RECONSIDERING THE BAN ON PHYSICIAN-OWNED HOSPITALS TO COMBAT CONSOLIDATION

Matthew C. Mandelberg
Michael H. Smith
Jesse M. Ehrenfeld
*Brian J. Miller**

Ongoing consolidation by hospitals and providers threatens to further reduce competition in U.S. healthcare markets. Physician-owned hospitals (POHs) served as a rare countertrend for many years—a pathway for innovative and efficient alternatives to enter hospital markets and offer a bulwark against this consolidation. However, that countertrend came to an abrupt and enduring halt in 2010, when hospital incumbents leveraged passage of the Affordable Care Act to obtain an ill-conceived and unrelated ban on POHs. While health services researchers have scrutinized the POH ban, this Article analyzes it through a competition lens. It incorporates the growing attention in antitrust to labor markets and explores how physicians, through POHs, are particularly well-positioned to identify market opportunities. In doing so, physicians can defeat the market power possessed by hospital incumbents, upstream against physicians and downstream against payors and patients.

This Article first provides an overview of the seemingly inexorable trends towards further consolidation among healthcare providers and the related competition concerns this consolidation raises. Next, the paper discusses the factors that positioned POHs to counterbalance these consolidation trends as market entrants and innovators, and how, after lobbying by incumbent hospitals and health systems, POHs faced regulatory pushback culminating in a

* Matthew C. Mandelberg, J.D., M.P.A., Attorney, Appellate Section, Antitrust Division, U.S. Department of Justice (written in his personal capacity and not as a representative of the DOJ; the views expressed do not necessarily reflect those of the United States Department of Justice). Michael H. Smith, J.D., Attorney, Technology Enforcement Division, Bureau of Competition, Federal Trade Commission (written in his personal capacity and not as a representative of the FTC; the views expressed are his own and not necessarily those of the Commission or any individual Commissioner); Adjunct Professor, Georgetown University Law Center. Jesse M. Ehrenfeld, M.D., M.P.H., FAMIA, FASA, FCPP, President, American Medical Association; Senior Associate Dean & Tenured Professor of Anesthesiology, Department of Anesthesiology, Medical College of Wisconsin; Director, Advancing A Healthier Wisconsin Endowment. Brian J. Miller, M.D., M.B.A., M.P.H., Assistant Professor of Medicine at the Johns Hopkins University School of Medicine; Nonresident Fellow at the American Enterprise Institute; Commissioner, Medicare Payment Advisory Commission, the views here are his own and do not necessarily represent those of any of his employers or affiliations. We are grateful to our families, with special appreciation to our partners: Lindsay R. Chura, Talia M. Schatz, and Judd H. Taback.

federal ban on further POH growth and expansion. The Article then describes how market power by hospital incumbents in both upstream and downstream markets accentuates the incentives and importance of physicians in identifying opportunities for market entry and innovation. It further discusses how the POH ban affects healthcare competition, identifies the potential benefits of relaxing the ban, and suggests more narrowly tailored policy options that could mitigate policymakers' concerns about POHs—concerns that may not be unique to physician ownership and do not justify depriving the market of POH competition. The Article concludes with our recommendation that Congress remove the ban on POHs and apply more appropriately tailored policies.

Introduction

U.S. healthcare provider markets continue to grow increasingly concentrated. This ongoing consolidation can reduce innovation and leave those seeking medical care with fewer provider choices, reduced quality of care, and higher prices. For doctors, nurses, and other healthcare workers, it can reduce employment opportunities, benefits, and pathways to practice and improve medicine. Provider consolidation is a leading concern among the antitrust community, the health policy community, market participants, and community stakeholders, yet existing policy proposals have been inadequate to stall or reverse these trends. This Article aims to help fill that gap, arguing that lawmakers could reinvigorate a dynamic source of entry and competition by revisiting the ill-advised ban of physician-owned hospitals ("POHs"), a peripheral change added to secure passage of the 2010 Patient Protection and Affordable Care Act ("ACA").

POHs represented one of the few countertrends to hospital consolidation in recent history. They grew rapidly in number from 67 in the early 2000s to approximately 250 by 2010 (in a country of just over 6,000 hospitals), in spite of high barriers to entry and resistance by incumbents. Despite this rapid growth and its potential to disrupt the market power of incumbent hospitals, this story of market entry came to an abrupt and enduring halt in 2010. After intense lobbying by incumbent hospitals, a ban on new or expanded POHs was added to the ACA. This biproduct of legislative horse trading was entirely inconsistent with the laudable goals of the ACA, which sought to expand healthcare access and promote competition in insurance markets. It also was anomalous in barring a market's premier technical experts and practitioners (i.e., physicians) from the roles of owner and innovator.

The POH ban is an important, largely overlooked obstacle to increased competition in healthcare markets. The time is ripe to reexamine the ban. The recent publication of the first systematic review of over a decade's worth of health services research on the cost and quality of POH services calls into question the purported justifications for the POH ban offered by incumbent hospitals.[1] This Article builds on this research by offering a competition policy perspective.

This Article uniquely addresses the interplay of three kinds of markets where hospitals may exercise increasing market power and where that power is further entrenched by the POH ban: downstream (output) markets to provide patients hospital services, downstream (output) markets for the sale of hospital services to payors, and upstream (input) labor markets where hospitals compete for physician services.[2] This analytic approach quickly bears fruit. Because hospital market power can be exercised both upstream against physicians and downstream against insurers and patients, physicians have unique incentives to defeat this market power. In doing so, physicians can benefit both themselves and downstream patients and payors. Moreover, physicians are particularly well-positioned to identify and act on hospital market opportunities for entry and innovation, given their unique role in providing and directing care, their relationships with market participants, and their access to capital. As mere employees of dominant hospital systems, physicians may not have the incentive or ability to seize these opportunities, but by becoming hospital owners, they are given the incentive and ability to do so.

Removing the POH ban could help allay consumer harms caused by provider consolidation and the shrinking role of physicians in leading and designing patient care. POHs can enhance competition in markets where hospitals may be exercising market power, which is vital for reducing costs and improving quality. This benefits patients (which is eventually everyone) and also taxpayers who fund publicly-financed health benefits for nearly one in two Americans. Physicians also benefit

1. Ted Cho et al., Mercatus Ctr. at George Mason Univ., Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review (2021), https://deliverypdf.ssrn.com/delivery.php?ID=770086120101088015116090108078096102097019000017052006005001 0112500212101012003009801103311 601101405112508900110309407109311111904104602805009509608810511900712506403207912301107109208802900109208710409308206612008512201511401807411302401500008 1083&EXT=pdf&INDEX=TRUE [https://perma.cc/9HCN-LF7N].

2. This paper uses the term "markets" to describe various services affected by the ban on physician-owned hospitals. This paper does not purport to define relevant antitrust markets in the legal sense of the term and takes no position on whether any specific services in any particular geographic areas would in fact constitute relevant antitrust markets.

from the increased competition for their services and greater opportunities for entrepreneurship and innovation in patient care.

This Article proceeds as follows. Part I provides an overview of the seemingly inexorable trend toward further consolidation among healthcare providers and the competition concerns this consolidation raises. Part II discusses the factors which position POHs well as potential innovators and market entrants, describing the history of their rapid growth and the opposition they faced from incumbents culminating in the ACA ban. Part III describes how the accrual of market power by incumbent hospitals and health systems accentuates the incentives and importance of physicians to identify opportunities for market entry and innovation. Part IV then discusses the effects of the POH ban on competition in healthcare markets, the benefits of relaxing the ban, and the value of more narrowly tailored policies to address concerns not exclusively associated with physician ownership. Lastly, the Article concludes with our recommendation that Congress remove the ban on POHs.

I. Trends and Competition Concerns in Hospital Markets

For decades, concern has been building about consolidation among health care providers, including standalone hospitals, multi-hospital health systems, and related businesses (e.g., physician practices, ambulatory surgery centers,[3] and home health care agencies). Multiple threads of evidence suggest that market concentration in healthcare provider markets is high and growing, implicating the accumulation and misuse of market power. There were 1,412 hospital mergers from 1998 to 2015, with 561 occurring from 2010 to 2015.[4] From 2010 to 2016, the share of primary care physicians employed by hospitals increased from 28 percent to 44 percent.[5] Larger physician practices have been growing larger while smaller practices have been growing smaller.[6] Per recent estimates, over 90 percent of metropolitan statistical areas

3. *Ambulatory Surgery Centers: A Positive Trend in Healthcare*, Ambulatory Surgery Ctr. Ass'n, https://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare [https://perma.cc/VE6G-E37P] ("Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting.").

4. *Examining the Impact of Health Care Consolidation*: *Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Com.*, 115th Cong. (2018) [hereinafter *2018 Health Care Consolidation Hearing*] (statement of Martin Gaynor, Professor, Carnegie Mellon Univ.).

5. Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 Health Affs. 1530, 1534 (2017).

6. *2018 Health Care Consolidation Hearing*, *supra* note 4 (statement of Martin Gaynor, Professor, Carnegie Mellon Univ.) (defining larger practice as 11 or greater physicians and smaller practice as 10 or fewer physicians).

(MSAs) were consolidated for hospitals, 65 percent for specialist physicians, and 39 percent for primary care physicians.[7]

For many physician specialties, this trend continues apace. Over half of physicians (51%) are now affiliated with vertically integrated health systems, after an 11 percent increase just from 2016 to 2018.[8] This trend is pronounced in procedural practice areas like cardiology and orthopedics[9] that are commonly offered at physician-owned specialty hospitals.

This consolidation can be harmful for patients and payors.[10] Competition tends to result in lower prices, higher quality, higher output, and more innovation. When paired with high entry barriers, increased consolidation can reduce competition and enhance the market power of incumbent market participants. Indeed, courts find that hospital markets exhibit high entry barriers.[11] Not surprisingly then, research finds that mergers and increased consolidation in hospital markets are associated with higher prices,[12] worse patient experience, and lack of quality improvements.[13] Higher hospital prices are passed onto patients and the public through higher health insurance costs and reduced wages.[14]

Consolidation can harm important aspects of hospital quality and safety including overall mortality and readmission rates.[15] Insufficient safety is a persistent problem as prominently highlighted by the

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7. Fulton, *supra* note 5, at 1534 (using the Herfindahl-Hirschman Index (HHI) to identify highly concentrated MSAs).

8. Michael F. Furukawa et al., *Consolidation of Providers into Health Systems Increased Substantially, 2016-18*, 39 Health Affs. 1321, 1322 (2020).

