

— 2020 SURVEY OF —

# AMERICA'S PHYSICIANS

## COVID-19 Impact Edition

A Survey Examining How the  
Coronavirus Pandemic is Affecting and  
is Perceived by the Nation's Physicians

**PART THREE OF THREE: COVID-19 and  
the Future of the Health Care System**

Survey completed October, 2020.  
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# 2020 SURVEY OF AMERICA’S PHYSICIANS

## **COVID-19 IMPACT EDITION**

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PART THREE OF THREE: COVID-19 and the Future of the Health Care System

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# INTRODUCTION: WHERE DO WE GO FROM HERE?

COVID-19 has presented the U.S. health care system with a wide range of challenges unprecedented in recent history. The question now is – where do we go from here?

Part Three of The Physicians Foundation's *2020 Survey of America's Physicians* reflects physicians' perspectives on the future of the health care system. [Part One](#), released in August 2020, revealed how the pandemic is affecting physician practices and their patients. [Part Two](#), released in September 2020, focused on how COVID-19 is affecting physician wellbeing.

This year, The Physicians Foundation redirected the focus of its biennial national physician survey exclusively to the pandemic. Trends and topics typically addressed by the survey to provide a "state of the union" of the medical profession, including physician work hours, use of electronic health records (EHR), valued-based compensation and others, are not addressed in this special edition. The Physicians Foundation will continue to examine these and related issues in future surveys.

# A SURVEY IN THREE PARTS

Physicians face significant time constraints under the best of circumstances. As they deal with the current pandemic, they may have even less time to devote to completing surveys.

Therefore, rather than conducting one extensive survey, The Physicians Foundation determined to conduct the 2020 survey in three smaller parts. Each part is designed for rapid completion in respect of physicians' limited time, and each focuses on a different aspect of COVID-19's impact on physicians, as follows:

**Part One:** The Impact of COVID-19 on Physicians' Practices and Their Patients

**Part Two:** The Impact of COVID-19 on Physician Wellbeing

**Part Three:** The Impact of COVID-19 and the Future of the Health Care System

Because COVID-19 has created a highly fluid environment in which circumstances are continually changing, the three-part survey format also was selected to ensure data relevance.

We believe the surveys will be of interest to health care professionals, policy makers, academics, media members and to anyone concerned by how the current pandemic is affecting today's physicians. We encourage all of those who have a stake in the medical profession and in health care delivery to reference the surveys and comment on their findings.

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**Gary Price, M.D.**  
*President*

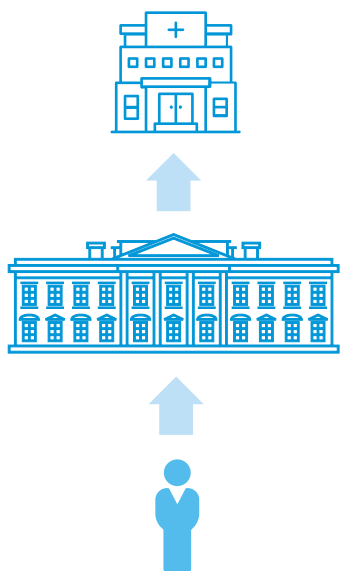
**Robert Seligson**  
*Chief Executive Officer*

**Ripley Hollister, M.D.**  
*Chairman, Research Committee*

## KEY FINDINGS:

Part Three of The Physicians Foundation's *Survey of America's Physicians: COVID-19 Edition* reflects the direction physicians believe the health system should take or will take. The survey was conducted from September 14 – 28, 2020. Data is based on 1,270 responses. Complete methodology is available on page 22.

Key findings of the survey include:



- **A majority of physicians (67%), rate a two-tiered system featuring a single payer option plus private pay insurance as the best or next-best direction for the U.S. health care system.**
- 49% of physicians rate maintaining/improving the current Affordable Care Act (ACA) influenced system as the best or next-best direction for the U.S. health care system.

- 45% of physicians rate a market-driven system featuring Health Savings Accounts (HSAs) and catastrophic plans as the best or next-best direction for the U.S. health care system.
- 40% of physicians rate a single payer/"Medicare for All" system as the best or next-best direction for the U.S. health care system.



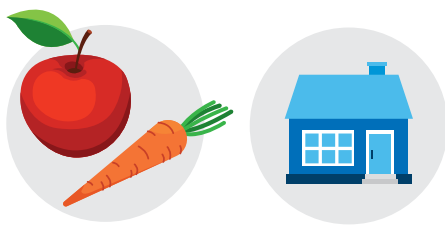
- **Of various immediate policy steps that should be taken to ensure access to high-quality, cost-efficient care to all, physicians rate streamlining/simplifying prior authorizations as the most important.**
  - 89% of physicians agree this is an important or very important step.
- Physicians rate simplifying access to mental health services as the second most important immediate policy step that should be taken.
  - 86% of physicians agree this is an important or very important step.



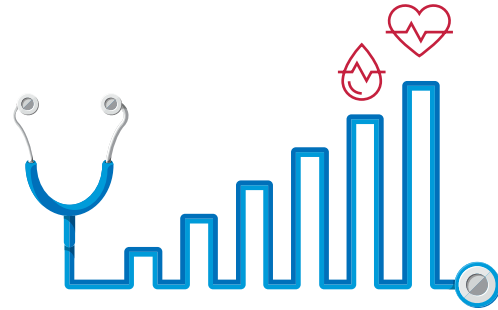
- Of various **future** policy steps that should be taken to ensure access to high-quality, cost-efficient care for all, physicians rate providing affordable health insurance as the most important.

