Surprise Billing: Avoiding the Wrong Solution

How a Federal Benchmark Would Negatively Impact Access to Care

Physicians for Fair Coverage
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I. Executive Summary

Sustained attention by voters and patients on medical balance billing—sometimes referred to as “surprise medical billing”—continues to spur action and debate among policymakers looking to mitigate the financial impact to patients. There are a variety of proposals, some of which have been enacted at the state level, that are being discussed by policymakers. These proposals would have varying effects on healthcare providers, though all appropriately seek to take the patient out of the middle of reimbursement disputes between the insurer and the physician.

Any policy proposal to address balance billing for unanticipated out-of-network care should allow fair compensation for providers to ensure access to care. Proposals seeking to protect patients that would harm physicians and hospitals ultimately will result in reduced access and compromised care, which would have the unintended consequence of harming patients as well. Specifically, proposals to set a payment benchmark or create a bundled reimbursement for unanticipated out-of-network acute and emergency services to address balance billing would negatively affect reimbursement to physicians and jeopardize hospital operations, thereby threatening patient access to care.

This white paper provides a brief overview on the problem of balance billing, summarizes some of the proposed policy models to address it for unanticipated out-of-network services, and discusses the associated challenges various rate setting proposals would have on providers, particularly emergency medicine physicians, anesthesiologists, and radiologists.

In particular, four main points demonstrate why a standard payment rate is not the solution to surprise medical bills or balance billing, particularly for emergency medicine, anesthesiology, and radiology services. The four points are summarized as follows:

1. The proposal to address balance billing by tying out-of-network services for commercially insured patients to median in-network or public payer rates would significantly cut reimbursement to physicians.
2. Hospital-based physicians treat significantly more uninsured, Medicaid, and Medicare patients than typical office-based practices. Medicare and Medicaid provider reimbursement rates are substantially below the cost of providing care.¹

3. Emergency medicine physicians, anesthesiologists, and radiologists are not driving increases in healthcare spending. Targeting them will not solve the issues around healthcare costs or surprise or balance billing.

4. Patient access to care is at risk under these proposals and is further impacted by the potential effects on the physician workforce, as summarized below:

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II. Overview of Balance Billing and Surprise Medical Bills

Balance billing, defined as patients being billed for the balance of what their health insurance will not cover for a specific service, has been a growing issue of concern for the public over the last several years. The practice is also commonly referred to as “surprise medical bills” because insured patients are often surprised when, after obtaining medical treatment at a hospital they know is in their health plan network, they receive a large additional bill for services performed by a provider outside of their insurance network. There is variance among plan designs in coverage of out-of-network care, as some do not cover any care from out-of-network providers, while others apply some standard reimbursement for out-of-network providers, such as a usual, customary, and reasonable (UCR) charge, or the median in-network negotiated rate.

When a patient is treated by an out-of-network provider, the patient’s health plan generally does not pay the amount charged by the provider and there are no negotiated reimbursement rates in place. Instead, the health plan will make its own determination about what payment will be made for the provider’s service. The difference between the charged amount and the health plan’s payment—if they pay anything—leads to a “balance due” that providers may charge to the patient. These “balance due” bills can be substantial, representing a financial hurdle for both the patient and the provider. These bills may come as a surprise to patients who believe they had already paid applicable cost sharing for the service.

Compounding the sticker shock for patients is the proliferation of high-deductible health plans (HDHPs), which have grown to include nearly 30 percent of all employer-sponsored insurance, that require patients pay a large deductible prior to a standard cost-sharing amount that would apply following the deductible. Patients who have not met their deductible or have a separate out-of-network deductible may receive a “surprise medical bill” that is a result of their plan design and is misinterpreted as a balance billing case. The issues outlined above have contributed to calls for solutions that protect patients. While reducing financial strain and frustration of patients are priorities, solutions that simply cut reimbursement to providers are misguided and may negatively impact patient access.