9. Fulton, *supra* note 5, at 1531.

10. *E.g.*, Fed. Trade Comm'n, FTC Policy Perspectives on Certificates of Public Advantage (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf [https://perma.cc/D5GM-8K9D]; Karyn Schwartz et al., *What We Know About Provider Consolidation*, KFF (Sept. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/ [https://perma.cc/ZT5Z-PZAT].

11. *See infra* Part III.A.4.

12. Martin Gaynor & Robert Town, The Synthesis Project, The Impact of Hospital Consolidation - Update (2012), https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=0cf955cf2e6ce5428a61fdf7666df8123ee27c5d [https://perma.cc/GD63-36NV].

13. Nancy D. Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 New Eng. J. Med. 51, 56 (2020).

14. *See* Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, Rand Corp. (2020), https://www.rand.org/content/dam/rand/pubs/working_papers/WRA600/WRA621-2/RAND_WRA621-2.pdf [https://perma.cc/3APS-KW3W]; Gaynor & Town, *supra* note 12; Jean Marie Abraham et al., *Entry and Competition in Local Hospital Markets*, 55 J. Indus. Econ. 265 (2007).

15. *See, e.g.*, Erwin Wang et al., *Quality and Safety Outcomes of a Hospital Merger Following a Full Integration at a Safety Net Hospital*, 5 JAMA Network Open e2142382 (2022).

Institute of Medicine's landmark 1999 report, *To Err is Human*.[16] To this day, preventable, adverse hospitalization events remain too high and represent "an urgent national public health issue."[17] Many mitigation strategies are inconsistently implemented at the hospital level,[18] suggesting that more competition and innovation could induce more health systems to implement better safety systems.

In addition to its effects on downstream patients and payors, hospital consolidation can also affect upstream markets for hospital labor, including physician services. Over the past 25 years, the Bureau of Labor Statistics ("BLS") has found that private community hospital labor productivity growth has been stagnant or negative.[19] This is in sharp contrast with businesses generally, which saw a doubling of labor productivity over the same time period.[20] Though BLS suggests some of this difference reflects "many [measurement] challenges," along with shifts in hospital services from inpatient to outpatient care,[21] the scale of this discrepancy strongly suggests there is significant scope for improvements and innovation in hospital labor markets.

Federal antitrust agencies have long been concerned that "[a] merger between competing buyers may harm sellers just as a merger between competing sellers may harm buyers."[22] In recent years, buyer

16. U.S. Inst. of Med., To Err Is Human: Building a Safer Health System (Linda T. Kohn et al., eds., 1999).

17. President's Council of Advisors on Science and Technology, A Transformational Effort on Patient Safety 2 (2023), https://www.whitehouse.gov/wp-content/uploads/2023/09/PCAST_Patient-Safety-Report_Sept2023-Letter-ExecSumm.pdf [https://perma.cc/42SP-9JKV]; U.S. Dep't of Health and Hum. Servs., Off. of Inspector General, OEI-06-18-00400, Adverse Events in Hospitals: A Quarter of Medicare Patients Experiences Harm in October 2018 (2022), https://oig.hhs.gov/oei/reports/OEI-06-18-00400.pdf [https://perma.cc/E47W-KKJP].

18. *See, e.g.*, David W. Bates & Hardeep Singh, *Two Decades Since* To Err Is Human: *An Assessment of Progress and Emerging Priorities in Patient Safety*, 37 Health Affs. 1736, 1737 (2018) ("Much of the remaining variation in hospital infection rates is believed to result from inconsistency in the use of prevention techniques.").

19. *Private Community Hospitals Labor Productivity*, U.S. Bureau of Lab. Stats. (Jun. 29, 2023), https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm#:~:text=The%20BLS%20output%20measure%20for,the%20intensity%20of%20those%20treatments [https://perma.cc/X8FV-KABC].

20. BLS Data Viewer of Major Sector Productivity and Costs, U.S. Bureau of Lab. Stats. (2023), https://beta.bls.gov/dataViewer/view/timeseries/PRS84006093 [https://perma.cc/U4DH-BMMF] (index to 1993 and data until 2020).

21. *Private Community Hospitals Labor Productivity*, *supra* note 19.

22. U.S. Dep't of Just. & Fed. Trade Comm'n, Merger Guidelines § 2.10 (2023) [hereinafter 2023 Merger Guidelines], https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf [https://perma.cc/D63F-5J6G]; U.S. Dep't of Just. & Fed. Trade Comm'n, Horizontal Merger Guidelines § 1 (2010) [hereinafter 2010 HMG], www.ftc.gov/system/files/

market power over labor markets has been the source of increased antitrust scholarship[23] and enforcement,[24] including cases addressing market power over healthcare service providers such as physicians.[25] Recent trends suggest closer scrutiny of physician service markets is appropriate. As hospital markets have consolidated, physician employment has changed, with 50.2% of physicians reporting being employees in 2020 and 40% of physicians reporting working directly for a hospital or in a practice with at least partial health system ownership (as opposed to private practice, where physicians provide care through an entity wholly owned by physicians).[26] Physician-hospital consolidation, especially in the form of integrated delivery systems, has been found to increase prices for physician services[27] and treatment intensity

documents/public_statements/804291/100819hmg.pdf [https://perma.cc/4MXU-JKSZ] ("Enhancement of market power by buyers, sometimes called 'monopsony power,' has adverse effects comparable to enhancement of market power by sellers."); U.S. DEP'T OF JUST. & FED. TRADE COMM'N, 1992 MERGER GUIDELINES § 0.1 (1992) (applying an "analogous" legal framework to "monopsony concerns"), https://www.justice.gov/sites/default/files/atr/legacy/2007/07/11/11250.pdf [https://perma.cc/K5GZ-BCUT]; U.S. DEP'T OF JUST., 1982 MERGER GUIDELINES 2 n.5 (1982), https://www.justice.gov/sites/default/files/atr/legacy/2007/07/11/11248.pdf ("Market power by buyers has . . . effects analogous to those associated with market power by sellers.").

23. *See, e.g.*, Suresh Naidu et al., *Antitrust Remedies for Labor Market Power*, 132 HARV. L. REV. 537 (2018).

24. *See e.g.*, United States v. Bertelsmann SE & Co. KGaA, 646 F. Supp. 3d 1, 11 (D.D.C. 2022) (noting the "government's case sounds in 'monopsony,' a market condition where a buyer with too much market power can lower prices or otherwise harm sellers"); U.S. DEP'T OF JUST. ANTITRUST DIV. & FED. TRADE COMM'N, ANTITRUST GUIDANCE FOR HUM. RES. PROS. (2016), https://www.justice.gov/atr/file/903511/download [https://perma.cc/ZQ6M-MPT3]; Press Release, U.S. Dep't of Just., Health Care Company Pleads Guilty and is Sentenced for Conspiring to Suppress Wages of School Nurses (Oct. 27, 2022), https://www.justice.gov/opa/pr/health-care-company-pleads-guilty-and-sentenced-conspiring-suppress-wages-school-nurses [https://perma.cc/EQ52-9EZ2].

25. *E.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 187 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017) (noting "plaintiffs allege . . . the merger will result in harm to competition in the market for the purchase of healthcare services, or a monopsony" though not reaching this claim because the court found in plaintiff's favor on other grounds); Press Release, U.S. Dep't of Just., Justice Department Comments on Settlement in Private "No-Poach" Class Action That Allows Government to Enforce Injunction Against Duke University (Nov. 8, 2019), https://www.justice.gov/opa/pr/justice-department-comments-settlement-private-no-poach-class-action-allows-government [https://perma.cc/N6D2-H9XG].

26. Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, AMA POLICY PERSPS. (2021), https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf [https://perma.cc/P4AY-BCJB].

27. Caroline S. Carlin et al., *The Impact of Provider Consolidation on Physician Prices*, 26 HEALTH ECON. 1789 (2017) (finding higher physician prices post acquisition of clinics).

at hospital settings,[28] yet physicians do not necessarily benefit in the form of increased wages under a model where they are salaried employees.[29] Further research examining 803 hospitals that switched to an employment model compared to 2,085 control hospitals demonstrated that acquisitions of physician practices were not associated with improvements in quality of care,[30] a finding that runs counter to efficiency arguments made by health systems that pursue these mergers.[31]

Physician labor markets have also been impacted by various anticompetitive practices employed by those with market power. As a stark example, two university-based medical schools, the University of North Carolina at Chapel Hill and Duke University, were alleged to have entered into a no-poach agreement with one another—an agreement to not compete for the services of each other's physicians. This prompted a class action lawsuit where the Antitrust Division of the Department of Justice intervened,[32] ultimately leading to a $54.5 million settlement.[33] Providers' increased monopsony power and greater use of an employee model may also contribute to greater use of non-compete agreements in physician employment.[34] Non-compete agreements in labor markets were the subject of 2019 Department of Justice ("DOJ")[35] and 2020 Federal Trade Commission ("FTC")[36] workshops, given their potential

28. Christopher M. Whaley et al., *Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration*, 40 HEALTH AFFS. 702 (2021).

29. Christopher M. Whaley et al., *Physician Compensation In Physician-Owned And Hospital-Owned Practices*, 40 HEALTH AFFS. 1865 (2021).

30. Kirstin W. Scott et al., *Changes in Hospital–Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care*, 166 ANNALS INTERNAL MED. 1 (2016).

31. The Federal Trade Commission is also undertaking an econometric study of physician-hospital consolidation using data from six health plans. Press Release, Fed. Trade Comm'n, FTC to Study the Impact of Physician Group and Healthcare Facility Mergers (Jan. 14, 2021), https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers [https://perma.cc/S6X9-G36N].

32. Order Granting the United States of America's Unopposed Motion to Intervene, Seaman v. Duke Univ., No. 15-CV-462-CCE-JLW, 2019 WL 4674758 (M.D.N.C. May 22, 2019); *see also* Statement of Interest of the United States of America, *id.*, No. 15-CV-462-CCE-JLW (M.D.N.C. Mar. 7, 2019).

33. Jake Satisky, *Duke Agrees to Pay $54.5 Million to Settle Class Action Lawsuit*, CHRONICLE (May 25, 2019), https://www.dukechronicle.com/article/2019/05/duke-university-settles-class-action-lawsuit-for-54-5-million [https://perma.cc/8SWZ-9XPW].

34. *Cf.* Kurt Lavetti et al., *The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians*, 55 J. HUM. RES. 1025, 1042 (2020) (finding physician employees are more likely to have non-compete agreements than physician owners).

35. *Public Workshop on Competition in Labor Markets*, U.S. DEP'T OF JUST. ANTITRUST DIV. (Sept. 23, 2019), https://www.justice.gov/atr/event/public-workshop-competition-labor-markets [https://perma.cc/J4SD-XX5P].

