Big Med

Lawton R. Burns, Ph.D., MBA

The James Joo-Jin Kim Professor

The Wharton School

University of Pennsylvania

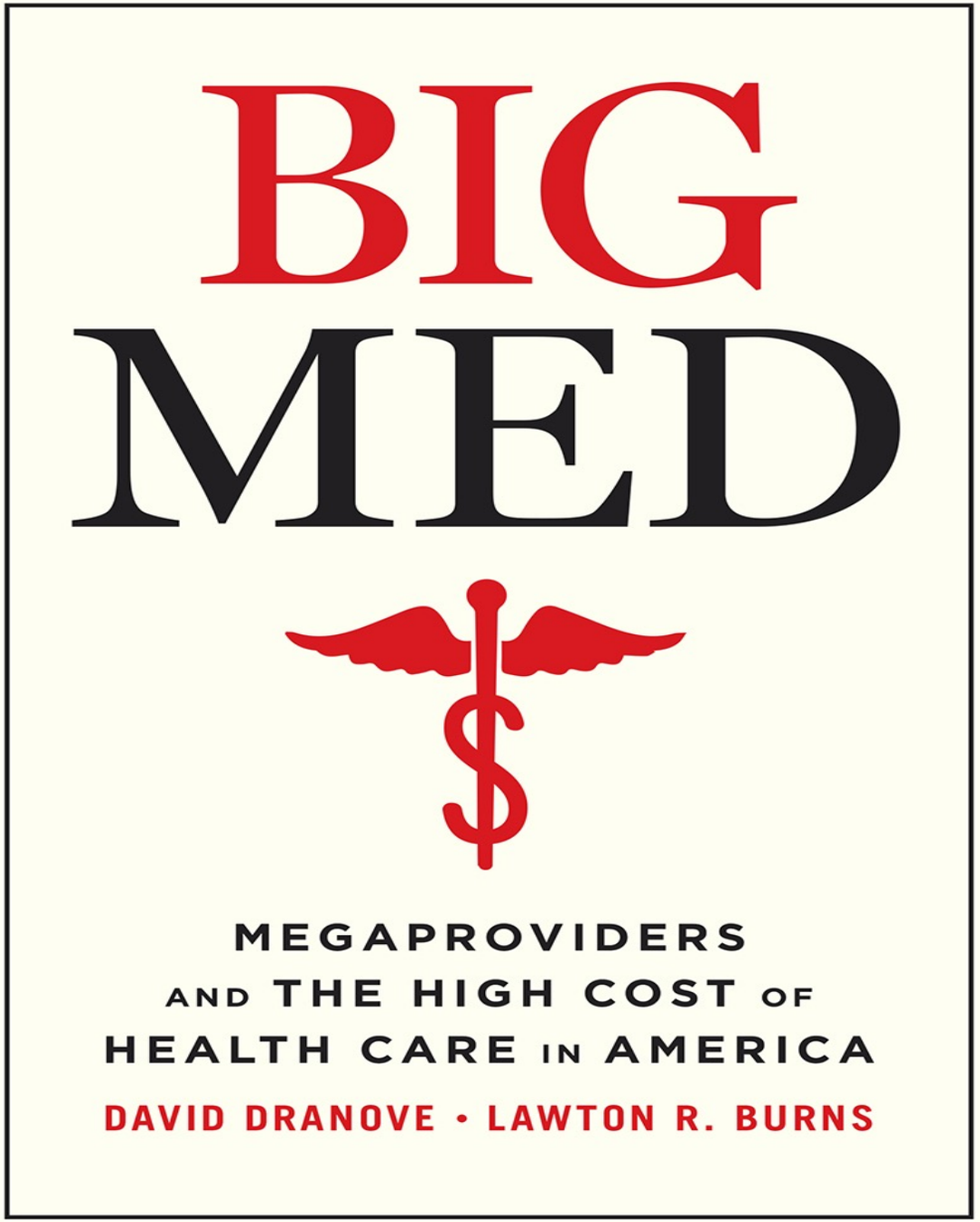
burnsL@wharton.upenn.edu

215-898-3711

Hospital Consolidation & Market Oversight

Oregon Senate Committee on Health Care

November 6, 2023



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)