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Balance Billing and Surprise Medical Bills a Top Voter Concern

“Surprise” medical bills were the top financial concern of voters in the 2018 midterm election, with 67 percent of voters reporting they were somewhat worried or very worried about unexpected medical bills.9 In response to public concern, state and federal policymakers have introduced proposals to mitigate the impact of balance billing and surprise medical bills. Over the last several years, 13 states (CA, CO, CT, FL, IL, MD, NV, NH, NJ, NY, OR, WA, TX) have enacted comprehensive balance billing laws, while 16 states have implemented limited protections for patients subjected to surprise medical bills. An overall sense of financial fragility in the U.S. continues to drive attention to balance billing and the financial risk of patients. Over the last several years, the Federal Reserve Board’s annual, “Report on the Economic Well-Being of U.S. Households” has found that in 2018, more than a third of Americans would have to borrow or sell something to pay for an unexpected expense of $400.10

Reasons for Patients Facing Surprise Medical Bills

Patients generally expect all services at an in-network facility to be covered by their health insurance. However, not all physicians who provide services at an in-network hospital may be in the patient’s plan network. Rather, it is common for certain hospital-based specialties—namely emergency medicine, anesthesiology, and radiology physicians—to not be employed by a hospital and therefore not automatically considered part of the network in which the hospital participates. Instead these specialists are usually employed by an independent physician specialty group that contracts with hospitals to supply specialists as needed.

These Professional Services Arrangements (PSAs) between hospitals and specialty group practices have been the standard way of operating for several decades for the emergency medicine, radiology, and anesthesiology physician specialties. The PSA model offers a hospital a more predictable annual total labor cost for these specialties, and, particularly for hospitals with fewer resources, allows them to outsource more costly billing, collection, and coding functions to one group that can leverage economies of scale for such niche administrative functions. As one former hospital system executive from North Carolina, interviewed for this paper, put it, “it’s less expensive to contract [physicians] to oversee the Intensive Care Units than to give them salaries. At no point did we [as a hospital] give considerations to employ any of those [emergency medicine, radiology, or anesthesiology] specialists.”

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The savings achieved by harnessing economies of scale underly why specialty physician groups operate separately from hospitals. This efficiency is extended to the contract negotiations that happen between specialty practices and health plans. While many specialty practices are, by choice, in the same network as the hospitals for which they supply physicians, it is not always the case, leading to disputes over payment that cause patients to receive bills for out-of-network services.

III. Overview of Current Payment Proposals and Challenges

Using a Payment Rate Standard to Resolve Out-of-Network Billing Disputes

In light of voter concerns, states have taken several approaches to protect consumers from balance billing, and likewise several different approaches are being debated at the federal level. One approach that policymakers have implemented in six states (CA, CT, FL, MD, ME, OR), and that is currently being debated on the federal level, would settle out-of-network billing disputes between facilities and physicians using a set reimbursement or payment standard—effectively price-setting for out-of-network care. This approach would—in the event of the physician and health plan not being able to agree on reimbursement—set a standard payment rate for out-of-network care on behalf of the health plan. The reimbursement may be tied to Medicare rates or some percentage of Medicare rates, which limits the amount billed to the health plan. Tying provider payment to a set benchmark rate limits the amount of potential liability for the patient but is a blunt approach that significantly cuts the reimbursement physicians receive for services in the commercial market. Out-of-network price setting could also unintentionally undermine in-network negotiations between plans and providers, destabilizing the benefits of networks for patients, plans, and providers.

Using Median In-Network Rates to Resolve Out-of-Network Billing Disputes

One proposed payment standard to address balance billing concerns would utilize median in-network rates as the payment for out-of-network disputes between providers and plans. This is


12 Source: Interviews with partners of regional or national physician practice groups conducted by Physicians for Fair Coverage throughout June 2019.


an approach that has been featured in recent bipartisan House and Senate legislation and would apply to both patient cost sharing as well as provider reimbursement for services provided. The use of median in-network rates raises several concerns for emergency physicians, anesthesiologists, and radiologists. These include how median in-network rates would be calculated, whether claims data from an independent data source that is free from manipulation would be utilized to calculate rates, and whether those rates are representative of the geographic market. Additionally, this payment standard would further entrench the power of increasingly consolidated insurers, who would be empowered further to dictate payments to physicians and would likely negotiate rates toward the median rate or below. This solution lacks transparency and would cause significant harm to the negotiating power of physicians, increasing their financial risk and creating access concerns for patients.