36. *Non-Competes in the Workplace: Examining Antitrust and Consumer Protection Issues*, FED. TRADE COMM'N (Jan. 9, 2020), https://www.ftc.gov/news-events/

to decrease labor mobility, reduce competition, and suppress wages. More recently, non-competes have been the subject of successful FTC enforcement actions[37] and a proposed rulemaking banning non-competes.[38] There are reasons to think their potential anticompetitive effects in physician labor markets likely outweigh the purported benefits,[39] especially if their use or the strictness of their terms increases in concentrated labor markets, rather than in competitive labor markets.

Unfortunately, the potential exercise of market power in physician labor markets can be further exacerbated by regulations. For example, state laws that restrict the use and portability of medical licenses issued by other states reduces the ability of physicians to move or offer services across state lines.[40]

This Article is far from the first to report on these alarming and persistent consolidation trends in healthcare markets. Some in the literature have suggested various approaches to try to address these trends, such as increased agency resources for antitrust enforcement,[41] revi-

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events-calendar/non-competes-workplace-examining-antitrust-consumer-protection-issues [https://perma.cc/C3DC-UPDH].

37. *See* Press Release, Fed. Trade Comm'n, FTC Cracks Down on Companies That Impose Harmful Noncompete Restrictions on Thousands of Workers (Jan. 4, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/01/ftc-cracks-down-companies-impose-harmful-noncompete-restrictions-thousands-workers [https://perma.cc/HZJ3-5N6G] (describing FTC legal actions against firms for imposing non-competes); *In re* DaVita, Inc., F.T.C. File No. 211-0013 (2021), https://www.ftc.gov/system/files/documents/cases/davita_order_9_24_final.pdf [https://perma.cc/4V56-JFQK] (agreeing to drop physician non-competes as part of a merger remedy).

38. Non-Compete Clause Rule, 88 Fed. Reg. 3482 (proposed Jan. 19, 2023) (to be codified at 16 C.F.R. pt. 910).

39. *See, e.g.*, Letter from James L. Madara, MD, CEO & Exec. Vice President, Am. Med. Ass'n to Joseph J. Simons, Chair, Fed. Trade Comm'n (Feb. 7, 2020), https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-2-7-Letter-to-Simons-re-Non-Compete-in-the-Workplace.pdf [https://perma.cc/3HX8-GEH9]; Louis Garcia, *Lose-Lose: Noncompete Agreements Hurt Doctors and Patients*, Am. Acad. Fam. Physicians: News Blog (Mar. 3, 2021), https://www.aafp.org/news/blogs/freshperspectives/entry/20210303fp-noncompete.html [https://perma.cc/6HR2-DVV7].

40. *See U.S. State Participation in the Compact*, Interstate Med. Licensure Compact, https://www.imlcc.org/#map [https://perma.cc/D6G2-MD22]; *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, Fed'n St. Med. Bds. (Dec. 21, 2022), https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf [https://perma.cc/F6XX-RPPY] (listing only 2 states that still have telehealth out-of-state licensure waivers due to the COVID-19 emergency).

41. *See, e.g.*, *Antitrust Applied: Hospital Consolidation Concerns and Solutions: Hearing Before the Subcomm. on Competition Pol'y, Antitrust, & Consumer Rts. of the S. Comm. on the Judiciary*, 117th Cong. 17–18 (2021) (statement of Martin Gaynor, E.J. Barone University Professor of Economics and Health Policy, Heinz College, Carnegie Mellon University). Brian Miller, a co-author of the present paper, also testified at

sions to the antitrust laws and merger guidelines,[42] rate setting for all payers (commercial and government),[43] and global budgets (where providers receive a fixed payment for a patient population)[44] or other forms of price regulation (e.g., administrative pricing, price caps, price growth gaps, etc.).[45]

This Article is distinct from prior scholarship in noting the links between the upstream and downstream effects of provider consolidation and how POHs may be especially effective at entering and intensifying competition in upstream markets for the employment of physicians and in downstream markets for the provision of physician hospital services to payers and consumers. Part II explores the market entry potential of POHs and how their success in the early 2000s faced regulatory pushback culminating in the ACA ban.

II. Market Entry by Physician-Owned Hospitals Emerges as a Countertrend to Hospital Consolidation and Receives Regulatory Pushback

The POH model represented a promising source of new entrants in healthcare provider markets until 2010 when the hospital industry successfully lobbied for a ban on new or expanded POHs. This Part first analyzes the characteristics of POHs that—absent the ban—facilitate hospital market entry. It then reviews the rapid growth of POHs and the 2010 ban that removed this promising source of new entrants.

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this hearing regarding harms of hospital consolidation and potential legal and policy reforms. *See id.* (testimony of Brian Miller, Assistant Professor of Medicine at the Johns Hopkins University School of Medicine).

42. *See, e.g.*, *id.* at 18 (statement of Martin Gaynor).

43. *See, e.g.*, Robert Murray & Robert A. Berenson, Urb. Inst., Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform? (Nov. 2015), https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf [https://perma.cc/7USK-2BM6].

44. *See, e.g.*, Troyen A. Brennan, *Maryland Hospital All-Payer Model: Can It Be Emulated?*, Health Affs. Forefront (May 31, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220526.939479/; Maximilian Pany et al., *Price Regulation, Global Budgets, and Spending Targets: A Road Map to Reduce Health Care Spending, and Improve Affordability*, KFF (May 31, 2022), https://www.kff.org/health-costs/report/price-regulation-global-budgets-and-spending-targets-a-road-map-to-reduce-health-care-spending-and-improve-affordability/ [https://perma.cc/PB34-3JD2].

45. *See, e.g.*, *Capping Hospital Prices*, Comm. Resp. Fed. Budget (Feb. 23, 2021), https://www.crfb.org/papers/capping-hospital-prices [https://perma.cc/N4D8-S9SL]; Michael E. Chernew et al., Hamilton Project, A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market (Mar. 2020), https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf [https://perma.cc/U5VA-8JT8].

A. Physicians as Innovators and Entrepreneurs for Hospitals

Physicians and physician ownership offer value to the hospital industry; physicians are experts who can identify market opportunities for entry and innovation that others might miss. Ownership gives physicians incentives to pursue those opportunities by allowing them to profit from entry and innovation. The POH model also provides additional means to attract and retain physicians by providing them an ownership stake in a hospital.

1. The Unique Role of Physicians in Providing and Directing Care Helps Them Identify Opportunities for Hospital Market Entry and Innovation

Healthcare provider markets stand to benefit from both new entry and innovation. Physicians are well-positioned to identify opportunities for both entry and innovation because they are highly-trained experts in medical science and practice, they work closely with patients and other stakeholders, and they often have significant business-related experience from their medical practices.

Physicians are technical experts in medicine based on their extensive scientific education, medical training, and their role directing patient care on a team of providers. They are the only licensed healthcare providers who can perform most surgeries and procedures and can prescribe most medicines; other licensed providers (physicians assistants, nurse practitioners, etc.) are frequently limited by their training or by laws that restrict or require physician oversight of their practice.[46] Given their comprehensive technical knowledge and broader perspective on patient care, physicians are well-positioned to innovate on the services they provide.

Physicians also sit at the forefront of the business of medicine as the coordinators for patient care. They often engage directly with patients—the consumers of hospital services. Even as salaried hospital employees, physicians help patients navigate the medical benefits and the pecuniary costs of important medical decisions during medical visit.[47] Physicians frequently have management experience from owning a clinical practice or ambulatory surgical center, leading clinical

46. *See e.g.*, Andrew I. Gavil et al., Fed. Trade Comm'n, Competition and the Regulation of Advanced Practice Nurses 1–2 (Mar. 2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [https://perma.cc/TZ9F-894Q] (providing a competition perspective on physician supervision requirements).

47. Brian Miller et al., *Price Transparency: Empowering Patient Choice and Promoting Provider Competition*, 44 J. Med. Sys. 80, 82 (2020); Brian Miller et al.,

teams, or helping to run hospital departments as department chairs. They are familiar with the coverage and bureaucratic requirements for reimbursement from public and private payers. Physicians are the primary coordinators responsible for marshalling staff to provide complex services or procedures, as well as for managing and referring patients for follow-on care. In this role, physicians gain a thorough understanding of which providers are needed for a range of patient needs within a given specialty. They also grow familiar with the range of specific providers available in a given market. From this vantage on day-to-day medical practice, physicians can develop insights into how a market is performing and collect actionable information for improving hospital services, making them strong healthcare business leaders. Indeed, research shows that while hospitals infrequently employ physicians as CEOs,[48] hospitals with physician-executives experience improved quality of services without an associated loss in profits.[49] Additionally, physicians may have access to capital, reflecting their relatively high incomes, educational attainment, and social capital.[50] Thus, physicians are well-placed to know where there are opportunities for entry and innovation in healthcare markets and to take action on those opportunities as entrepreneurs.

A ban on physician-owned hospitals is a ban on technical experts owning their business ventures, which runs counter to the approach in other industries. For example, venture capital investors will often hesitate to invest in technology start-ups without a technical founder,[51] and

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Redefining the Physician's Role in Cost-Conscious Care: The Potential Role of the Electronic Health Record, 322 J. Am. Med. Ass'n 721, 722 (2019).

48. *Should Hospital CEOs Be Physicians?*, BHM Healthcare Sols. (Feb. 27, 2015), https://bhmpc.com/2015/02/hospital-ceos-physicians/ [https://perma.cc/3X2J-9U8H] (noting that only 5% of hospital CEOs are physicians).

49. Michael C. Tasi et al., *Does Physician Leadership Affect Hospital Quality, Operational Efficiency, and Financial Performance?*, 44 Health Care Mgmt. Rev. 256, 256–57 (2019).

50. *See, e.g.*, Will Maddox, *Physicians Buy Out Steward Health Care from Private Equity Group*, D Mag. (June 5, 2020), https://www.dmagazine.com/healthcare-business/2020/06/physicians-buy-out-steward-health-care-from-private-equity-group/ [https://perma.cc/C343-7UJN] (describing physician purchase of a health system from private equity investors); Neil Badlani, *Ambulatory Surgery Center Ownership Models*, 5 J. Spine Surgery S195, S195 (2019) (noting physicians are frequent developers and investors in ambulatory surgery centers).

