatient stay at Transylvania Regional Hospital is $19,886 versus only $12,668 at Pardee UNC

[37] Similar data from the county level that includes all hospital discharges, not just Medicare discharges, indicates that Defendants collectively control 80.7% of this market, with Mission Hospital-Ashville having a 47.1% market share, and HCA's Transylvania Regional Hospital having a 33.6% market share. *See North Carolina Hospital Discharge Data, Fiscal Year 2020*, North Carolina Hospital Association, https://www.shepscenter.unc.edu/wp-content/uploads/2022/05/ptorg_hosp_by_pt_res_2020.pdf (last visited Oct. 31, 2022).

Hospital, the closest non-HCA facility. Similarly, the standardized price per outpatient service is $347 at Transylvania Regional Hospital versus only $290 at Pardee UNC Hospital.

243. In total, using a variety of sources, HCA/Mission controls over 80% of the commercial inpatient market share in Transylvania County and charges significantly higher prices the closest non-HCA facilities. Quality of care at Transylvania Regional Hospital has also declined significantly since HCA took over. According to recent reporting, due to cuts to doctors and staffing, there have been "reoccurring" and "systemic" issues with wait times, loss of access, and other problems. Indeed, "there is an overall loss of confidence in the hospital, such that 90 percent of those who attended the sessions elect to go elsewhere for treatment like Pardee or AdventHealth, if possible."[38] But HCA's restraints impede that competitive process, by preventing insurers from directing patients to those competitors in the first instance, or from removing Transylvania Regional Hospital from their networks. Absent these restraints, HCA would not have been able to maintain such a high market share and charge so much more than its competitors, while at the same time slashing quality.

244. Similarly, according to the Medicare Hospital Market Service Area File for 2019 for inpatient origin, HCA has a 92.4% market share in zip code 28741 in Highlands, NC, the top inpatient zip code for HCA's Highlands-Cashiers Hospital in Highlands, NC. This total HCA market share comes from Highland-Cashiers Hospital's 43.8% market share in the zip code and Mission Hospital-Asheville's 48.7% market share in the zip code. Northeast Georgia Medical Center only holds 7.6% market share, despite being closer driving distance from Highlands and substantially lower cost than Mission Hospital-Asheville. In total, using a variety of sources,

[38] Laura Denon, *Hospital committee seeking feedback from current, former staff*, The Transylvania Times (Oct. 23, 2022), *available at* https://www.transylvaniatimes.com/news/hospital-committee-seeking-feedback-from-current-former-staff/article_eb784972-52f8-11ed-bdde-ebbb37d76190.html.

HCA/Mission controls over 75% of the inpatient commercial market share in Macon County despite charging significantly higher prices than the closest non-HCA facility. Similarly, this monopolization cannot be explained in a competitive market without tying and/or contracting provisions that prevent insurers from encouraging members to seek care at a closer and lower cost facility, as discussed below.

3. Use of anti-steering, anti-tiering contracting practices

245. Steering arrangements are arrangements by which a commercial health plan is able to steer plan subscribers to a lower-cost rather than a higher-cost facility. Commercial health plans may seek to steer patients by including language in insurance plan documents encouraging subscribers to choose one facility rather than another or conditioning the selection of a higher-cost facility on a higher copay or deductible from the subscriber.

246. In addition, or alternatively, commercial health plans may seek to place providers in tiers, with the insurance plan subscriber being encouraged through a variety of means to choose the provider in the tier of better-value providers over a discouraged tier of more costly providers.

247. Steering is an important tool commercial health plans can use to control healthcare costs, particularly in consolidated markets. President Trump's Assistant Attorney General for Antitrust criticized the type of contracting provisions and negotiating tactics HCA uses, saying, "Without these provisions, insurers could promote competition by 'steering' patients to medical providers that offer lower priced, but comparable or higher-quality services. Importantly, that practice benefits consumers, but the anti-steering restrictions prevented it." Likewise, Senator Chuck Grassley, then chairman of the Senate Judiciary Committee said the anti-steering practices of HCA and several other systems were, "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."

248. During the pertinent times, on information and belief, Defendants have required one or more insurers not to use steering or tiering language, or to use weaker language or provisions than the insurers would have desired to use, as a condition of obtaining access to Defendants' "must have" Mission Hospital-Asheville for their commercial health plans.

249. Investigative reporting has shown that HCA has a history of using anti-steering or similar contract language.

250. Defendants' anti-steering restrictions restrain and distort competition throughout Defendants' entire service area, both in the Outlying Regions and in the Asheville Region, for both inpatient and outpatient services. As noted above, *see* Section VI.A.3, Defendants' use of anti-steering provisions has had anticompetitive effects in the Asheville Region, because Mission Hospital-Asheville competes with other hospitals for patients, particularly for those who live outside of Buncombe and Madison Counties. Put differently, while all of the patients who are treated at Mission Hospital-Asheville receive care (by definition) in the Asheville Region, a sizable portion of these patients are from other counties who could and would receive care more frequently from Defendants' competitors absent the anti-steering restrictions.