Tying Payment to Medicare Reimbursement Rates to Resolve Out-of-Network Billing Disputes

The USC-Brookings Schaeffer Initiative for Health Policy recently proposed two potential solutions to out-of-network medical bills, both of which rely on creating a standard payment rate tied to Medicare. The first option would limit out-of-network charges to standard commercial market rates, with a floor on out-of-network charges set at 125 percent of the Medicare rate. The standard rate would be set as a percentage of Medicare rates and could be adjusted upward by states as needed to be closer to the average commercial rate or to reflect local market conditions. The patient and the health plan would split the cost of paying the standard out-of-network rate. However, patient liability would be capped at whatever the patient’s health plan charged for in-network cost sharing.

The second USC-Brookings proposal would be consistent with the first proposal, but introduces contractual regulations that would require the health plan to make payments solely to the in-network facility—rather than directly to physicians—which would then be responsible for compensating out-of-network emergency and other hospital-based physicians.

Under the second proposal, providers would effectively be paid via a prospective “bundled payment” model. Because providers must contain spending within the predetermined bundled payment rate, they assume financial risk as they must care for a patient without spending above the predetermined bundled payment amount. Providers can make a profit if they keep costs below the bundled payment amount. However, having multiple parties (i.e., different physician staffing groups) split one bundled payment could be problematic. As one Texas anesthesiologist pointed out in an interview for this paper, “bundled payments set up an adversarial relationship between the hospital and its providers.”

Logistically, this proposal would reimburse an in-network facility with one “bundle” equal to some percentage (e.g., 125 percent) of Medicare and capped at the average commercial rate, for all services performed by out-of-network physicians during a patient’s acute episode of care at the facility. The facility would then compensate the physicians involved in the patient’s care by distributing the one bundled payment. Because emergency medicine, anesthesiology, and radiology physicians are commonly employed by specialty-specific staffing groups, the hospital would be passing through the bundled payment from the insurance company to the physician groups with which they contract. This gives the hospital—that is not experienced with billing or coding for these specialties—power to divide among specialties the appropriate amount of reimbursement.

While the goal of a bundled payment is to create more efficient high-quality care, studies show bundled payments do little to reduce overall healthcare costs. Research has also shown that bundled payments do not produce significant improvement in quality of care for acute care services. Despite these results, bundled payment proposals tied to Medicare rates continue to be presented as the solution for many of the healthcare system’s challenges.

IV. Payments Based on a Low Benchmark or Medicare Will Dramatically Reduce Reimbursement for Providers

Knowing the payer mix (i.e., the proportion of a hospital’s patients covered by public versus private coverage) is critical to understanding how rate-setting policies for out-of-network services would affect physicians, hospitals, and patients.

Relying on a benchmark rate for out-of-network cost disputes would substantially lower physician reimbursement for some private-paying patients.

As providers are already experiencing a long-term trend of reductions to aggregate Medicare reimbursement, and at the same time are seeing a greater proportion of Medicare patients due to demographic shifts, further reducing provider reimbursement will add to financial pressure.

that results in more rapid physician burnout, fewer providers, and threatened patient access to care.

**Emergency Medicine:** Emergency medicine (EM) physicians care for a high proportion of patients who are uninsured or covered by public payers such as Medicare or Medicaid, more than nearly every other physician practice.\(^\text{22}\) Patients with private health insurance on average use the emergency department (ED) at a lower rate than other patients. Only 29 percent of patients that visit EDs have commercial insurance coverage, making it harder for EDs to be independently financially solvent.\(^\text{23}\) This pattern is in stark contrast to other high-acuity specialties, such as orthopedic surgery, where 62 percent of patients have commercial coverage.\(^\text{24}\) Further compromising the ED’s ability to rely on commercially insured patients to stay financially solvent is a decline in the value of commercial reimbursement. Commercial payer compensation for ED services has not kept pace with inflation, increasing only 1-2 percent from 2015 to 2017 while medical inflation increased 3.4 percent.\(^\text{25,26}\)

Thus, due to patient mix and the mandate and mission of the Emergency Medical Treatment and Active Labor Act (EMTALA), the ED is reimbursed below cost for a majority of its patients and requires subsidization from other areas of the hospital. This subsidization compensates for negative margins and bad debt, or unpaid claims. A 2003 American Medical Association (AMA) study reported that emergency medicine physicians incur an average of $138,000 of bad debt annually due to EMTALA-related care.\(^\text{27}\) One-third of these physicians also dedicated more than 30 hours a week to treating patients under EMTALA, which shows the substantial demand for care and associated time for which providers are not directly reimbursed. Increasing the potential debt burden on these providers by forcing them to accept public payer rates or benchmark rates that do not fully address costs would represent an undue financial burden on both physicians and the hospital.