51. *See, e.g.*, Marc Andreessen, Quora (2011) ("it is irresponsible to start a technology company without a technical founder, for all but a very small number of non-technical entrepreneurs."), https://www.quora.com/How-important-is-it-to-have-a-technical-cofounder-in-order-to-get-funding-from-a-VC-or-an-incubator-seed-program-in-Ecommerce [https://perma.cc/DT76-Q9WS]; Adora Cheung, *How to Find a Technical Co-Founder*, Y Combinator, https://www.ycombinator.com/library/3i-how-to-find-a-technical-co-founder [https://perma.cc/K87D-PHYY] (last visited Dec. 25, 2022)

at least one study has found that start-ups that have technical founders who hire businesspeople are more likely to succeed than the reverse.[52] While the technology industry is different in many ways from the hospital industry, technical expertise is relevant to both. Indeed, non-physician investors can and do benefit when they hire physicians as leaders and managers.[53] A ban on software companies owned by founders with computer science degrees would on its face appear absurd; but that is analogous to the ban on physician-owned hospitals. Instead, hospitals should be allowed to operate like other businesses that offer professional services, like law firms, where the technical experts also serve as both owners and employees.[54]

2. Physician Ownership Provides Incentives and Opportunities for Market Entry and Innovation

Physicians have always been healthcare entrepreneurs, making this ban even more counterproductive. For example, around 70% of physicians had an ownership stake in their medical practices in the 1980s, and despite steady declines, 44% had an ownership stake in their practices as of 2022.[55] Over the past 50 years, physicians pioneered ambulatory surgery centers, freestanding sites that perform outpatient surgeries.[56] Physicians have an ownership stake in approximately 90%

("You first need to understand how important it is to have a technical co-founder. . . . [I]f you plan to fundraise, any investor will think this.").

52. Martin Murmann, *The Startups Most Likely to Succeed Have Technical Founders Who Quickly Hire Businesspeople*, HARV. BUS. REV. (Nov. 06, 2017), https://hbr.org/2017/11/the-startups-most-likely-to-succeed-have-technical-founders-who-quickly-hire-businesspeople [https://perma.cc/AM2C-TNXG]; Bettina Müller & Martin Murmann, *The Workforce Composition of Young Firms and Product Innovation – Complementarities in the Skills of Founders and Their Early Employees* (Ctr. for Eur. Econ. Rsch. Discussion Paper No. 16-074, 2016), https://ftp.zew.de/pub/zew-docs/dp/dp16074.pdf [https://perma.cc/KN5W-P76H].

53. Tasi et al., *supra* note 48, at 2.

54. *See, e.g.*, MODEL RULES OF PRO. CONDUCT r. 1.1, 1.3, 1.6, 1.7 (AM. BAR ASS'N 2020). This point is discussed further in Part III.B *supra*.

55. *See, e.g.*, Carol K. Kane & David W. Emmons. AM. MED. ASS'N, NEW DATA ON PHYSICIAN PRACTICE ARRANGEMENTS: PRIVATE PRACTICE REMAINS STRONG DESPITE SHIFTS TOWARD HOSPITAL EMPLOYMENT (2013), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf [https://perma.cc/K3WT-S25V] (finding ownership share in 1983 to be 75.8% and in 1988 to be 72.1%); CAROL K. KANE, AM. MED. ASS'N, RECENT CHANGES IN PHYSICIAN PRACTICE ARRANGEMENTS: SHIFTS AWAY FROM PRIVATE PRACTICE AND TOWARDS LARGER PRACTICE SIZE CONTINUE THROUGH 2022, at 1 (2023) https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf [https://perma.cc/9SJW-DP9H] (finding ownership shares to be 44.0% in 2022).

56. *Ambulatory Surgery Centers: A Positive Trend in Healthcare*, *supra* note 3.

of ambulatory surgery centers,[57] and these sites gain market share by competing aggressively on cost and quality with other outpatient providers, including hospitals.[58]

Physician hospital ownership combines control by physician experts with market incentives to optimize delivery of healthcare services and costs. Healthcare economists and competition agencies have long recognized that healthcare providers are market participants who respond to market incentives, regardless of their for-profit or nonprofit status.[59] Physicians likewise are responsive to market incentives, whether as owners or practitioners. Indeed, many innovations in healthcare financing aim to align the incentives of providers with improved health outcomes for patients.[60]

However, with physician ownership foreclosed by statute, the innovating physician has less incentive or ability to bring about hospital-level improvements in management or care.[61] Instead, the innovating physician must rely on hospital executives to identify and act on the same opportunities or to empower physician staff to do so. A salaried

57. *Id.*

58. *Id.*

59. *See, e.g.*, DAVID A. HYMAN ET AL., U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Executive Summary, 4–5 (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [https://perma.cc/T85C-SBTZ] [hereinafter A DOSE OF COMPETITION]; FTC v. Univ. Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991) (citing Nat'l Collegiate Athletic Ass'n v. Board of Regents, 468 U.S. 85, 100 n.22 (1984)) (noting "the Supreme Court has rejected the notion that nonprofit corporations act under such a different set of incentives than for-profit corporations that they are entitled to an implicit exemption from the antitrust laws"); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (concluding institutional form is irrelevant to merger analysis).

60. Sylvia M. Burwell, *Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care*, 372 NEW ENGL. J. MED. 897 (2015); Jordan M. VanLare & Patrick H. Conway, *Value-Based Purchasing — National Programs to Move from Volume to Value*, 367 NEW ENG. J. MED. 292 (2012); Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment*, COMMONWEALTH FUND ISSUE BRIEFS (Feb. 10, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits [https://perma.cc/R7RU-CCWF].

61. Ownership provides the innovating physician an incentive to innovate and improve the performance of a hospital by providing the physician with a claim on the hospital's profits, and ownership provides the ability to effect those changes by providing the authority to direct the operations of the hospital. *See, e.g.*, CORE, THE ECONOMY 1.0 § 6.2 (2024) (ebook), https://www.core-econ.org/the-economy/v1/book/text/06.html#62-other-peoples-money-the-separation-of-ownership-and-control [https://perma.cc/3NS5-JPJ5] ("The firm's profits legally belong to the people who own the firm's assets, which include its capital goods. The owners direct the other members of the firm to take actions that contribute to the firm's profits. This in turn will increase the value of the firm's assets, and improve the wealth of the owners.").

physician may even be disincentivized from pursuing innovation if, for example, short-sighted hospital managers discourage physicians from taking time away from their revenue-generating clinical practices.[62]

Physician ownership may improve system-wide performance at general acute care hospitals through the application of cross-specialty knowledge. Over half of POHs (55%) are general acute care hospitals, rather than specialty hospitals.[63] Medical schools provide physicians with an educational foundation that spans medical specialties and increasingly incorporates an understanding of the organization of the healthcare delivery system. And physicians may learn about innovations or market trends in a single specialty that can be applied more broadly to improve management and care across many specialties, such as the similar setup of procedural rooms for vascular surgeon-performed endovascular procedures and interventional cardiologist-performed cardiac catheterizations, or the adoption of similar technical description formats in surgical notes across surgical specialties. Indeed, physician control over operations is associated with increased nurse staffing (an indirect indicator of quality) at POHs as compared to non-profit or investor-owned general acute care hospitals.[64]

POHs' response to the COVID-19 pandemic illustrates how physician ownership can help general acute care hospitals rapidly respond to market needs. Doctors Hospital at Renaissance (DHR), a general acute care POH at the Texas-Mexico border, originated as a 2-room ambulatory surgery center in 1997 that grew to a 530-bed general acute care POH with over 60 clinics.[65] Serving a high-need market, DHR expanded its offerings to services like kidney transplants that were unavailable in the region.[66] To address physician recruitment in the underserved Rio Grande Valley region, DHR developed multiple medical residency

62. *See, e.g.*, Ron Ashkenas, *Managers Don't Really Want to Innovate*, HARV. BUS. REV. (May 1, 2012), https://hbr.org/2012/05/managers-dont-really-want-to-I [https://perma.cc/4RWW-VE5M] ("*[M]anagers need immediate results*, often reinforced by short-term incentive plans or the regular expectation of earnings improvements. Innovation may take a long time to produce returns, which conflicts with these short-term requirements. So even though managers know that innovation is necessary, most do not have the patience to wait years for results. Consequently, they say that innovation is important, but they don't back it up with time or resources.") (emphasis in original).

63. *See* Daniel M. Blumenthal et al., *Access, Quality, and Costs of Care at Physician Owned Hospitals in the United States: Observational Study*, 351 BMJ 1, 4, app. 6, app. 8 (2015) (120 General Acute POHs / 219 Total POHs = 55%).

64. *Id.* at 3 tbl.1.

65. Telephone Interview with Carlos Cardenas, Board Chairman, Doctors Hospital at Renaissance (June 2021).

66. *Id.*

programs.[67] Then, during the COVID-19 pandemic, DHR rapidly converted its rehabilitation hospital into a 102-bed COVID hospital in 10 days.[68] DHR's physician leadership enabled the innovation required to achieve that level of speed in converting the hospital.[69] DHR's response to market needs is not unique. Aurora BayCare Medical Center, a general acute care POH jointly owned with a non-profit health system, is a high-performing hospital (by cost per discharge and by patient satisfaction) and adapted quickly to demand during the COVID-19 pandemic, temporarily increasing 167 beds to 238.[70]

In addition to the benefit physician ownership confers on general acute care hospitals, this ownership model may be especially apt for specialty hospitals. Physicians practice within particular specialties, making them especially well-suited to identify market opportunities for hospital specialization in their respective fields. Moreover, they can directly apply their specialized knowledge to customize and efficiently deliver care. Because they work directly with patients, physicians are also likely to be the first to notice operational inefficiencies, such as long changeover times for operating rooms or burdensome bureaucracy.[71] Indeed, market data suggests that physician owners are particularly effective at identifying opportunities to open specialty hospitals. Forty-five percent of POHs are specialty hospitals,[72] whereas only a small fraction of the nearly 5,900 non-physician-owned hospitals are similarly specialized.[73]

Surgeons' familiarity with the specific requirements imposed by the medical procedures they perform make them well-suited and highly motivated to identify opportunities for greater operating room efficiency. This extends to owning and operating specialty hospitals,

67. *Id.* This is particularly important in a region like the Rio Grande Valley because just over half of physicians practice in the region where they completed their training. *See generally* Lyndra Vassar, *Where New Physicians Practice: 3 Key Postresidency Trends*, Am. Med. Ass'n (Feb. 10, 2016), https://www.ama-assn.org/medical-residents/transition-resident-attending/where-new-physicians-practice-3-key-postresidency [https://perma.cc/W2WK-VZRH].

68. *Id.*

69. *Id.*

70. Telephone Interview with Daniel Meyer, President, Aurora BayCare Medical Center (July 2021).

71. *See* Ankeet S Bhatt et al., *Improving Operating Room Turnover Time: A Systems Based Approach*, 38 J. Med. Sys. 148, 153 (Nov. 8, 2014).