BIG MED = Big Deal

Table I.1. The nation's largest megaproviders, as of 2017

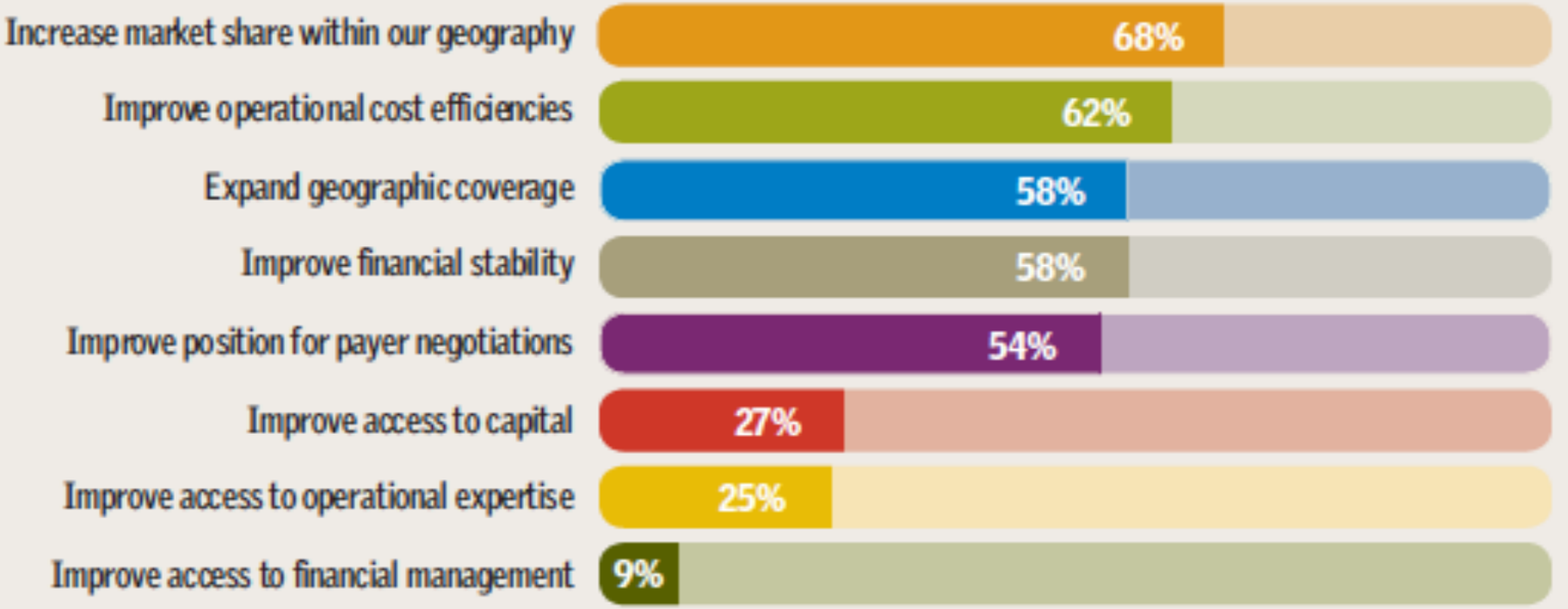
System	Location	Revenue	Comparable
UPMC	Western Pennsylvania	$16b	Whole Foods
Partners	Eastern Massachusetts	$13.4b	Gucci
Sutter	Northern California	$12b	Tesla
Northwell Health	Long Island	$9.0b	Adobe Systems
Cleveland Clinic	Northeast Ohio	$8.4b	National Basketball Association
Intermountain	Mountain states	$7.6b	Jet Blue
Advocate Health	Northern Illinois	$6.2b	Spotify
NY Presbyterian	New York City	$5.6b	Regeneron
Sentara Health	Southeast Virginia	$5.3b	Yahoo
Baylor, Scott, and White	Dallas, Texas	$4.8b	Chipotle
Total		$88.8b	Boeing
			Hyundai Motor
			IBM
			Johnson & Johnson

Two Oft-Cited Rationales by Executives for *Big Med*

Predominance of **“Scale”** in Big Med Goals

FINANCIAL OBJECTIVES

Which of the following are among the financial objectives of your overall merger, acquisition, and/or partnership planning or activity?