– 89% of physicians agree this is an important or very important step.

- 84% of physicians rate increasing the number of physician leaders in key decision-making roles as the second most important **future** step to ensuring high-quality, cost-efficient care to all.



- 70% of physicians agree that insurance companies should include problems patients have accessing healthy food and safe housing into risk scoring formulas that determine patient complexity.



- 94% of physicians indicate that chronic diseases such as diabetes and heart disease will place the strongest demand on the health care system in 2021, followed by conditions made worse by pandemic-induced treatment delays (86%).

- 73% of physicians indicate that social determinants of health (SDOH) such as access to healthy food and safe housing will drive demand for health care services in 2021.



- 67% of physicians indicate that 11% or more of their patients delay or decline treatment due to costs.

– 44% indicate that 26% or more of their patients delay or decline care due to costs.

## PART THREE: QUESTIONS ASKED AND RESPONSES RECEIVED

**Q1 - Considering all relevant issues such as patient access, value and quality, health system efficiency, physician autonomy and compensation, and the COVID-19 public health response, what direction should the health care system take? Rank the options below 1-4, with 1 being the best approach.**

Question	1	2	3	4
Maintain/improve the current Affordable Care Act (ACA) influenced system	19%	30%	39%	12%
Implement a single payer/Medicare for All system (government funded and administered)	19%	21%	22%	38%
Implement a two-tiered system (single payer available for all, with private pay/insurance option)	36%	31%	22%	11%
Move to a market-driven system with Health Savings Accounts and catastrophic policies	30%	15%	13%	42%

### WHAT PHYSICIANS PRESCRIBE FOR THE HEALTH CARE SYSTEM

The 2020 presidential election and the coronavirus pandemic have brought renewed attention to the state of the U.S. health care system. Health care professionals, policy makers, academics, media members and the public continue to debate what direction the health care system should take.

Part Three of The Physicians Foundation’s 2020 *Survey of America’s Physicians* seeks input from physicians on this critical topic. As front-line practitioners of care handling over one billion patient encounters each year, physicians are uniquely positioned to evaluate how health care is delivered in the U.S.



Physicians were asked to rank four of the most prominent proposals for the future direction of the health care system, with one indicating the most favorable direction and four the least favorable.

The first of these options is to maintain the current system, which features a range of private insurance options that are available through employers, through Affordable Care Act (ACA) insurance exchanges or other private insurance plans, as well as publicly funded options such as Medicare, Medicaid and others.

Relatively few physicians (19 percent) gave this the highest favorable ranking of one, while relatively few (12 percent) gave it the lowest ranking of four, suggesting that neither enthusiasm for this option nor opposition to it is very strong. Physicians are essentially split on this option, with 49 percent ranking it a one or a two, and 51 percent ranking it a three or a four.

There were some variations in rankings based on physician type. In particular, older physicians are more favorable toward this option than younger ones.

#### Maintain the Current System 1 or 2 Ranking by Physician Type

	2020
45 or younger	44%
46 or older	50%
Male	49%
Female	50%
Employed	48%
Independent	50%
Primary care	50%
Specialist	47%

A second option is commonly described as single payer or Medicare for All, a system in which health insurance is paid for by the government, usually through tax-payer funding, and may be administrated by government agencies.

Nineteen percent of physicians gave this the highest ranking of one, while 38% gave it the lowest ranking of four, suggesting that enthusiasm for this

option is relatively weak while opposition to it is relatively strong. Physicians are more unfavorable on this option, with 60 percent ranking it a three or a four, and 40 percent ranking it a one or a two.

There were some variations in rankings based on physician type. Female physicians are more favorable toward this option than males, younger physicians are more favorable toward this option than older ones, employed physicians are more favorable toward this option than independent practice owners and primary care physicians are more favorable toward this option than specialists.

#### Single Payer/Medicare for All 1 or 2 Ranking by Physician Type

	2020
45 or younger	48%
46 or older	37%
Male	36%
Female	49%
Employed	42%
Independent	32%
Primary care	41%
Specialist	37%

A third proposed option is a two-tiered system in which a single payer/Medicare for All plan is available to those who choose it, while private pay options provided through employers or purchased directly by consumers also are available.

Thirty-six percent of physicians gave this the most favorable ranking of one, while only 11 percent gave it the most unfavorable ranking of

four, suggesting enthusiasm for this option is relatively strong while opposition to it is relatively weak. Physicians are more favorable on this option, with 67 percent ranking it a one or a two, and 33 percent ranking it a three or a four.

There were only minor variations in rankings based on physician type, with the most distinct being that younger physicians are more favorable toward this option than older ones.

### Two-Tiered System 1 or 2 Ranking by Physician Type

	2020
45 or younger	70%
46 or older	66%
Male	67%
Female	67%
Employed	68%
Independent	63%
Primary care	67%
Specialist	68%

A fourth option promotes the use of market-driven mechanisms to provide health insurance, particularly Health Savings Accounts (HSAs) that offer consumers tax-advantaged medical savings to pay for health care needs, sometimes combined with high-deductible “catastrophic” insurance plans.

Thirty percent of physicians gave this the most favorable ranking of one, while 42 percent gave it the most unfavorable ranking indicating significant polarity of opinions.

Forty-five percent of physicians gave this option a favorable ranking of one or two while 55 percent gave it an unfavorable ranking of three or four.

There were some variations in rankings based on physician type. Older physicians are considerably more favorable toward this option than younger ones, male physicians are considerably more favorable to it than female physicians and independent physicians are considerably more favorable to it than employed physicians.

