THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Trends in the Financing and Ownership of US Health Care

Moderated by Reed Abelson of *The New York Times*

June 21, 2023

Panelists

- **Adam Gaffney,** Cambridge Health Alliance, Harvard Medical School
- **Lawton Robert Burns**, The Wharton School
- **Erin C. Fuse Brown**, Georgia State College of Law
- **John E. McDonough**, Harvard School of Public Health

Century-Long Trends in the Financing and Ownership of American Health Care

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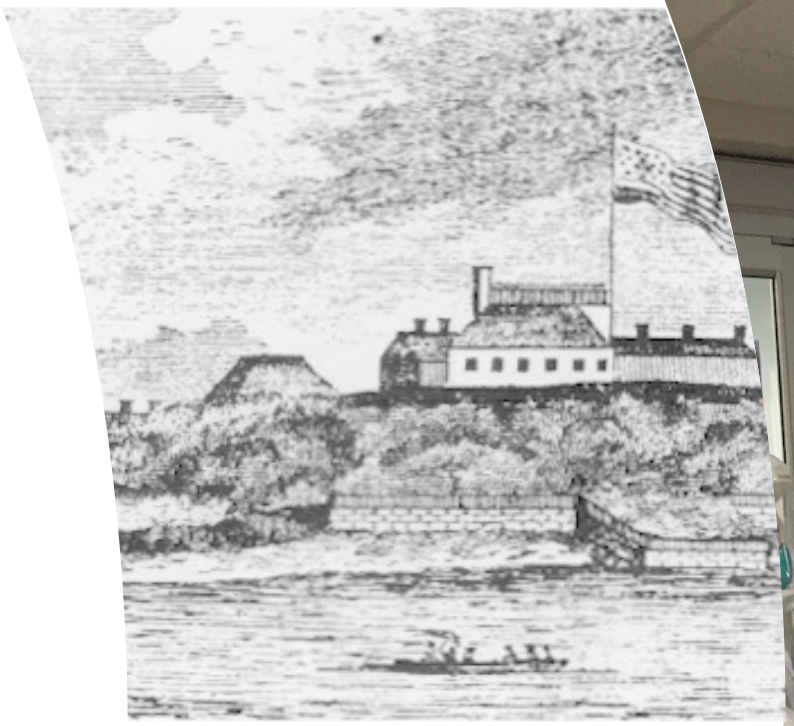
- https://www.nlm.nih.gov/exhibition/phs_history/seamen.html
- https://www.history.navy.mil/our-collections/photography/numerical-list-of-images/nhhc-series/nh-series/NH-115000/NH-115774.html



Study Design

Used multiple historical and contemporary data sources to examine:

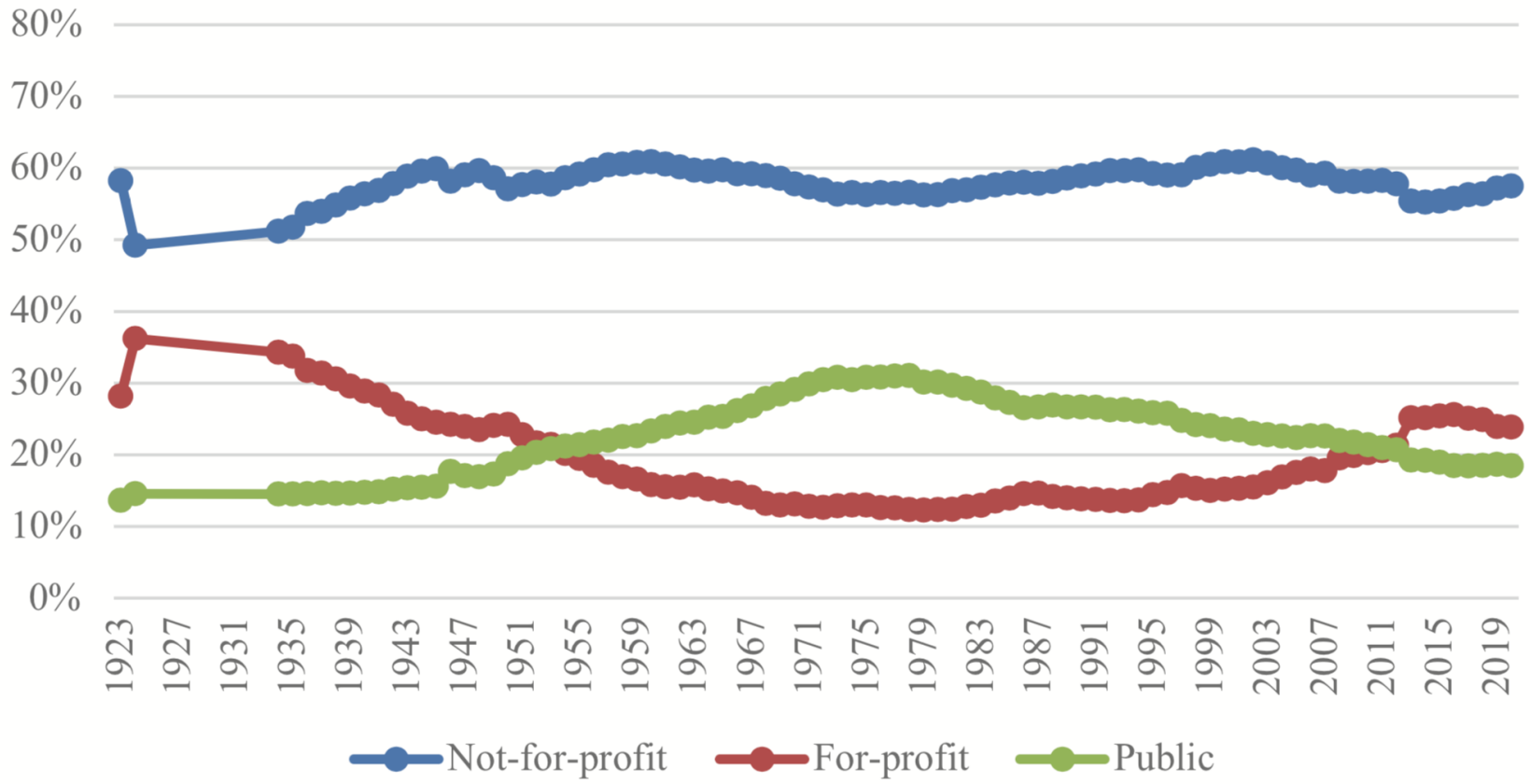
(1) Trends in healthcare ownership in 3 categories:

- Public
- Private: not-for-profit
- Private: for-profit

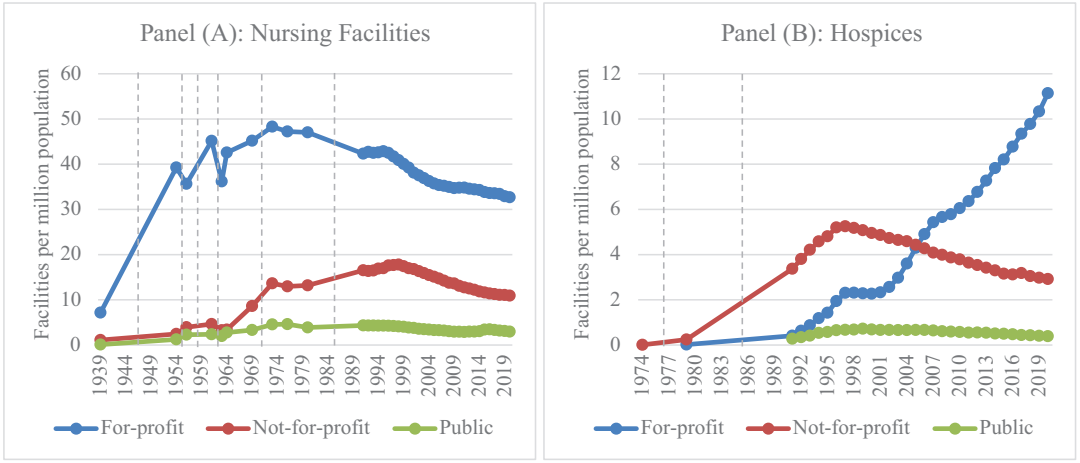
(2) Trends in public vs. private healthcare financing, with and without adjustment for publicly-sponsored private expenditures, e.g.:

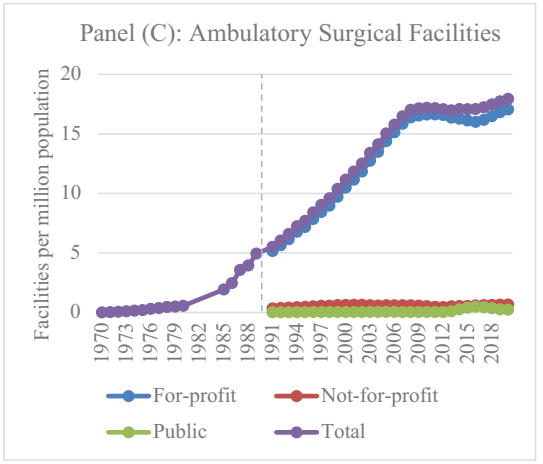
- Tax exclusion on private health insurance
- Federal subsidies for ACA marketplace plans
- Private health insurance premiums of public employees