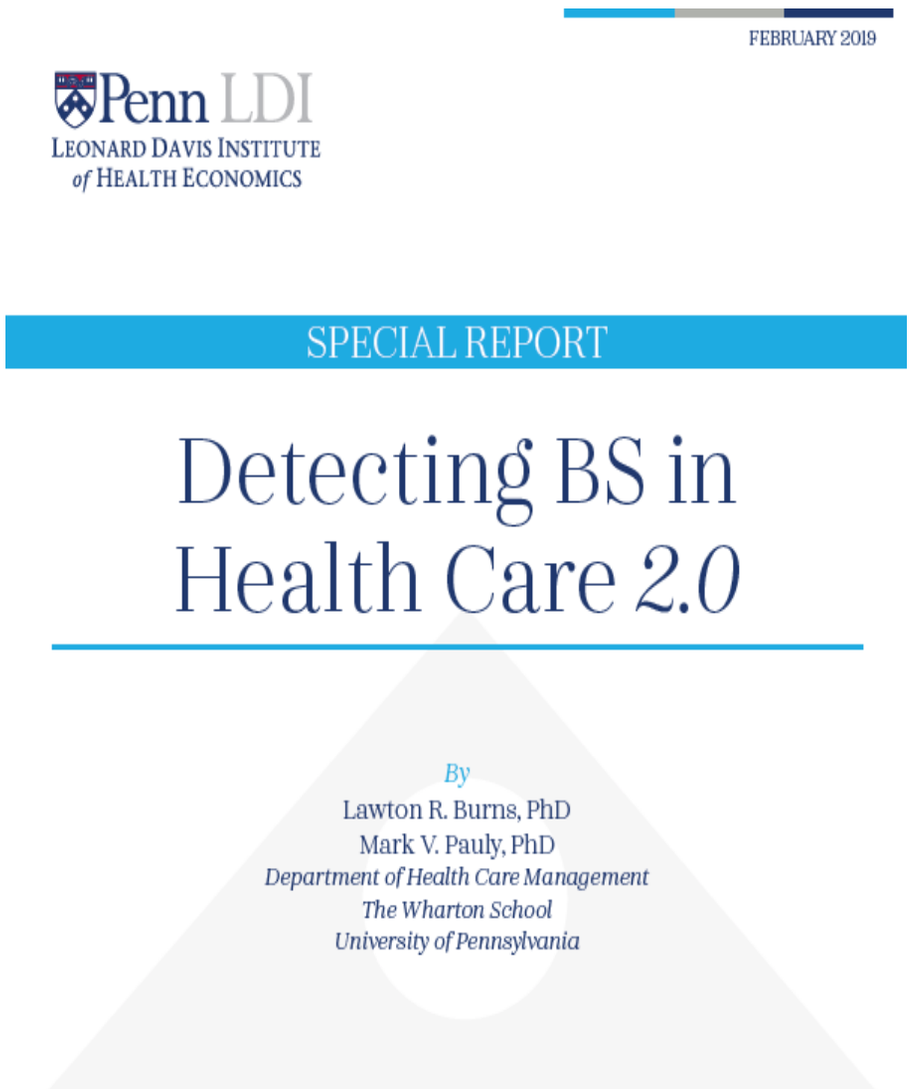
Multi-response

SOURCE: HealthLeaders Media Intelligence Report, *The M&A and Partnership Mega-Trend: Deals for Growth and Survival*, February 2015; hlm.tc/1zHAJc1.

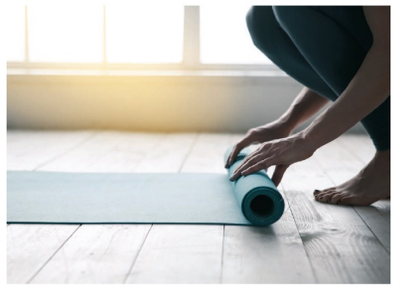
Asserted **“Synergies”** in Big Med

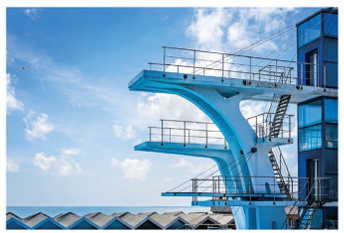
- Produce more services (revenue synergies)
- Reduce excess or redundant capacity (cost synergies)
- Reap synergies across business units (e.g., referral flows between hospitals)
- Physician alignment and integration
- Complementarities in clinical expertise, assets, and resources that can be combined
- Innovation
- Tackling health inequities & greater access to care
- Data analytic capabilities and digital consumer infrastructure to address:
  - safety
  - affordability
  - environmental sustainability
  - next generation workforce
  - learning & discovery
  - “do more, be better, go faster”

