Physician-Owned Hospitals: Subsidy-Seekers or Market Disruptors?

Physicians and corporations should stop fighting each other to take on the status quo together.

By Reinier Schuur, PhD and Colleen Smith, MD

Bakers can own bakeries, barbers can own barbershops, but doctors can't own hospitals!?

Well, technically, they can. But Section 6001 of the Affordable Care Act (ACA) prohibits new Physician-Owned Hospitals (POHs) from getting paid by Medicare for seeing Medicare patients. With ninety-five percent of Americans over the age of sixty-five enrolled in Medicare, a hospital simply cannot afford to forgo such a massive share of the healthcare market.

Moreover, Medicare's conditions of participation severely restrict a non-participating hospital's interactions with Medicare providers and patients. The ban on POHs receiving Medicare dollars therefore also limits broader participation in the healthcare market. Indeed, since the ACA was enacted in 2010, the growth of new POHs has stalled, and many have closed their doors. Only the POHs that existed before the law's implementation can still receive Medicare dollars.

Given that Medicare dollars shape so much of the American healthcare market, the ban on POHs taking those dollars raises a pressing question for those who generally advocate for free markets in healthcare: Would repealing ACA Section 6001 be good for freedom because it lifts a restriction on the healthcare market, or would it be bad if it ends up increasing public spending?

Michael Cannon, CATO Institute's director of health policy, and neurosurgeon Dr. Anthony DiGiorgio—both fierce advocates for free markets—fundamentally disagree on the answer. To understand this divide, we have to look at why physicians were singled out in the first place.

The Case Against POHs Accepting Medicare Dollars

The ACA's statutory ban on POHs receiving Medicare dollars stemmed from three main fears: physician-hospital-owners' self-referrals creating a conflict of interest, physicians "cream-skimming" the best-paying or healthiest patients for themselves, thus threatening the viability of for-profit and nonprofit corporate-owned hospitals (COHs), and the specter of a "rent-seeking" or "subsidy-seeking" lobby of physicians going after taxpayer dollars.

For Cannon, the ban on POHs receiving Medicare dollars is not anti-free market for two reasons. First, Medicare is *a public program, not a private market*; therefore, the government has an obligation to taxpayers to protect the program from subsidy-seeking behaviors that target public funds. Second, physicians as a group *are* uniquely positioned to engage in behaviors that increase costs to taxpayers. In the absence of broader reforms targeting this physician lobby, Cannon views the ban as a necessary defense of the public purse.

From this perspective, lobbying efforts to repeal 6001 merely use the language of free markets as a cover for subsidy-seeking behavior. The ban protects taxpayer money from the strain of expanded Medicare spending; a repeal would balloon Medicare costs at taxpayers' expense.

The Case for Allowing POHs to Accept Medicare Dollars

Cannon's concerns make sense. After all, there is some evidence that physician ownership is associated with increased utilization. But there is also compelling data that provides a counterargument to Cannon's line of reasoning: it is actually the growth of COHs and their aggressive takeover of independent medical practices - *not POHs* - that pose the greater threat to taxpayers and patients' pocketbooks. This data indicates generally lower prices, higher-quality care, and no differences in patient acuity or reimbursement patterns for POHs.

That is the argument Dr. Anthony DiGiorgio has delivered in congressional testimony on the rising cost of healthcare. Indeed, since the passage of the ACA, the number of smaller independent, physician-owned practices has drastically declined. In their place, COHs have grown exponentially by acquiring competing facilities and absorbing independent doctors.

Crucially, the trend toward corporate-owned healthcare is not a market phenomenon driven by patient preference. Numerous regulations and reimbursement asymmetries rig the healthcare market in favor of corporate-led healthcare at the expense of physician-led healthcare, such as higher CMS reimbursements for COHs versus POHs, and facility fees and non-profit tax-exempt status that independent physicians lack. Moreover, as DiGiorgio testified, healthcare costs are notably higher in geographic areas dominated by consolidated corporate healthcare systems.