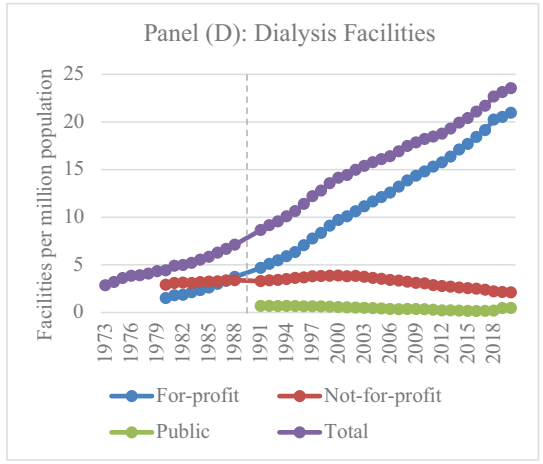
Hospital Ownership, 1923-2020

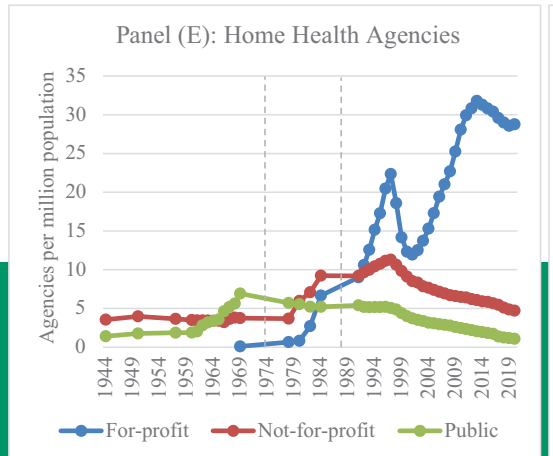


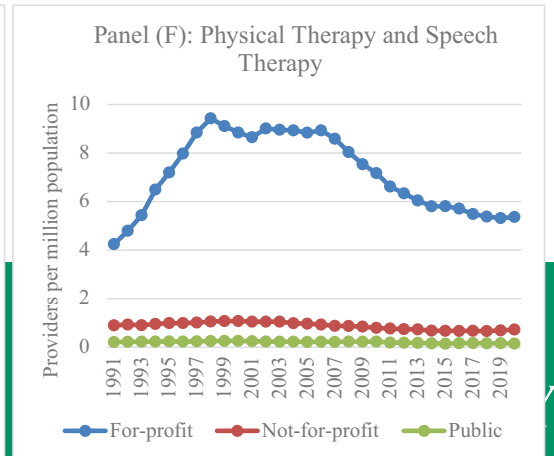
Other Facility Ownership, 1939-2020



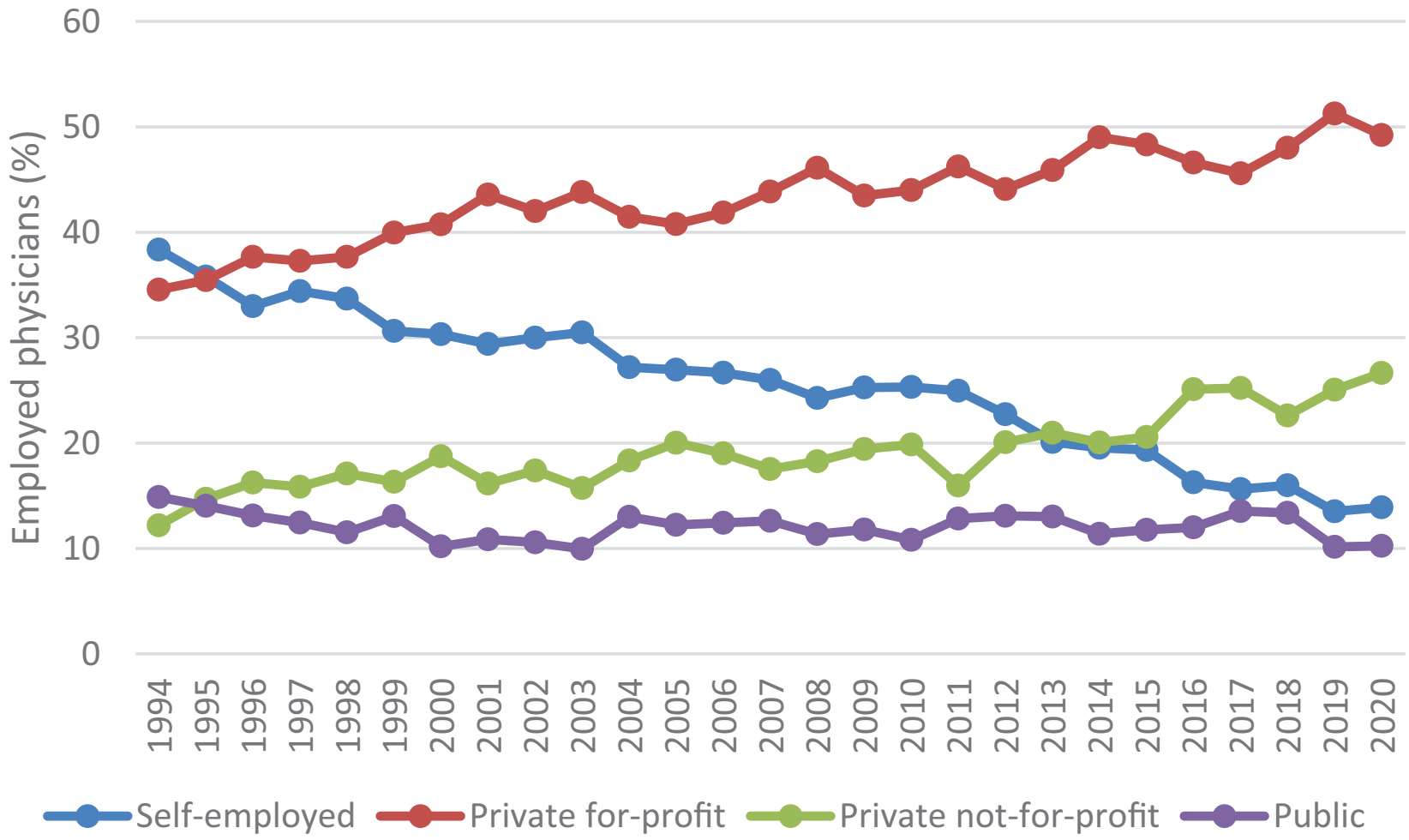




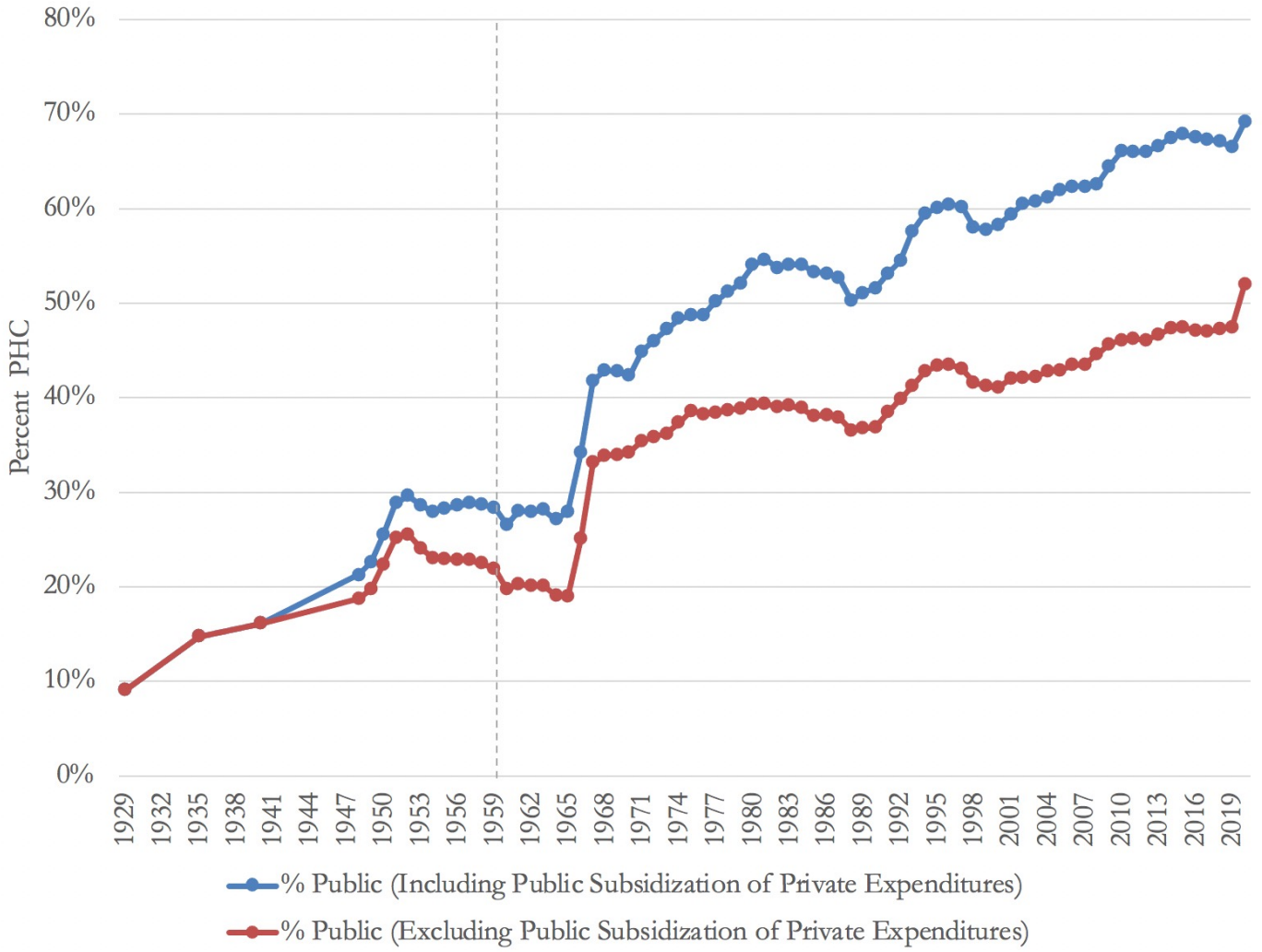




Physician Employment, 1994-2020



Public Share of Personal Healthcare Spending (PHC), 1929-2020



Conclusions

- US healthcare is an increasingly publicly financed yet investor-owned enterprise.
- High levels of existing publicly sponsored care could limit budgetary impact of a universal coverage expansion.
- Rising for-profit ownership may have adverse effects on care quality.
- Observed trends have been accompanied by soaring costs, administrative inefficiency, and stagnating health outcomes: re-assessment of financing and ownership of US healthcare is warranted.