The Layman's Guide to BS Detection

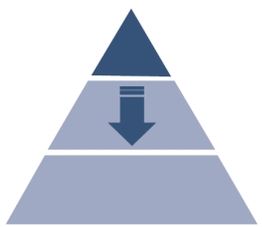


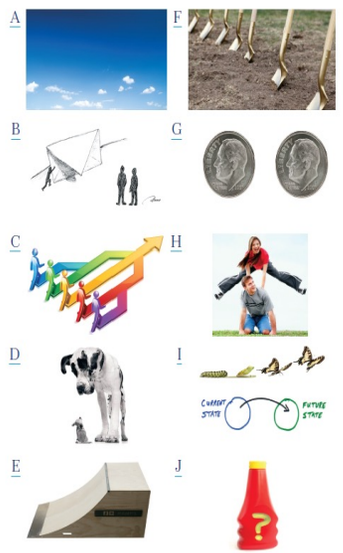

baboonery
fiddle-faddle
Trumpery
babble
stump-water
treacle
malarkey
blarney
bilge
bosh
flubdub
blather
bafflegab
crapola
ackamarackus
Skimble-skamble
bird-turd

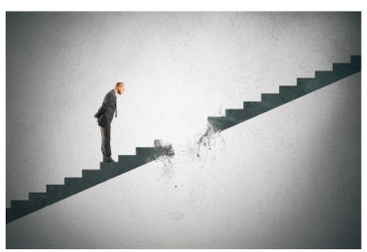


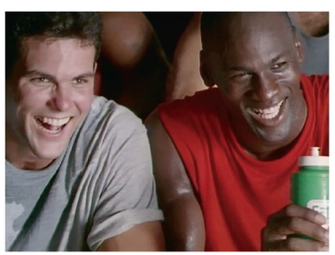


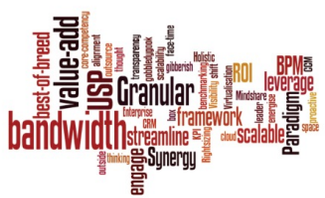

Codswallop
Baloney
Crap
Mumbo-jumbo
Hokum
Piffle
Poppycock
Tripe
Guff
Claptrap
Bunkum
Balderdash
Bushwa
Rubbish
Hooey
Hogwash
Twaddle
Jibberish
Jive
Bollocks
Cockamamie
Tommyrot
Flapdoodle










best-of-breed
value-add
USP
Granular
bandwidth
streamline
framework
Synergy
engage
scalable
Paradigm
leverage
BPM
ROI
CRM

Advocates of *Big Med*

What Big Medicine Can Learn from the Cheesecake Factory

Atul Gawande

Medicine has long resisted the productivity revolutions that transformed other industries. But the new chains aim to change this.Illustration by Harry Campbell

"The Cheesecake Factory model represents our best prospect for change."

Atul Gawande : “Big Med”

- “Want to create Cheesecake Factories for health care”
- Big chains like the Cheesecake Factory “will make us better and more efficient”
- “Size is the key”
- “Deliver **range** of services to MMs of people at reasonable **cost** with consistent **quality**”
- “Reinvent medical care” to move healthcare “from a Jeffersonian ideal of small guilds and independent craftsmen to a Hamiltonian recognition of the advantages that size and centralized control can bring”
- **Cleveland Clinic** : Cleveland ➔ NE Ohio ➔ Florida ➔ US ➔ Abu Dhabi ➔ UK
  (“Big Medicine is on the way”)