251. For example, according to patient discharge data released by the North Carolina Hospital Association, Defendants' facilities account for 81.7% of discharges for patients who reside in Transylvania County, one of the Outlying Regions. Of this total market share, 47.1% of it comes from discharges at Mission Hospital-Asheville, and 33.6% comes from discharges at Transylvania Regional Hospital in Brevard, Transylvania County (another HCA facility). For patients from Transylvania County, Pardee UNC Health Care and AdventHealth Hendersonville have market shares of 10.2% and 5.1%, respectively. Thus, these are viable, lower-cost competitors that, absent Defendants' anti-steering restrictions, would treat more patients who

reside in Transylvania County. Instead, an artificially inflated number of those patients go to Defendants' two hospitals that serve this region, even though they are significantly higher priced and, particularly in the case of HCA's Transylvania Regional Hospital, significantly lower quality.

252. Mission Hospital-Asheville also competes for patients in the other Outlying Regions. Mission Hospital-Asheville accounts for 70.1% of discharges for patients who reside in Yancey County, 47.4% of patients who reside in McDowell County, 44.9% of patients from Macon County, and 51.5% of patients who reside in Mitchell County. While in each of these markets, Defendants have a monopoly level market share (when their Outlying Facilities in these geographies are taken into account), there are competing hospitals that see patients from these regions, and these hospitals would see more patients—and thereby save insurers, employers, and patients a significant amount of money—if Defendants' restrictions had not grossly interfered with the competitive process. These anti-steering restrictions, therefore, have anticompetitive effects throughout Defendants' service area, including by substantially and artificially inflating Defendants' profits at Mission Hospital-Asheville.

253. These restraints have directly led to Plaintiffs and the putative class to pay higher insurance premiums throughout Defendants' entire service area.

4. Use of gag clauses and lack of transparency.

254. For years, Defendants have obscured their price increases and anticompetitive contracts from regulators and the public through use of gag clauses that prevent insurers from revealing their agreements' terms. The effect of this gag clause language is anticompetitive as it prevents competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by Defendants.

255. Moreover, HCA has continued to refuse to release the prices it charges for these and other procedures in a fully transparent manner despite a recent change in federal law requiring it to do so. Effective January 1, 2021, a new federal regulation required the public disclosure of certain aspects of HCA's negotiated price terms in agreements with private insurance companies. *See* 45 C.F.R. § 180.50. HCA has however failed to fully disclose this information in a timely, complete, and understandable manner.

256. By violating this price disclosure regulation, and by including gag clauses in HCA/Mission's provider agreements with insurers, Defendants have kept community members, regulators, and the general public from learning of the grossly inflated, monopolistic prices that are being charged.

257. This rule was first created by the Trump Administration over the opposition of HCA's lobbying and then proactively continued by the Biden Administration—signaling growing bipartisan consensus that the lack of price transparency with regard to hospital services leads to higher prices for consumers and employers.

D. Defendants' unlawful course of conduct has led directly to substantially higher insurance premiums and other costs for Plaintiffs and the putative class

258. Insurance premiums in the counties where Mission operates are substantially higher than the state average and substantially higher than areas with higher costs of living. For example, individual insurance premiums are now approximately 50% higher in Mission's self-defined service area than Winston-Salem; about 55% higher in Mission's service area than Durham, Raleigh, or Charlotte; and about 60% higher than Greensboro.

259. Mission's anticompetitive impact on prices is perhaps most obvious for an individual who simply moved across a county line outside of Mission's 18 county service area. For example, crossing the county line from Rutherford County (in Mission's self-defined service

area) to Cleveland County (outside of Mission's service area), an individual would see premiums ***drop immediately by 29%.*** Similarly, driving East from Cherokee County or South from Macon County (in Mission's self-defined service area) into Tennessee or Georgia, an individual would see an immediate premium decline of over 20% as visualized below:

KFF Lowest Cost Plan in the County for 40-Year-Old Male 2020

Mission Health System Western North Carolina Service Area

$290 $470

260. These dramatic differences can be primarily attributed to market power, according to academic studies. For example, a Harvard University analysis found that, "Variation in spending in the commercial insurance market is due mainly to differences in price markups by providers rather than to differences in the utilization of health care services . . . 70 percent of variation in total commercial spending is attributable to price markups, most likely reflecting the

varying market power of providers." And the US government's official guide to shopping for individual health insurance indicates that "differences in competition" are one of the primary sources of variation in premiums.

261. During the pertinent times, Defendants' anticompetitive practices have allowed them to charge of supracompetitive prices to commercial health plans and TPA payers.