Big Med & Its Spread

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"Trends in the Financing & Ownership of US Health Care"
Milbank Memorial Fund Webinar
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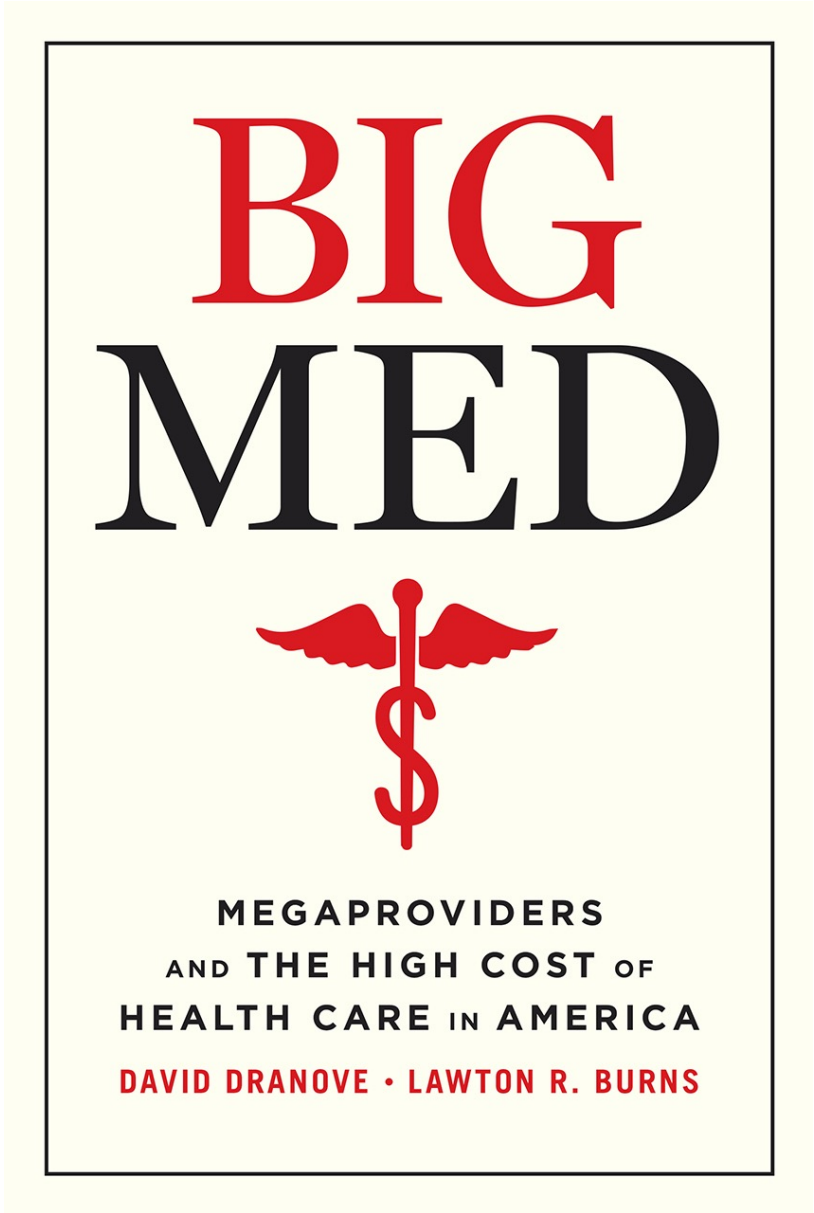
Cross-Market Mergers: Three Recent Studies

- Lewis & Pflum (*Rand Journal of Economics*, 2017)
- Schmitt (*American Economic Journal: Economic Policy*, 2018)
- Dafny, Ho, & Lee (*Rand Journal of Economics*, 2019)

Econometric studies suggest that mergers across state lines are NOT likely to achieve higher prices in other states.

Why so? Dealing with different insurers in those states ➔ no multi-state contract and bargaining leverage



THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Original Research

Big Med's Spread

LAWTON ROBERT BURNS and MARK V. PAULY

The Wharton School, University of Pennsylvania

Policy Points:

- Hospital executives posit a number of rationales for system mergers which lack any basis in academic evidence. Decades of academic research question whether system combinations confer public benefits. Antitrust authorities need to continue to closely scrutinize these transactions.
- Recently, mergers of hospital systems that span different geographic markets are on the rise. Economists have alerted policymakers about the potential impacts such cross-market mergers may have on hospital prices. We suggest there are *other reasons* for concern that scholars have not often confonted. Cross-market mergers may be conducted for purely self-serving reasons of organizational growth that increases executive compensation. Combinations of sellers should have clear advantages to consumers. System executives and their boards should bear the burden of proof.
- Federal regulators and state attorney generals should be cognizant that rationales for cross-market systems advanced by merging parties are unlikely to be operative or dominant in merger decision making.
- Policymakers should be careful about passing legislation that encourages hospitals to consolidate.

Context: There is a growing trend of combinations among hospital systems that operate in different geographic markets known as cross-market mergers. Economists have analyzed these broader systems in terms of their anticompetitive behavior and pricing power over insurers. This paper evaluates the benefits advanced by these new hospital systems that speak to a different set of issues not usually studied: increased efficiencies, new capabilities, operating synergies, and addressing health inequities. The paper thus "looks under the hood"

The Milbank Quarterly, Vol. 0, No. 0, 2023 (pp. 1-38)

THE MILBANK QUARTERLY

Aug 2020

Q&A

'We are big proponents on the value of scale'

Healthcare will not return to a pre-COVID way of doing business even after the pandemic is over. The question in front of all executives is: How does the industry reshape itself going forward? **Jim Skogsbergh,** president and CEO of Advocate Aurora Health, says health systems can use scale to improve cost, safety and outcomes. With hospitals in Illinois and Wisconsin, Advocate Aurora—which came together in 2018—is now eyeing a merger with Michigan-based Beaumont Health, but that has run into some snags. Skogsbergh spoke last week with Modern Healthcare Managing Editor Matthew Weinstock. The following is an edited transcript.

