The Quiet Ban on Physician-Owned Hospitals

In most fields, we celebrate innovators and experts that start new firms and improve efficiency. In health care, we've forbidden it for a decade.

Jared Rhoads • November 26, 2025

In most sectors of the American economy, we celebrate the moment when insiders break away to build something better. Engineers start their own firms. Chefs open their own restaurants. Innovators leave incumbents and test their mettle in the market. Only in US healthcare do we treat that entrepreneurial impulse as a threat worthy of prohibition.

Section 6001 of the 2010 Affordable Care Act froze the growth of physician-owned hospitals (POHs) by barring new POHs from getting paid by Medicare and Medicaid, and by restricting the expansion of existing POHs. It did not ban POHs outright, but it had roughly the effect of a ban; after years of growth, the number of POHs in the US abruptly plateaued at around 230-250, and practically no new POHs have opened since 2010.

Supporters of the ban on POHs say it is needed to prevent conflicts of interest, cream-skimming, and overuse.

One argument is that without such a ban, POHs would cherry-pick the healthier and more profitable patients, leaving other hospitals with sicker and more costly patients. There is some evidence that physician-owned specialty hospitals tend to attract healthier patients and tend to focus on lucrative service lines. But why does that justify a ban on POHs? Specialization is one way that entrepreneurs create value. Cardiac centers, orthopedic hospitals, and focused surgical facilities exist precisely because repetition and standardization can improve outcomes and reduce costs. Specialty hospitals can even exert a positive influence on surrounding general hospitals to improve quality and reduce costs for everyone.

Another argument is that uncontrolled self-referral would result in the overutilization of services and a rise in healthcare spending. Overutilization is a major contributor to wasteful spending in healthcare, which has been estimated to account for approximately 25 percent of total healthcare spending, or between $760 billion and $935 billion nationwide. The reasoning is that if physicians are able to refer patients internally for services, procedures, and tests, then physicians will cease to exercise careful cost control. This, however, is more of an indictment of the current price and payment systems than an indictment of physician ownership. By setting prices via committee instead of relying on genuine market prices, policymakers have created in Medicare and Medicaid a gameable system that rewards volume. The response to poorly designed

reimbursement mechanisms should be to fix the mechanisms, not blame ownership models.

The POH issue illustrates how, in a mixed economy, controls beget controls. To keep the program politically popular, Medicare's pre-payment review and protections against waste are generally less stringent than those found in the private insurance world. Given that context, preventing physicians from referring patients to the entities they own can seem like a sensible check against waste and abuse.

In a more market-driven system, however, the problem would evaporate without the need for a ban on POHs. Individuals (or their plan sponsors) would control more of their healthcare dollars; prices would be transparent and site-neutral; and hospitals and physician-led facilities would compete on bundled prices, warranties, and measured outcomes. The alleged perils of physician ownership would be addressed through competition and reputation. Insurers and self-funded employers would exercise discipline on overuse through selective contracting, reference-based pricing, and value-based payments, and patients would reward cost-effective specialists.

In a free-market system, a physician's ownership stake in a hospital is no more a threat to the taxpayer than a chef's ownership stake in a restaurant is to an individual looking for a good place to dine.

Often in US health policy, we are in the position of needing to make multiple fixes simultaneously in order to take a real step forward. Philosophically, the ban is indefensible. Physicians should be as free as any other professionals to become entrepreneurs and form, finance, and run institutions. Entrepreneurship should not require special permission. In nearly every other industry, the very engine of specialization, quality improvement, and cost discipline is entrepreneurship. Entrepreneurial profit is a reward for foresight, innovation, and service. But prior policy decisions give the ban a veneer of justification.

If we let the POH ban stand, then incumbency triumphs over innovation, with large hospital systems holding a legislated shield against potential competitors. If we lift the ban but make no accompanying changes, some fleecing of the taxpayer could occur.

We ought to lift the ban on POHs while *simultaneously* making reforms that let individuals control more of their own healthcare dollars. This would incentivize physicians to compete on value, mitigating concerns about overutilization.

One way to do this is to pair the repeal of the POH ban with payment neutrality and consumer control. This would end the artificial price differences that federal policy has assigned to different sites of care. MedPAC has long recommended site-neutral payment to strip away hospital markups for services that can be safely delivered in lower-cost settings. Efficient entrants will thrive by being better at care, instead of being better at "location arbitrage."

Another way to do this is to put more real dollars under patient control. Empowering individuals with flexible accounts — yes, even in the Medicare and Medicaid contexts — would guard against overutilization. Evidence shows that when consumers face prices and control the marginal dollar, spending becomes more disciplined. This could be the proving ground for broader reforms involving the pairing of portable health savings accounts with catastrophic coverage in the Medicare and Medicaid populations.

Maintaining the ban on POHs is wrong. It denies clinicians the freedom to build their own institutions, and it denies patients the freedom to choose them. However, simply repealing the ban without making any other changes could open the door to overutilization at the expense of taxpayers, which is why we should pair the lifting of the ban with other changes. We should protect voluntary exchange among free individuals, while taking steps to align incentives so that patients, not political pull, direct the flow of dollars.

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