72. Blumenthal, *supra* note 63, app. 6 (99 Specialty POHs / 219 Total POHs = 45%)

73. *Fast Facts on U.S. Hospitals, 2021*, Am. Hos. Ass'n (Jan. 2021), https://www.aha.org/system/files/media/file/2021/01/Fast-Facts-2021-table-FY19-data-14jan21.pdf [https://perma.cc/5FSS-Q4VR] (6,090 Total Hospitals – 219 POH hospitals = 5,871 non-POH hospitals); Blumenthal, *supra* note 63, at tbl. 1 (showing non-POHs are less specialized). Specialty hospitals are most common for orthopedic, cardiac, and general surgical services. *Id.* at 4.

which can facilitate customization around the needs of the narrow set of procedures they perform and the surgeons' individual preferences. To illustrate, consider the case of surgeons who are not hospital employees, yet routinely perform inpatient procedures that cannot be managed in an ambulatory setting (e.g. at a clinic or ambulatory surgery center).[74] The surgeon must obtain admitting privileges[75] and contract with a hospital to use its operating room and associated facilities. Having a variety of surgeons operating in a hospital may be efficient for many sets of procedures but could also lead to frustrations and inefficiencies for surgeons who would benefit from greater control over the operating room set-up to account for factors such as the amount of notice required, procedure duration, and the generalized or specialized nature of a procedure's setup. Even for a given procedure, different surgeons may have different staffing, equipment, and setup preferences. Consequently, there may be diverse market strategies for optimizing the number of operating rooms, the way rooms are equipped and staffed, the range of procedures performed in a given setting, and the way hospitals handle transitions and scheduling. Physician ownership allows surgeons to optimize these factors based on their needs and the needs of their patients, rather than making do with whatever hospital facilities are available in a given market where the physician has contracted to operate.

For example, otolaryngologists and orthopedic surgeons have competing preferences for operating room setups. Otolaryngologists typically operate on a patient's ear, nose, and throat, necessitating that the operating room table be rotated 180 degrees away from the anesthesia machine, ventilator, and other pieces of equipment. By contrast, orthopedic surgeons typically operate on a patient's extremities or spine, requiring an operating room setup that is functionally the opposite of an

74. *See Defining Ambulatory Care*, INST. FOR PATIENT- AND FAM.-CENTERED CARE, https://www.ipfcc.org/bestpractices/ambulatory-care/defining-ambulatory-care.html [https://perma.cc/J5LQ-NCNR] ("Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility . . ."); *Ambulatory Surgery Centers*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/medicare/health-safety-standards/guidance-for-laws-regulations/ambulatory-surgery-centers/ambulatory-surgery-centers [https://perma.cc/548Z-BXZ7] (last updated Sept. 6, 2023) (describing CMS requirements to be certified as an ambulatory surgical center).

75. *See* Debra Wood, *Credentialing and Privileging: Essential Processes for Physician Success*, AMN HEALTHCARE, (July 3, 2023), https://www.amnhealthcare.com/blog/physician/locums/credentialing-and-privileging-essential-processes-for-physician-success/ [https://perma.cc/YA9Q-SHMB] ("Privileging typically falls into three primary categories, including: Admitting Privilege — Allows a doctor to admit a patient to the hospital[;] Courtesy Privilege — Allows physicians to occasionally treat or admit at the hospital[; and] Surgical Privilege — Allows the physician to perform outpatient or operating room surgeries[.]").

otolaryngologist's requirements and often requires a different operating table that can facilitate intraoperative imaging. Inefficiencies can arise from the time required to change between these setups or from errors caused by mistakes in the changeover. Physicians would likely be the first to recognize when these inefficiencies justify specialized settings.

Hospitals may further impede efficiency by failing to alleviate shortages of key specialists (e.g., anesthesiologists or nurses) during periods of high demand for particular surgical procedures. These delays may result in fewer treated patients and lost revenue for surgeons and the facility. Additionally, a surgeon is frequently unable to fully control and customize the pre- and post-operative care (i.e. the medical care before and after surgery) that their patients receive when much is handled by the hospital and its hospital-managed nursing staff. Physician ownership can help mitigate all of these issues.

Therefore, physicians are keenly attuned to when local hospitals are poorly optimized for their specialty. Physician ownership can provide a strong incentive to act when physicians identify market opportunities to design and optimize their own hospital operations improving the efficiency of care, along with pre- and post-operative care.

Specialty hospitals—which are more common among POHs than non-POHs—may offer an especially compelling model of care when there are scale efficiencies and scope efficiencies to tailoring care towards a limited set of procedures—a "focused factory" model[76] that benefits from a quality-volume relationship, which can be found in many parts of medicine.[77] To illustrate, studies show that patients at the physician-founded Shouldice Hernia Hospital in Canada have experienced a lower rate of recurrence for inguinal hernia repairs.[78] Other areas of

76. *See, e.g.*, Eelco Bredenhoff et al., *Exploring Types of Focused Factories in Hospital Care: A Multiple Case Study*, BMC Health Serv. Res., June 7, 2010, at 1 (exploring "the application of the focused factory concept in hospital care"); Regina E. Herzlinger & Stacy Schwartz, *Hospital for Special Surgery*, Harv. Bus. Sch., April 22, 2005 (discussing Hospital for Special Surgery as "a focused factory for orthopedics and joint disease"); James L. Heskett & Roger H. Hallowell, *Shouldice Hospital Limited (Abridged)*, *in* Harv. Bus. Sch. Case Collection (2004), https://www.hbs.edu/faculty/Pages/item.aspx?num=31326 [https://perma.cc/L58Y-ZHFV] (discussing Shouldice Hospital).

77. *E.g.*, Badhwar V, Vemulapalli S, Mack MA, et al., *Volume-Outcome Association of Mitral Valve Surgery in the United States*, 5 JAMA Cardiology 1092 (2020); Syed Hamza Mufarrih et al., *Effect of Hospital Volume on Outcomes of Total Hip Arthroplasty: A Systematic Review and Meta-Analysis*, J. Orthopaedic Surgery & Rsch., Dec. 27, 2019, at 1; Anshu Sign et al., *The Effect of Surgeon and Hospital Volume on Shoulder Arthroplasty Perioperative Quality Metrics*, 23 J. Shoulder & Elbow Surgery 1187 (2014).

78. Atiqa Malik et al., *Recurrence of Inguinal Hernias Preaired in a Large Hernia Surgical Specialty Hospital and General Hospitals in Ontario, Canada*, 59 Can. J. Surgery 19 (2016); Heskett & Hallowell, *supra* note 76.

orthopedic surgery also benefit from quality-volume relationships, such as better outcomes in total knee arthroplasty (knee replacement)[79] and lower mortality with total hip arthroplasty (hip replacement).[80] Cardiac care shows a similar pattern, with domestic data demonstrating a positive quality-volume relationship for percutaneous coronary intervention (cardiac catheterization) with lower in-hospital mortality associated with higher volumes,[81] with a similar positive quality-volume relationship seen in cardiac surgery with mitral valve surgery.[82] This helps explains why a systematic review of over thirty years of research found improved quality at lower or comparable cost for specialty POHs as compared with non-POH competitors.[83]

Physician-owners may also recognize opportunities to partner with other healthcare providers to meet patient and payor needs that non-POHs may not recognize. For example, Lincoln Surgical Hospital, a POH in Nebraska, partnered with OneHealth Nebraska, an Independent Physicians Association[84] comprised of 81 clinics with over 400 primary and specialty care physicians,[85] to serve as a network offering both fully

79. Rick L. Lau et al., *The Role of Surgeon Volume on Patient Outcome in Total Knee Arthroplasty: A Systematic Review of the Literature*, 13 BMC MUSCULOSKELETAL DISORDERS, Dec. 14, 2012, at 1.

80. Jeffrey N. Katz et al., *Association Between Hospital and Surgeon Procedure Volume and Outcome of Total Hip Replacement in the United States Medicare Population*, 83 J. BONE & JOINT SURGERY 1622 (2011).

81. Alexander C. Fanaroff et al., *Outcomes of PCI in Relation to Procedural Characteristics and Operator Volumes in the United States*, 69 J. AM. COLL. CARDIOLOGY 2913 (2017) [hereinafter Fanaroff (2017)]; Alexander C. Fanaroff et al., *Relationship Between Operator Volume and Long-Term Outcomes After Percutaneous Coronary Intervention: Report From the NCDR CathPCI Registry*, 139 CIRCULATION 458 (2019) [hereinafter Fanaroff (2019)].

82. Joanna Chikwe et al., *Relation of Mitral Valve Surgery Volume to Repair Rate, Durability, and Survival*, 69 J. AM. COLL. CARDIOLOGY 2397 (2017); Vinay Badhwar et al., *Mitral Valve Surgery in the United States*, 5 JAMA CARDIOLOGY 1092 (2020).

83. CHO ET AL., *supra* note 1, at 16; *see also, e.g.*, Yang Wang et al., *Comparison of Commercial Negotiated Price and Cash Price Between Physician-Owned Hospitals and Other Hospitals in the Same Hospital Referral Region*, JAMA NETWORK OPEN, June 23, 2023, at 2 (finding lower prices at POHs compared to non-POHs).

84. *Independent Physician Associations (IPAs) Definition*, AM. ACAD. OF FAM. PHYSICIANS, https://www.aafp.org/about/policies/all/independent-physician-associations.html [https://perma.cc/7D8T-AB72] (last updated Dec. 2019) ("An independent physician association (IPA) is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACO) and/or managed care organizations (MCOs).").

85. *Who We Are*, ONEHEALTH NEB., https://onehealthne.com/about/ [https://perma.cc/2DNS-PAYU].

insured and self-insured plans[86] and as a network for a messenger model plan with BlueCross BlueShield Nebraska.[87]

In short, there are many reasons to think that physician ownership can offer important benefits for entry and innovation in hospital markets, both for general acute care hospitals and for specialty hospitals.

3. The Physician-Ownership Model Provides Further Means to Attract and Retain Physicians

Physician ownership incorporates an ownership stake into physician compensation packages that facilitate more competition for physician labor, both through the type of compensation and the terms of employment. As used in other industries, an ownership stake can provide greater employee stability and help align incentives for care delivery.[88] Greater employee stability also improves the odds of firm survival because owner-physicians bear the costs of withdrawing their labor from a firm unlike when they are employee-physicians.[89] This allows for market entry of smaller hospitals in low-volume practices that would not happen without employee ownership.