MH: There are reports that some physicians at Beaumont Health are concerned about the proposed merger and the Beaumont board will postpone a vote. From your perspective, where do things stand?

Skogsbergh: We're very excited about the Beaumont opportunity and have great respect for the organization. Clearly, they have some internal issues that have come up of late and been reported in various news outlets. All I know is that their board has ... voted unanimously three times.

I understand a relatively small group of physicians has pushed back. They need to take care of their own internal things first and then turn their attention to the merger. So if they can pull it off, that'd be fantastic. If they can't, they can't.

Our philosophy hasn't changed, our strategic approach hasn't changed. I also know that there's a natural resistance to change, any kind of change. And these kinds of transactions can be a bit worrisome for folks. We tend to look at what we're gaining, not what we're losing. We'll see how that shakes out. We're still hopeful.

MH: Do you have a timeline for when you'd like to see a decision made?

Skogsbergh: We'd love to see a third-quarter decision and then the (regulatory) approval process take place. So maybe this could be effective as early as Jan. 1.

MH: More broadly, what impact do you think the pandemic will have overall on merger and acquisition activity?

Skogsbergh: Consolidation in our industry will not change. I think that's going to continue to move forward—there's tremendous pressure to improve your cost position, to improve your safety, to improve your health outcomes—all of which scale can be a contributing factor if executed properly. Of course the key word there is "if" executed properly. We are big proponents on the value of scale. It's not big for bigness' sake, it's really to get stronger. And that strength then can be translated in what we say is, better health outcomes and less costs.

Cone Health and Sentara Healthcare announced (a merger on Aug. 12). A lot of these conversations were in the making before COVID. Our Beaumont conversation certainly was. And then everybody pushed pause because it's all hands on deck, and appropriately so. Now you're seeing folks re-emerging with, "OK, where were we? And let's pick up where we were." The impetus for some of these partnerships has probably only grown stronger.

MH: How has Advocate Aurora used its scale during the pandemic?

Skogsbergh: I'm a big believer in finding a silver lining in every cloud. And COVID-19 has been a dark cloud without a doubt. Advocate Aurora Health came together about 2½ years ago.

We went into 2020, two organizations striving to become one, right? Or I should say one organization striving to become closer and fully integrated. We'll come out of this as absolutely one very strong organization. COVID-19 has been a disaster economically, and that's true for all healthcare providers, absolutely a financial disaster. Culturally, it's probably been a blessing for us. And what I mean by that is when COVID hit hard in Illinois we had nurses from Wisconsin come down and take shifts at our Illinois hospitals where it was very desperately needed.

Conversely, when the numbers started creeping up in Wisconsin, we moved ventilators from Illinois to Wisconsin. So the ability to work back and forth and

May 11, 2022 11:00 AM

Advocate Aurora Health, Atrium Health to form $27 billion system

ALEX KACIK

Advocate Aurora Health CEO Jim Skogsbergh (right) and Atrium Health CEO Eugene Woods (left)

Advocate Aurora Health and Atrium Health will form a $27 billion health system spanning six states, making it the sixth largest health system in the country, the not-for-profit providers said Wednesday.

The combined organization would have 67 hospitals—40 from Atrium and 27 from Advocate Aurora—and nearly 150,000 employees across Illinois, Wisconsin, North Carolina, South Carolina, Georgia and Alabama. The health system will use both the Advocate Aurora and Atrium brands, but transition to

Advocate Health's *Scale*

- $27B healthcare system
- 6 states
- 67 hospitals over 1,000 sites of care
- 150,000 employees
- Serve 5.5M patients
- Makes it the 6th largest system in the US

Advocate Health Rationale - - acc to Cain Brothers

Manifold Scale Advantages:

- Scale fixed costs of producing inpatient services
- Scale physician alignment
- Scale clinical capabilities
- Scale innovation
- Scale technology
- Scale access to capital
- Scale covered lives
- Scale in insurance risk
- Scale in partnerships with non-traditional players
- Scale in tackling health inequities

Industry Insights

Contents

The Trend of Health System Mergers Continues

Banker Commentary by David Levine

While healthcare is delivered locally, the business of healthcare is regional, and the regions are only getting bigger. Hospital and health system mergers alike have continued to shift from local to regional, and the recently announced merger between Advocate Aurora Health and Atrium Health clearly highlights that the regions are only getting bigger.

Advocate Aurora, with a presence in Illinois and Wisconsin, and Atrium Health, with a presence in North Carolina, South Carolina, Georgia, and Alabama, will combine to create a $27 billion health system that will span six states and make it one of the leading healthcare delivery systems in the country. The combined organization, which will transition to a new brand, Advocate Health, will operate 67 hospitals and over 1,000 sites of care, employ nearly 150,000 teammates, and serve 5.5 million patients. Together, Advocate Health will become the 6th largest system in the country behind Kaiser Permanente, HCA Healthcare, CommonSpirit Health, Ascension, and Providence.

We have seen a number of large health systems come together recently, including Intermountain Healthcare + SCL Health to create a $15 billion revenue system, Spectrum Health + Beaumont ($14 billion), NorthShore University Health System + Edward-Elmhurst Healthcare ($5 billion), LifePoint Health + Kindred Healthcare ($14 billion), and Jefferson Health + Einstein Healthcare Network ($8 billion).

