American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 23, 2024

The Honorable Jodey Arrington
Chair
House Budget Committee
204 Cannon House Office Building
Washington, D.C. 20515

The Honorable Brendan Boyle
Ranking Member
House Budget Committee
507 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Arrington and Ranking Member Boyle,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's hearing entitled, "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation." We deeply appreciate the opportunity to provide our comments and insights on how growing consolidation within the health care sector continues to affect the practice of emergency medicine (EM) and the patients we serve, and we are grateful for the Committee's bipartisan attention to this critical issue.

Emergency physicians serve the essential role of strengthening the health care safety net for our communities. They treat all patients who come through the emergency department (ED) 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 ED without worrying about whether the services they receive will be covered by their insurance. Given this vital responsibility that EM 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 EM groups have tried to achieve this goal in different ways, and as described further below, mergers and acquisitions have at times come into play.

The consolidation of health care practices has profoundly reshaped the landscape for emergency physicians and the patients they serve, with nearly 6 out of 10 physician practices now owned by hospitals, health systems or other corporate entities.[1] This shift, accelerated by financial pressures during the COVID-19 pandemic, has led to significant labor-related impacts. Such vertical consolidation especially can result in reduced physician autonomy, altered wage structures, and diminished non-wage benefits, and may be a contributing factor to the high rate of burnout in emergency medicine.

ACEP has carefully monitored how the rapidly growing acquisition of EM practices has affected emergency physicians and the patients they serve. Specific to EM, 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.[2] ACEP continues to hear about labor-related impacts of the acquisitions and mergers and the effect they have on physician wages, non-wage benefits and other aspects of emergency physicians' contracts with their employers, and physician autonomy

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[1] https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

[2] 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

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.

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 may 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 EM 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 hospital and health system ownership of physician practices.[3] 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 acquired by hospitals and corporate entities throughout 2019 and 2020 – especially in the first half of 2020 as the pandemic began.[4] More recently, PAI reports that nearly 78 percent of physicians are employed by hospital systems or other corporate entities, meaning that only 22 percent of physicians practice independently.[5]

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, several years ago, Congress commissioned the Medicare Payment Advisory Commission (MedPAC) to assess whether provider consolidation has led to higher health care costs and affected 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.[6] 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. A recent study by the AAMC Research and Action Institute highlights the significant market power disparity between health systems and insurers, revealing that the top three large-group insurers control an average of 82.2% of the market share in each state, compared to 43.1% held by the largest health systems.[7] This imbalance allows insurers to negotiate lower reimbursement rates for physicians and providers without passing savings to consumers, leading to higher premiums and reduced benefits for patients. The study underscores the need for stronger oversight to mitigate the adverse effects of this consolidation on health care affordability and quality.

To gain specific and up-to-date information on how consolidation is affecting emergency physicians in particular, ACEP used the opportunity of the call for comment by the 2023 Federal Trade Commission (FTC) and Antitrust Division of the Department of Justice (DOJ) to ask our members a series of structured and open-ended questions about their experiences with mergers and acquisitions. Specifically, for those members whose practice had undergone a merger recently, we asked questions about the merger, such as how they were notified about it, along with how that merger impacted their wages, non-cash benefits, right to due process, and autonomy for medical decision-making. We also asked for their general views about the labor-related impacts of mergers or acquisitions in emergency medicine. We received more than 110 responses to this questionnaire.

The results revealed numerous examples of where mergers had a significant effect on competitiveness in the EM 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. Anecdotal quotes directly from emergency physician respondents are italicized below.

Wages

Overall, the impact on wages from these acquisitions seemed to vary. 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. Additional considerations within Medicare reimbursement like MACRA, budget neutrality and the lack of inflationary updates to the conversion factor have further reduced emergency physician wages. Examples of responses included:

[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01007
[4] https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21
[5] https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023
[6] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf
[7] https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-market-power-matters

"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 seeing more patients per hour without a commercial pay increase.

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."

This further amplifies physician burnout, as described in a section of this letter below.

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."

Labor Market Characteristics Associated with Lessening Competition

The need to stay profitable and have leverage in negotiations with insurance companies make the EM 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.

