Minnesota Health Care Accountability Act

SF2939 (Mann) / HF2779 (Reyer)

Across Minnesota, rapid system **consolidation** has led to **skyrocketing health care costs** and **service reductions** that **limit people's access to care.** Increased **private equity takeovers** and **corporate interference in medicine harms patients and medical professionals.**

Why Minnesota needs the Health Care Accountability Act:

While Minnesotans spend a record $66 billion per year on health care, we need the Health Care Accountability Act to:

- **Understand how corporate ownership is impacting care costs and access.** Minnesota needs transparency requirements to understand the complex web of healthcare ownership and assets and how vertical integration and private equity takeovers impact care costs, consolidation, closures, and access to care.

- **Protect patients and medical professionals.** Outdated laws and loopholes allow private investors in health care to make profit-driven medical decisions affecting care quality, service delivery, and access.

- **Rein in out-of-control health care costs.** Rising health care costs hurt all of us. The state needs tools to address profiteering, monopoly power, and corporate interference in medicine that are driving up costs and reducing care access and quality.

How does consolidation impact health care costs and access?

- **Health care spending is rising due to higher prices**, not increased use of services and consolidation is a key driver of those rising costs. [1]
- As large hospital or health care systems merge or buy previously independent clinics like labs, primary care practices, and imaging centers, **consolidated systems increasingly have the market power to raise prices and limit services without competition.**
- Minnesota has taken important steps to strengthen oversight of health care mergers. However, the state needs **transparency around the opaque web of ownership** and financial backing and **protections against the harms of consolidation, private equity, and other investors** driving up costs and limiting access to care.

Minnesota needs the Health Care Accountability Act to address **consolidation** in health care, **private equity takeovers,** and **corporate interference** in medicine.

KEY FACTS

- Health system **consolidation** leads to increased prices for care services–**up to 65% more–and often to decreased services in rural areas**. **Private equity investments** in health care lead to up to **32% higher costs** for patients and payers. [2]

- In Greater Minnesota, **rural communities are facing a severe shortage of primary care providers**, surgery service declines, and average drive times over an hour for mental health, maternity/neonatal services, and surgery. [3]

- In Minnesota, **45% of rural hospitals no longer provide labor and delivery services**. Twelve counties lost hospital birth services between 2012 and 2022. [4]

- **Half a million Minnesotans live in a pharmacy desert.** Nearly 70% of independently owned pharmacies have been driven out of business in the last two decades. [5]

- As growing health care costs raise premiums, **18% of adults reported a claim denial** by their insurance company in the past year. [6]

- **1 in 5 medical professionals** in Minnesota reported plans to leave their field in the next five years, often citing burnout. [7]

Minnesotans spent a **record $66.8 billion on health care** in 2022, a 15% increase from the previous year due to price spikes. [8]

[1] Trends in health care spending, American Medical Association, July 2024.
[2] Hospital Mergers and Healthcare Price Increases: A Primer, Association of Health Care Journalists, September 2024; Ten Things to Know About Consolidation in Health Care Provider Markets, KFF, April 2024 and New findings show private equity investments in healthcare may not lower costs or improve quality of care, University of Chicago Medicine, July 2023.
[3] Rural Health Care in Minnesota: Data Highlights, Minnesota Dept. of Health, November 2023.
[4] Nearly half of Minnesota's rural hospitals don't offer labor and delivery, Axios Twin Cities, January 2024.
[5] More Minnesotans face 'pharmacy deserts' with chain drugstore closures, Star Tribune, November 2024.
[6] Consumer Survey Highlights Problems with Denied Health Insurance Claims, KFF, September 2023.
[7] Minnesota's Health Care Workforce, MDH, 2022.
[8] Prices for medical care surged in Minnesota. Here's what the state is trying to do about it, Star Tribune, December 2024.

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COMMITTEE TO PROTECT HEALTH CARE

SEIU Healthcare MN & IA

April 7, 2025

Co-Chair Bierman and Co-Chair Backer
Minnesota House of Representatives, Health Finance and Policy Committee
75 Rev. Dr. Martin Luther Dr. Jr. Blvd.
St. Paul, MN 55155

Professional Distinction

Personal Dignity

Patient Advocacy

Dear Co-Chairs Bierman and Backer and Members of the Committee,

On behalf of the Minnesota Nurses Association (MNA), I am writing to express our strong support for HF2779, the Health Care Accountability Act (HCAA), which would provide for more transparent reporting of who controls and benefits from our state's healthcare delivery system. By addressing existing loopholes in annual reporting of some information to MDH, more information can be provided to the Legislature and public about where money is being wasted that could instead be used to provide care for Minnesotans. In addition to closing reporting loopholes to better reflect the structure of the current healthcare landscape, this bill also safeguards our healthcare system and infrastructure by creating new statutory language prohibiting the corporate practice of medicine.

Last biennium, MNA supported a number of legislative proposals focused on financial transparency and addressing healthcare consolidation, several of which became law. This legislation builds on some of those same themes – supporting the notion that our publicly-funded healthcare system requires information to be transparent and accessible to the public, and that our entire state healthcare delivery system should be accountable to patients, communities, and taxpayers.The existing reporting structures in place have not kept pace with the changing nature of healthcare service delivery, including the fact that most Minnesota hospitals are now owned and operated by large corporations who often have various subsidiary or affiliated entities with shared financial interests. This bill would help illuminate data that is now unavailable due to the further corporatization and growth of large healthcare corporations. This is precisely the type of data that the Legislature and public needs if we are ever going to tackle the various sources of waste, fraud, abuse, and senseless profiteering that lead to access and affordability issues in our healthcare systems.