### Market-Driven System 1 or 2 Ranking by Physician Type

	2020
45 or younger	36%
46 or older	46%
Male	48%
Female	34%
Employed	42%
Independent	53%
Primary care	44%
Specialist	45%

The four health system options are listed below based on those receiving the highest number of favorable (one or two) rankings from all physicians responding to the survey.



### Health System Options/Most Favorable Rankings (1 or 2) – All Respondents

	2020
Implement a two-tiered system (single payer available for all, with private pay/insurance option)	67%
Maintain/improve the current Affordable Care Act (ACA) influenced system	49%
Move to a market-driven system with Health Savings Accounts and catastrophic policies	45%
Implement a single payer/Medicare for All system (government funded and administered)	40%

The two-tiered system featuring single payer and private pay options achieved the highest number of positive one or two rankings (67 percent) from all physicians. This was consistent for all physician types, including younger and older physicians, male and female physicians, employed physicians and independent practice owners, primary care physicians and specialists.



### Q2 - Considering our current health care system, how important are each of these policy steps if the goal is to ensure access to high-quality, cost-efficient care for all?

Question	Not At All Important	Of Little Importance	Moderately Important	Important	Extremely Important
Reimbursement for physician-directed efforts to address social determinants of health (e.g., poverty, homelessness, poor nutrition, etc.)	6%	11%	20%	31%	32%
Simplify/streamline prior authorization for medical services and prescriptions	1%	1%	9%	29%	60%
Prevent/eliminate surprise medical billing	2%	4%	16%	33%	45%
Reimburse physicians for providing telemedicine services	1%	3%	14%	26%	56%
Provide insurance coverage for COVID-19 diagnosis and treatment	1%	4%	12%	29%	54%
Simplify access to integrated mental health services	1%	2%	11%	30%	56%

## ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Physicians were asked to consider the current health care system and rate various policy steps that could be taken to ensure high-quality, cost-efficient care for all.

Among these steps is reimbursing physicians for addressing the social determinants of health (SDOH) such as poverty, homelessness, poor nutrition and others.

The majority of physicians (63 percent) rated this as an important or extremely important policy step. There were some variations in responses based on physician type. Younger physicians are more favorable toward this step than older ones, female physicians are more favorable than male physicians, employed physicians are more favorable than independent practice owners and primary care physicians are more favorable than specialists.

### Importance of Paying Physicians for SDOH Important or Extremely Important By Physician Type

	2020
45 or younger	75%
46 or older	61%
Male	59%
Female	74%
Employed	65%
Independent	60%
Primary care	66%
Specialist	59%

Physicians, health care policy makers, academics and others are becoming more aware that addressing the underlying social determinants of health is critical to improving overall health and reducing costs. It is these factors, more than access to care or even quality of care, that largely determine health outcomes (see chart below from County Health Rankings):

### Factors Determining Health Outcomes

	2020
Behaviors (diet, exercise, tobacco, drugs, sexual activity)	30%
Social/economic factors (employment, education, income, family support)	40%
Environment (air quality, water quality, housing, transportation)	10%
Clinical care (access to care, quality of care)	20%

Source: County Health Rankings Model. <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model>



In The Physicians Foundation’s *2018 Survey of America’s Physicians*, 57 percent of physicians said all or many of their patients are affected by a social condition that poses a serious impediment to their health. Only one percent of physicians said that none of their patients are affected by such conditions. The economic disruption caused by the coronavirus pandemic, during which millions of people have filed

for unemployment benefits, is likely to exacerbate the social conditions that cause poor health.

Despite these trends, the mechanisms physicians have at their disposal to improve patient conditions caused by SDOH are limited. Moreover, physicians who do take steps to address SDOH find this work generally goes uncompensated and is burdensome in the context of a health care system that is still designed primarily to treat (and pay for treating) acute illness. As a result, physicians bear the burden when “social risk” is not accounted for in payment models or risk adjustment.

Including SDOH in quality measures and physician financial incentives in emerging payment models (e.g., ACOs, medical homes, bundled payments, etc.) would make physicians better equipped to address the root causes of poor health. At present, SDOH are not routinely accounted for in state or federal quality measures or financial incentives. In addition, none of the Center for Medicare & Medicaid Services’ (CMS) Medicare Shared Savings ACO cost/quality measures include social conditions.

## **STREAMLINING PRIOR AUTHORIZATIONS**

Eighty-nine percent of physicians rated streamlining prior authorizations as an important or extremely important policy step. There were only minor/negligible variations by physician type, so these are not indicated in this report.

Prior authorization is a utilization management process used by many health insurance companies to determine if they will cover a prescribed procedure, service or medication.

Prior authorization is among the many compliance, regulatory and reimbursement requirements that

physicians find burdensome and which erode their autonomy over clinical decision-making. In The Physicians Foundation’s *2018 Survey of America’s Physicians*, physicians cited regulatory/insurance requirements and loss of clinical autonomy as two of the three factors that they find least satisfying about medicine. In a survey by the Medical Group Management Association (MGMA), 83 percent of respondents said prior authorizations are “very” or “extremely” burdensome and rated prior authorization as the most burdensome of all requirements. (*MGMA 19: No progress to fix prior authorizations as practice leaders say it has gotten worse. Fierce Healthcare. Oct 16, 2019*).



In a separate MGMA Stat poll, 90 percent of practice leaders said payer prior authorization requirements increased in 2019. Only 1 percent said those requirements have decreased, and 9 percent said they have stayed the same. The cost of prior authorization requirements on physician practices also has continued to increase—up 60 percent from 2018 to 2019 to manually generate a request to insurers. (*Costs of prior authorization increase for physician practices at an alarming rate. Fierce Healthcare. January 22, 2020*).