From this perspective, the ban on POHs receiving Medicare dollars is just one more regulation favoring corporate-led healthcare over physician-led models. Rather than protecting taxpayers

from greedy doctors in the name of fiscal responsibility, Section 6001 protects greedy corporations from the discipline of market competition. Therefore, it should be repealed.

Physician-Led Healthcare Versus Corporate-Led Healthcare

While both sides of this issue identify real pathologies, their dispute boils down to one narrow question: Who is a bigger threat to taxpayers, corporate executives or physician-entrepreneurs?

We believe that this question presents a false alternative, and that attempting to answer it to settle whether Section 6001 should be repealed will leave the underlying issues unresolved.

Cannon seems to assume that physician-owners are uniquely primed to exploit public funds compared to corporate owners. And DiGiorgio seems to assume that physicians are more virtuous market actors than are corporate overlords. But ownership structure is not the primary driver of rising costs; it's the system's underlying design that poses a threat to taxpayers because *both groups of owners respond to the same distorted financial incentives.*

Even if, for the sake of the argument, one class of owners proved to be a greater threat to taxpayers than the other, that is not a legitimate reason to ban *an entire class of owners*. All doctors should *not* be considered guilty until proven innocent, nor should all corporations.

The real threat to taxpayers is not who owns the hospitals, but who pulls their purse strings, which is ultimately the Centers for Medicare & Medicaid Services (CMS). Rising hospital costs are primarily the result of CMS's centralized, arbitrary price-setting system that mutes pricing signals. Moreover, CMS, by design, forces all specialties to compete over the same limited subsidy pie because it imposes strict participation rules governing how providers can operate in the wider market. Cannon's accusation of 'subsidy-seeking' is therefore deeply unfair because providers are not completely free to *seek* private alternatives per CMS's own rules.

Section 6001, therefore, arbitrarily penalizes physicians for an already distorted market yet leaves corporations free to exploit those very same distortions.

But the solution to this problem is not merely to level the playing field between corporate- and physician-owned and led healthcare by repealing Section 6001. Rather, it is to question the

separation between corporations and physicians in healthcare, which is itself a consequence of regulatory distortions and would not exist as it does in a free market.

Chief among the distortions are state laws limiting the so-called Corporate Practice of Medicine (CPOM). CPOM laws limit the ownership and management of medical practices to physicians. Hospitals are often exempt from CPOM laws, allowing them to realize necessary corporate capital investment.

While not exactly the same, the underlying rationale for CPOM laws closely mirrors that of Section 6001; allowing corporations to own and manage medical practices is bad for patients because corporations will prioritize profits at the expense of patients. But allowing physicians to own and manage hospitals is also seen as bad for patients for the very same reason.

Yet neither Section 6001 nor CPOM targets either the physicians or corporations *that do* inappropriately prioritize short-term profits at the expense of patients. Representatives of both groups have taken advantage of patients, profiting at their expense to the detriment of their long-term well-being.

And while theoretically protecting physicians from corporate influence, CPOM in practice actually disempowers physicians by cutting off the capital and business expertise they need to truly compete with larger hospital systems that are free to leverage these assets.

The real damage of laws such as section 6001 and CPOM is not necessarily that they disadvantage physicians over corporations (or vice versa); rather, it is that they pit physicians and corporations against each other in the first place.

Issues like 6001 and CPOM also create another clash that warrants rethinking: they unnecessarily set the freedom of both patients and physicians up against the interests of the American taxpayer.

Limiting Public Expenditure on Healthcare Versus Freeing the Private Pursuit of Health

The other false alternative driving this debate is that we need to choose between protecting taxpayers' interests and the freedom to produce and pursue healthcare privately. To be sure, the current system does pit these two against each other, but that is by no means a given.