262. When private insurance and TPA payers have been obligated to pay these supracompetitive prices to Defendants, the payers in turn have passed the prices along to their insurance plan subscriber base.

263. Patients also are directly harmed by Defendants' supracompetitive prices through direct payments made by patients to Defendants, in the form of copays, coinsurance payments, and deductibles. These direct payments are often calculated as a percentage of the allowed amount for which the patient is responsible for, so when allowed amounts reach supracompetitive levels, as they have at HCA/Mission, patients who must go to Defendants' system for care suffer direct financial injury.

264. As a result of Defendants' supracompetitive prices, and the pass-through by insurance and TPA payers of the amounts at issue, ordinary insurance and healthcare consumers have been injured by having to pay higher premiums, copays, coinsurance payments, and deductibles.

E. Antitrust Injury

265. As a result of the Defendants' monopoly power, monopolization and attempted monopolization, and the anticompetitive practices Defendants have used to increase negotiated prices with insurers and self-funded TPAs, reduce provider competition, and reduce quality of services, patients such as Plaintiffs and other putative class members throughout Western North

Carolina have paid within the last four years, and continue today to pay higher prices for health insurance coverage (including premiums, employee contributions, copays, deductibles and out-of-pocket payments) and pay higher coinsurance payments directly to Defendants for services than they otherwise would, while receiving lower quality care than they would in a competitive market. In addition, Defendants' conduct has caused injury to competition for the reasons stated herein.

F. Additional facts regarding the named Plaintiffs

1. William Davis

266. William Alan Davis is a citizen and resident of North Carolina with a residence address in Clyde, North Carolina, Haywood County. Mr. Davis resides to the west of Candler. In the last several years, Mr. Davis received medical care from Timothy Plaut, M.D. in Candler. Dr. Plaut worked for Mission MyCare Plus in Candler.

267. After HCA bought the Mission system, HCA announced that it was shutting down the Candler primary care practice. Mr. Davis learned from Dr. Plaut about the shutdown. Pursuant to a news article dated February 23, 2021,[39] Dr. Plaut was described as stating that he was shocked to learn that the clinic and job he loved would be gone in just 45 days. He stated that "[i]t created a lot of hardship for our patients." Dr. Plaut estimated that more than 7,000 patients total, many without insurance, were treated at the two clinics. "Our practice in Candler was one of the original safety nets through Mission and we took care of a lot of Medicaid and Medicare; we had homeless folks and severe mental illness."

268. Recently, when Mr. Davis visited his father at the hospital in Asheville, he noted that the hospital environment and his father's room was dirty. Mr. Davis and his wife noticed

[39] Karen Zatkulak, *Clinics closed, dozens of doctors leave Mission Health since HCA takeover*, WLOS.com (Feb. 23, 2021), *available at* https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover.

there was a trash can which had not been emptied. When Mr. Davis' father was in the hospital, it appeared that the nurses who took care of him for the most part were all "travelling nurses," including his main nurse and the phlebotomist who treated him. There appeared to be a shortage of certified nurse assistants and unit coordinators.

269. When Mr. Davis himself was a Mission Hospital patient, he went to the emergency room. It was his impression that one or more unnecessary tests were ordered.

270. Mr. Davis also received care at Mission WorkWell, located in Asheville, NC, including in the time period from 2018 onward.

271. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the respective health plans. As a result of HCA's anticompetitive conduct, he, and each other Plaintiff described below, within the last four years paid artificially high premiums, co-payments, deductibles, co-insurance payments, and/or out-of-pocket payments not covered by the health plans.

2. Lorraine Nash, Administrator of the Estate of Richard Nash

272. Lorraine Nash is the Administrator of her deceased husband Richard Nash's estate. Mr. Nash passed away in September 2021 shortly after the filing of this case.

273. Richard Nash was a citizen and resident of North Carolina with a residence address in Candler, North Carolina, Buncombe County. Mr. Nash was born in 1960.

274. Mr. Nash had health insurance with Blue Cross through his wife's employment which she has held for over 25 years.

275. Mr. Nash worked in construction for years and later worked in a plant. Mr. Nash was injured on the job several years ago and had significant medical issues. During his time

working in the construction industry, Mr. Nash helped during the construction of the cardiology ward at the Mission Asheville hospital during the time period of approximately 1991 until 1995.

276. In 2017, while covered by his insurance with Blue Cross, Mr. Nash was scheduled to receive cataract surgery in both eyes. He was scheduled to receive the cataract surgery from a physician he was assured was very renowned. Then, Mission allowed its contract with Blue Cross to expire due to a dispute over Mission's demand to increase the amount the insurance company, and by extension its policyholders, would have to pay. When Mission fell out of the Blue Cross network, Mr. Nash had to cancel his surgery. He subsequently had to reschedule the procedure through a different facility.

277. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the health plan. As a result of HCA's anticompetitive conduct, he paid additional amounts similar to the other Plaintiffs.