Hospital Consolidation

Responses to our questionnaire suggested a pattern of acquisition of many emergency physician groups being triggered by the *hospital* first being acquired by another entity. This pattern points towards a growing trend of vertical integration in addition to the ongoing horizontal integration. Some respondents noted the following:

> *"Very successful single contract of truly democratic EM physician group at the same hospital for 21 years. Hospital was acquired by a larger hospital system, and soon after, they replaced our group with a national corporate entity backed by private equity because this entity offered to provide hospitalist services at a substantially lower stipend than the existing hospitalist group as long as the hospital gave the entity the ED physician contract as well."*

> *"My nonprofit hospital was taken over by [large for-profit hospital chain…] We were subsequently forced to sell our group to a contract medical group, which is backed by private equity."*

> *"Big private equity group bought the hospital, contracted a private equity CMG for ED physicians."*

> *"New hospital administration essentially forced the acquisition of our single democratic group that had provided services to the same hospital for over 20 years. CMG that provided services at the hospital system's other facilities was brought in."*

> *"Our hospital wanted a bigger EM group with more resources. They allowed us to research and choose which group with which to merge."*

It is a struggle for hospitals, especially those in rural areas, to remain solvent, much less profitable. More than 130 hospitals in rural areas have closed since 2010, and this number is growing as COVID-19 pandemic aid ended. Nearly 900 rural hospitals – over forty percent of all rural hospitals in the country – have been identified as at risk of closing in the near future.[8]

Negotiation with Insurers

There are several major factors in the current EM practice environment that make it extremely difficult for smaller, independent EM practices to stay in business. With respect to our questionnaire, nearly 27 percent of respondents cited profit as the primary reason for acquisition – and these same individuals were often concerned that this came at the expense of quality of patient care.

The inability to negotiate fair contracts with insurance companies that have a large market share is at the top of the list of reasons that smaller EM practices struggle to stay in business. 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."*

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[8] Center for Healthcare Quality and Payment Reform. The Crisis Facing Rural Healthcare. https://ruralhospitals.chqpr.org. Accessed Apr 2022.

"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."

The significant consolidation of health insurance companies has made contract negotiations even more difficult. The American Medical Association (AMA) published a comprehensive study in 2023 of health insurance concentration for 381 metropolitan statistical areas (MSAs), the 50 states, and the District of Columbia. The report detailed some stark, but not shocking, results about the level of concentration of many health care markets across the country. The AMA found that:

- 73 percent of the MSA-level markets were considered highly concentrated according to federal guidelines set by the DOJ and FTC.
- 46 percent of MSA-level markets and fourteen states had one insurer with a share of 50 percent or more of the commercial health insurance market.
- In 2022, 53% of markets that were already highly concentrated in 2014 saw further increases in concentration.
- By 2022, 29% of markets that were not highly concentrated in 2014 experienced enough growth in the Herfindahl-Hirschman Index (HHI) to become highly concentrated.

According to the AMA's report, health insurer consolidation can lead to monopsony power.

Transition to a Less Skilled Workforce

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, whereas emergency physicians have a median annual pay of around $350,000. 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. Physician assistant 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."

These concerns are also reaffirmed by data from Stanford University showing that hiring nurse practitioners (NPs) instead of physicians costs more money overall and results in poorer outcomes, especially for complex patients. Researchers evaluated three years of data on ED visits at the Veterans Health Administration, where NPs were practicing without physician supervision. Unlike previous studies on the topic, this data was based on real world experience and the analysis is causal, not just correlative. The study found that relying on unsupervised NPs led to unnecessary tests and procedures, and hospital admissions. Overall, the study shows that NPs increase the cost of care in the emergency department by 7%, about $66 per patient. The study notes that "differences in training may play some role in productivity differences between NPs and physicians," and lower productivity was the primary contributor to these increased costs – nurse practitioners were more likely than physicians to order x-rays, CT scans, and seek formal consults. These choices also affect patient outcomes. NPs practicing without physician supervision increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%, according to the study.

Medical Decision-Making

As noted above, emergency 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. Therefore, they should be trusted to have the utmost expertise in medical decision-making, especially in the most urgent situations. However, 53 percent of 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:

"There are pressures from administration to avoid admitting certain patients that appear to relate to reimbursement reasons."

"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'."

"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."