For example, a cardiac specialty hospital typically has only a small number of cardiac surgeons, such that the departure of a surgeon may be very costly. This departure will lead to a substantial drop in surgical capacity and revenue until the hospitals finds a replacement. Large hospital systems can mitigate this risk by employing a larger number of cardiac surgeons, but a geographic area may not offer enough case volumes to support many such units. Physician ownership helps smaller, specialty hospitals mitigate the risk of losing a cardiac surgeon. Where the cardiac surgeon shares ownership in the hospital, the surgeon could earn more through profit-sharing but also shares in the losses if his or her departure left the hospital in the lurch. Specialty orthopedic hospitals are small enough to similarly benefit from physician ownership, though to a lesser degree as case volumes in a given area tend to support

86. *Insurance Plans*, OneHealth Neb., https://onehealthne.com/insurance-plans/ [https://perma.cc/X6EP-Y32N].

87. *Contracting*, OneHealth Neb., https://onehealthne.com/contracting/ [https://perma.cc/45C5-FYVB].

88. Thomas Dudley & Ethan Rouen, *The Big Benefits of Employee Ownership*, Harv. Bus. Rev.: The Big Idea Series (May 13, 2021), https://hbr.org/2021/05/the-big-benefits-of-employee-ownership [https://perma.cc/PA2U-QBLL]. Properly aligning incentives also means reducing misaligned incentives that reduce adverse outcomes, which are especially worrisome in healthcare and are discussed in Part III.

89. Rhokeun Park et al., *Does Employee Ownership Enhance Firm Survival?*, *in* Employee Participation, Firm Performance and Survival 3 (2004).

more orthopedic than cardiac surgeons.[90] By sustaining smaller specialty hospitals, physician ownership can thus allow a market to support more competition.

POHs may also provide alternative terms of employment compared to non-physician-owned hospitals that allow for physicians to choose how they would like to practice. Non-profit and investor-owned hospitals continue to aggressively transition to a closed-staff model[91] with employed, salaried medical groups, often with mandated in-system referral,[92] and frequently require physicians to sign non-compete agreements.[93] Non-compete agreements are an area of current focus in antitrust enforcement and policy circles.[94] By contrast, physician-owned facilities more frequently employ an open staffing model—where physicians are allowed but not obligated to practice at the facility—in order to serve independent physicians and practices.[95] Thus, POHs facilitate competition in the market for physician labor, providing flexibility in practice modalities.

B. Growth, Scrutiny, and Early Interventions

The role of physicians as innovators and entrepreneurs is demonstrated by the growth of POHs prior to the 2010 ban. Hospitals were frequently owned and managed by physicians during the first half of the twentieth century.[96] Physicians began giving up ownership and con-

90. *See, e.g.*, IMS HEALTH & SK&A, MARKET PROFILE OF U.S. ORTHOPEDIC SURGEONS: MARKET INSIGHTS REPORT 3 (2016), http://www.coa.org/docs/SKA.pdf [https://perma.cc/CB45-FTTJ] (noting almost 50% of orthopedic surgery practices have 3-10 physicians and about 30% of practices have 11 or more).

91. *See, e.g.*, P. Elliott Miller et al., *Transition from an Open to Closed Staffing Model in the Cardiac Intensive Care Unit Improves Clinical Outcomes*, 10 J. AM. HEART ASS'N, at 2 (2021). A more traditional "open" staffing model refers to a "staffing model, where multiple attending physicians are admitting and managing patients," whereas a "closed" staffing model involves a "unit where there is a dedicated team or teams caring for the entire unit." *Id.* at 1.

92. Anna Wilde Mathews & Melanie Evans, *The Hidden System That Explains How Your Doctor Makes Referrals*, WALL ST. J. (Dec. 27, 2018), https://www.wsj.com/articles/the-hidden-system-that-explains-how-your-doctor-makes-referrals-11545926166.

93. Andis Robeznieks, *AMA Backs Effort to Ban Many Physician Noncompete Provisions*, AM. MED. ASS'N (June 13, 2023), https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-noncompete [https://perma.cc/9979-QCC4] ("Unfair noncompete clauses are extensive in health care, affecting between 37% and 45% of physicians.").

94. *See supra* Part I.

95. *Cf.* Kurt Lavetti et al., *The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians*, 55 J. HUM. RES. 1025, 1042 (2020) (finding physician employees are more likely to have non-compete agreements than physician owners).

96. NANCY J. NILES, BASICS OF THE U.S. HEALTH CARE SYSTEM 5 (2d ed. 2014).

trol of hospitals and other large medical institutions in the 1930s and 1940s,[97] spurred on further by the Hill Burton Act of 1947, which provided federal funding for the development of public and tax-exempt community hospitals.[98]

POHs began to re-emerge in the 1980s, driven in part by a push for efficiency and specialization.[99] Physicians sought a greater ability to improve general hospital medical care and customize the entire treatment process, including operating room workflows and associated pre- and post-op care, and ancillary clinical operations[100] such as radiology, diagnostic laboratories, etc., which all can be facilitated by physician ownership. As POHs gained steam, they emerged as a countertrend to consolidation in hospital markets.

The number of POHs grew rapidly throughout the 2000s. As of 2003, there were sixty-seven POHs.[101] From 2002–2004, the number

97. *Id.*

98. *See, e.g.*, Barbra Mann Wall, *History of Hospitals*, Univ. of Pa. Sch. of Nursing, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/ [https://perma.cc/EJ8Z-Q2DY]; John H. Schumann, *A Bygone Era: When Bipartisanship Led To Health Care Transformation*, NPR (Oct. 2, 2016), https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation [https://perma.cc/B3LJ-3MDR]; *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 Md. L. Rev. 316 (1979); Julie A. Bargo, *The Hill-Burton Act of 1946: America's First Health Policy*, PA Times (Mar. 14, 2020), https://patimes.org/the-hill-burton-act-of-1946-americas-first-health-policy/ [https://perma.cc/82WJ-EMTX]; Editorial, *The Hospital Survey And Construction Act*, 132 JAMA 148 (1946).

99. Staff, *Attack on Physician-Owned Hospitals in America: History, Current Efforts and the Impact on the Future of Healthcare*, Becker's Hosp. Rev. (Mar. 22, 2010), https://www.beckershospitalreview.com/news-analysis/attack-on-physician-owned-hospitals-in-america-history-current-efforts-and-the-impact-on-the-future-of-healthcare.html [https://perma.cc/NHC6-PXZQ].

100. For a definition of "ancillary services," see Peter Reid Kongstvedt, Essentials of Managed Healthcare 157–58 (5th ed. 2007) ("Ancillary services are those services that are provided as an adjunct to primary or specialty services and include most everything other than institutional services (although institutions can provide ancillary services). Ancillary services are broadly divided into diagnostic and therapeutic services. Examples of ancillary diagnostic services include laboratory, routine radiology, nuclear testing, computed tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET) scans, electrocardiography, cardiac testing (including plain and nuclear stress testing, other cardiac nuclear imaging, other invasive imaging, echocardiography, and Holter monitoring), and so forth. Examples of ancillary therapeutic services include cardiac rehabilitation, noncardiac rehabilitation, physical therapy (PT), occupational therapy (OT), speech therapy, and so forth.")

101. Ctrs. for Medicare & Medicaid Servs. (CMS), HHS-0938-2005-F-2951, Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, at i (2005) [hereinafter 2005 CMS Report].

of POHs roughly doubled.[102] By the end of the decade, the number of POHs had peaked at 265 in the U.S. then fell to 238 in 2013 in a country of just over 6,000 hospitals.[103]

Throughout this period of growth, POHs faced extensive scrutiny, in response to industry allegations of cherry-picking and inducing demand.[104] Congress and federal agencies conducted hearings and issued multiple reports examining POHs. These include: the 2005 and 2006 MedPac reports,[105] the 2005 GAO report,[106] the 2005 CMS report,[107] the Senate Finance Committee's May 17, 2006 hearing on Physician-Owned Specialty Hospitals,[108] and the 2006 HHS report.[109] These studies scrutinized issues such as referral patterns,[110] quality of care,[111] patient satisfaction,[112] costs,[113] patient population,[114] rationales

102. MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC), REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, at vi (2006) [hereinafter 2006 MEDPAC REPORT].

103. Tanya Albert Henry, *Physician-Owned Hospitals Seize Their Moment*, 110 MO. MED. 282 (2013); *Fast Facts on U.S. Hospitals*, *supra* note 73 (6,090 Total Hospitals).

104. *See infra* Part IV.B.

105. MEDPAC, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS (2005) [hereinafter 2005 MEDPAC REPORT]; 2006 MEDPAC REPORT, *supra* note 102.

106. U.S. GOV'T ACCOUNTABILITY OFF., GAO-05-647R, SPECIALTY HOSPITALS: INFORMATION ON POTENTIAL NEW FACILITIES (2005) [hereinafter 2005 GAO REPORT].

107. 2005 CMS REPORT, *supra* note 101.

108. *Physician-Owned Specialty Hospitals, Profits Before Patients?: Hearing Before the S. Comm. on Fin.*, 109th Cong. (May 17, 2006).

109. U.S. DEP'T OF HEALTH AND HUM. SERVS. (HHS), FINAL REPORT TO THE CONGRESS AND STRATEGIC AND IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter 2006 HHS Report].

110. *E.g.*, 2005 CMS REPORT, *supra* note 101, at iii (concluding "the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals was not supported by our study" and that "[t]he notion that specialty cardiac hospitals are systematically screening out more severely ill patients using the ED is not supported by our findings").

111. *E.g.*, 2005 CMS REPORT, *supra* note 101, at iii (concluding cardiac POHs delivered quality of care good or better than competitors).

112. *E.g.*, 2005 CMS REPORT, *supra* note 101, at iii ("Patient satisfaction was very high in both cardiac and orthopedic/surgery hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for their family members if needed, easy parking, and good food.").

113. *E.g.*, 2005 MEDPAC REPORT, *supra* note 105, at vii ("Physician-owned specialty hospitals, thus far, do not have lower costs for Medicare patients than community hospitals, although their patients have shorter lengths of stay."); 2006 MEDPAC REPORT, *supra* note 102, at vi-vii (finding the same result of no lower costs but shorter lengths of stay).

114. *E.g.*, 2005 MEDPAC REPORT, *supra* note 105, at vii ("[Physician-owned specialty hospitals] treat patients who are generally less severe cases (and hence expected to be relatively more profitable than the average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable. They tend to have lower shares of Medicaid patients than community hospitals.").

for POHs,[115] share of uncompensated care,[116] and responses of community hospitals to increased competition.[117]

Fierce marketplace resistance to POHs by incumbent hospitals began in the 2000s. Some of this is illustrated by antitrust litigation. There are at least three examples in the 2000s and at least two examples in the 2010s where local incumbent hospitals faced antitrust litigation for employing tactics, sometimes in concert, to exclude POHs from the market. The most common tactic the plaintiffs alleged in these cases is conditioning contracts with private health plans on excluding a POH from their networks. For example, suits in Texas on behalf of the state Attorney General and private plaintiffs alleged a hospital coerced health plans to refuse to deal with a rival POH.[118] Other suits in Arkansas challenged an incumbent hospital's alleged exclusionary conduct against a cardiac specialty POH.[119] A 2012 FTC complaint—discussed further below—challenged a proposed acquisition of a surgical institute by a health system in Pennsylvania.[120] More recently in Ohio, the Sixth Circuit found that four hospitals with a joint operating agreement could conspire to boycott plaintiff POH by forbidding insurers from contracting with the POH.[121]

115. *E.g.*, 2005 MedPac Report, *supra* note 105, at vii ("We found that physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to provide greater satisfaction for them and their patients. They may also be motivated by the financial rewards, some of which derive from inaccuracies in the Medicare payment system.").

