American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

June 4, 2024

Docket No. ATR 102

Lina M. Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, DC 20201

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

RE: Request for Information on Consolidation in Health Care Markets

Dear Chair Khan, Assistant Attorney General Kanter, and Secretary Becerra:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide comments on the "Request for Information on Consolidation in Health Care Markets" issued by the Federal Trade Commission (FTC), the Antitrust Division of the Department of Justice (DOJ), and the Department of Health and Human Services (HHS) (collectively, the "agencies"). ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its members and the more than 150 million patients they treat on an annual basis.

The agencies are issuing this request for information (RFI) in response to concerns that recent trends in the health care market may generate profits for larger firms at the expense of patients' health, workers' safety, quality of care, and affordable health care for patients and taxpayers. They seek public comment regarding the effects of transactions involving health care providers, facilities, or ancillary products or services conducted by private equity funds or other alternative asset managers, health systems,

or private payers. They are also interested in public input regarding the goals or objectives of these transactions, particularly those conducted by private equity funds, as well as their effects on participants in the health care market including patients, communities, payers, employers, providers, and other health care workers and businesses, which will inform the agencies' identification of enforcement priorities and future action, including new regulations, aimed at promoting and protecting competition in health care markets and ensuring appropriate access to quality, affordable health care items and services.

We commend the Administration's ongoing efforts to address consolidation and mitigate its negative impacts on consumers and workers, and we are particularly appreciative of the agencies' specific request for information on consolidation in the health care market.

ACEP has been carefully monitoring how the rapidly growing acquisition of emergency medicine practices has affected emergency physicians and the patients they serve. In less than ten years, the number of emergency physicians working in large, national groups increased from one in seven in 2012 to one in four in 2020.[1] Particularly, ACEP has been hearing about labor-related impacts of the acquisitions and mergers and the effect they have had on physician wages, non-wage benefits and other aspects of emergency physicians' contracts with their employers, and physician autonomy in their medical decision-making. Our overall goal is to support emergency physicians and ensure that they are treated fairly by their employer and practice in an environment where they can serve their patients to the best of their abilities. To that end, we are pleased to respond to the RFI from the specific perspective of our emergency physician members.

Background

While mergers and acquisitions are occurring across the health care sector, it is important for the agencies to understand the unique qualities of the emergency medicine market. Emergency physicians serve the essential role of strengthening the health care safety net for our communities. They treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency health care safety net, including the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to provide a medical screening examination to every individual who "comes to the emergency department" seeking examination or treatment. The "prudent layperson" (PLP) standard, first established under the Balanced Budget Act of 1997, is another such law which allows people who reasonably think they are having an emergency to come to the emergency department (ED) without worrying about whether the services they receive will be covered by their insurance. Given this vital responsibility that emergency medicine plays in our health care system, ensuring that EDs across the country are appropriately staffed so they can provide care 24 hours a day, 7 days a week, 365 days a year is essential. Hospitals and emergency medicine groups have tried to achieve this goal in different ways, and as described below, mergers and acquisitions have at times come into play.

Emergency physicians work in a variety of employment models. While some are employed directly by hospitals, many are employed by independent entities that contract with the hospital to provide 24/7 ED coverage. These independent entities range in size, from small, independent democratic (i.e., owned by the physicians) groups that serve only one or two local hospitals to larger groups that staff EDs (and sometimes service lines of other specialties) nationwide. In recent years, physician practices, including independent emergency medicine practices, have been acquired by hospitals, health systems, and corporate entities (such as private equity and health insurance companies) at a relatively high rate. A recent study in Health Affairs found that between 2014 and 2018, there was an 89 percent increase in

[1] Pollock JR, Hogan JS, Venkatesh AK, et al. Group Practice Size Consolidation in Emergency Medicine. Annals of Emergency Medicine. 2022;79(1):2-6. doi:10.1016/j.annemergmed.2021.07.122

hospital and health system ownership of physician practices.[2] The pressures of staying financially viable during the COVID-19 pandemic seems to have accelerated this trend even further. According to a report from the Physicians Advocacy Institute (PAI), there was a sharp rise in the number of physician practices being acquired by hospitals and corporate entities throughout 2019 and 2020—especially in the first half of 2020 as the pandemic began. Now, PAI reports that 70 percent of physicians are employed by hospital systems or other private entities—meaning that only 30 percent of physicians practice independently.[3]

Effects of Consolidation

The agencies invite responses regarding how a transaction involving health care providers (including providers of home- and community-based services), facilities, or ancillary products or services conducted by private equity funds or other alternative asset managers, health systems, or private payers (e.g., a health system, a private payer, or a private equity fund buying independent ambulatory surgery centers, dialysis clinics, PBMs, GPOs, or nursing homes) has affected patients, public and private payers, health care workers, and employers who provide health insurance to their employees.