Prior authorization requirements reduce physician time for direct patient care and may have a negative effect on quality of care. In a survey by the American Medical Association, 28 percent of

responding physicians said the prior authorization process required by health insurers for certain drugs, tests and treatments has led to serious or life-threatening adverse events for patients. (AMA survey: 28 percent of physicians say prior authorization led to a serious adverse event. *Fierce Healthcare*. February 6, 2019).



## **ELIMINATING SURPRISE MEDICAL BILLING**

Seventy-eight percent of physicians rated eliminating surprise medical bills as an important or extremely important policy step.

The term “surprise medical bill” describes charges arising when an insured person receives care from an out-of-network physician or other provider. Surprise medical bills can arise in an emergency when the patient has no ability to select the hospital emergency room to which he or she is taken, the treating physicians or ambulance providers.

Surprise billing for emergency services remains relatively common in the U.S. Stanford University researchers found that from 2010 through 2016, 39 percent of 13.6 million trips to the emergency department at an in-network hospital by privately insured patients resulted in an out-of-network bill. That figure increased during the study period from about a third of emergency department visits

nationwide in 2010 to 42.8 percent in 2016. (*Assessment of out-of-network billing for privately insured patients receiving care at in-network hospitals*. *JAMA Network*. August 12, 2019).

Surprise bills also may occur after elective procedures which, unlike emergencies, are planned. For example, a patient could go to an in-network facility, but later find out that an anesthesiologist, radiologist or other physician providing treatment does not participate in the patient’s health plan.

One in five Americans who undergo elective surgery incur unexpected out-of-network medical bills, according to a study of nearly 350,000 people published by the *Journal of the American Medical Association (JAMA)*. The patients who incurred surprise medical bills ended up owing \$2,011 more, on average, than the nearly \$1,800 cost the average privately insured patient would owe to their insurance company based on in-network rates. (*Out of network bills for privately insured patients undergoing elective surgery*. *JAMA Network*. February 19, 2020).

## **PAYING PHYSICIANS FOR TELEMEDICINE SERVICES**

Eighty-two percent of physicians rated reimbursing physicians for telemedicine services as an important or extremely important policy step.

Although the coronavirus limited in-person patient encounters, the rapid adoption of telemedicine helped physicians maintain important patient engagements. The Physicians Foundation’s *2018 Survey of America’s Physicians* indicated that as recently as two years ago only 18 percent of physicians practiced some form of telemedicine. Of that 18 percent, the considerable majority (73 percent) indicated they derived 10 percent or less of their revenues from telemedicine.

By contrast, in a survey conducted in April 2020 by Merritt Hawkins in collaboration with The Physicians Foundation, 48 percent of physicians indicated they are treating patients through telemedicine. Part One of *The Physicians Foundation's 2020 Survey of America's Physicians* indicated that 12 percent of physicians (approximately 100,000 physicians) have moved to a primarily telemedicine position.



In response to the pandemic, CMS relaxed telemedicine reimbursement restrictions effective March 6, 2020, allowing payment for telehealth services given to Medicare beneficiaries beyond rural areas and expanding sites of services, including to the patient's home. The federal government also relaxed HIPAA regulations regarding telemedicine in order to expand the use of telemedicine services and to allow physicians to eliminate or reduce co-pays to lower cost barriers.

To further expand the use of telemedicine, on April 1, 2020, CMS announced it added more than 80 new telemedicine services to the list of services covered by Medicare during the coronavirus pandemic and reiterated that all connected health services are now reimbursed at the same rate as in-person services.

It is not clear, however, if these new policies will continue or be made permanent. Should the health care system revert to old policies, in which

reimbursement to physicians for telemedicine services was limited, many physicians would likely be unable to continue providing telemedicine services.

In Part One of *The Physicians Foundation's 2020 Survey of America's Physicians*, 72 percent of physicians agreed that widespread use of telemedicine services will not continue unless reimbursement for telemedicine and in-person services are comparable. Part Three of the survey indicates physicians are virtually unanimous in agreeing on the importance of this policy step.

### **PROVIDING INSURANCE COVERAGE FOR COVID-19**

Eighty-three percent of physicians rated providing insurance coverage for COVID-19 treatment as an important or extremely important policy step.

Medicare Part B currently covers laboratory tests for COVID-19 if ordered by a physician. Medicare Part A covers all necessary hospitalization expenses caused by the virus. Comprehensive private health insurance plans provided through employment or purchased by individuals that meet requirements spelled out in the Affordable Care Act (ACA) cover COVID-19 tests and COVID-19-related physician office visits and ER visits. Short-term private insurance plans and those that are non ACA-compliant may not. Given the uncertain fate of the ACA, it is not clear to what extent private insurance plans will cover COVID-19 tests and treatments in the future.

### **SIMPLIFYING ACCESS TO MENTAL HEALTH SERVICES**

Eighty-six percent of physicians rated simplifying access to integrated mental health services as an important or extremely important step.



Increasing patient access to mental health services has been an ongoing challenge for the health care system, due in part to a pervasive shortage of psychiatrists. A National Council of Behavioral Health report indicates that 77 percent of U.S. counties are experiencing a severe shortage of psychiatrists (*The psychiatric shortage: causes and solutions. National Council of Behavioral Health. March 28, 2017*).

The coronavirus pandemic has accelerated the need for additional mental health services. An April 2020 survey by the Kaiser Family Foundation found that

almost half of all U.S. adults (45 percent) say the pandemic has affected their mental health, while 19 percent say it has had a “major impact.” (*The impact of coronavirus on life in America. Kaiser Family Foundation. April, 2020*).