Whether it is behavioral health services in the Metro, or Labor and Delivery in Greater Minnesota, vital healthcare services are often on the chopping block in our state. Please support this legislation so we can begin to start collecting the information necessary to determine a new way forward – one that prioritizes patients before profits. This bill is a huge step forward in that direction, and we hope to see it garner bipartisan support.

Sincerely,

Shannon M. Cunningham

Shannon Cunningham
Director of Governmental and Community Relations
Minnesota Nurses Association

345 Randolph Avenue
Suite 200
St. Paul, MN 55102
Tel: 651.414.2800
800.536.4662
Fax: 651.695.7000
Email: mnnurses@mnnurses.org
Web: www.mnnurses.org

GCC/IBT

AFL-CIO

Code Blue:

How Allina Health's Financial Ties Compromised its Mission, Patient Care, and Business

Executive Summary

As Allina Health has surrendered greater control to for-profit companies like Piper Sandler, UnitedHealth Group, Huron Consulting Group, and Flare Capital Partners, they have become less accountable to their community and more beholden to the market and the financial executives who sit on the board, with impacts to their workers, patients, and the business.

Impact on Workers and Patients:

- **Short Staffing:** Assisted by Huron, Allina has recently undergone aggressive staffing "benchmarking" across its facilities, with a stated ambition of staffing their units at the 40th percentile based on national estimates. Nurses allege Allina is engaged in a race to the bottom when it comes to patient care.
- **Questionable Changes to Patient Care Model:** Inbound Health – a joint venture between Allina Health and the investment firm Flare Capital Partners – offers controversial hospital-at-home and skilled nursing-at-home programs that would move sick patients back home without around-the-clock nursing care, burdening family members, replacing skilled professionals, and potentially putting these patients at risk.
- **More Contracted Staff**: As the percentage of board members with experience in financial services, insurance, and real estate (FIRE) industries increased from under a third in 2012 to nearly sixty percent in 2022, labor costs for contracted employees hired to provide direct patient care (e.g., Registered Nurses, Licensed Professional Nurses, etc.) increased by over two thousand percent. Whereas these contract staff comprised just one percent of the total direct patient care labor cost in 2012, ten years later they represented nearly fourteen percent.
- **More Outsourcing:** On February 1, 2024, Allina Health announced their plans to outsource approximately 2,000 of their Information Systems and Revenue Cycle Management employees to Optum Health, a division of UnitedHealth Group.

More Debt, Worse Credit, More Profits for Piper Sandler:

- From 1998 to 2023, as the percentage of board members with ties to FIRE industries increased from 36% to 54.5%, Allina Health's debt ballooned to $1.7 billion, while its credit rating dropped from AAA to AA-. With Allina's board led by Debbra Schoneman, a Piper Sandler executive whose investment bank earned $5.2 million in fees along with other bond underwriters, one might ask, *"Who is profiting from the increased debt load that has sunk Allina's rating?"*

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Introduction

In the past century, Minnesota's healthcare landscape has undergone a rapid transformation. Whereas most community hospitals were historically charitable institutions dedicated to the sick and indigent, today's hospitals increasingly belong to large systems and wield their market power to extract higher prices from patients and insurers.[1] Driven less and less by social values, healthcare has become increasingly profit-driven, due in part to the growing influence of the financial sector. Hospital executives today push agendas familiar to the rest of corporate America: cutting labor costs, closing "underperforming" service lines, hospitals, and clinics, and pursuing mergers and acquisitions to enter lucrative markets. These changes continue to reshape the delivery, accessibility, and quality of healthcare throughout the nation.

Access to high-quality, affordable healthcare is under ever more threat in Minnesota despite the fact that nearly all hospitals in the state are organized as "nonprofits."[2] As individual healthcare spending has grown more than 18 percent between 2017 and 2021, so too have prices – by nearly 9 percent.[3] In 2023, the Minnesota Department of Health noted: "If health care spending grows unchecked, it will remove even more funds from the community, leaving fewer resources for other priorities."[4] With hospitals representing the greatest share of healthcare spending in the state,[5] it is essential to understand what is driving these trends. This report examines one of those factors – the increasing entanglement of the financial sector in healthcare.

As spending and prices have increased, Minnesota hospital executives at the largest health systems – Allina, Mayo Clinic, Essentia, Fairview, North Memorial, and Sanford, among others – have cut or reduced services and closed hospitals,[6] requiring patients to travel farther for necessary care. Threatened and realized mergers and acquisitions have reduced patients' options for providers; academic research consistently concludes that consolidation leads to increased prices with little to no improvement in quality.[7] Promises of cost reduction and efficiencies have provided little solace to patients, workers, and communities as concerns about the prioritization of profits over patient care, reduced accessibility for vulnerable populations, and the erosion of community control bubbled up in recent years.

The unique characteristics that made Minnesota a destination for medical care are changing, as healthcare decisions are increasingly made by those who never worked at the bedside. Today, financial institutions and healthcare are mutually reliant. Hospital systems call upon a network of lenders, underwriters, corporate trustees, and advisors to assist in strategic partnerships and transactions.