In response to the FTC and DOJ's joint RFI on Merger Enforcement in 2022, ACEP asked our members a series of both structured and open-ended questions to gain specific and up-to-date information on how mergers and acquisitions are impacting their lives, their jobs and the care they provide. We received over 110 responses to this questionnaire. The questionnaire results, including both quantitative analyses and actual anecdotal quotes directly from emergency physician responders (all italicized), revealed numerous examples of where mergers within hospital systems, insurers, and physician practices have had effects on their day-to-day practice and experiences in the workplace, most notably infringing on their clinical decision-making autonomy, patient-physician relationships, and their ability to place the needs of patients over profits as compared to prior to the mergers they experienced. We believe that these responses still reflect the overall sentiment of our emergency physician members.

Impact on Patients

There have been numerous assessments conducted to determine the effect of this consolidation on both health care costs and quality of patient care. For example, a couple of years ago, Congress commissioned the Medicare Payment Advisory Commission (MedPAC) to assess whether provider consolidation has led to higher health care costs and impacted quality of care. In 2020, MedPAC issued a report which looked at all of the available research at the time and concluded that consolidation leads to higher prices for commercially insured patients. While provider consolidation leads to higher prices, MedPAC found that in areas where insurers have more market power, prices decrease—but those savings are not necessarily passed on to consumers in the form of lower premiums.

MedPAC also looked at whether provider consolidation affects the quality of care that hospitals and clinicians provide but could not draw any definitive conclusions. However, as identified by the aforementioned questionnaire ACEP sent to members, anecdotal evidence suggests that patient safety and care quality can suffer under corporate ownership:

> *"Huge pushes regarding patient disposition and turnaround times. I'm forced to see patients in the waiting room, violating HIPAA, due to these pushes, given that the hospital will not provide sufficient staff/space to bed them within the emergency department in order to maximize profits."*

---

[2] Whaley CM, Arnold DR, Gross N, and Jena AB. Physician Compensation In Physician-Owned And Hospital-Owned Practices. Health Affairs. 2021;40(12). doi:10.1377/hlthaff.2021.01007

[3] Physician Employment and Acquisitions of Physician Practices 2019-2021. Physician Advocacy Institute. 2021: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/Physician%20Practice%20Trends%20Specialty%20Report%202019-2022.pdf?ver=MWjYUAcARbuGP9uxcgQkPw%3D%3D

> *"There are endless cuts to staffing and hours that cause significant patient safety concerns and poor patient experiences and outcomes. I feel like my medical license is being exploited by private equity to maximize profits to shareholders at the expense of my patients and coworkers."*

Further, consolidation and private equity ownership of emergency medicine groups has anecdotally decreased patient safety due to the transition to a less-skilled workforce. In our survey, many emergency physicians noted that larger national groups tended to hire advanced practice providers (APPs) over emergency physicians. This may be due in part to an attempt to cut labor costs: for example, physician assistants (PAs) have a median annual pay of $115,390,[4] whereas emergency physicians have a median annual pay of around $350,000.[5] However, there is a vast difference in the education and training of physicians versus other health care professionals, including PAs. The well-proven pathways of education and training for physicians include medical school and residency, and years of caring for patients under the expert guidance of medical faculty. Physicians complete 10,000-16,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training. PA programs are two years in length and require only 2,000 hours of clinical care–and these PA programs do not include a residency requirement. Anecdotally, emergency physicians found that when APPs were hired over physicians after mergers, patient safety decreased, and although labor cost to the hospital decreased, cost to the patient often increased due to over-testing and over-consultation. Some examples of respondents' concerns include the following:

> *"[…] staffing policies that were extremely dangerous to the patients with over staffing of APPs and understaffing of physicians. Patients were hurt and likely killed because of these staffing policies by these contract management groups."*

> *"Shortly after taking over, the corporation moved to cut physician hours and instead increase the use of non-physician providers in the emergency department such as PAs and NPs. By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services."*

> *"They are intentionally understaffing emergency departments as a driver of profit. Patient care is being dangerously impacted, as the physicians are being asked to see an unsafe number of patients because they do not want to staff the emergency departments appropriately."*

Extensive medical training should qualify emergency physicians to be trusted to have the utmost expertise in medical decision-making, especially in the most urgent situations. However, 53 percent of survey respondents indicated that their medical decision-making autonomy was curtailed following the merger or acquisition of their practice. They noted that there was now "pressure to take short cuts [and] give inappropriate and potentially harmful care" to meet profit-driven metrics, that patients "are treated as numbers rather than individuals," and care is no longer patient-centered but "metric-centered." Some further examples from questionnaire responses include:

> *"Worsened in that heavy handed pressure placed on meeting nonclinical metrics and removal of RVU payment for non-billable patients seen in the ER. Pressure on hospitalist to discharge all patients in 4 days which has led to significant increase in return visits and readmissions. Not to mention poor care and sicker patients in the community."*

> *"Directly, no change. Indirectly by increasing the required patients per hour, Press Gainey results, etc it resulted in a pressure to take short cuts, give inappropriate and potentially harmful care in the name of 'customer satisfaction'."*

---

[4] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physician Assistants, at https://www.bls.gov/ooh/healthcare/physician-assistants.htm

[5] Emergency Medicine Physician Compensation Report 2023. Medscape.

"Worsen. We have already had several emails from our more recent director re: test utilization. Instead of getting to the root cause of why these tests were ordered, such as looking at the patients that the physicians felt required them and why, these remains essentially targeted the physicians who ordered the most of whatever test they would like us to perform less."

"Worsened my ability to do medical decision-making. The rate at which we see patients, now in the 5-7 patients per hour sustained for up to 8 hours at a time is too much. We do not have the mental bandwidth to make so many decisions on so many patients in that short of a period of time. In addition, we are unable to spend any time at bedside with patients to elucidate histories or physicians that would help our MDM."

Impact on Public and Private Payors

The agencies seek comment on the effects of consolidation on changes in reimbursement rates for in-network providers, out-of-network rates and costs to patients, quality of care including the patient's experience, access to and denials of care, utilization of services, medical loss ratio, coding practices, rates of fraudulent billings or claims, coverage and formulary design, referral practices, claims processing, network adequacy, ability to implement innovative payment models, ability to implement value-based care plans, and ability to negotiate with the facility and with competing facilities.

The need to stay profitable and have leverage in negotiations with insurance companies make the emergency medicine labor market, and the market for health care providers (including both clinicians and facilities) in general, prime candidates for mergers and acquisitions and the potentially anti-competitive behavior that follows these transactions. As described above, the current emergency medicine practice environment impedes smaller practices' ability to stay profitable. In our survey, ten percent of respondents employed by a large national physician group said that the main rationale for their smaller group moving forward with its acquisition was the inability to negotiate with insurers. Some independent practices struggle to even have insurance companies respond to exploratory inquiries, much less agree to work with them. Respondents noted that:

"Our independent EM group (120 providers) had our contract with the hospital system for 50 years. We managed 12 EDs in [state]. The hospital no longer wanted (could afford) to subsidize our services with a stipend at their hospitals. As part of this contract many of the EDs were small volume and included several critical access hospitals and most were not profitable. Because we were a smaller to medium size independent group, the insurance companies would not negotiate or give us better rates/payments. As such, we were forced out of our 50-year contract and the majority of our providers were forced to join the EM Mega group that won the contract and has the ability to negotiate better payment rates from insurers and is able to take bigger risks."

"We were a democratic group of only boarded EM physicians. We were finding it increasingly difficult to acquire cost effective benefits, malpractice insurance and dealing with insurance companies."

"Because we were a small group, insurers gave us very poor contract rates which led to low reimbursement and difficulty recruiting. Now our pay rates and benefits are better and we are competitive in our market."

Consolidation can impact reimbursement rates in a variety of ways, depending on which party (health plans or physician groups) are the dominant force in a particular market. If physician groups or hospital systems consolidate, they may be able to negotiate better rates with health plans. As illustrated in one of the narratives above, sometimes that scenario could be beneficial for small groups who were previously receiving low reimbursement rates. Conversely, if insurers consolidate and have more market power than physician groups in an area, they could either negotiate lower rates or decide to remove a physician group from its network entirely. Unfortunately, we have heard antidotally that this practice of significantly cutting rates (by 30 percent or more) or deciding to unilaterally cancel

long-standing in-network contracts has been happening more since the *No Surprises Act* has been implemented. Lastly, it is important to note that even in situations where physician groups are able to consolidate and negotiate better contracts with health plans, that does not necessary always translate to higher reimbursement rates and payments for physicians. The leadership of the physician group ultimately decides what the reimbursement rates are for their physicians versus what is used to cover overhead and expenses and kept as profit.