3. Will Overfelt

278. Will Overfelt is a citizen and resident of Asheville, NC. Mr. Overfelt has lived in the Asheville area for approximately 20 years.

279. In February 2020, Mr. Overfelt's father was ill. He was sent to the Mission Hospital Asheville emergency room by his primary care physician and was found to have advanced cancer.

280. Mr. Overfelt's father was admitted to Mission Hospital Asheville for approximately one week. During that time, Mr. Overfelt and his mother frequently visited Mr. Overfelt's father and noticed that the conditions at the hospital were deteriorated compared to how they had been in years past when family members had gone to the hospital.

281. Mr. Overfelt noticed that the rooms were dirty. It was hard to get information. He had trouble getting his father his pain medications timely.

282. He would push the call button and an excessive amount of time would lapse before someone would come to his father's room. The quality of care was clearly worse that it had been in years past.

283. Mr. Overfelt recalls early on, he saw a napkin on the floor in his father's hospital room. He left it where it was, wondering if any cleaning was really being done. The napkin was still there on the floor a week later when his father was discharged.

284. There were delays in getting help so his father could go to the bathroom. There were delays in obtaining water and various other items of sustenance and comfort. His father apparently was never bathed while there.

285. His father was discharged to go to a nursing home/rehabilitation facility, where he passed away approximately three days thereafter from his cancer. The date of death was February 18, 2020.

286. Mr. Overfelt applied for an insurance policy under the Affordable Care Act ("Obamacare") in December 2020. He was approved for a policy through Blue Cross. The health policy coverage began on January 1, 2021.

287. Since that time, Mr. Overfelt has paid a premium of approximately $168 per month. He believes the total premium cost is approximately $480 / month but that part of it is covered by a subsidy component of the Act.

288. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the health plan. As a result of HCA's anticompetitive conduct, he paid additional amounts similar to the other Plaintiffs.

4. Jonathan Powell

289. Jonathan Walton Powell is a citizen and resident of North Carolina who resides at 2960 Henderson Mill Rd, Morganton, NC 28655, in Burke County.

290. Mr. Powell has been employed as a machinist for a local company and has worked at that company for approximately 28 years. He has been and continues to be a very good worker at his job. In fact, his father worked in the same building that he works in today for many years. Mr. Powell grew up in Burke County and most of his family continues to reside there.

291. Mr. Powell has been fortunate to be insured through his employer with group health insurance. His insurance is with Blue Cross Blue Shield and he has had that insurance for over the last 20 years.

292. For the last several years, Mr. Powell has had the need to seek medical care. His primary care physician had always been associated with Mission Hospital and as a result, when he has begun ill and needed additional care and testing, his primary care physician has sent him to the Mission facilities. Mr. Powell had great confidence in his primary care physician as he had taken very good care of Mr. Powell for over the last ten years.

293. Unfortunately, after the sale of Mission Hospital and the other Mission facilities, his physician spoke to him about his inability to continue Mr. Powell's care. He was told by his physician that the new owner, HCA, overloaded him with so many patients, he could not continue to provide the proper care for them and he had had enough. He shared with Mr. Powell that he was going to work for another hospital. Since this past March, 2021, Mr. Powell's former physician has provided medical care for others in an adjoining town.

294. Mr. Powell believes that if HCA had not purchased Mission, his care would have continued to be provided by the physician who was most knowledgeable about him and his condition and who had treated him for years.

295. Since March, 2021, the former medical office that he went to in Morganton, which was called Mission Community Medicine, Burke, was completely closed down by HCA.

296. Because he lost his physician and the practice was closed, Mr. Powell is now being treated at Mission Health, Nebo Family Medicine, Nebo, N.C. He is being cared for by a Physician's Assistant and he still has not had another physician assigned to him since his primary care physician left.

297. Mr. Powell has been recently treated at Mission Hospital in Asheville, having last been seen there on June 10, 2021, where he remained for over two hours.

298. Mr. Powell has been seen a number of times at the Urgent Care Office at Mission McDowell Hospital. Numerous tests have been ordered on his behalf. He is scheduled for an appointment at Mission McDowell Hospital this month on August 17, 2021.

299. Mr. Powell has lung problems and his pulmonologist at Asheville Pulmonology, a clinic also associated with Mission Hospital, sends him to Mission McDowell Hospital, which is closer than Mission Hospital, Asheville, for his CT scans.

300. During the pertinent times, Mr. Powell has received medical care both from HCA-Mission facilities related to the Mission McDowell Hospital in Marion, NC, as well as from facilities related to the Mission Asheville Hospital. Mr. Powell believes that while there is another community hospital, Grace Hospital, in his county, he is being referred to the Mission hospitals because his physicians are affiliated with those hospitals.