Healthcare is also big business for financial institutions. Minnesota-based investment bank Piper Sandler recently reminded investors: "Both the healthcare and financial services sectors are significant contributors to our overall results, and negative developments in either of these sectors, including negative developments that result from legislative or regulatory actions, could negatively affect our results of operations, even when general economic conditions are strong."[8] While financial institutions may bring needed capital and outside perspective to drive innovation and growth, these executives too often come with a focus on short-term profitability and cost-cutting.

While this trend is pervasive across the nation, Allina Health is the poster child in Minnesota for the growing creep of non-healthcare executives influencing decisions at the bedside. In the past decade, Allina has demonstrated a record of putting profits before patients: reducing and closing services,[9] shifting services from the hospital to more profitable outpatient sites,[10] spending millions to break a strike,[11] and up until June 2023 cutting off services to patients who had accrued at least $4,500 in outstanding bills.[12]

In Part I, we survey two interconnected players influencing patient care, Allina Health System and Piper Sandler. In Part II, we provide three case studies on the growing corporate influence in local healthcare at Allina and other major health systems. In Part III, we analyze how the profit-driven approach of executives has failed in large part. We conclude with recommendations to shift Allina's values to make it a community-centered and truly charitable institution.

Part I: The Decisionmakers Behind Minnesotans' Healthcare

Allina Health System

Headquartered in Minneapolis, MN Allina Health System ("Allina Health") is a $5.2 billion nonprofit integrated healthcare delivery network primarily serving the greater Twin Cities metro area and western Wisconsin.[13] Allina Health owns 11 hospital campuses – Abbott Northwestern Hospital (Minneapolis, MN), Buffalo Hospital (Buffalo, MN), Cambridge Medical Center (Cambridge, MN), District One Hospital (Faribault, MN), Mercy Hospital (Coon Rapids/Fridley, MN), New Ulm Medical Center (New Ulm, MN), Owatonna Hospital (Owatonna, MN), River Falls Area Hospital (River Falls, WI), United Hospital (St. Paul/Hastings, MN) – and jointly owns St. Francis Regional Medical Center with Essentia Health and Park Nicollet Health Services, a HealthPartners subsidiary.[14] Allina providers also see patients at more than 60 primary care clinics and 20 same-day and urgent care centers.[15]

Allina is one of the largest systems in the state, operating 2,451 acute care beds as of December 31, 2023,[16] and comprising 17% of patient days in 2022, second only to Fairview Health Services,[17] its primary competitor. Allina's size requires an enormous labor force - over 29,000 employees, making it one of the largest employers in the state.[18]

Though healthcare consolidation has become a recent topic of intense debate and legislation in Minnesota, it is not a new phenomenon. Allina was born out of a series of mergers beginning in the 1970s, which resulted in the formation of HealthSpan Health Systems Corporation in 1993.[19] As with recent mergers, this transaction was scrutinized by community groups as well as regulators, including Attorney General Hubert Humphrey III and the Minnesota Department of Health (MDH).[20] The deal was ultimately given conditional approval, though after 1997 HealthSpan no longer had to report on the merger's benefits to consumers.[21]

Following legislation in 1993 that encouraged the development of integrated service networks, HealthSpan affiliated with Medica, one of the largest health plans in Minnesota.

HealthSpan evolved into Allina Health System and Medica became a wholly controlled subsidiary.[22] By the end of the 20th century, Allina oversaw Medica's 550,000 enrollees and 5,000 physicians, as well as HealthSpan's 17 hospitals and long-term care facilities, and 45 medical clinics.[23]

However, this iteration of Allina would not last long. Controversy appeared to follow the new company left and right: a federal review found that Medica misspent Medicare money (Allina was required to repay $16 million);[24] an investigation by Attorney General Mike Hatch uncovered millions spent on executive perks and corporate consultants[25] (Allina reportedly spent hundreds of thousands on public relations to have positive stories written about the health system in light of the allegations).[26] Under pressure from the Attorney General alleging conflicts of interest, Allina and Medica split into two independent companies, though executives claimed the decision was their own.[27] This is the Allina we know today.

Allina's Board Composition

The composition of a company board speaks volumes about its priorities. This is even more true for nonprofit organizations, which are ostensibly organized for a purpose other than simply making a profit. While it would be easy to assume a health system tasked with delivering patient care would seek out a board comprised of healthcare experts to help set the organization's direction, hire a CEO, navigate legal complexities, and oversee quality and safety, this is largely not the case. A recent study found that less than 15 percent of board members overseeing the nation's top hospitals have a professional background in healthcare, whereas more than half have a background in finance or business services.[28] Nurses, essential to the daily operation of a hospital, comprise less than one percent of board members at these elite institutions.[29]

Allina's board reflects these trends. Of its twenty-two members, eleven have some experience working in healthcare.[30] Fewer still - four - have direct patient care experience. The financial services, insurance, and real estate sector ("FIRE") is overrepresented relative to other industries, with nearly fifty-five percent of board members working for banks, investment firms, accounting, insurance, and related companies.[31]

However, this was not always the case. Just a few years after Allina was organized, seventy-two percent of the board had healthcare experience, perhaps a reflection of bylaws allowing up to fifty percent of directors to be physicians.[32] Around a third worked in financial services and related industries. Allina's bylaws, then as now, required that a majority of voting members must be "independent civil leaders," however, the desired backgrounds of board members have changed significantly.[33] As Allina heads in a more profit-driven direction, it is doing so led by fewer with direct healthcare experience and an increasing number of MBAs.