Impact on Emergency Physicians

The agencies seek comment on the effects of consolidation and private equity on health care workers and staff through changes in their take-home pay, workplace safety, compensation model (e.g., from fixed salary to volume based), policies regarding patient referrals, mix of patients, the volume of patients, the way providers practice medicine, administrative or managerial organization (e.g., transition to a management services organization), patient billing, collections, financial assistance practices, data reporting requirements, claims processing, employment benefits, staffing levels, scope and/or duration of non-compete agreements or other restrictions on worker mobility and working conditions such as training repayment agreements, and differences between rural and urban settings as to these issues.

The results of our questionnaire revealed numerous examples of where mergers have had a significant effect on competitiveness in the emergency medicine labor market and harmed the emergency physician, notably in terms of their wages, workload and hours, and their ability (or lack thereof) to find or keep employment.

Wages

As alluded to above, the impact on wages from these acquisitions seemed varies. In our questionnaire, sixty percent of respondents reported that their wages had been reduced, with around forty percent of them indicating a pay cut of more than 20 percent. Forty percent of respondents indicated that they experienced no change in pay or a pay raise after the merger. However, although these respondents' pay itself stayed the same or increased, in many instances their overall hours were cut, ultimately resulting in an overall wage decrease. Examples of responses included:

> *"Roughly 25-30% reduction due to lowered hourly rate and fewer hours."*
>
> *"Compensation has remained flat or down. Under the democratic group, there were yearly cost of living and performance-based increases. Those disappeared. Benefits like CME were cut. Performance demands increased, with productivity going from 1.9 patients per hour to 2.0 to 2.2 in the course of two years."*
>
> *"Actually a slight improvement with improved collections from insurance companies, they were screwing us before."*
>
> *"Increased current, decreased later earning potential"*
>
> *"Hourly rate increased but overall much worse when factoring in benefits, insurance, retirement."*

Workload and Staffing

In addition to more direct wage impacts, physicians reported they were being pressured to see more patients per hour without a commercial pay increase or without consideration for the best clinical practice for the individual patient. Further, some practices post-consolidation transitioned physician payment to a metric-based payment model, resulting in physicians' reimbursement rates reflecting the new firm's business practices, rather than the performance of the physician. For example:

> *"Huge pushes regarding patient disposition and turnaround times. I'm forced to see patients in the waiting room, violating HIPAA, due to these pushes, given that the hospital will not provide sufficient staff/space to bed them within the emergency department in order to maximize profits."*

"There are endless cuts to staffing and hours that cause significant patient safety concerns and poor patient experiences and outcomes. I feel like my medical license is being exploited by private equity to maximize profits to shareholders at the expense of my patients and coworkers."

"[…] the schedule changed for the worse as there was significantly less physician coverage. It became very dangerous for the patients."

"They incorporated metric based pay on items we do not control, such as length of stay in the ED. We do not control many things that affect length of stay, such as nursing, radiology, labs, etc. This has led to a metric that is impossible to meet, and in effect, a pay cut."

Ability to Find or Keep a Job

When asked how mergers and acquisitions affect competition in the local job market for emergency physicians, 63 percent of respondents to our questionnaire indicated that the presence of larger national groups (often called contract management groups, or CMGs) made it more difficult to find and/or keep a job.

"Merger made it harder to find jobs since the new group monopolized the market in my area. The monopoly essentially lowered over market value and drove down the pay significantly."

Many respondents remarked that they in fact had no job options other than the large national group that had acquired their practice due to regional consolidation and horizontal integration. Respondents felt pressured to conform to patient care practices that they believed were substandard and feared for their job security if they spoke out against the directives of the group:

"[Large national group] own[s] nearly all of the contracts in emergency departments within driving distance to my home. I essentially have no choice but to work for them as I have a family and cannot travel. I do not agree with their practices, but have to comply due to this CMG having a regional monopoly of ED contracts."

"Shortly after taking over, the corporation moved to cut physician hours […] By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services."

Non-Compete Clauses

In 2023, the FTC issued a proposed rule to categorically ban non-compete clauses in employee contracts. To inform our comments on the proposed rule, ACEP asked our members a series of structured and open-ended questions about their experiences with non-compete clauses. We asked members about how non-compete clauses impact their job search process, the limitations of their clause, and the effects of non-compete clauses on local job market competition, including the relationship between health care consolidation and the usage of non-compete clauses. We received over 75 responses to this questionnaire. The questionnaire results, including both quantitative analyses and actual anecdotal quotes directly from emergency physician respondents (all italicized), are embedded below.