116. *E.g.*, 2005 CMS Report, *supra* note 101, at iv (finding "total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care").

117. *E.g.*, 2005 MedPac Report, *supra* note 105, at 24 (finding competitor community hospitals cut expenses, instituted "aggressive pricing strategies," and expanded profitable business lines in order to maintain profit margins in line with national averages).

118. Texas v. Memorial Herman Healthcare Systems, Inc., No. 2009-04609 (Tex. Dist. Ct. 281st Jud. Dist. 2009) (Texas Attorney General sued and settled with hospital coercing health plans to refuse to deal with rival physician-owned hospital); *In re* Memorial Herman Healthcare Systems, Inc., 274 S.W.3d 195 (Tex. App. 14th 2008) (follow-on private litigation on behalf of plaintiff physician-owned hospital).

119. Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591 (8th Cir. 2009) (rejecting plaintiff's product and geographic market definition in a physician-owned hospital challenge against a hospital's exclusionary conduct). *But see* Baptist Health v. Murphy, 373 S.W.3d 269 (Ark. 2010) (granting state tortious interference claim by plaintiffs on overlapping facts with 8th Cir. case); FTC v. Penn State Hershey Ctr., 838 F.3d 327 (3d Cir. 2016) (rejecting legal tests on market definition in *Little Rock Cardiology Clinic*).

120. *See* discussion *infra* in Part III.B.

121. *E.g.*, Medical Ctr. at Elizabeth Place v. Atrium Health Sys., 817 F.3d 934 (6th Cir. 2016).

One illustrative example involved Heartland Surgical Specialty Hospital, LLC ("Heartland"), a POH in the Kansas City metro area, which filed suit in 2005 against five traditional hospitals and six managed care organizations ("MCOs") for conspiring to boycott its entry into the Kansas City market in violation of the Sherman Act.[122] Heartland opened in 2003 and was owned by physicians specializing in orthopedic, neurological, plastic, pain management, and general surgery disciplines.[123] Heartland claimed that it outperformed other local providers on patient recovery times and infection rates that translated into better outcomes and lower overall costs for its patients.[124] Likewise, defendant hospitals acknowledged in their own negotiations with payers that POHs were "lower cost providers" that "can schedule faster, [were more] convenient, [offered] 'better' quality etc."[125] Despite these benefits, Heartland was unable to obtain an in-network contract prior to filing the lawsuit from any of the six managed care organization defendants,[126] who collectively accounted for approximately 90 percent of the Kansas City payor market.[127] Heartland learned that five of its competitors, traditional hospitals accounting for 74 percent of patient revenues,[128] were pressuring the MCOs to reject Heartland's business while still adding new facilities from those hospitals to their networks.[129] Defendant hospitals also asked payers to help address "referral practices" to prevent "leaking" to Heartland.[130] Defendants' motions for summary judgment were denied regarding the Sherman Act conspiracy claim, except as to one defendant.[131] The judge found that plaintiff had provided sufficient evidence to support bringing their case to trial, noting that Heartland had shown not only that the defendants acted in parallel, but that there was a "motivation to enter an agreement to boycott and that the competing defendants cooperated with each other to effectuate the agreement."[132] The defendants ultimately settled with Heartland before trial.[133]

122. Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc., 527 F. Supp. 2d 1257, 1263 (D. Kan. 2007).
123. *Id.* at 1266.
124. *Id.* at 1267.
125. *Id.* at 1281, 1284.
126. *Id.* at 1277.
127. *Id.* at 1266.
128. *Id.*
129. *Id.* at 1283–88.
130. *Id.* at 1284.
131. *Id.* at 1309–21.
132. *Id.* at 1321.
133. *E.g.*, Staff, *Physician-Owned Hospital Settles Landmark Antitrust Suit Against Regional Insurers and Hospitals*, BECKER'S HOSP. REV. (Aug. 26, 2008), https://www.beckershospitalreview.com/news-analysis/physician-owned-hospital-settles-landmark-antitrust-suit-against-regional-insurers-and-hospitals.html [https://perma.cc/LFR9-6BVK].

Antitrust violations can expose defendants to stiff penalties, such as treble damages, meaning that hospitals would not be expected to risk such liability unless the expected return of anticompetitive behavior exceeded that of competing on the merits. Defendant hospital HCA Midwest, the largest in the Kansas City metro area (28% market share),[134] explained that it was "under attack from physician-syndicated specialty hospitals (particularly in high margin services)," warning in internal documents that "[w]e have high risk of losing this volume if the regulatory environment doesn't help us out" and "if they stay so entrenched in their business model."[135] Other defendant hospitals spoke in similar terms of the need to deny Heartland access to the market.[136] The message was heard by the MCOs. For example, Humana explained, that "[the] major systems . . . view [POHs] as direct competitors" and "are placing intense pressure on carriers not to contract with these entities."[137]

Efforts to exclude competition from POHs are also reflected in the lobbying activity of the American Hospital Association ("AHA") and other industry groups. Throughout this period these groups regularly advocated for legislative scrutiny and restrictions curtailing POHs, describing POHs as limited-service specialty hospitals while ignoring that half of POHs are general acute care hospitals. For example, in 2005, George Lynn, then Board Chair of the AHA, called for a ban on POHs,[138] followed by both an AHA letter to CMS,[139] denoting POHs as "physician-owned, limited service hospitals," and an AHA-commissioned case study of the impact of POHs on community hospitals.[140] Investor-owned hospitals chimed in, with Federation of American Hospitals ("FAH") CEO Chip Kahn calling for their ban, describing POHs as an "intolerable risk of irreparable harm" in a 2006 *Health Affairs* column.[141]

134. *Heartland Surgical Specialty Hosp.*, 527 F. Supp. 2d at 1266 n.8.
135. *Id.* at 1281.
136. *See id.* at 1281–83.
137. *Id.* at 1281.
138. Mary Ellen Schneider, *AHA: Ban Self-Referrals to Specialty Hospitals*, Internal Med. News, Apr. 1, 2005, at 26, https://cdn.mdedge.com/files/s3fs-public/issues/articles/70724_main_3.pdf [https://perma.cc/269W-VFPF].
139. Letter from Rick Pollack, Exec. Vice President, Am. Hospital Ass'n, to Mark McClellen, Adm'r, Ctrs. for Medicare and Medicaid Servs. (June 12, 2006), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Comments_from_American_Hospital_Association.pdf [https://perma.cc/9D4W-DTDA].
140. *See* McManis Consulting, The Impact of Physician-owned Limited-service Hospitals: A Summary of Four Case Studies (2005), https://slideplayer.com/slide/725315/ [https://perma.cc/R58Z-EXL6].
141. Charles N. Kahn, Perspective, *Intolerable Risk, Irreparable Harm: The Legacy of Physician-Owned Hospitals*, 25 Health Affs. 130, 133 (2006).

In 2003, Congress passed temporary restrictions on the growth of POHs, which effectively imposed an 18-month moratorium, through June 8, 2005, on new specialty POHs.[142] The moratorium operated by prohibiting physician referrals to new specialty hospitals in which the physician has an ownership interest, except for those specialty hospitals already in development or operation as of November 18, 2003.[143]

At the state level, there were also efforts to single out physician-owned facilities. For example, Florida banned specialty hospitals that treat a single condition, which are disproportionately physician-owned facilities, while relaxing certificate of need (CON) requirements for open-heart surgery and angioplasty programs at general hospitals.[144]

The American Medical Association ("AMA") opposed efforts to extend the POH ban.[145] Notably a 2004 AMA report found, "Many physicians are frustrated over hospital control of management decisions and investment decisions that affect their productivity and quality of patient care. They want a greater involvement in governance and management, reinvestment of profits to maintain state-of-the art care and equipment, and greater control over scheduling and the types of cases performed in the operating room. They also have a perception that hospitals are not working to align hospital processes or providing opportunities for joint ventures. Specialty hospitals allow physicians to increase their

142. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 507, 117 Stat. 2066 (2003) [hereinafter MMA of 2003]; *see also* 2006 HHS Report, *supra* note 109, at 3–4 (summarizing the 18-month POH moratorium imposed by section 507 of the MMA of 2003).

143. *See* 2006 HHS Report, *supra* note 109, at 3–4.

144. *See* A Dose of Competition, *supra* note 59, at ch. 3, p. 23, n.116 (noting "certificate of need laws [have been used] to encumber specialty hospital entry" and explaining that "[a] new Florida law [effective in 2004] that bars licensure of any specialty hospital illustrates an example of this allegation. The law bans specialty hospitals that treat a single condition, and it eliminates its CON requirement for new adult open-heart surgery and angioplasty programs at general hospitals. The law also exempts from CON the addition of beds to existing structures, but new structures will still be required to file a CON."). As additional background for readers unfamiliar with certificate of need requirements, they are laws that generally "prevent firms from entering certain areas of the health care market (e.g., building a new hospital) unless they can demonstrate to a state regulator that there is an unmet need for the services." U.S. Dep't of Justice & Fed. Trade Comm'n, Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62 (Apr. 12, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf [https://perma.cc/QE8H-6T5D].

145. Am. Medical Ass'n, *Board of Trustees Report*, *in* 2004 Proceedings of the Interim Meeting of the House of Delegates 88 (Dec. 2004), http://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00004%2F00000005&pg_seq=1 [https://perma.cc/GR7Y-4TDU].

productivity and have more control over scheduling and purchasing of desired equipment."[146]

Congress also considered legislation during this period to make the moratorium permanent before successfully passing the ACA which effectively banned new or expanded POHs in 2010. For example, Senators Charles Grassley and Max Baucus introduced legislation in 2005 that would have made the moratorium retroactive and permanent.[147] In 2007, the House passed a bill that would have effectively banned new or expanded POHs.[148] The House passed similar legislation in 2008, with a nearly identical ban on new or expanded POHs, but with authority for the Secretary of the Department of Health and Human Services ("HHS") to grant exceptions to expand POH capacity by 50%.[149]

C. The 2010 Physician-Owned Hospitals Ban

The 2010 ACA, which largely focused on setting up a system of competitive market-driven insurance exchanges based upon a premium support model[150] and reforms to other insurance markets, also contained a provision effectively banning opening new POHs and expanding existing ones.[151] At the time of the ban, the number of POHs was around 250 POHs.[152]

1. The Legislative Deal with Traditional Hospitals

The restrictions on POHs in the ACA were unrelated to the creation of insurance exchanges, the expansion of Medicaid coverage, and other significant provisions of the ACA. Rather, the restrictions arose as part of the legislative horse trading with hospital interest groups to reduce opposition to ACA's passage. As part of these negotiations,

146. *Id.* at 90.