The exact reasoning for each merger differs slightly, but one of the common threads across all is scale. But not scale in the traditional M&A sense. Rather, scale in covered lives; scale in physician infrastructure and alignment; scale in clinical and operational capabilities; scale in technology, innovation, and partnerships with non-traditional players; scale for capital access; and scale for insurance risk to compete in a value-based world. It is no longer the strong acquiring the weak. Rather, strong players are coming together to gain scale to face the headwinds in a unified manner.

Do hospital systems really *serve underserved communities?*

The New York Times | https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html

PROFITS OVER PATIENTS

How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits

Bon Secours Mercy Health, a major nonprofit health system, used the poverty of Richmond Community Hospital's patients to tap into a lucrative federal drug program.

By Katie Thomas and Jessica Silver-Greenberg
Published Sept. 24, 2022 Updated Sept. 27, 2022

The New York Times | https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html

PROFITS OVER PATIENTS

They Were Entitled to Free Care. Hospitals Hounded Them to Pay.

With the help of a consulting firm, the Providence hospital system trained staff to wring money out of patients, even those eligible for free care.

By Jessica Silver-Greenberg and Katie Thomas
Sept. 24, 2022

Journal of Health Economics 86 (2022) 102696

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Understanding the relationship between nonprofit hospital community benefit spending and system membership: An analysis of independent hospital acquisitions

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ARTICLE INFO

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Community benefit spending
Hospital acquisitions

ABSTRACT

The Internal Revenue Service (IRS) requires nonprofit hospitals to report community benefit spending to justify their nonprofit tax exemption. We examined whether nonprofit hospital acquisitions influence the amount and type community benefit spending. We analyzed 2011–2018 data on urban, nonprofit hospitals. The analysis dataset included 57 hospitals that were acquired and a matched control group. We estimated difference-in-differences specifications to measure the effect of acquisitions on total community benefit spending, and three subcategories – clinical, population health, and other spending types. We found that acquisitions led to decreased population health spending (−$0.32 million, $p < 0.01$) and other spending categories (−$1.5 million, $p < 0.05$), but no significant change in total or clinical spending. If the acquirer was located out-of-state, total community benefit spending declined by $2.4 million ($p < 0.10$). Our findings support the need for community benefit spending to be considered, along with quality, efficiency, and prices, when evaluating the welfare impact of acquisitions.