**Radiology and Anesthesiology:** As radiologists and anesthesiologists perform services across the vast majority of hospital departments, they see a more diverse patient payer mix than other hospital-based physicians who on average are more likely to have a higher proportion of commercial patients.\(^\text{28}\)
Patients covered by commercial insurance are only 35 percent and 40 percent of patient mix for anesthesiologists and radiologists on average, respectively.29 Thus radiologists’ and anesthesiologists’ overall reimbursement can be lower than other hospital-based physician specialties, such as cardiologists, who tend to treat more private-paying patients. Differences in payer mix can have a significant impact on overall reimbursement, as commercial providers pay on average higher rates for physician services than Medicare.30

Importantly, anesthesiologists face the greatest discrepancy between Medicare and commercial rates because anesthesiology is the only specialty that factors time into reimbursement rate calculation.31 Anesthesiologists are also more likely to see a higher number of Medicaid or uninsured patients because their caseload follows the payer mix of the hospital more closely than many other specialists given their presence across units of care.

Providers Are Increasingly Under Financial Pressure Due to Medicare Payment Cuts

Since the Affordable Care Act of 2010 (ACA) was passed into law nearly a decade ago, providers increasingly have felt financial pressures as a result of numerous cuts to Medicare physician and hospital reimbursement.32, 33, 34 These cuts increased the insufficiency of Medicare payments to providers. Hospitals’ aggregate Medicare margin has significantly declined from 5.5 percent in 2001, to -4.9 percent in 2010, to -9.6 percent in 2016.35, 36 Further compounding the effect of lower Medicare reimbursement rates, is the growing share of Medicare and Medicaid in a hospital’s payer mix.37 In 2016, Medicare and Medicaid contributed to 59 percent of costs compared to 51 percent in 2000, while commercial payments shrank from approximately 39 percent to 33 percent over the same period.38 Medicare and Medicaid reimbursement rates as well as uninsured patients all contribute to aggregate negative profitability for hospitals while commercial payment profitability remains positive.39

35 Ibid.
36 Some of this decline was $1.1 billion reduction in Disproportionate Share (DSH) and uncompensated care payments according to the March 2019 MedPAC Report to Congress. Other significant cuts include the mandated reduction in inpatient base payments and in reductions to the hospital market basket update.
37 According to the MACPAC March 2018 Report to Congress, in 2016, hospitals reported $20 billion in Medicaid shortfall, and further planned cuts to the Disproportionate Share Hospital (DSH) program that mandates supplemental payments to hospitals that provide care for Medicaid and uninsured patients would expand this deficit.
Additionally, lower Medicare reimbursement and shifts in payer mix have contributed to hospitals increasingly relying on mergers and acquisitions to show growth or sustainability. The number of hospital mergers increased 70 percent from 2010 to 2015. In 2016 and 2017, hospital mergers and acquisitions continued at a rate of over 100 a year. The largest hospital systems now account for half of all hospitals. Acquisitions have resulted in greater market power for hospitals in negotiating contracts with physicians. Increased hospital consolidation year over year has in turn contributed to physician wages plateauing for the first time in 2019. These statistics all indicate that applying Medicare, in-network, or other benchmark rates to out-of-network commercial services would further weaken hospital financial position and negatively impact access to critical physician services.

V. Reimbursement Cuts Will Lead to Negative Consequences for Patient Access to Care

Hospital Closures Threaten Patient Access

A symptom of the mounting hospital financial pressure due to lower public payer reimbursement, likely to be exacerbated by a benchmark or bundled payment, is the trend of hospital closures. Between 2013 and 2017, 113 hospitals—including 64 rural hospitals—closed due to financial pressure that was exacerbated by public program payment cuts. Even following the most vulnerable hospitals closing, an estimated 20 percent of hospitals operating today do so with a negative margin. Not surprisingly, hospital EDs which serve a higher proportion of public payer and uninsured patients are affected by overall hospital financial