Table 1. Composition of Allina Health System's Board

	1998	**2023**
Total Number of Board Members (inc. ex-officio)	25	22
Percentage of Board Members with Healthcare Experience	72%	50%
Percentage of Board Members with Direct Care Experience	56%	18%
Percentage of Physician Board Members	48%	5%
Percentage of Board Members with FIRE Experience	36%	55%

Source: Analysis of Allina Bond Disclosures

Piper Sandler and Minnesota Healthcare

Originally formed in 1895 to help finance the growth of the local booming milling and grain-elevator businesses,[34] the firm now known as Piper Sandler played an integral role in helping to finance major Minnesota-based companies including Honeywell, 3M, and Greyhound.[35] Piper grew for its first hundred years until it was purchased for $730 million by another Minnesota giant – U.S. Bancorp.[36] Five years later, Piper was spun off as an independent public company, Piper Jaffray.[37] Today Piper Sandler boasts 60+ offices in the United States, Europe, and Asia and promises "deep expertise" across sectors.[38]

A family business with big ambitions, Piper built a reputation as an elite institution whose influence extended beyond its clients. As one *Star Tribune* reporter wrote in 1994:

> "It is difficult, if not impossible, to separate Piper from the social and cultural fabric of the Twin Cities. The firm was one of the first to commit 5 percent of its pretax earnings to charity. The Piper family has a long history of giving, and the firm's top executives help guide some of the region's best-known charitable and nonprofit institutions ... The pedigree of Piper Jaffray's top executives rivals that of any corporation in the region. They include alumni of Dartmouth, Wharton, Yale, Stanford, Carleton and St. Olaf. Country club memberships include old-monied Woodhill in Orono, where the Pillsburys, MacMillans and Daytons record their handicaps along with [then CEO and chairman] Tad Piper..."[39]

Though longtime Piper CEO, Harry (Bobby) Piper Jr., once said, "With wealth comes responsibility ... So many people don't realize that, or they don't give a rip," Piper came under fire by investors and regulators in the mid-1990s when "controversial" Piper-managed mutual funds tanked, and 7,000 clients saw losses of 25 percent or more.[40] Major clients at the time who faced financial consequences of Piper's decisions included the Minnesota Orchestra, the University of Minnesota, and Allina Health.[41]

The Minnesota investment bank is connected to local healthcare in at least three ways. First, Piper offers financial and advisory services to healthcare clients, including services related to mergers and acquisitions.[42] Healthcare mergers and acquisitions ("M&A") are big business,[43] however, such deals are increasingly controversial and have spurred regulatory action and

legislation as elected officials and community groups have called into question whether these deals serve the public interest.[44]

Second, Piper executives have a strong presence on the boards of influential businesses, foundations, educational institutions, and industry lobbying groups. Here are just a few examples:

- **Debbra L. Schoneman**, President, serves on the board of trustees for the University of St. Thomas, whose Bachelor of Science in Nursing (BSN) program will graduate its first class in 2026.[45] As detailed below, Schoneman also serves as chair of Allina's board with Piper Sandler board member Tom Schreier.
- **Chad Abraham**, Chairman & CEO, is on the board of directors of the Minnesota Business Partnership, a powerful advocacy group representing over 100 top executives, including leaders of all of Minnesota's Fortune 500 companies. The Partnership has opposed efforts to make corporate finances and tax bills more transparent, paid family and medical leave, and campaign finance reform.[46] Abraham also serves as a trustee of the prestigious Blake School, whose alumni include politicians, business, and community leaders.[47]
- **J.P. Peltier**, Global Head of Healthcare, is an executive committee member of Medical Alley, Minnesota's medical tech trade group.[48]

The third area is Piper's role as an important intermediary in the municipal bond issuance industry where the company serves as a financial advisor to municipalities and private employers.[49] Piper has been involved in this market since the mid-1920s, a prescient strategy given that the "muni" market grew in the mid-1930s with federal investment in public works projects.[50] The company often serves as a bond underwriter, where it purchases bonds directly from a bond issuer and resells them to investors, pocketing the difference.[51] The company purports to be a "leading adviser in the healthcare industry for decades serving clients through capital advisory services, underwriting and award-winning research," with the Piper name appearing as an underwriter for tax-exempt hospital bonds in Minnesota dating back to the early 1980s.[52]

Given that Minnesota is an enormous market for healthcare, it is unsurprising Piper has done business with multiple local health systems. In early 2024, Piper and J.P. Morgan underwrote $500 million in bonds for HealthPartners, earning a collective $2.375 million in the process.[53] In 2020, the companies also underwrote $214 million in bonds for Children's Minnesota, earning $1.35 million.[54] Piper has also underwritten over a billion dollars in bonds for Allina Health, which is detailed in the following section.

Piper is no stranger to controversy. Since 2000, Piper Sandler, its subsidiaries, and predecessors racked up more than $53 million in regulatory fines, many of which were related to investor protections.[55] At times, these cases have related to the company's role in the municipal bond market, a key intersection with healthcare. In 2016, Piper agreed to pay nearly $9.8 million to settle a class action lawsuit where state, local, and municipal governments alleged they were shortchanged due to price fixing in the municipal derivatives industry.[56] In addition, Piper has been fined and censured by both the New York Stock Exchange (NYSE) and the Nasdaq Stock Market (NASDAQ).[57]

Piper Sandler and Allina Health

Piper's influence over local healthcare can be best seen at Allina Health. Piper executives had strong representation on the board of HealthSpan, Allina's predecessor in 1993.[58] HealthSpan's board was chaired by Stanley R. Cowle, a retired EVP and Director of Administration at Piper Jaffray, and included CEO Addison "Tad" Piper. A family business for its first hundred years, Addison succeeded his father and grandfather as the company's top executive.[59] Tad's mother also served on Abbott's board[60] and the Virginia Piper Cancer Center was started in her honor following her death in 1988.[61] Addison would go on to serve as an Abbott Northwestern board member and board chair between 1995 and 1997 as well as on the Allina board.[62] Today Allina's board is chaired by a different Piper Sandler executive – **Debbra L. Schoneman** – and includes Piper board member and former investment banker **Tom Schreier**.[63]

In the last two decades, Piper has served as the bond underwriter on eight bond issuances for Allina Health. Piper and other underwriters collectively earned over $5 million on bonds totaling $1.2 billion.