301. Mr. Powell has continued to and plans to continue to receive care from and including at My Care Now-McDowell, 472 Rankin Drive, Marion NC 28752; from Mission Hospital, Memorial Campus, 509 Biltmore Avenue, Asheville NC 28801; at Mission McDowell Hospital, 430 Rankin Dr, Marion, NC 28752; and at Asheville Pulmonary & Critical Care Associates, P.A., 30 Choctaw Street, Asheville NC 28801 who are affiliated with Mission Asheville Hospital.

302. As a result of HCA's anticompetitive conduct, Mr. Powell paid additional amounts similar to the other Plaintiffs.

5. Faith C. Cook, Psy.D

303. Faith C. Cook, Psy.D. is a citizen and resident of North Carolina who resides in Black Mountain, North Carolina, Buncombe County.

304. Dr. Cook is a Clinical Psychologist who received her Doctorate from the University of Hartford and her Bachelor's Degree from the University of Georgia. She practices with Sylva Clinical Psychology in Sylva NC.

305. Dr. Cook has health insurance through a Blue Cross policy under the Affordable Care Act.

306. As a dedicated health care provider, Dr. Cook has a great interest in ensuring that her patients and others have access to very good and reasonably priced health care. She has concerns regarding the Mission monopoly and the resulting increasing costs since HCA took over Mission while simultaneously the quality of the patient care has been significantly deteriorating.

307. During the pertinent times, Dr. Cook has excessive amounts as a proximate result of Defendants charging supra-competitive prices for healthcare, similar to the other Plaintiffs.

6. *Katherine Button*

308. Ms. Button is the executive chef and in a leadership role with a restaurant group. The restaurant group has a self-insured plan through Roundstone.

309. During the pertinent times, Ms. Button and her family have had insurance through a self-funded plan which includes Mission hospital in the plan. She and her family have received medical care through Mission, including from Mission Hospital-Asheville.

310. One reason why her business switched over to a self-funded format was due to the crushing costs of regular health insurance in the Asheville area, due to HCA/Mission. However, even with self-funding, the costs are still high. The self-funded administrator, Roundstone, has advised that the reason why the costs are so high in the Asheville region is due to HCA/Mission.

311. During the pertinent times, Ms. Button has paid excessive amounts as a proximate result of Defendants charging supra-competitive prices for healthcare, similar to the other Plaintiffs.

VII. CLASS ALLEGATIONS

A. Class definition

312. Plaintiffs define the putative class in this litigation as follows:

> Any individual or entity in the Relevant Region who is a North Carolina resident and who, during all or part of the period beginning August 10, 2017 to the present, with regard to Defendants' acute care hospital services or ancillary products, paid some portion of premiums, deductibles, copays or coinsurance for a self-insured or fully-insured product offered by or administered by Aetna, Blue Cross Blue Shield, BMS TPA, Cigna, Coventry, CWI Benefits, Crescent TPA, Humana, Healthgram TPA, Key Benefits Administrators TPA, MedCost, MedCost Ultra, MultiPlan PHCS, United Healthcare, Wellpath, and Western North Carolina Healthcare Coalition.[40]

[40] This class definition with regard to identities of insurers and TPAs relies on public information from Defendants. Plaintiffs reserve the right to modify or amend this definition as they receive additional information.

313. The "Relevant Region" in this case is the 18 Counties that comprise Defendants' total service area: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey. This is identical to the 17-County western North Carolina geographic market known as Rating Area 1 under the Affordable Care Act, except that Burke County is added.

314. Excluded from the class are the Presiding Judge, employees of this Court, and any appellate judges exercising jurisdiction over these claims as well as employees of that appellate court(s).

315. This class definition is subject to revision or amendment as the matter proceeds.

B. Rule 23 requirements

316. This action is suitable for resolution on a class-wide basis under the requirements of North Carolina Rule of Civil Procedure 23.

317. Numerosity: The class is composed of hundreds and thousands of class members, the joinder of whom in one action is impractical. The class is ascertainable and identifiable from Defendants' records and documents.[41]

318. Commonality: Questions of law and fact common to the class exist as to all members of the class and predominate over any questions affecting only individual members of the class. These common issues include, but are not limited to:

a. Whether Defendants have a monopoly in a defined product market in Buncombe County;

b. Whether Defendants have a monopoly in a defined product market in Madison County;

[41] Populations per US Census information for the 18 Counties include: Avery (17,506), Buncombe (256,886), Burke (89,968), Cherokee (27,969), Clay (10,946), Graham (8,509), Haywood (61,053), Henderson (114,913), Jackson (42,938), Macon (34,813), Madison (21,499), McDowell (45,227), Mitchell (15,004), Polk (20,557), Rutherford (66,599), Swain (14,260), Transylvania (33,775) and Yancey (17,760).

c. Whether Defendants have a monopoly in a defined product market in the Counties of Yancey; Mitchell; Transylvania; McDowell; and/or Macon.