Physicians responding to Part Three of the survey rated simplifying access to mental health services as the second most important step that could be taken to ensure that access to high-quality, cost-efficient care is available to all in the current health care system.

**Q3 - In the near future (next two to five years) how important will each of the following steps be if the goal is to ensure high-quality, cost-efficient care for all?**

Question	Not at all Important	Of Little Importance	Moderately Important	Important	Extremely Important
Reducing health inequity/inequality of access	3%	5%	17%	31%	44%
Clarifying the effect of Pharmacy Benefit Managers and the integration of insurance and pharmaceutical companies on drug costs	2%	5%	19%	38%	36%
Establishing price transparency for medical services	1%	4%	16%	34%	45%
Determining the impact of health systems/hospital consolidation on health care cost and quality	2%	5%	21%	37%	35%
Increasing the number of physician leaders in key decision making positions	1%	3%	12%	29%	55%
Providing affordable health insurance coverage that ensures improved health care access	<1%	2%	9%	25%	64%

Physicians were asked to consider the future of the health care system over the next two to five years and indicate how important various policy steps would be to ensuring high-quality, cost-efficient care for all.

Among these steps is reducing inequity/inequality of health care access. The majority of physicians (75 percent) rated this as an important or very important step. There were some variations in responses based on physician type. Younger

physicians are more favorable toward this step than older ones, female physicians are more favorable than males, employed physicians are more favorable than independent practice owners and primary care physicians are more favorable than specialists.

**Importance of Reducing Health Inequity/Inequality Important or Extremely Important By Physician Type**

	2020
45 or younger	81%
46 or older	74%
Male	72%
Female	84%
Employed	75%
Independent	66%
Primary care	78%
Specialist	71%

Inequities in health care access based on economic, race and other social factors have been increasing in recent years. The wealthiest Americans now live 10 to 15 years longer on average than the poorest. (*America: equity and equality in health. The Lancet. April 8, 2017*).

Health inequities by race have been particularly apparent during the coronavirus pandemic. Black Americans are infected with COVID-19 at nearly three times the rate of white Americans and are twice as likely to die from the virus. The infection rate for Blacks is 62 per 10,000, compared with 23 per 10,000 for whites. Latinos see even more

infections: 73 per 10,000 (*State of Black America unmasked. National Urban League/Johns Hopkins Center for Health Equity. August, 2020*).

**CLARIFYING THE IMPACT OF PBMs**

Seventy-four percent of physicians rated clarifying the effect of Pharmacy Benefit Managers (PBMs) and the integration of insurance and pharmaceutical companies on drug costs as an important or extremely important step.

PBMs are companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers and other payers. By negotiating with drug manufacturers and pharmacies to control drug spending, PBMs have a significant behind-the-scenes impact in determining total drug costs for insurers, shaping patients' access to medications and determining how much pharmacies are paid.



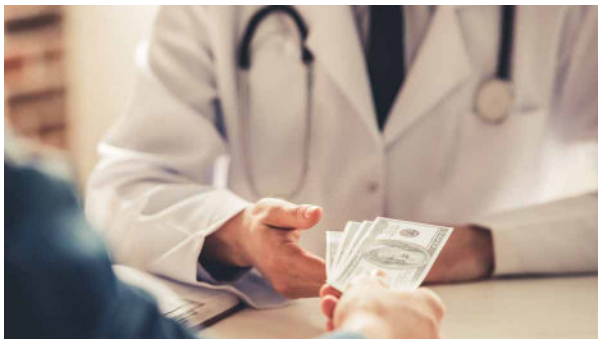
Controversy has arisen over PBMs because they may have an incentive to favor high-priced drugs over drugs that are more cost-effective. Because they often receive rebates that are calculated as a percentage of the manufacturer's list price, PBMs receive a larger rebate for expensive drugs than they do for ones that may provide better value at lower cost. As a result, people who have a high-

deductible plan or have copays based on a drug's list price may incur higher out-of-pocket costs.

## **ESTABLISHING PRICE TRANSPARENCY**

Seventy-nine percent of physicians rated establishing price transparency for medical services as an important or very important policy step.

Prices for medical services are often unstated or vague, due in part to the fact that third parties pay most medical bills and patients therefore rarely shop for health care services based on cost comparisons. In many cases, prices for the same service vary from hospital to hospital or even within a hospital based on how patients pay. It has been documented that some hospitals charge 40 percent less to patients who pay cash for a service than to those who pay through insurance for the same service (*Make transparent health care prices a price of any future aid to the health care industry. Health Affairs. June 16, 2020*).



With the advent of more high deductible plans and higher co-pays, in addition to a growing number of uninsured patients, price transparency in health care has become a more pressing issue.

As of January 1, 2019, the Trump administration required that all hospitals post their list prices

online. However, hospital web sites today often post thousands of medical codes that are next to impossible for consumers to interpret.

## **DETERMINING THE IMPACT OF HOSPITAL CONSOLIDATION**

Seventy-two percent of physicians rated determining the impact of hospital consolidation on health care costs and quality as an important or very important policy step.

There were 92 hospital mergers and acquisitions in 2019, up from 90 the previous year, continuing a trend toward health care market consolidation that has been apparent for at least a decade (*Hospital merger and acquisition activity strong and steady in 2019. Revenue Cycle Intelligence. January 22, 2020*).