Table 2: Allina Health System Bonds with Piper Sandler (formerly Piper Jaffray) as Underwriter

Issuance	**Valuation**	**Piper Role**	**Underwriter Fees**
Series 2023A/B[64]	$363.0M	Underwriter	$1.5M
Series 2021[65]	$167.8M	Underwriter	$805.3K
Series 2019[66]	$68.2M	Underwriter	$276.1K
Series 2017A[67]	$78.5M	Underwriter	$362.3K
Series 2009A-1 and 2009A-2[68]	$185.2M	Underwriter	$1.6M
Series 2007B-2[69]	$43.5M	Underwriter and remarketing agent for Series 2007B-2 Bonds	$52.2K
Series 2007A[70]	$132.0M	Underwriter	$422.3K
Series 2007C-1 and 2007C-2[71]	$125.0M	Underwriter and broker-dealer	$306.3K
Total	**$1.2B**		**$5.2M**

Source: Allina Bond Disclosures

Piper executives sat on the board for the four most recent bond issuances, which paid bond underwriters $2.9 million. Earlier issuances took place under boards whose members worked for Piper-connected companies. In 2007, three investment bankers sat on Allina's board: [72]

- Edson W. Spencer, General Partner at Affinity Capital. Affinity's President, B. Kristine Johnson, sat on Piper's board at the same time Spencer served as Allina's board chair.[73]
- Mark Jordahl, Chief Investment Officer at U.S. Bancorp Asset Management.[74] Until just a few years earlier, Piper had been owned by U.S. Bancorp.[75] Following their separation, U.S. Bank and Piper continued to partner and, under a 2004 agreement, recommend each other's services to clients, including investment banking services.[76]
- John Turner, Chairman at Hillcrest Capital Partners. Turner founded Hillcrest in 2004 with his son, Jeff, an ex-Piper executive.[77]

Two years later when Allina issued 2009 bonds, the board included Mark Sheffert, Chairman and CEO of investment banking and management advisory firm, Manchester Companies.[78] As detailed in the next section, Piper is not the only influential for-profit company Allina and other health systems are entangled with.

Part II: The Growing Influence of FIRE in Minnesota Healthcare

The shifting composition of healthcare boards of directors is not merely of academic interest. As healthcare boards have been captured by FIRE executives, hospital systems have been increasingly subject to the influence of for-profit entities and venture capital firms. The dominance of boardrooms and c-suites by executives lacking bedside care backgrounds is likely related to the financialization of Minnesota healthcare. Who holds decision-making power in healthcare systems has very material effects on hospitals. Below are several case studies to demonstrate what healthcare looks like when under the direction of FIRE boards and executives.

Optum and UnitedHealth Group

Optum, Inc. is a division of UnitedHealth Group.[79] Both Optum and UnitedHealth are headquartered in Minnesota; Optum's headquarters is in Eden Prairie, and UnitedHealth's in Minnetonka, an affluent suburb of the Twin Cities.[80] UnitedHealth Group, Optum's parent company, is a multinational health insurance company.[81] Optum was formed in 2011 by UnitedHealth Group and currently operates in diverse intersections with healthcare delivery, finance, and administration.[82] It is difficult to overstate UnitedHealth's financial scale; in 2023, Forbes ranked UnitedHealth as the fourth-largest company in the United States based on revenue.[83] Apple, Amazon, and Walmart were the only companies with a higher revenue than UnitedHealth that year.[84]

On February 1, 2024, Allina Health announced their plans to outsource approximately 2,000 of their Information Systems and Revenue Cycle Management employees to Optum Health.[85] The change in employment structure came as a shock. In the press release announcing this decision, Allina claimed that outsourcing workers would allow them to "streamline" their billing processes and incorporate technologies at Optum's disposal.[86] Optum recently formed a similar partnership with St. Louis-based SSM Health where administrative functions including revenue cycle management were outsourced to Optum. [87] This partnership began in 2022, though it unraveled just two years later in early 2024.[88] After outsourcing some 2,100 employees from SSM Health to Optum, the health system reverted to in-housing those positions "after the two organizations were not able to meet 'mutually agreed-upon expectations.'"[89]

On February 27 of this year, *The Wall Street Journal* reported that the United States Justice Department (DOJ) opened an antitrust investigation into UnitedHealth Group.[90] Reports indicate that the probe is most concerned with UnitedHealth's effect on competition in markets it has a presence in, and "the relationship between UnitedHealth's insurance business, UnitedHealthcare, and Optum, its health services arm that includes doctor's offices."[91] This is not the first time UnitedHealth has been the focus of the Justice Department: UnitedHealth's planned $3.3 billion

acquisition of home-health company Amedisys is also under scrutiny from the DOJ.[92] A private antitrust suit has been issued "by a California system called Emanate Health, alleging that [UnitedHealth] tried to strong-arm the nonprofit over its affiliated physician groups and exert control over primary-care doctors in its region."[93]