Some real downsides to Big Med

Hospital Systems with greatest operating income losses

Bottom 25	2015-2016		2016 - 2017		2015-2017	
	Name	**$ Changes**	**Name**	**$ Changes**	**Name**	**$ Changes**
1	Providence Health	$ (511,000.00)	Community Health Systems	$ (485,000.00)	Community Health Systems	$ (588,000.00)
2	Dignity Health	$ (501,729.00)	HCA	$ (393,000.00)	Dignity Health	$ (506,290.00)
3	Trinity Health	$ (330,579.00)	Tenet	$ (259,000.00)	HCA	$ (311,000.00)
4	Cleveland Clinic	$ (262,032.00)	Ascension	$ (257,889.00)	Baylor, Scott & White	$ (294,626.00)
5	Indiana University Health System	$ (233,739.00)	NorthWell Health	$ (160,314.00)	Providence Health	$ (259,000.00)
6	Partners Healthcare System	$ (214,337.00)	Memorial Hermann	$ (154,408.00)	Tenet	$ (234,000.00)
7	Baylor, Scott & White	$ (181,733.00)	Sharp HealthCare	$ (145,680.00)	Memorial Hermann	$ (231,426.00)
8	PeaceHealth	$ (175,959.00)	Baylor, Scott & White	$ (112,893.00)	Trinity Health	$ (219,251.00)
9	SSM Health	$ (167,976.00)	Novant Health	$ (108,088.00)	SSM Health	$ (204,223.00)
10	Promedica	$ (163,146.00)	Intermountain Healthcare	$ (104,700.00)	Sharp HealthCare	$ (200,576.00)
11	CHI	$ (156,578.00)	Hartford HealthCare	$ (102,721.00)	Indiana University Health System	$ (198,655.00)
12	CHRISTUS	$ (137,602.00)	Cedars Sinai	$ (102,469.00)	Cleveland Clinic	$ (194,840.00)
13	Stanford Medicine	$ (127,579.00)	Premier Health Partners	$ (90,629.00)	Houston Methodist	$ (179,150.00)
14	UPMC	$ (110,472.00)	Houston Methodist	$ (90,477.00)	UPMC	$ (160,199.00)
15	Baptist Health South Florida	$ (109,355.00)	Scripps Health	$ (75,172.00)	Aurora Healthcare	$ (123,352.00)

The Scale of the Cleveland Clinic Didn’t Help!

Other Downsides Besides Poor Financial Performance

- Reduced competition
- Higher rates extracted from insurers ➔ higher hospital prices, higher hospital costs
- Higher rates passed onto employers & employees as higher premiums/prices
- Front office vs. front-line mentality
- Lower quality or no improvement in quality
- Lack of attention to care coordination
- Resistance to risk contracting and alternative payment methods

NIHCM FOUNDATION

Hospital Consolidation:
Trends, Impacts and Outlook

What's The Big Deal?

- CONSOLIDATION IMPACTS: The vast majority of empirical evidence indicates that consolidation raises the prices hospitals receive from payers, often by very significant amounts and even when the consolidation did not increase market power in specific local markets.
- There is very little evidence that consolidation improves the quality of clinical care, and some evidence that quality is worse in less competitive markets or after a hospital acquisition.
- Some evidence points to lower post-merger production costs for some acquired hospitals, but not all consolidations lower costs and cost efficiencies may not be passed on to the consumer.

What We Know About Provider Consolidation

Karyn Schwartz (https://www.kff.org/person/karyn-schwartz/) , Eric Lopez ,

Matthew Rae (https://www.kff.org/person/matthew-rae/) (https://twitter.com/matthew_t_rae) ,

and Tricia Neuman (https://www.kff.org/person/tricia-neuman/)

(https://twitter.com/tricia_neuman)

Published: Sep 02, 2020

Provider consolidation leads to higher prices

A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance; this is true for both horizontal and vertical consolidation. In Medicare, payment policies protect Medicare from increased prices due to horizontal consolidation but have led to higher Medicare costs in the case of vertical consolidation. However, recent administrative and legislative changes are bringing Medicare reimbursement at hospital outpatient departments in line with reimbursement at independent physicians' offices.