d. Whether Defendants, including Mission, and HCA, have acted willfully or otherwise unlawfully to maintain, abuse, or expand their monopoly or attempted to do so;

e. Whether Defendants have used their market power and anticompetitive means to impose prices far above those that would be charged in a competitive market, causing harm to Plaintiffs and others;

f. Whether Defendants have engaged in improper tying practices with regard to their provider agreements with insurance companies and TPAs;

g. Whether Defendants have engaged in improper anticompetitive practices with regard to the terms and provisions that they have required to be included in their payer/provider agreements;

h. Whether Defendants have willfully abused their monopoly power by reducing output and quality, including by reducing budgets and staffing at facilities;

i. Whether Defendants' conduct has violated N.C.G.S. § 75-1 *et seq*.;

j. Whether Defendants COPA immunity defense at most only applies to some period of time for Buncombe County and Madison County, and does not apply to a monopoly during some or all of the pertinent times in the Counties of Yancey; Mitchell; Transylvania; McDowell; or Macon;

k. Whether Defendants COPA immunity defense does not even apply for Buncombe or Madison Counties, due to regulatory evasion;

l. Whether Defendants' breaches of state law caused antitrust injury to the Plaintiffs and class members, injured competition and/or injured consumer welfare; and

m. Whether the Plaintiffs and the class members are entitled to an award of compensatory damages and/or injunctive, declaratory or equitable relief.

319. Typicality: Plaintiffs' claims are typical of the claims of the other class members. Plaintiffs and the other class members have been injured by the same wrongful practices. Plaintiffs' claims arise from the same practices and course of conduct that give rise to the other class members' claims and are based on the same legal theories.

320. Adequate Representation: Plaintiffs will fully and adequately assert and protect the interests of the other class members. Plaintiffs have retained class counsel who are experienced and qualified in prosecuting class action cases. Neither Plaintiffs nor their attorneys have any interests conflicting with class members' interests.

321. Predominance and Superiority: This class action is appropriate for certification because questions of law and fact common to the members of the class predominate over questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy, since individual joinder of all members of the class is impracticable. Should individuals be required to bring separate actions, courts would be confronted with a multiplicity of lawsuits burdening the court system while also creating the risk of inconsistent rulings and contradictory judgments. This class action presents fewer management difficulties while providing unitary adjudication, economies of scale and comprehensive supervision by a single Court.

322. Injunctive, Declaratory, Equitable Relief: The prosecution of the claims of the putative class in part for injunctive relief, declaratory or equitable relief, is appropriate because Defendants have acted, or refused to act, on grounds generally applicable to the putative class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the putative class as a whole.

VIII. CLAIMS FOR RELIEF

COUNT ONE
MONOPOLIZATION IN VIOLATION OF STATE ANTITRUST LAW
(N.C. Const. Art. 1 § 34; N.C.G.S. § 75-1 *et seq.*)

323. The above-alleged paragraphs 1 through 322 are incorporated by reference.

324. N.C.G.S. § 75-2.1, entitled, "Monopolizing and attempting to monopolize prohibited," provides: "It is unlawful for any person to monopolize, or attempt to monopolize, or combine or conspire with any other person or persons to monopolize, any part of trade or commerce in the State of North Carolina."

325. N.C.G.S. § 75-8, entitled, "Continuous violations separate offenses," provides: "Where the things prohibited in this Chapter are continuous, then in such event, after the first violation of any of the provisions hereof, each week that the violation of such provision shall continue shall be a separate offense."

326. N.C.G.S. § 75-16, entitled, "Civil action by person injured; treble damages," states: "If any person shall be injured or the business of any person, firm or corporation shall be broken up, destroyed or injured by reason of any act or thing done by any other person, firm or corporation in violation of the provisions of this Chapter, such person, firm or corporation so injured shall have a right of action on account of such injury done, and if damages are assessed in such case judgment shall be rendered in favor of the plaintiff and against the defendant for treble the amount fixed by the verdict."

327. N.C.G.S. § 75-16.1, entitled, "Attorney fee," provides, in pertinent part: "In any suit instituted by a person who alleges that the defendant violated G.S. 75-1.1, the presiding judge may, in his discretion, allow a reasonable attorney fee to the duly licensed attorney representing the prevailing party, such attorney fee to be taxed as a part of the court costs and payable by the losing party, upon a finding by the presiding judge that: (1) The party charged with the violation has willfully engaged in the act or practice, and there was an unwarranted refusal by such party to fully resolve the matter which constitutes the basis of such suit…."

328. Defendants have monopolized, and continue to monopolize, the relevant markets alleged herein in violation of North Carolina General Statutes Section 75-2.1.

329. During the pertinent times including the last four years, Defendants possessed monopoly power in the relevant market.