Due Process Rights

Due process rights are essential for creating a fair and supportive environment where emergency physicians can advocate for their patients without fear of retribution or termination. Emergency physicians, who often work under various contractual arrangements, can be especially vulnerable to unfair practices. Contracts for emergency physicians often lack due process protections, leaving them susceptible to disciplinary actions without a fair hearing. In fact, over fifty percent of respondents indicated that their due process rights worsened or were eliminated after a merger, which can result in physicians being left unable to advocate for their patients or for their own mental well-being in fear of employer retaliation. To this end, ACEP supports the bipartisan "Physician and Patient Safety Act" (H.R. 8325) led by Representatives Raul Ruiz, MD (D-CA), John Joyce, MD (R-PA), Greg Murphy, MD (R-NC), and Katie Porter (D-CA), to protect emergency physician due process rights by ensuring that any physician with medical staff privileges at a hospital has a fair hearing and appellate review before any termination, restriction, or reduction of professional activity, regardless of their particular employment arrangement.

Due process plays a foundational role in ensuring a physician can carry out their promise to patients without fear of retribution or termination by their employer, so further erosion in contracts following acquisition is a significant concern. One respondent noted that their contract was terminated after attempting to address their practice's lack of personal protective equipment (PPE) in the midst of the COVID-19 pandemic. Among other questionnaire responses:

"[The acquisition] worsened our right to due process because the corporate entity's contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff's executive committee as our democratic group previously had."

"The contracts with the new group have a clause that I will not resolve any "disagreements" in court, but through a mediator."

"We used to have due process but the acquisition forced us to give up those rights through a 3rd party agreement between the hospital and [large national group]."

"[The acquisition] worsened our right to due process because the corporate entity's contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff's executive committee as our democratic group previously had."

Physician Burnout

Even before the COVID-19 crisis, emergency physicians have historically had higher rates of career burnout and post-traumatic stress disorder (PTSD) than other medical specialties. According to a 2024 study published in Medscape, upwards of 63 percent of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers. Further, approximately 15 to 17 percent of emergency physicians and upwards of 20 percent of EM residents met the diagnostic criteria for PTSD in 2019. Throughout the pandemic, these unsettling trends in emergency medicine only worsened.

Consolidation in the EM market may also contribute to this high rate of burnout. Overall, respondents associated consolidation with decreased morale and burnout among physicians. Many emergency physicians cite the current working conditions at large national groups as reasons for quitting medicine altogether, for they feel that they are trapped in a system that does not respect their autonomy or mental well-being and that there are no other options for their employment in the EM sector. The potential of a significant exodus of emergency physicians from the workforce threatens the maintenance of the health care safety net that emergency medicine provides. The following responses exemplify the frustration that many emergency physicians are experiencing now:

"I no longer feel that the medicine I practice is safe or good, and that I am pushed to see more patients in less time to turn a profit. I feel this is at odds with the oaths I took as a physician, and sadly, am actively searching for ways out of medicine."

"These corporations taking over medicine need to be stopped. They are taking away basic rights employees should have and they are mandating profit related changes that are bad for patients and physicians making the burn out worse than it already is."

"Medicine has changed for the worse with the rise of these stockholder driven corporate groups. I don't recommend being a doctor to young people."

"We are continually asked to do more with less resources, for less income, and work in unsafe environments, yet with the same liability. I am actively pursuing career opportunities outside of clinical medicine."

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.

Conclusions and Recommendations

The personal anecdotes shared above truly reflect the non-financial-related effects of mergers and acquisitions on the practice of emergency medicine, and especially individual emergency physicians themselves. All in all, with some notable exceptions, it appears that the current practice of consolidation in EM detrimentally affects physicians' interests and well-being, which in turn may affect their ability to serve their patients.

ACEP hopes that our members' experiences with mergers and acquisitions provide legislators and regulators with a comprehensive view of the labor-related impacts of mergers in emergency medicine and perhaps in health care more broadly. While there are some benefits to acquisitions and mergers, including the ability for EM practices to stay profitable and negotiate fairly with insurance companies, the potential anti-competitive labor-related effects must not be ignored since they may affect wages, non-cash benefits, rights to due process, autonomy for medical decision-making, and the ability to serve patients.

ACEP is proud to have its own antitrust policy in place to ensure that as a medical society it does not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather, it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice. Additionally, ACEP also has a policy on private equity and corporate investment in emergency medicine.

Once again, we appreciate the Committee's attention to this critical issue and the opportunity to share these comments with you. We would also welcome the opportunity to meet with you and committee staff to discuss our findings and questionnaire results in further detail. Should you have any questions, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

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