As consolidation throughout health care continues to grow, some employers of small, independent practices who are not mandated to use non-compete clauses said they choose to use them because they offer a sense of stability and workforce security, especially in rural and underserved areas. They noted that a non-compete can offer a means of protection against hostile takeover of an independent ED practice wherein a contracting hospital terminates the contract but retains some members of the group:

"The non-compete is an attempt to protect our group from being terminated by the hospital or to at least force an acquiring competitor to negotiate with us if it desires to employ some or all of our physicians and APPs."

"Unfortunately, there are many variations of non-competes, many of which are more restrictive than ours. I do understand the negatives of non-competes but believe that having a limited non-compete that helps protect the owners of a group from being summarily shoved out the door without any recourse is proper. The FTC needs to understand that the hospital that contracts with the ED group has significantly more power regarding the future for those physicians than does the group itself."

Conversely, a larger number of respondents to ACEP's questionnaire felt that health care consolidation increased the negative impact of non-compete clauses:

"One of the major problems with non-compete clauses is that they increase the cost of leaving your job. Employers are then able to change contracts, schedules, and working conditions knowing that it's more difficult to leave the current one. A group took over my local ER. They hired all the physicians and had non-compete clauses. Within 6 months the physician coverage was halved, and we were each covering up to 4 PAs at a time. Leaving the group meant leaving the area and most of us were unwilling to do that. The few who left were impossible to replace because of the working conditions. Administration took this as a "growing pain" with the new group. The group considered this a process working as intended. And the patient's suffered with physicians unable to protect them."

"Currently, my employment contract has a non-compete clause. It states that I cannot work for other hospitals within 5 miles of the many hospitals that my employer has contracts with. In addition, I also cannot be employed by the very same hospitals that my employer has contracts with so that I cannot switch employer and work at the same hospitals. That practically eliminates many local jobs if I stop working for the current contracting group."

"Job I was considering included geographic noncompete that prohibited any ED that "shares more than 20% patient population." Group staffs multiple EDs in this corner of the state, so non-compete effectively excludes ANY work in northwest Ohio or southeast Michigan if leave the group."

We applaud the FTC's decision to issue the final rule banning non-compete clauses and making current non-competes unenforceable.

Consolidation & Growing Threats and Dangers of Cyberattacks

In a consolidated health care environment, the danger of cyberattacks also increases significantly, as demonstrated by the recent attack on Change Healthcare, part of Optum and a subsidiary of UnitedHealth Group (UHG). This incident halted payments to thousands of health care providers and prevented patients from accessing essential medications, such as lifesaving cancer treatments and insulin. According to UHG Chief Executive Officer Andrew Witty during his recent testimony before Congress, it is estimated that one-third of all Americans may have had their personal health data compromised as a result of this single breach. Additionally, the financial strain on practices and groups forced many to take out loans and exhaust lines of credit, or even consider closing or selling their practice to other entities, threatening livelihoods and further limiting patient access to care.

Consolidation ultimately leads to fewer but significantly larger entities handling vast amounts of sensitive data, making them prime targets for cybercriminals. Future cyberattacks on these heavily consolidated entities could destabilize health care delivery, complicate reimbursement processes, and bring the health care system to a halt for millions of Americans. And now, even as our health care system is still recovering from the Change Healthcare breach, one of the largest hospital systems in the country, Ascension, has been incapacitated by a ransomware attack for more than two weeks with no clear indication on when its systems will be restored. We encourage legislators and regulators alike to ensure that entities in the health care space take more significant measures to

prevent and respond to cyberattacks or other major disruptions, and especially to ensure there are robust mechanisms in place to protect patients and physicians from the impacts of these events.

Need for Government Action

The agencies request suggestions for actions to consider taking to identify and address transactions that have major adverse impacts on patients, payors, and health care workers.

ACEP supports actions that the FTC and the DOJ have taken or plan to take to help address the anticompetitive and potentially harmful effects of consolidation. First, ACEP appreciates the Agencies' proposals to update guidelines that explain to the public, business community, practitioners, and courts the factors and frameworks the Agencies consider when investigating potentially illegal mergers. The emergency medicine market is rampant with anticompetitive practices, and the influx of consolidation impedes smaller, independent emergency physician groups from establishing themselves and entering what in many areas is an already-concentrated market.

Further, this consolidation is often difficult to detect by regulatory agencies. To our knowledge, no existing data sources fully capture the ownership structure of physician groups. Many larger physician groups bill to Medicare under multiple names and taxpayer identification numbers (TINs), often derived from the smaller groups they had previously acquired. Therefore, at first glance, a large physician group may not appear to have a large concentration in a particular market – but these smaller groups no longer exist, only the large entity does. We urge the Agencies to consider how they can ensure they become aware of such acquisitions to be able to assess them adequately.

We appreciate the opportunity to provide comments. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President