One rationale for these mergers is that they reduce costs through economies of scale and by reducing duplication of services. However, an analysis conducted for the *New York Times* shows the opposite is true in many cases, according to an examination of 25 metropolitan areas with the highest rate of hospital consolidation from 2010 to 2013. The analysis showed that the price of an average hospital stay soared after consolidation, with prices in most areas going up between 11 percent and 54 percent (*When hospitals merge to save money, patients often pay more. New York Times. November 14, 2018*).

## **INCREASING THE NUMBER OF PHYSICIAN LEADERS**

Eighty-four percent of physicians rated increasing the number of physician leaders as an important or very important policy step.



In the past, leadership roles, particularly in hospital settings, were divided between administrative leaders such as chief executive officers (CEO) and clinical leaders, such as chief medical officers (CMOs). CMO roles often were filled by physicians who were affiliated with the hospital but who also operated their own independent private practice group.



Due in part to hospital mergers and the acquisition of physician practices by hospitals, a growing number of physicians are employed while fewer remain in private practice. In *The Physicians Foundation's 2018 Survey of America's Physicians*, only 31 percent of physicians identified as independent practice owners, while the remaining 69 percent were employed by a hospital, a hospital-owned medical group, a physician-owned medical group or were in some other status. By contrast, in 2012, 44 percent of physicians identified as independent practice owners.

Today, large hospital systems and medical groups employ thousands of physicians. Many of these systems and groups are implementing new delivery models that financially reward quality of care rather than volume of services provided. Standards of care, methods for documenting quality, electronic health records, the composition of care teams and physician compensation all

must be standardized for these integrated, valued-based systems to work.

Physicians have emerged as key administrative leaders who can achieve this integration by bridging the gap that often has existed between hospital and health systems administrators and the medical staff. Based on their clinical experience, they can design and implement evidence-based treatment protocols that other physicians will accept and adopt. Their clinical experience also allows them to judge which treatments are both clinically effective and cost effective.

A 2011 study that examined the 100 best hospitals for cancer, digestive disorders and cardiovascular care—as ranked by *U.S. News & World Report*—found that hospitals run by physicians scored approximately 25 percent higher on overall hospital quality than hospitals run by professionals from management backgrounds (*What many top-rated hospitals have in common: Physicians in the C-Suite. Advisory Board. January, 2017*).

## **PROVIDING AFFORDABLE HEALTH INSURANCE**

Eighty-nine percent of physicians rated providing affordable health insurance as an important or very important policy step.

Data from the US Census Bureau indicate that a total of 27.5 million Americans had no health insurance in 2018, while millions have lost employer-based insurance as a result of COVID-19. Others who are insured may have insurance plans that limit their access to needed care. As is indicated below, many physicians report that their patients delay care or do not seek care due to costs.

Physicians responding to the survey rated providing affordable health insurance as the most important step that could be taken in the future to ensure that access to high-quality, cost-efficient care is available to all.



**Q4 - To what extent do you agree or disagree with the following?**

Question	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree
<b>Problems accessing healthy food or safe housing due to COVID-19 or for any other reason should be included in the risk scoring that insurance companies use to determine patient complexity</b>	6%	6%	18%	32%	38%

A risk score is a number that is assigned to patients based on their demographics and diagnoses—a numerical representation of how costly they are expected to be compared to the average patient and how complex their care is likely to be. A risk score may indicate the probability of a high cost event, such as a hospital readmission.

Health care payers, hospitals and physicians all use risk scores to estimate costs, target interventions, gauge a patient’s health literacy and lifestyle choices, and try to prevent patients from developing more serious conditions that could result in higher spending and worse outcomes. By many estimates, only five percent of U.S. patients are high-risk/high-cost, yet they account for approximately 50 percent

of health care spending (*Why there’s a need to reduce high-cost health care utilization among high-risk patients. Healthcare Finance. January 4, 2019*).

Typically, risk scores are based on the personal and clinical characteristics of patients, rather than social characteristics such as their access to healthy food or safe housing. When these factors are not measured, patient risk may be much higher than is actually scored.

The majority of physicians (70 percent) agree that social determinants of health should be included in-patient risk scoring as a future means of ensuring access to high-quality, cost-effective care for all.

**Q5 - COVID-19 has had a detrimental effect on the economy and on the personal finances of many. What percent of your patients now cite cost as a reason to delay or decline treatment?**

	2020
0-10%	14%
11-25%	23%
26-50%	25%
51-75%	14%
76% or more	5%
N/A	19%

According to the Kaiser Family Foundation Health System Tracker, in 2017, about one in ten Americans delayed or did not get health care due to costs ([www.healthsystemtracker.org/chart-collection/cart-affect-access-care/#item-start](http://www.healthsystemtracker.org/chart-collection/cart-affect-access-care/#item-start)).

Part Three of the survey suggests that number could be higher today. The majority of physicians (67 percent) indicated that 11 percent or more of their patients cited cost as a reason to delay or decline care. Forty-four percent indicated that 26 percent or more of their patients now cite cost as a reason to delay or decline treatment.

**Q6 - To what extent do you agree that the following will place a high demand on our health care system in 2021?**

Question	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree
Chronic conditions (e.g., heart disease, diabetes, kidney disease, etc.)	1%	1%	4%	24%	70%
Conditions worsened by pandemic-induced care delays	1%	3%	10%	44%	42%
Ongoing and new COVID-19 challenges	2%	5%	13%	42%	38%
Health related social needs (e.g., access to healthy food, transportation, safe housing, etc.)	4%	7%	16%	39%	34%
Preventive care (e.g., physicals)	3%	10%	29%	36%	22%
Other infectious diseases	2%	8%	37%	39%	14%
Emergencies (e.g., broken bones, heart attacks, etc.)	1%	7%	37%	39%	16%

Virtually all physicians surveyed (94 percent) agreed that chronic conditions such as heart disease, diabetes, kidney disease and others will place a high demand on the health care system in 2021. Six in 10 adult Americans now have one chronic disease while four in 10 have two or more, according to the Centers for Disease Control and Prevention, and these conditions account for the majority of deaths in the U.S. and the majority of health care spending ([www.cdc.gov/chronicdisease](http://www.cdc.gov/chronicdisease)).