There is no clear evidence that consolidation improves quality of care

While provider consolidation holds the promise of greater efficiencies and better care coordination, evidence of the benefits of improved quality after a merger are mixed at best, and some studies suggest that market consolidation—particularly for horizontal consolidation—can actually lead to lower quality care. It is difficult and takes time and resources to achieve true integration of care among newly merged health systems, while price increases often occur immediately after consolidation.[57]

Systems may drive health inequities

- Systems lead to higher costs borne by insurers
- Insurers pass those higher costs onto employers
- Employers pass those higher costs onto employees as higher premiums
- Some employees drop insurance coverage due to higher cost
- Loss of insurance coverage leads to poor health status

- Robert Town, Douglas Wholey, Roger Feldman, and Lawton R. Burns. "Hospital Consolidation and Racial/Income Disparities in Health Insurance Coverage." *Health Affairs* 26 (4): 1170-1180. 2007.

Do hospital systems really *serve under-served 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.

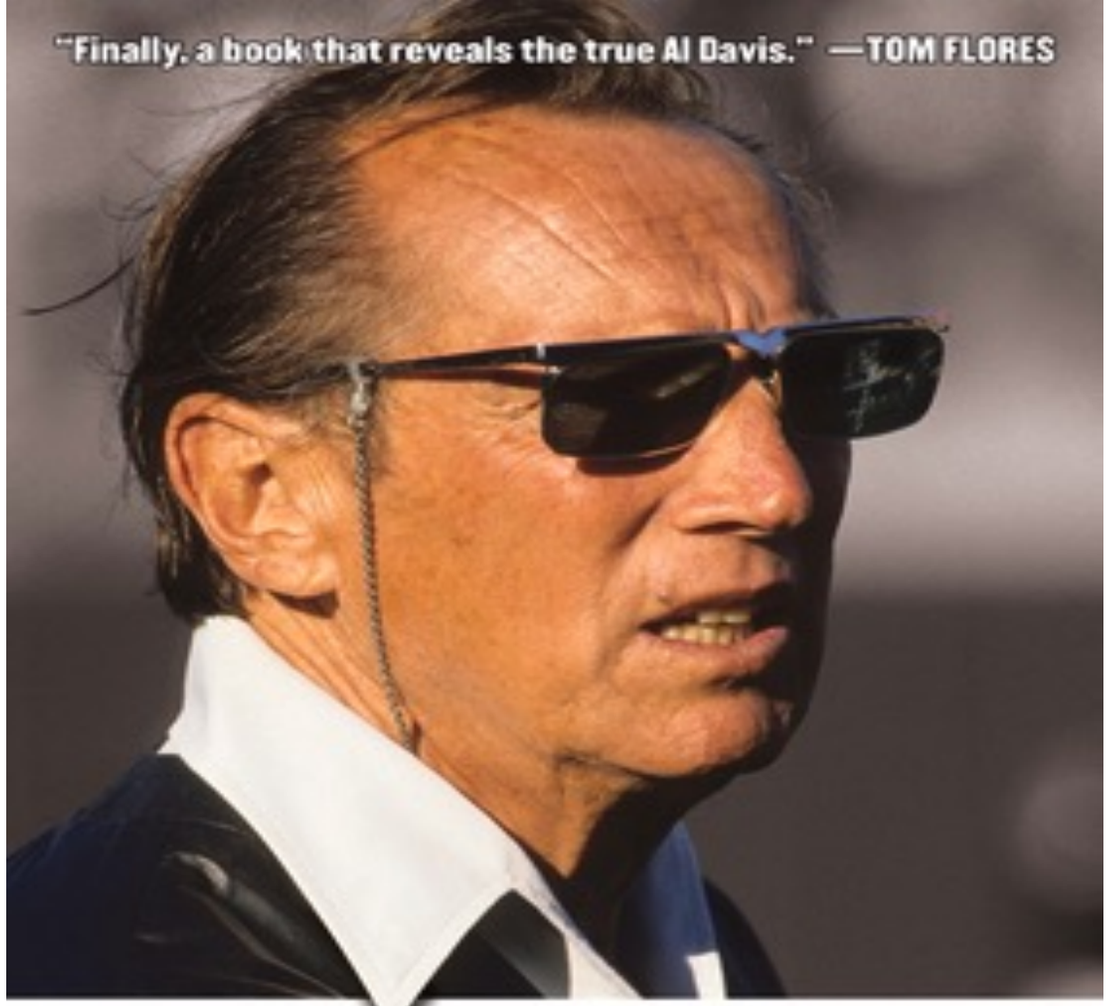
With the help of a consulting firm, the Providence hospital system trained staff to wring money out of patients, even those eligible for free care.