In a truly free market, those who pay for healthcare and those who pursue health would be the same person — the individual paying patient. Taxpayer-funded healthcare, on the other hand, by its very nature separates those who pay for (most) of healthcare, the taxpayer, from those who pursue health, the patient. This separation creates a conflict when determining what healthcare is worth paying for. Worth it to *whom*? The taxpayer or the patient? And *which* taxpayer and *which* patient?

Such conflicts violate each individual's right to pursue their *own* health. But two conditions further violate such a right. The first is when no private market is allowed to exist in parallel to the public healthcare system. The second is when, in theory, there is a parallel private market to the public healthcare system, yet in practice the public system shapes this private market to such an extent that there is a private market in name only, because its actors aren't truly free.

This second condition is pervasive in the American healthcare system. It is not merely the size of Medicare and Medicaid that warps the so-called private healthcare market; it is their conditions of participation that indirectly force all would-be private actors to accept CMS pricing schedules, which are products of bureaucracy, not markets. Both Cannon and DiGiorgio have written at length on the lack of a real market in American Healthcare.

Under both of these conditions — no parallel market at all or heavy government control of an alleged market — your right to privately pursue your own health is violated, not because you have a right to taxpayer-funded healthcare, but because the taxpayer-funded healthcare system limits and distorts your pursuit of health.

The solution to this problem is not merely to balance sacrificing the interests of taxpayers with violating the interests of those pursuing their own health. Rather, in the absence of a truly free market, the solution is to untangle the interests of both groups. That is, unlike the separation between physicians and corporations, which is artificial and should be broken down, *public expenditure on healthcare and its private pursuit are not nearly separated enough*, and we should work to separate them as much as possible.

As long as our limited private system is so inextricably linked to the public system, cutting public spending or justifying policies solely on the grounds that they protect taxpayers' interests unnecessarily holds the right to pursue your own health hostage to legitimate taxpayer concerns.

A proper reform effort would therefore seek to radically relax CMS's rules of participation, thereby limiting its outsized role as a *de facto* price setter and rule maker for the entire healthcare system. At the state level, the ambiguity or prohibition on parallel practice in Medicaid should be clarified or lifted, so that Medicaid patients can see providers privately outside of the program (a practice that is normal in most advanced countries).

The Principled Case for Repealing ACA Section 6001

Our verdict is that whether one's advocacy toward keeping or repealing Section 6001 is right depends on what one's broader plans, goals, and actions are for reforming American healthcare. If physicians were pushing for a narrow repeal of Section 6001 and *nothing more,* such efforts would ring hollow to us. Such a lack of interest in other related policy issues would undermine whatever moral high ground they might claim in the interest of fairness or anti-discrimination.

In such a case, they would deserve to be thought of as "subsidy-seekers" because their inactivity would suggest approval of the broader context that gives rise to this thorny issue. By contrast, physicians who support repealing Section 6001 *and do so clearly as part of a broader effort to reduce special privileges, eliminate payment distortions, flatten the reimbursement treatment of all owners, providers, sites, and settings, and move healthcare to a more market-oriented framework* can plausibly claim that they are on the right side of the issue *for the right reasons.*

Any *good* reform of Section 6001 should not further entrench the artificial separation between physicians and corporations, nor further force private enterprise and pursuit of healthcare to conflict with the interests of taxpayer-funded care. Put positively, as much as possible, reforms should further the private pursuit of health within our system.

We should reject reforms that seek to repeal 6001 while simultaneously imposing stricter CPOM laws, or seek to increase payments for POHs above those of COHs. Replacing corporate-led

healthcare with physician-led healthcare is not pro-free-market; it merely replaces one beneficiary of a government-distorted healthcare market with another.

The real divide isn't between physicians and corporations or between public spending and pursuing health; it's between those physicians and corporations who want to change the system to one in which everyone's wider interests can profitably align, versus those who want to maintain a system where narrowly constructed interests and "subsidy-seekers" must clash.

Word count: 2161