40 Ellison, A. “Hospital M&A activity jumps 70% in 5 years”. Becker’s Hospital Review, January 21, 2016.
pressure as well, declining in number by 4 percent between 2005 and 2014.\textsuperscript{49,50} Closures in EDs can disparately affect access to care for low-income and elderly populations who often have higher emergency service utilization and difficulties with transportation.\textsuperscript{51} In rural communities in particular, the ED often acts as a gateway to primary care.\textsuperscript{52} Additionally, lack of inpatient care facilities in areas that have an absence of specialty treatments may leave those with acute mental health and addiction needs without a safety net.\textsuperscript{53}

Further, hospitals with a relatively higher need for emergency services (i.e., hospitals with a higher proportion of uninsured and Medicaid patients), also tend to be those most vulnerable to closure due to patient mix. Many of these hospitals are located in rural areas, and their size and more limited service mix cannot provide for the cross-subsidization that emergency or anesthesiology services necessitates.

Notably, safety net hospitals, which treat a disproportionate number of indigent and public payer patients, are also the hospitals that tend to have the greatest need for robust services like emergency departments.\textsuperscript{54} These hospitals have experienced the greatest increase in utilization following passage of the ACA in 2010\textsuperscript{55} and are hospitals that already have the lowest profit margins.\textsuperscript{56} The Congressional Budget Office has noted that hospitals not able to reduce costs, such as those already operating on thin margins, would likely experience further decline in their margin under bundled payment proposals.\textsuperscript{57}

Thus, increasing the proportion of Medicare in hospitals’ payer mix—for example, by reimbursing commercial services at Medicare-like or benchmark rates—would exacerbate the already tenuous financial position of many hospitals. Bundling or using benchmark rates for emergency services in particular, which are unpredictable and extemporized in nature, will negatively impact providers, hospitals, and patients both on a systemic and individual level.

**Disruption to Physician Workforce and Payments Will Impact Access**

Payment reform efforts, like benchmark rates or bundled payments, that would have a negative impact on reimbursement to specialty providers in emergency medicine, anesthesiology, and radiology should be balanced against potential provider shortages in these specialties. Reductions in payments for these providers may worsen existing provider shortages and reduce patient access to care. Numerous states, as noted in the figures below, have thousands of

\textsuperscript{52} Ibid.
\textsuperscript{53} Ibid.
\textsuperscript{55} Ibid.
\textsuperscript{56} Ibid.
residents per emergency physician, anesthesiologist, and radiologist, which means less access and greater demand for those existing physicians in the state—especially when natural disasters or terrorist incidents occur. All three specialties were in the top 20 most in-demand specialties in 2018.\textsuperscript{58} Across the country, and especially in rural areas, the need for specialists has grown, and appropriate levels of reimbursement will be important in attracting providers to these critical specialties.

**Figure 1.1 – Geographic Density of Emergency Physicians**

Demand for emergency physicians has increased in a rapidly evolving emergency care environment. Even as EDs have closed across the country, the total number of emergency visits has increased.\textsuperscript{59} This creates significant staffing needs, especially in rural areas. Currently, nearly 64 percent of emergency physicians practice in urban areas. In order to ensure access to emergency services in diverse communities across the country, hospitals have been focused on recruiting a greater number of emergency physicians to handle increased visit volume and need to be able to pay their providers fairly.


Anesthesiologists are also in demand across the country. As the population ages and the need for procedures increases, the demand for anesthesiologists has increased in recent years. A limited candidate pool of anesthesiologists also contributes to this rise in demand.

In recent years, demand for radiologists has increased dramatically and the specialty was in the top four most searched in the Merritt Hawkins 2018 Review of Physician and Advanced Practitioner Recruiting Incentives report. The recent increased demand for radiologists is due in part to an aging workforce, in which nearly 50 percent of radiologists are over the age of 55 and are therefore leaving the labor pool. An increased focus on teleradiology and other advances in imaging have also contributed to rising demand.

As demand for providers increases substantially, payment cuts will not help improve patient access or ensure that needed specialists are available for patients.