Behind these established causes of demand for health care services, physicians ranked conditions made worse by pandemic-induced delays in getting care as the second likely driver of demand for health care services in 2021. Eighty-six percent of physicians indicated that conditions made worse by pandemic-induced care delays will place demand on the health care system in 2021, while

80 percent said ongoing and new challenges presented by COVID-19 will put demand on the health care system.

Physicians also indicated that other factors, such as social determinants of health, preventive care, other infectious diseases and emergencies will place demand on the health care system.



***Q7 - If you could make a statement to the public and policy makers about the state of the medical profession today and how health care delivery can be improved, what would you say?***

More than 700 physicians provided answers to this question, offering a range of opinions and insights regarding how physicians feel about the medical profession and about where the health system should go from here. Below is a small sample.

*“Allow physicians to do what we are trained to - be physicians.”*

*“Physicians have shown you our commitment to the wellbeing of our communities despite the personal risk to ourselves during COVID. Now it’s time to return the favor by putting us in charge as thought leaders, and listening to our perspective.”*

*“We need to refocus the health care system on the delivery of health care, and away from a for-profit business model where every player is trying to get a piece of the pie and the patient becomes a cog in a machine; the physician-patient relationship is pushed to the purpose of running that machine rather than the personal delivery of care through the long term doctor-patient relationship.”*

*“We are in desperate need of leaders to increase the cap on payment for residency spots in order to keep pace with increased medical school enrollment to help with shortages in primary care physicians.”*

*“Stop listening to those making the most noise and start listening to those of us who provide health care, if you really want to understand.”*

*“Our system is broken, overburdened by bureaucratic red tape, and with multiple restrictions on prescribing beneficial treatment options for our patients. Unless something changes (and soon), too many physicians will opt out of health care altogether and leave the majority of the population without anyone to care for them.”*

*“I recommend that telemedicine become a permanent option that continues to be reimbursed at the current levels with availability to all patients. Lawmakers should write laws that abolish prior authorization which unnecessarily causes delays in patient health care. Medical liability reform is needed for physicians working with COVID patients.”*

*“Health care is becoming a mass market enterprise in which physicians’ skill and time are increasingly less valued. Visits are squeezed into 10 minute intervals leaving little time to get to the root of the issue let alone evaluate and address needs involving social determinants of health. Many physicians do not get a lunch break in order to see more patients over the lunch hour to meet RVUs. There is no time to address any complexity of a patient.”*

*“Investing in social determinants of health is of utmost importance as they cause or complicate every chronic condition.”*

*“Health care delivery and reimbursement is needlessly complicated and expensive and I believe that streamlining it would increase access and decrease cost. The most important care we can provide is not technically difficult. It needs to be widespread preventive and public health care, and that is where we are utterly failing.”*

## CONCLUSION

Part Three of The Physicians Foundation's *2020 Survey of America's Physicians: COVID-19 Edition* reveals the policy steps physicians prescribe for both the current and future health care system. The majority (67 percent) rate a two-tiered system featuring a single payer/Medicare For All option combined with private insurance options as the best or second-best direction, 49 percent rate maintaining the current systems as the best or second-best direction, 45 percent rate a market-driven system as the best or second-best direction, and 40 percent rate single payer/Medicare for All as the best or second-best direction.



Of various immediate policy steps that should be taken to ensure access to high-quality, cost-efficient care to all, 89 percent of physicians rate streamlining/simplifying prior authorizations as important, followed by 86 percent of physicians who rate simplifying access to mental health services as important.

Of various future policy steps that should be taken to ensure access to high-quality, cost-efficient care for all, 89 percent of physicians rate providing affordable health insurance as important, followed by 84 percent of physicians who rate increasing the number of physician leaders as important.

The majority of physicians (70 percent) agree that patient problems accessing healthy food, safe housing or other social determinants of health (SDOH) should be included in the risk scoring that insurance companies use to determine patient complexity.

The majority of physicians (67 percent) indicate that at least 11 percent of their patients delay or decline treatment due to costs, while 44 percent of physicians indicate that 26 percent or more of their patients delay or decline treatment due to costs.

Physicians indicate that chronic diseases such as diabetes and heart disease will place the strongest demand on the health care system in 2021, followed by conditions made worse by pandemic-induced treatment delays. Seventy-three percent of physicians indicate that social determinants of health (SDOH) such as access to healthy food and safe housing, will drive demand for health care services in 2021.

Part Three of the *2020 Survey of America's Physicians* marks the last in a series of surveys which examine how COVID-19 has affected physician practices and their patients, how COVID-19 has affected physician wellbeing and what the direction physicians believe the health system should take in light of the pandemic.

# METHODOLOGY

Part Three of the survey was sent by email to a list of physicians derived from an American Medical Association/Physician Master File-approved vendor, and to physicians in Merritt Hawkins’ proprietary data base. The survey was sent from September 14 to 28, 2020. It was received by more than 500,000 physicians nationwide. Data is based on 1,270 responses.