The federal investigation concerns similar practices, according to *The Wall Street Journal*:

> The new Justice Department inquiry [...] is partly examining Optum's acquisitions of doctor groups and how the ownership of physician and health-plan units affects competition, according to the people with knowledge of the matter. Investigators have asked whether UnitedHealthcare favored Optum-owned groups in its contracting practices, potentially squeezing rival physicians out of certain types of attractive payment arrangements. Investigators have also explored whether Optum's ownership of healthcare providers could present challenges to health insurers that are rivals of UnitedHealthcare.[94]

These are not the first antitrust lawsuits leveled at UnitedHealth and Optum. Just two years ago, the Justice Department filed a suit to block the "$13 billion acquisition of health-technology firm Change Healthcare Inc., arguing the tie-up would unlawfully reduce competition in markets for commercial insurance and the processing of claims."[95] Part of the DOJ's argument was that "Change provided key industry technologies that are relied upon by UnitedHealth's health-insurance rivals."[96] These suits were ultimately dropped, and Change Healthcare and UnitedHealth successfully merged in 2022. Just two years after this merger, Change Healthcare has become the subject of nearly fifty lawsuits over a massive security breach that occurred earlier this year.[97] A cyberattack took Change Healthcare's services offline, resulting in significant cashflow problems for their clients.[98] According to the U.S. House Committee on Energy and Commerce, "Change Healthcare is one of the largest health payment processing companies in the world. It acts as a clearing house for 15 billion medical claims each year—accounting for nearly 40 percent of all claims."[99] In addition to this disruption in services, "millions of Americans may have had their sensitive health information leaked onto the dark web."[100]

Healthcare providers involved in lawsuits against Change Healthcare and UnitedHealth regarding the handling of the cyberattack allege that disruption to payment services threatens their financial health and that UnitedHealth did not do enough to prevent the attack from happening.[101] UnitedHealth CEO admitted that the computer server accessed by hackers in the cyberattack lacked the "basic" form of security known as multifactor authentication.[102] While the Change Healthcare outage has been felt nationally, Optum's local partner Allina Health has acknowledged the difficulties it is causing them by forcing them to use "manual workarounds to help patients with their insurance coverage and authorization" and even then "experiencing a gap in our ability to bill for most of our hospital services."[103]

Most recently, UnitedHealth's priorities became apparent when the company sued Minnesota over a law banning for-profit Medicaid managed-care providers from participating in the state's Medicaid program.[104] Even with the existing ban, Minnesota hospitals and insurers are almost singularly focused on revenue generation.

Huron Consulting Group

Huron Consulting Group, a management consulting firm based in Chicago, operates on an international scale and boasts over $1.3 billion in current assets.[105] Huron describes its business as a "global professional services firm that partners with clients to develop growth strategies, optimize operations and accelerate digital transformation, including using an enterprise portfolio of technology, data and analytics solutions."[106] Huron considers the three dominant industry segments it operates in to be healthcare, education, and commercial.[107]

Huron's education consulting arm has garnered a reputation for guiding teaching administrations through austerity-driven layoffs. In 2020, the administration at The New School in New York City spent hundreds of thousands of dollars to contract with Huron for consulting services.[108] Five months after school administration hired Huron, 122 school employees were laid off.[109] In response, members of The New School staff highlighted Huron's suspect origins: "[Huron] was established in 2002 by 25 former executives of Arthur Andersen, an accounting agency that went under in 2001—02. The agency had been cooking the books for the energy giant Enron."[110] Enron's profound and spectacular misdeeds are beyond the scope of the present analysis. The New School faculty highlighted perhaps the most germane similarities between Andersen/Enron and Huron; "[u]sing 'mark-to-market' (MTM) accounting, Enron was able to claim *prospective* future profits and list them on its *current* balance sheet, wildly and fraudulently inflating the company's value [...] It didn't take long for Huron to follow in the footsteps of its corrupt creators. In 2009, Huron became embroiled in its own scandal, accused of overstating pretax income from 2005 to early 2009. The consulting firm ended up having to pay out millions of dollars, between a civil fine and reparations of shareholders."[111]

Allina Health has contracted with Huron Consulting at least as far back as April 2023, when they were engaged to achieve key performance initiatives.[112] While aspects of this work such as "optimizing patient flow" and reviewing "corporate overhead" are inarguably noble, this initiative is anything but patient-focused. Partnering with Huron, Allina has recently undergone aggressive staffing "benchmarking" across its facilities, with a stated ambition of staffing their units at the 40th percentile based on national comparisons. Nurses and other healthcare workers at Allina facilities held informational pickets last October to draw attention to Allina's aggressive benchmarking plans, citing concerns over a race to the bottom in quality patient care.[113]

Flare Capital Partners

Compared to the rest of the United States, Minnesota's healthcare ecosystem is arguably unique in its limited entanglement with private equity and venture capital. Even still, many Minnesotans struggle to access or afford healthcare, and frontline workers caring for patients cite chronic short-staffing, and profit-over-patients approaches in facilities. Minnesota's healthcare has significant room for improvement, especially as for-profit and venture capital interests are increasing their foothold in the state.