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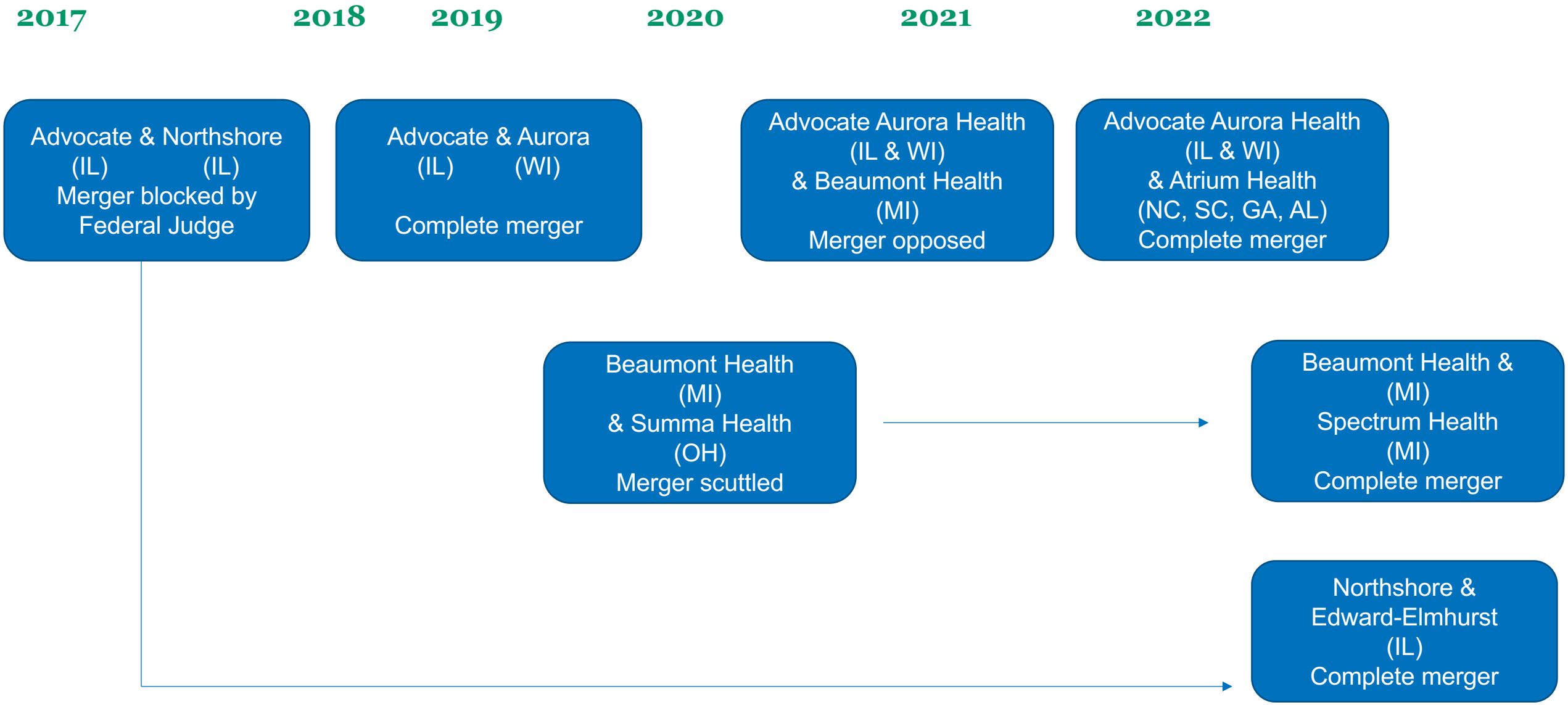
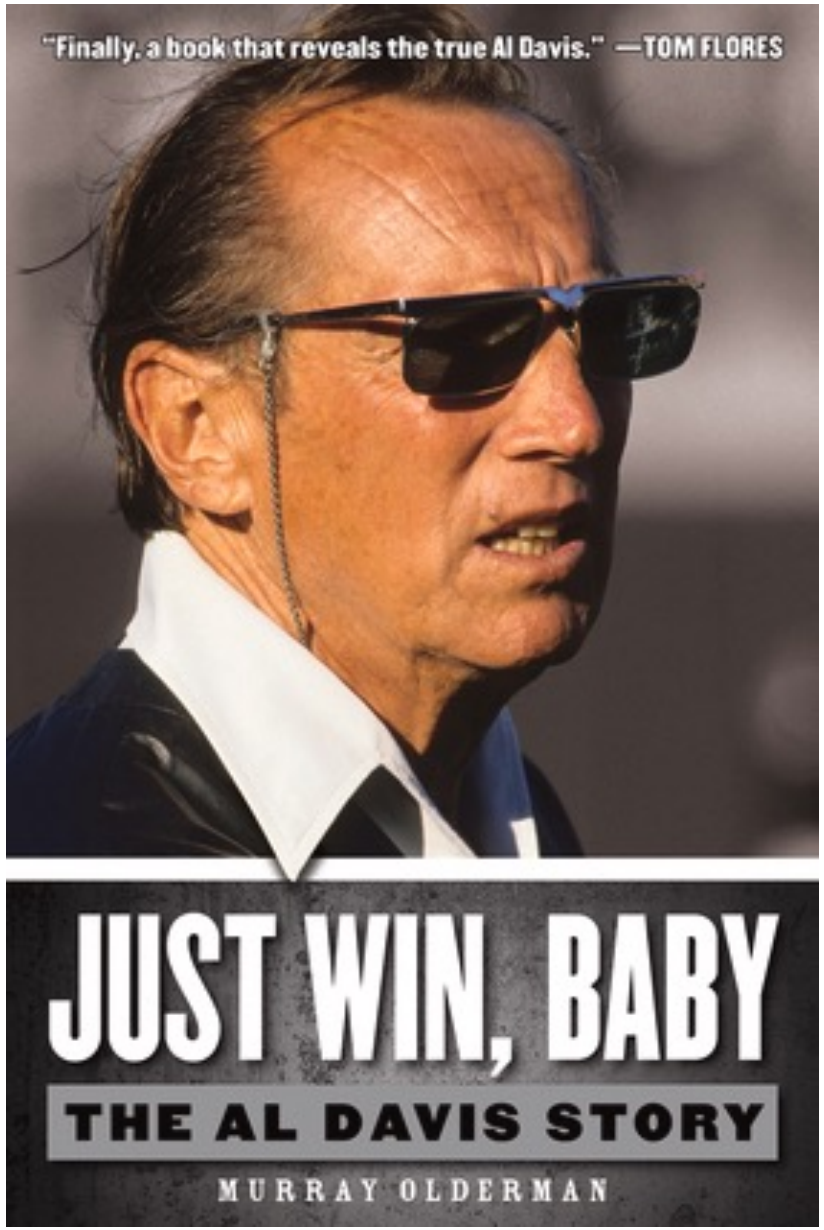

2017
2018
2019
2020
2021
2022
Advocate & Northshore
(IL) (IL)
Merger blocked by
Federal Judge
Advocate & Aurora
(IL) (WI)
Complete merger
Advocate Aurora Health
(IL & WI)
& Beaumont Health
(MI)
Merger opposed
Advocate Aurora Health
(IL & WI)
& Atrium Health
(NC, SC, GA, AL)
Complete merger
Beaumont Health
(MI)
& Summa Health
(OH)
Merger scuttled
Beaumont Health &
(MI)
Spectrum Health
(MI)
Complete merger
Northshore &
Edward-Elmhurst
(IL)
Complete merger


"Finally, a book that reveals the true Al Davis." —TOM FLORES
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"Finally, a book that reveals the true Al Davis." —TOM FLORES
Grow
JUST WIN, BABY
THE AL DAVIS STORY
MURRAY OLDERMAN

Governance Problems

- Boards incentivize CEOs to grow their system's size & financial performance
- CEO comp is tied to volume, growth, "heads in beds"
- CEO comp NOT tied to value, uncompensated care, cost containment
- Board service is often voluntary/unpaid
- Boards meet quarterly for < 3 hours
- < half of board meeting time devoted to deliberation/debate
- Boards are really peripheral monitors and/or advisors to CEOs
- "Boards only exist when they meet"

Thank you for listening