330. During the pertinent times, including after the 2016 repeal of the COPA but prior to its 2019 asset sale to HCA, Mission possessed monopoly power in the Asheville Region Inpatient Services market. From August 10, 2017, onward, Mission possessed an approximate 80 to 90% market share in Buncombe and Madison Counties. Mission's market power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

331. During the pertinent times, including after the asset sale from Mission, HCA possessed monopoly power in the Asheville Region Inpatient Services market. From 2019 onward, HCA has possessed an approximate 90% market share in Buncombe and Madison Counties. HCA's market power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

332. During the pertinent times including the last four years, Defendants engaged in the willful maintenance and abuse of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident; and Defendants accompanied their possession of monopoly power with an element of anticompetitive conduct.

333. Regardless of whether Mission unlawfully acquired a monopoly in light of the COPA, during the pertinent times, including after the COPA was repealed in September 2016, Defendants have unlawfully maintained and abused their monopoly power over the Asheville Region Inpatient Services market by forcibly imposing the restraints described herein on all or

nearly all insurers in the region. This has precluded insurers from, inter alia, steering patients who may be able to receive inpatient care from hospitals outside of the Asheville Region to less expensive, higher quality competitors. This is particularly true for patients who reside in counties neighboring the Asheville Region. This has directly led to more patients receiving more expensive care from Mission Hospital-Asheville than otherwise would have absent Defendants' anticompetitive restraints.

334. In addition to or in the alternative to the above-stated monopolization claim, the Plaintiffs also allege that Defendants have used the anticompetitive restraints described herein to unlawfully acquire monopoly power in other markets, namely, the markets for inpatient and outpatient services in the Outlying Regions, and the market for outpatient services in the Asheville Region.

335. HCA today owns and controls monopoly market shares for inpatient care in seven counties in Western North Carolina. In the market for inpatient services in the Outlying Regions, HCA today has monopoly market power in each county in the Outlying Regions. Specifically, based on multiple sources measuring total hospital discharges in the Outlying Regions, HCA today has the following market shares in the five counties in the Outlying Region: Yancey – 91-96%; Mitchell – 84-96%; Transylvania – 80-87%; McDowell – 79-88%; and Macon – 76-84%. At the time of the COPA's repeal, Defendants did not have monopoly level market shares in these geographies. Defendants gained and/or expanded its monopoly power over inpatient services in the Outlying Regions through the use of the anticompetitive restraints described herein.

336. HCA today has monopoly power in the market for outpatient services in the Outlying Regions, as demonstrated by its near-total control over several key outpatient specialties in these geographies, as well as its ability to control prices over outpatient services in these

geographies. At the time of the COPA's repeal, Defendants did not have such strong monopoly power in these geographies. Defendants gained and/or its monopoly power over outpatient services in the Outlying Regions through the use of the anticompetitive restraints described herein.

337. HCA today has monopoly power in the market for outpatient services in the Asheville Region, as demonstrated by its near-total control over several key outpatient specialties in the Asheville Region, as well as its ability to control prices over outpatient services in geographic market. At the time of the COPA's repeal, Defendants did not have such strong monopoly power in this market. Defendants gained and/or expanded its monopoly power over outpatient services in the Asheville Region through the use of the anticompetitive restraints described herein.

338. For every market, the restraints Defendants have used to maintain, abuse, acquire, and/or expand their monopoly power have no procompetitive benefits, and certainly do not have procompetitive benefits that outweigh their anticompetitive effects.

339. This artificial inflation of hospital spending, due to Defendants' restraints, has led directly to Plaintiffs and the putative class suffering economic harm in the form of, inter alia, higher insurance premiums throughout Defendants' service area.

340. Defendants have engaged in continuing violations within the meaning of N.C.G.S. § 75-8 since the COPA was repealed in 2016.

341. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT TWO
ATTEMPTED MONOPOLIZATION

342. The above-alleged paragraphs 1 through 341 are incorporated by reference.

343. N.C.G.S. § 75-2.1, entitled, "Monopolizing and attempting to monopolize prohibited," provides, in pertinent part: "It is unlawful for any person to … attempt to monopolize … any part of trade or commerce in the State of North Carolina."

344. During the pertinent times, including within the last four years, Defendants possessed monopoly power in markets including, but not limited to, the Buncombe and Madison County market.

345. During the pertinent times, Defendants engaged in the willful and unlawful attempt to obtain, create, maintain or expand their monopoly power.

346. During the pertinent times, Defendants attempted to acquire, maintain, or expand their monopoly through illegitimate means.

347. During the pertinent times, Defendants had a specific intent to monopolize a relevant market, including by attempting to monopolize the Asheville Region Outpatient Services Market, and the Outlying Regions Inpatient and Outpatient Services Markets.

348. During the pertinent times, Defendants engaged in predatory or anticompetitive acts, as more specifically alleged above.