One example is Inbound Health, a joint venture between Allina Health and the investment firm Flare Capital Partners, which offers controversial hospital-at-home and skilled nursing-at-home programs.[114] Advocates allege that under these programs, patients who would otherwise be admitted to an acute-care, inpatient setting with continuous proximity to healthcare professionals

and emergency response capabilities, become reliant upon family members and community emergency response, therefore placing them at greater risk.[115] The appeal of hospital-at-home to healthcare executives is straightforward: it reduces their overhead expenditure on the brick-and-mortar infrastructure of hospitals as the caregiving environment shifts to patients' homes, and arguably reduces staffing costs as some elements of care are performed remotely while others that would normally fall under the responsibilities of nurse aides are now performed gratis by family members.[116]

For the Boston-based Flare Capital Management Co LLC, their Inbound Health venture with Allina is just one of fifty-two enterprises they advertise in their portfolio.[117] As such, their commitment to the project and patients' lives could come into question should Flare change course.

Part III: Corporate Healthcare Does Not Work

As Allina Health has surrendered greater control to for-profit companies like Piper Sandler, UnitedHealth Group, Huron, and Flare Capital Partners, they have become less accountable to their community and more beholden to the market and the financial executives who sit on the board. Though funded in large part by Minnesotan taxpayers, health systems are now burdened by the voices and interests of attorneys, bankers, investors, real estate owners, and self-proclaimed 'disruptors.' Despite their stated intent to improve health care and less explicit goal of increasing profitability, these efforts have only made Allina more vulnerable and a more desirable target for private equity firms, large, for-profit firms, and so-called "vulture capitalists."

As described in the first section above, Allina has undergone several large-scale changes since its origins in the late 1990s. Part of this transformation is the composition of Allina's governing board. One measurable and arguably positive change is the increased gender diversity of Allina's board over the past 25 years. However, a less apparent shift is from a board primarily composed of individuals with direct patient care experience to a board where four out of every five board members have never cared for a patient. In contrast, the percentage of board members with ties to finance, insurance, real estate, and related industries ("FIRE") jumped during this period, from just over a third to over fifty percent.

This meaningful shift in board composition has been accompanied by massive inflation in Allina's long-term debt, currently $1.7 billion as of March 31, 2024.[118] While an increase in long-term debt is to be expected when a system grows (i.e., acquiring existing hospitals and assuming their debt promises), this is not obvious in the case of Allina, which has not seen an expansion in terms of the number of hospital beds.[119] In fact, in recent years, Allina consolidated multiple hospitals under a single license and reduced services.[120] Allina is now obliged to spend more to pay down its debt while it engages in benchmarking to reduce the number of nurses and healthcare workers at the bedside. As described above, Piper Sandler executives sat on Allina's board as Allina engaged Piper and others to raise capital via the municipal bond market, which in turn increased the company's debt load.

Table 3: Allina Health System Composition, Financial Metrics, and Board Composition, 1998 – 2023

Year	Fitch Bond Rating	Proportion of Board Seats Held by Women	Percentage of Board Members with Direct Patient Care Experience	Percentage of Board Members with Experience in FIRE Industries	Number of Wholly-Owned Hospitals[121]	Long-Term Debt
2023	AA-	59.1%	18.2%	54.5%	9	$1.7B
2018	AA-	28.6%	14.3%	57.1%	11	$920.9M
2013	AA-	27.8%	11.1%	33.3%	11	$614.8M
2008	A	44.4%	16.7%	27.8%	10	$645.6M
2003	A-	28.0%	40.0%	36.0%	10	N/A
1998	AAA	28.0%	56.0%	36.0%	11	$369.4M

Source: Analysis of Allina Bond Disclosures, Company Website, and IRS Form 990s

Bond ratings agencies have not viewed Allina's transformation in an overwhelmingly positive manner. Since 1998, Fitch's rating dropped from AAA,[122] the agency's strongest rating, down to AA- as of 2023.[123] The most recent downgrade noted Allina's anticipated two-billion-dollar capital spending plans,[124] potentially a priority of the Piper-led board whose members may care more about flashy buildings and less about further burdens to the system.

A closer look at a similar period demonstrates changing priorities at Allina, including a growing appetite for spending hospital dollars on expensive contract labor and management. As the percentage of board members with experience in FIRE industries increased from under a third in 2012 to nearly sixty percent in 2022, labor costs for contracted employees hired to provide direct patient care (e.g., Registered Nurses, Licensed Professional Nurses, etc.) rose by over two thousand percent.[125] Whereas these contract staff comprised just one percent of the total direct patient care labor cost in 2012, ten years later they represented nearly fourteen percent.[126] In 2022, Allina spent nearly $27 million to combat a nursing strike,[127] and that year, the company's highest-paid independent contractor, Aya Healthcare, received $176,749,782.[128] In this process, Allina has not forgotten management. Labor costs for the management and administrative employees who do not provide patient care increased by twelve percent.[129]

Table 4: Allina Health System Financial Metrics and Board Composition, 2012 vs. 2022

Year	Proportion of Board Seats Held by Women	Percentage of Board Members with Direct Patient Care Experience	Percentage of Board Members with Experience in FIRE Industries	Direct Patient Care Contracted Labor Cost	Management and Administrative Labor Cost	Direct Patient Care Contracted Labor as a % of Direct Patient Care Labor Cost
2022	50.0%	13.6%	59.1%	$156,204,965	$110,857,942	13.9%
2012	33.3%	11.1%	27.8%	$7,390,555	$99,257,924	1.0%

Source: Analysis of Allina Bond Disclosures, IRS Form 990s, and Medicare Cost Reports

Ultimately those with decision-making power seem out of touch with Allina's frontline workers and the organization's own messaging to the community. While Allina publicly represents that its mission is to "put the patient first,"[130] the company has consistently shown otherwise, by cutting off services to patients who had at least $4,500 in outstanding bills as late as June 2023,[131] reducing access to services,[132] and reducing staffing of frontline workers.[133] Even by many key business metrics, Allina has failed – the organization's bond rating, long-term debt, and spending on expensive contract labor have consistently trended in the wrong direction. It is unclear who benefits from Allina's continued path, however, it is certainly not patients.