### Responses by Physician Type

PRACTICE	2020
Primary Care	40%
Specialty	60%

Forty percent of physicians who responded to the survey practice primary care, defined in this survey as family medicine, general internal medicine or pediatrics, while the remaining 60 percent practice one of various surgical, internal medicine, diagnostic or other specialties. Approximately 34 percent of all physicians practice primary care, according to the AMA’s Physician Master File, indicating primary care physicians are slightly overrepresented in the survey.

### Responses by Gender

GENDER	2020
Male	68%
Female	29%
Gender non-binary/Other/ Prefer not to answer	3%

Sixty-eight percent of physicians who responded to the survey are male, 29 percent are female and three percent indicated they are gender non-binary, other or preferred to not designate a gender. Approximately 64 percent of all practicing physicians in the U.S. are male, indicating males are somewhat overrepresented in the survey.

### Responses by Practice Status

PRACTICE STATUS	2020
Employed by a hospital or hospital-owned medical group	34%
Employed by a physician-owned medical group	16%
Practice owner or partner	30%
Other	20%

Thirty percent of physicians who responded to the survey are private practice owners, while the remaining 70 percent are employed by a hospital, a hospital-owned medical group, a physician-owned medical group or are in some other status. Physician practice status varies by source. 2018 AMA data indicate that 46 percent of physicians are in private practice while the remainder are in employed or other status. Data from The Physicians Foundation’s *2018 Survey of America’s Physicians* indicate 31 percent of physicians are in private practice while the remainder are in employed or other status.

### Responses by Age

AGE	2020
25-34	4%
35-44	13%
45-54	22%
55-64	31%
65+	30%

Forty-five percent of all active physicians are 55 or older, compared to 61% of physicians who responded to the survey, indicating that older physicians are overrepresented in the survey.



# MARGIN OF ERROR ASSESSMENT

Below is an excerpt from the survey *Sample Error Analysis Report on Margin of Error (MOE)* statement for Part Three of the survey provided to The Physicians Foundation by experts in survey research and methodology at the University of Tennessee:

*“The overall margin of error for the entire survey is a solid ( $\mu \pm 2.87\%$ ), supporting a relatively small sampling error for a survey of this length and type.*

*The brevity of the survey led to an acceptable sample size and completion rate, again with very few omitted responses.*

*This survey sub-segment can be seen as “accurate” overall, and there is roughly a 1 in 35 chance that a random physician not selected to participate in the survey would give responses that fall more than two standard deviations outside the observed distribution.”*

# ABOUT THE PHYSICIANS FOUNDATION

The Physicians Foundation is a nonprofit seeking to advance the work of practicing physicians and help them facilitate the delivery of high-quality health care to patients. As the health care system in America continues to evolve, The Physicians Foundation is steadfast in its determination to strengthen the physician-patient relationship and assist physicians in sustaining their medical practices in today’s practice environment. It pursues its mission through a variety of activities including grant-making, research, white papers and policy studies. Since 2005, the Foundation has awarded numerous multi-year grants totaling more than \$50 million. In addition, the Foundation focuses on the following core areas: physician leadership, physician wellness, physician practice trends, social determinants of health and the impact of health care reform on physicians and patients. For more information, visit [www.physiciansfoundation.org](http://www.physiciansfoundation.org).

Among other research endeavors, The Physicians Foundation conducts a national *Survey of America’s Physicians*. First conducted in 2008, the survey also was conducted in 2012, 2014, 2016, and 2018 and now is conducted on a biennial basis.

## **Signatory Medical Societies of The Physicians Foundation include:**

- Alaska State Medical Association
- California Medical Association
- Connecticut State Medical Society
- Denton County Medical Society (Texas)
- El Paso County Medical Society (Colorado)
- Florida Medical Association
- Hawaii Medical Association
- Louisiana State Medical Society
- Medical Association of Georgia
- Medical Society of New Jersey
- Medical Society of the State of New York
- Nebraska Medical Association
- New Hampshire Medical Society
- North Carolina Medical Society
- Northern Virginia Medical Societies
- South Carolina Medical Association
- Tennessee Medical Association
- Texas Medical Association
- Vermont Medical Society
- Washington State Medical Association.



## ABOUT MERRITT HAWKINS

Merritt Hawkins is the largest physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the leader in innovative healthcare workforce solutions. Founded in 1987, Merritt Hawkins has consulted with thousands of health care organizations nationwide on physician staffing and related issues.

Merritt Hawkins continuously produces data and analyses that are widely referenced throughout the healthcare industry. Notable Merritt Hawkins' surveys include its annual *Review of Physician and Advanced Practitioner Recruiting Incentives*; *Survey of Final-Year Medical Residents*; *Survey of Physician Inpatient/Outpatient Revenue*; and *Survey of Physician Appointment Wait Times*.

In addition to internal research, Merritt Hawkins conducts research for third parties and has completed six previous projects on behalf of *The Physicians Foundation*, including *The Physicians' Perspective, A Survey of Medical Practice in 2008*; *In Their Own Words, 12,000 Physicians Reveal Their Thoughts on Medical Practice in America*; *Health Reform and the Decline of Physicians Private Practice*, a white paper featuring the 2010 survey *Physicians and Health Reform*; the *2012, 2014 2106, 2018, and 2020 Part One Surveys of America's Physicians*; *Practice Patterns and Perspectives*.

Additional information about Merritt Hawkins and AMN Healthcare can be accessed at [www.merritthawkins.com](http://www.merritthawkins.com) and at [www.amnhealthcare.com](http://www.amnhealthcare.com).

For additional information about this survey, contact:



### **The Physicians Foundation**

Robert Seligson  
Chief Executive Officer  
919-306-0056  
[bob@physiciansfoundation.com](mailto:bob@physiciansfoundation.com)