VI. Benchmark or Bundled Payments Focus on the Wrong Part of the System

Providers Are Not Driving Higher Healthcare Costs

While bundled payments may at times be used when there are anticipated savings that would result from aligning incentives within a coordinated team, it is unusual to use them to solve a billing issue. Brookings acknowledges that their payment rate setting proposals “may seem radical” and recognizes the “associated loss of independence” for physicians that would arise from the proposal. Brookings also states that “the level of contractual disruption this policy approach would entail may present a practical challenge.” As a policy approach, benchmark and bundled payment rates are an ill-fitting solution to balance billing, and the detrimental impact on physician autonomy would be unacceptable. Payment rate setting would only be warranted if spending on physician services had increased dramatically or caused uncontrolled spikes in spending, burdening the healthcare system.

However, physicians are not the primary drivers of increased spending in healthcare and policies to control balance billing should not treat them as such. While overall pricing on primary healthcare services increased at an average rate of 4 percent per year between 2013-2017, growth in professional services pricing was only 3 percent. This is well below the increases seen in other spending categories, such as prescription drugs, for which spending increased 5.7 percent over the same period. Both inpatient and outpatient spending also increased at a faster rate than professional services over this period.

63 Ibid.
66 Ibid.
Furthermore, the professional fees for emergency department, anesthesia, and radiology physicians make up a very small portion of overall commercial beneficiary spending, accounting for only 2.3 percent of spending. While spending on emergency department professional fees has received blame in the discussion around surprise billing practices, these providers are responsible for only 1 percent of spending, while anesthesia providers and radiology providers account for 0.7 percent and 0.6 percent of spending, respectively. In developing policies that address increased healthcare spending, cutting reimbursement provided by these physicians is not an effective way to solve the issues with costs and balance billing.

Emergency Physician, Anesthesiologist, and Radiologist Salaries Reflect the Tight Labor Market and Unique Working Conditions

Practice patterns for emergency medicine physicians, radiologists, and anesthesiologists have evolved over the last decade contributing to the high demand for these hospital-based specialties. High demand would necessitate an increase in specialist compensation putting pressure on hospital labor costs and contractual arrangements. This demand for the specialties and the care they provide means that salaries and compensation for these providers are driven by the need for their services, not by arbitrary payments or inflation.

Importantly, proposals to cut hospital or physician reimbursement would likely mean a decrease in the volume of physicians, rather than physician salary, threatening access to timely patient care and adequate staffing to ensure quality care.

Emergency Medicine: Emergency medicine continues to be a tight labor market. EM has become increasingly “professionalized” over the last two decades by the introduction of EM residency programs and board certification, creating a new bottleneck of physicians considered qualified at the same time that EDs are experiencing higher patient volume following implementation of the ACA coverage provisions. Further, EM doctors now have options to practice outside the hospital, including in stand-alone EDs and urgent care centers, demonstrating that the practice of emergency medicine has adjusted with the trend of healthcare utilization shifting from the inpatient to outpatient setting, further making competition

67 The Emergency Department (ED) professional fee share of the commercial Per Member Per Year (PMPY) was calculated by finding the number of commercial ED visits PMPY (using US Centers for Disease Control and Prevention (CDC) 2015 data for total visits, HCUP 2014 data for payer mix, and Congressional Budget Office (CBO) 2017 baseline data for total commercial individuals) and multiplying by the average commercial professional fee payment per visit (based on median per-encounter payment in the Truven database). Anesthesia professional fee share of commercial PMPY was calculated by finding the number of commercial anesthesia cases PMPY (using HCUP 2014 data for total cases, American Medical Association (AMA) 2016 data for payer mix, and CBO 2017 baseline data for total commercial individuals) and multiplying by the average commercial professional fee payment per case (based on per-encounter payment in an American Society of Anesthesiologists survey). Radiology professional fee share of commercial PMPY calculated by finding number of commercial radiology procedures PMPY (using IMV 2010 data for total visits, AMA 2016 data for payer mix, and CBO 2017 baseline data for total commercial individuals) and multiplying by the average commercial professional fee payment per procedure (based on median per-encounter payment from the Truven database).

68 Ibid.

for emergency physicians practicing in the hospital more intense. Thus, despite hundreds of hospital closures over the last two decades, demand in the EM labor market has stayed strong. One study by Massachusetts General Hospital researchers estimates it would take 14 years before all EDs have the number of emergency medicine physicians that patient volume requires. This shortage of emergency medicine labor supply will be exacerbated in the coming years as nearly 30 percent of emergency medicine physicians are near retirement or are over 55 years old. 