349. Absent Court intervention, due to the Defendants' actions, there is a dangerous probability of successful monopolization, specifically in the Asheville Region as to Asheville Region Outpatient Services; and in the Outlying Regions as to Outlying Regions Inpatient and Outpatient Services.

350. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

<u>COUNT THREE</u>
RESTRAINT OF TRADE IN VIOLATION OF STATE ANTITRUST LAW
(N.C.G.S. § 75-1 *et seq.*)

351. The above-alleged paragraphs 1 through 350 are incorporated by reference.

352. N.C.G.S. § 75-1, entitled, "Combinations in restraint of trade illegal," states: "Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce in the State of North Carolina is hereby declared to be illegal. Every person or corporation who shall make any such contract expressly or shall knowingly be a party thereto by implication, or who shall engage in any such combination or conspiracy shall be guilty of a Class H felony."

353. N.C.G.S. § 75-2, entitled, "Any restraint in violation of common law included," states: "Any act, contract, combination in the form of trust, or conspiracy in restraint of trade or commerce which violates the principles of the common law is hereby declared to be in violation of G.S. 75-1."

354. During the pertinent times, Defendants have engaged in the use of contracts and agreements in restraint of trade as alleged hereinabove. Defendants have negotiated and enforced contracts containing anticompetitive provisions restrictions with insurers or TPAs which are contracts, combinations, and conspiracies within the meaning of North Carolina General Statutes Sections 75-1 and 75-2.

355. The challenged contractual restrictions unreasonably restrain trade in violation of North Carolina General Statutes Sections 75-1.1 and 75-2.

356. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT FOUR
INJUNCTIVE, EQUITABLE, DECLARATORY RELIEF

357. The above-alleged paragraphs 1 through 356 are incorporated by reference.

358. The Court has authority to award declaratory, injunctive or equitable relief under the Declaratory Judgment Act, which states at N.C.G.S. § 1-253: "Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations, whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declarations shall have the force and effect of a final judgment or decree."

359. Further, under G.S. § 1-254: "Any person interested under a deed, will, written contract or other writings constituting a contract, or whose rights, status or other legal relations are affected by a statute, municipal ordinance, contract or franchise, may have determined any question of construction or validity arising under the instrument, statute, ordinance, contract, or franchise, and obtain a declaration of rights, status, or other legal relations thereunder. A contract may be construed either before or after there has been a breach thereof."

360. Plaintiffs show that to the extent the facts and law allow for the imposition of equitable, declaratory or injunctive remedies, they plead recourse to any and all such remedies.

361. Plaintiffs request that the Court order the reformation of Defendants' practices, and/or contractual and agreement terms, including, for example, to require greater pricing transparency, express language against use of "all or nothing" arrangements, express provisions committing not to use anti-tiering or anti-steering provisions, and other such remedies.

362. Plaintiffs in addition to their damages claims, request injunctive, declaratory or equitable relief and show that the injunctive relief will prevent Defendants from imposing

anticompetitive all-or-nothing, anti-tiering, and anti-transparency provisions in their contracts, thus allowing health plans to steer patients away from lower value providers.

363. Plaintiffs and the Class members have standing to and do seek equitable relief against Defendants, including an injunction to prohibit Defendants' illegal conduct as well as an order of equitable restitution and disgorgement of the monetary gains that Defendants obtained from their unfair competition.

IX. JURY DEMAND

364. Plaintiffs demand a trial by jury.

X. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that this Court enter judgment on their behalf and that of the proposed class and adjudge and decree as follows:

A. certifying the proposed class, designating the named Plaintiffs as class representatives and the undersigned counsel as class counsel, and allowing the Plaintiffs and the class to have trial by jury;

B. finding that Defendants have monopolized, and continue to monopolize, the relevant markets alleged herein in violation of North Carolina General Statutes Section 75-2.1, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

C. finding that Defendants have engaged in a trust, contract, combination, conspiracy, or unlawful restraints of trade in violation of North Carolina General States Sections 75-1 and 75-2, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

D. ordering that Plaintiffs and members of the class recover threefold the damages determined to have been sustained by them as a result of Defendants' misconduct complained of herein, and that judgment be entered against Defendants for the amount so determined;

E. entering judgment against Defendants and in favor of Plaintiffs and the class awarding restitution and disgorgement of ill-gotten gains to the extent such an equitable remedy may be allowed by law;

F. awarding reasonable attorney’s fees, costs, expenses, prejudgment and post-judgment interest, to the extent allowable by law;

G. awarding equitable, injunctive and declaratory relief, including but not limited to declaring Defendants’ misconduct unlawful and enjoining Defendants, their officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on their behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts competition in the manner as alleged hereinabove; and

H. awarding such other and further relief as the Court may deem just and proper.

Dated: October 31, 2022

/s/ John Hughes
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CERTIFICATE OF SERVICE

Under Business Court Rule 3.9, the foregoing document was served on all parties on the date of filing.

/s/ John Hughes
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