By Jessica Silver-Greenberg and Katie Thomas

Sept. 24, 2022

Given the preponderance of downside effects,

why does Big Med continue to spread ??



JUST WIN, BABY

THE AL DAVIS STORY

MURRAY OLDERMAN


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

How the healthcare "ecosystem" really operates

What Execs Say vs. What Execs Do

Advocate Aurora (AA) & Atrium Health (AH) = Advocate Health

Advocate Health = merger of mergers

- AA = 2018 merger of Advocate (IL) and Aurora (WI), each a multihospital system
- AH = formerly Charlotte-Mecklenburg Hospital Authority ➔ renamed Carolinas HealthCare System ➔ combine with Wake Forest Baptist Health, Floyd Health, and Navicent Health

Advocate Health's New 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
- Just grow baby ? game of leapfrog ?

Advocate / Aurora Rationale - - acc. to CEO Skogsbergh

- Greater access & efficiencies
- Scale innovation
- Transform the care delivery model
- Create a destination in the Midwest for patients and clinicians who care for them
- Coming together from *unique* & *complementary* positions of strength
- Reimagining the possibilities of health as

    (a) bigger meets better

    (b) size meets value

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.

Industry Insights | May 24, 2022

Industry Insights

For Advocate Aurora and Atrium, coming together is about leveraging their combined clinical excellence, advancing data analytics capabilities and digital consumer infrastructure, improving affordability, driving health equity, creating a next-generation workforce, research, and environmental sustainability. Together, they have pledged $2 billion to disrupt the root causes of health inequities across underserved communities and create more than 20,000 new jobs.

Both Advocate Aurora and Atrium are no strangers to mergers. Advocate and Aurora came together in 2018, and prior to that Advocate was intending to merge with NorthShore before being blocked due to anti-trust. Atrium has grown over the years, merging with systems such as Navicent Health in Georgia in 2018, Wake Forest Baptist Health in North Carolina 2020, and Floyd Health System in Georgia in 2021. In the newly proposed merger, Advocate Aurora and Atrium are coming together via a joint operating arrangement where each entity will be responsible for their own liabilities and maintain ownership of their respective assets but operate together under the new parent entity and board. This may allow the combined entity more flexibility in local decision-making. The current CEOs, Jim Skogsbergh and Eugene Woods will serve as co-CEOs for the first 18 months, at which point Skogsbergh will retire, and Woods will take over as the sole CEO.

Mergers can come in various shapes and structures, but the driving forces behind consolidation are not unique. With the need to compete in value-based care, adequately manage risk, gain scale across covered lives, physicians, and points of access, successfully deliver affordable high-quality care, and the need to deal with the vertical and horizontal consolidation of the large-scale payers, the markets that health systems operate in must be large enough to be effective and relevant. We fully expect to see more of these larger scale health system mergers in the near term.

The physical delivery of healthcare is local, but, again, the business of healthcare is not; it is regional, and the regions are only getting bigger.

Advocate Health Rationale - - acc to Cain Brothers

- Leverage their combined clinical excellence
- Advance data analytics capabilities
- Advance digital consumer infrastructure
- Improve affordability
- Drive health equity (pledged $2B) via new Institute to address inequities in both rural and urban under-served communities
- Create a next-generation workforce
- Research
- Environmental sustainability

What To Do ??

What to do : Part I

- Take antitrust seriously
  - Perform due diligence *with care*
  - Analyze before announcing

- Be as skeptical as the agencies and AG's office
  - Are scale economies real?
  - Are employed physicians more productive?
  - Countervailing power is not an antitrust defense

- Be more skeptical than the agencies and AG's office
  - Avoid Certificates of Public Advantage (COPA)
  - Used to settle Geisinger's acquisition of Bloomsburg Hospital & Evangelical Community Hosp

- Watch out for illegal conduct
  - All or nothing contracts
  - Anti-tiering restrictions
  - Gag rules

Thank you for listening