Conclusion

Minnesota is nationally recognized as an oasis of healthcare. As the largest employing industry, healthcare is a significant contributor to the state's economy.[134] In many circumstances, accessing care is a matter of life and death. For those called to work in healthcare, the industry has historically offered stable and meaningful careers, however, in recent years, this has come under attack.

As one of the largest systems in Minnesota, the decisions Allina Health makes are consequential to millions throughout the state. Allina does not seem eager to publicize their deep ties with partners in the financial sector, such as hometown investment bank Piper Sandler. Today, Allina's board is led by Piper executive Debbra Schoneman. Piper's fingerprints can be found throughout Minnesota's most influential businesses and educational and charitable institutions.

Minnesota healthcare has become increasingly financialized, as profit-driven boards and executives have welcomed "technological disruptors" such as venture capital firms to use our hospitals as their playgrounds and piggybanks. While patients and bedside workers deserve the largest say in what Minnesota healthcare looks like, their voices compete in the boardrooms with the interests of multinational Fortune 500 company UnitedHealth, Boston-based venture capital firm Flare, and Chicago-based consulting firm Huron, among others.

MNA's investigation of Allina's board composition and performance over the past two decades reveals that as experience at the bedside became a less crucial qualification to run a healthcare organization, key business metrics have trended in the wrong direction and Allina has become more vulnerable to profiteers.

Patients and healthcare workers are not ready to surrender their healthcare, workplaces, and mission to profit-driven decision-makers. To realize Allina's self-identified goals of putting patients first, Minnesotans must wrestle control away from executives and board members playing games with our healthcare. In the current landscape, according to one study, hospital CEOs are rewarded more for initiatives that suggest innovation and improved patient satisfaction, more so than the actual quality of care.[135] When executives are focused more on improving their reputation in the short term to catapult them to their next position, patients and healthcare workers are left with the consequences of their decisions. Restoring Allina's board to be comprised of largely bedside workers may provide a more long-term orientation and a realignment of priorities, away from short-sighted initiatives or vanity projects and towards actual improvement of patient care and access to services.

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April 5, 2025

Chair Bierman, Chair Backer and committee members,

I am a family physician who trained in Minnesota and practiced here for 30 years. I worked in a variety of medical settings, including non-profit sliding scale community clinics, a physician-owned private practice, a trade union clinic, and an investor-owned practice.

I write in **support** of the **Minnesota Health Care Accountability Act, HF 2779**. This is about my experience in an investor-owned clinic.

It was a new practice, a start-up, providing outpatient primary care for seniors. When I was recruited, I was assured that we would have ongoing training, as none of us hired there were specialized geriatricians. (There is a dire shortage of geriatricians.) We would have continuing medical education, expert chart reviews and routine case consults. We would have the option of longer visits for more complex patients.

However, as the months went on, the focus shifted. The number of patients we were scheduled to see each day increased. The time to spend with each one got shorter. And time in the schedule for education and learning and collaboration was eliminated. Leadership became less interested in supporting our clinical care and more interested in improving our coding of the important diagnoses that would increase billing revenue.

Most of our training from leadership was about entering diagnostic codes for high-priority (highly-reimbursed) diagnoses. Here are examples, taken from my notes from a staff training:
- a cognitive assessment can be its own visit. Can code a non-face-to-face encounter as part of a diagnostic assessment (3d prior or 7d after). If total interaction is >99 minutes, code 6212 (extra time).
- 3 kinds of Medicare preventive visits. Initial Preventive Physical exam, IPPE G0402, once in first 12 months. Annual Wellness Visit, Initial 12 mo *after* they get part B or 12 mo after IPPE, code G0438. AWV subsequent, 12 months later, G0439.
- You can bill for a cognitive assessment every 180 days (2x/yr).
- You can bill for smoking cessation counseling – different code for 3-10 minutes, or >10 minutes.

Is this what you want your doctor studying??

The organization hired more and more employees to deal with billing, technology, and administration, but not for patient care. Support staff would review outside charts before the patient's first visit to draw out important diagnostic codes, highlighting those most important for billing purposes. These staff increase healthcare costs, but do not improve patient outcomes, or actual care.

Clinicians became demoralized. In order to see more patients per day, lunch time was changed to unpaid, the work day was lengthened, and visit time with each patient was shortened. Some days I worked 14 hours. The start-up business had to satisfy investors by reaching various targets. To that end, growth was more of a priority than solid clinical practice - by which I mean quality patient care.

This is the reason I retired a year sooner than I intended to.

MN has a significant and growing shortage of primary care physicians. This kind of experience, where the business and profit concerns run the practice more than the medical care of the patient, is a major reason that physicians are retiring early and leaving practice.

Please pass the Health Care Accountability Act so that Minnesota can monitor and mitigate the effects of private equity and other investors in health care. Doctors want to focus not on finances but on taking care of patients.

Sincerely,

Amy Gilbert, MD, MPH
St. Paul, MN