Despite this confluence of factors increasing demand for ED physicians, the salary of emergency physicians is lower than other hospital-based specialties with average salaries of between $336,000 and $358,000. This compensation is despite the fact that the long practice hours, high patient volume, and high stress levels make emergency medicine physicians tied for highest rate of burnout among doctors at 55 percent—a rate at least three times higher than the average physician. Emergency physicians handle a higher volume of more severely traumatized or injured patients as well as a higher volume of mentally unstable or difficult patients. The more challenging environment in which emergency medicine physicians practice is reflected in studies on violence towards emergency practitioners. Nearly half (47 percent) of 3,500 emergency physicians polled reported being physically assaulted, with more than 60 percent saying the assault had occurred within the last year. In addition, 96 percent of female emergency physicians and 80 percent of male emergency physicians surveyed reported a patient had made inappropriate or unwanted advances toward them.

Radiologists: After a slight dip in demand during the Great Recession and following cuts to Medicare imaging reimbursement, radiologists are again one of the top-most recruited and in-demand specialists due in part to increasing use of teleradiology and technology that requires more use of electronic images. Radiologists have average salaries ranging between $371,000 and $429,000 annually. Despite the high and growing demand for radiologists, the average compensation for this specialty still falls below that of other hospital-based specialties. In addition, radiology has one of the highest rates of physician burnout at 50 percent.
“We [radiologists] have to read more [scans] now than what we had to do before. Radiologists feel this pressure of seeing more patients to maintain their income, which can result in physician burnout…I’ve seen colleagues change practice setting to reduce volume when expectations were too great.”

**Anesthesiologists:** Average compensation for anesthesiologists has not increased in recent years. At the same time, the share of anesthesiologists employed by hospitals has decreased to 17 percent. Like radiologists, anesthesiologists experience burnout at a rate of 50 percent. As one anesthesiologist in Texas put it, “we tend to deal with more acute situations and [are] also one of the few practices that is consistently in the hospital overnight. A lot of the more frightening stuff happens between midnight and 6:00 am and that is one of the stressors of the specialty for people who provide in-house coverage.” The average annual compensation for anesthesiologists ranges between $371,000 and $405,000. This partially reflects the labor-intensiveness of the specialty.

“[Anesthesiologists] tend to deal with more acute situations and [are] also one of the few practices that is consistently in the hospital overnight. A lot of the more frightening stuff happens between midnight and 6:00 am and that is one of the stressors of the specialty for people who provide in-house coverage.”

Overall, salaries for radiologists, anesthesiologists, and emergency physicians are lower on average than other hospital physician specialties such as cardiology, pulmonology, urology, otolaryngology, gastroenterology, neurosurgery, and orthopedic, thoracic, and vascular surgery. This is despite the fact that their rates of burnout are consistently higher than other practices. These facts are yet another data point that demonstrates that hospital-based specialists are not the problem with healthcare spending in the U.S. nor the culprit around balance billing and surprise bills.

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VII. Conclusion

Decreased payments, especially through a benchmark rate or bundled payment, would have negative systemic effects throughout the healthcare industry. Physicians within the emergency setting are legally mandated to treat all patients, whether they have insurance coverage, or are uninsured, resulting in a disproportionate amount of unpaid medical bills for expensive, acute care. Federal solutions to set a benchmark rate or bundled payment do not appropriately address the payer mix that comes into an emergency department, leaving physicians responsible for the decreased compensation they may receive, even amidst emergency departments experiencing patient volume increases. Hospitals and care facilities may take on more debt and be forced to relocate physicians into certain geographic locations, causing shortages in emergency medicine physicians, anesthesiologists, and radiologists in some areas, especially vulnerable rural locations. Hospital margins may decrease below sustainable levels, forcing closures and further disproportionately affecting lower-income and rural populations. The Medicare and Medicaid programs reimburse health systems at rates significantly lower than commercial rates, and payment rate setting via bundled payments or benchmark rates, further lower commercial compensation, putting the viability of hospitals and the livelihood of physicians in jeopardy. Patient concerns over surprise billing should not be addressed at the expense of physicians and ultimately the patients they serve. Instead, policymakers should ensure fair compensation for providers, especially those that often treat a diverse mix of patients, to ensure access and continuity of care.