147. *See* 2006 HHS Report, *supra* note 109, at 4–5 (summarizing the Hospital Fair Competition Act of 2005).

148. Children's Health and Medicare Protection Act of 2007, H.R. 3262, 110th Cong. § 651 (as passed by House, Aug. 1, 2007) (effectively banning new or expanded POHs by eliminating the whole hospital exception for such POHs).

149. Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, 110th Cong. § 106 (as passed by House, Mar. 5, 2008). The Senate would have increased the expansion exception to 200% of a hospital's original capacity. *See* S. Amdt. 4803 to H.R. 2642, 110th Cong. § 6002 (as passed by Senate May 22, 2008).

150. A premium support model refers to one in which subsidies are used to lower the cost of healthcare premiums and other out-of-pocket expenses. *See Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KFF (Oct. 6, 2023), https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/ [https://perma.cc/M5VZ-UCSK].

151. *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 6001, 124 Stat. 119 (2010) (amending 42 U.S.C. § 1395nn).

152. *See* Blumenthal, *supra* note 63, at 1.

hospital interest groups publicly accepted $155 billion in cuts to Medicare and Medicaid reimbursements over ten years, and the administration agreed to demands of these groups, most notably restrictions on POHs.[153] Indeed, in their spoken and written comments announcing the deal, the hospital groups consistently listed the POH ban as their first and therefore presumably most important achievement from these negotiations.[154] In the final legislation, those restrictions took the form of an effective ban on the expansion of existing POHs or the opening of new POHs.

Chip Kahn, the President and CEO of the FAH, the entity representing investor-owned hospitals, later admitted that hospital industry groups, particularly his own, were instrumental to Congress passing the ban:

> [I]n 2003, we got the original moratorium placed in the Medicare Modernization Act and then the full ban—which, to be clear, was on being paid when they refer a patient—was enacted as part of the ACA in 2010.
>
> While other trade associations and the hospital community spent a lot of energy on it, I'd say the current ban on physician-owned hospitals wouldn't be there if it wasn't for the Federation. I don't think I've ever admitted this publicly, but I can remember emailing one of the staffers, literally sending in talking points to some of the senators as the process was taking place. If we hadn't been there, history might have been different.[155]

These admissions show that the ban on POHs in the ACA resulted from lobbying by incumbent hospitals.

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153. *U.S. Hospitals and Health Care Legislation*, C-Span (July 8, 2009), https://www.c-span.org/video/cc/?progid=209194; John Reichard, *Biden Announces Deal with Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, Commonwealth Fund (July 8, 2009), https://www.commonwealthfund.org/publications/newsletter-article/biden-announces-deal-hospitals-cut-medicare-medicaid-payments-155 [https://perma.cc/URB2-748E]; Jessica Zigmond, *Agreement Threatens to Strangle Physician-Owned Hospitals*, Modern Healthcare (July 13, 2009), https://www.modernhealthcare.com/article/20090713/MODERNPHYSICIAN/307059974/agreement-threatens-to-strangle-physician-owned-hospitals.

154. Press Release, Am. Hosp. Ass'n, Statement About Agreement with White House and Senate Finance Committee on Health Reform (July 8, 2009), https://www.aha.org/system/files/presscenter/pressrel/2009/090708-jointst-covreform.pdf [https://perma.cc/K42N-NGYW]; John Reichard, *Biden Announces Deal with Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, Commonwealth Fund (July 8, 2009), https://www.commonwealthfund.org/publications/newsletter-article/biden-announces-deal-hospitals-cut-medicare-medicaid-payments-155 [https://perma.cc/W7UN-XC7D].

155. Chip Khan, *'If We Hadn't Been There, History Might Have Been Different': Chip Kahn on Two Decades Helming the Federation of American Hospitals*, Advisory Bd. (June 1, 2021), https://www.advisory.com/blog/2021/06/two-decades [https://perma.cc/ZG96-JPBZ].

2. How the Ban Works

The ACA effectively bans new or expanded POHs by prohibiting such POHs from accepting referrals from physician owners of patients with Medicare or Medicaid coverage, which are important for hospitals to be commercially viable. Empirical results confirm that the POH ban effectively eliminated the formation of new POHs.[156]

Prior to the passage of the ACA, POHs were permitted to bill Medicare and Medicaid under the "whole hospital exception" to a collection of statutes and regulations known as the "Stark Laws."[157] The Stark Laws prohibit physician (but not corporate) self-referral for a variety of healthcare products and services[158] in the Medicare and Medicaid programs.[159] But for the whole hospital exception, the Stark Laws would apply to POHs because POH owners refer their patients to the hospital they own for surgery. The whole hospital exception was included in the initial Stark Law passed in 1989, which allowed for charges to Medicare and Medicaid for physician self-referrals when a physician's ownership interest was in a whole hospital facility like a POH as opposed to a subdivision of the hospital.[160] The ACA effectively removed the whole hospital exception for POHs and subjected them to these referral restrictions (a) if they did not have a provider agreement in place with CMS by December 31, 2010, (b) if they increased the physician ownership share in a POH beyond what existed on March 23, 2010, or (c) if they expanded the number of operating rooms, procedure rooms, or

156. Elizabeth Plummer & William Wempe, *The Affordable Care Act's Effects on The Formation, Expansion, And Operation Of Physician-Owned Hospitals*, 35 HEALTH AFFS. 1452, 1459 (2016) ("We found no evidence that existing physician-owned hospitals stopped accepting Medicare to avoid the ACA restrictions, although some investors adopted a seemingly unsuccessful strategy of not accepting Medicare at physician-owned hospitals formed after implementation of the ACA. We conclude that the ACA restrictions effectively eliminated the formation of new physician-owned hospitals, thus accomplishing what previous legislative efforts had failed to do.").

157. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, § 6204, 103 Stat. 2106 (Dec. 19, 1989) [hereinafter Stark I] (adding Section 1877 to the Social Security Act limiting physician self-referrals for Medicare patients for clinical laboratory services and providing for a whole hospital exception at Section 1877(d)(3)); *see also* Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, § 13562, 107 Stat. 312 (Aug. 10, 1993) [hereinafter Stark II] (amending Section 1877 of the Social Security Act to expand limitations on physician self-referrals to include certain hospital services and Medicaid patients and similarly amending the whole hospital exception provided in Section 1877(d)(3)); 42 U.S.C. § 1395nn(d)(3) (codifying whole hospital exception).

158. *Physician Self-Referral*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index [https://perma.cc/UL23-TSYH] (last modified Nov. 29, 2023).

159. Morey J. Kolber, *Stark Regulation: A Historical and Current Review of the Self-Referral Laws*, 18 HEC F. 61 (2006).

160. *See supra* note 158.

licensed beds beyond what existed on March 23, 2010—in other words, if they were a new or expanded POH.[161]

The restriction on expanding existing POH facilities includes an exemption where the expansion is approved by the Secretary of HHS.[162] However, this exemption has had little effect. First, the exemption only applies to the restriction on expanding existing POHs.[163] The requirement that a POH must have already been operating prior to December 31, 2010 contains no such exception.[164] Second, the statute includes extensive restrictions on what expansion the Secretary can approve,[165] including limiting increases in the number of operating rooms, procedure rooms, and beds to no more than twice the existing number[166] and

161. Specifically, Section 6001 of the ACA effectuates this change by adding additional requirements set forth in 42 U.S.C. § 1395nn(i)(1) to the whole hospital exception, codified in 42 U.S.C. § 1395nn(d)(3). *See* 42 U.S.C. §§ 1395nn(d)(3)(D), (i)(1). The statutory term "'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement)." *Id.* § 1395nn(i)(3)(C)(iii). Hospital beds are licenses at the state level. *See, e.g.*, D.C. Mun. Regs. tit. 22, § 2002.2 (2008) ("The application for a hospital license shall state each service for which the applicant undertakes to furnish hospital care and the number of beds allocated to each service; and shall furnish other information as may be required."). States also define other types of hospital rooms such as "operating rooms" and "procedure rooms" through state licensing regulations. *See, e.g.*, *id.* § 2035.20 ("Procedure Rooms: Procedure rooms for invasive and minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs shall have a minimum floor area of two hundred (200) square feet and a minimum of fourteen (14) feet clear dimension."); *id.* § 2035.21 ("Operating Rooms: Operating rooms for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a minimum floor area of three hundred (300) square feet and a minimum of sixteen (16) feet clear dimension."). The ACA additionally specifies with respect to procedure rooms: "In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed)." 42 U.S.C. § 1395nn(i)(3)(G).

162. *Id.* § 1395nn(i)(1)(B) ("Except as provided in paragraph (3) [which allows for approval by the Secretary of HHS], the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.").

163. *Id.*

164. *Id.* § 1395nn(i)(1)(A) ("The hospital had—(i) physician ownership or investment on December 31, 2010; and (ii) a provider agreement under section 1395cc of this title in effect on such date.").

165. *Id.* § 1395nn(i)(3) *et seq*.

166. *Id.* § 1395nn(i)(3)(C)(ii) ("The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of

allowing such increases only on the hospital's main campus.[167] Third, as discussed in the next subpart, the Secretary has in practice allowed only limited expansion of existing POHs.

Thus, while the ACA allowed existing POHs to continue to operate, it effectively prohibited the construction of new POHs and the expansion of existing POHs.

D. Frozen in Time from 2010 to Present

Since the passage of the ACA, the growth of POHs has been effectively frozen in time. Thirty-five expansion projects for existing hospitals were halted, according to the POH trade group Physician-Led Healthcare for America (PHA, previously Physician Hospitals of America).[168] PHA also identified another 38 hospitals that were under development but could not be completed before the December 31, 2010 deadline to qualify as existing POHs under the ACA.[169] PHA further identified 41 hospitals that were no longer under development following the passage of the ACA.[170] The PHA estimates the economic impact of halted hospitals to total $275 million.[171] Additionally, some POHs formed after implementation of the ACA attempted an unsuccessful strategy of not accepting Medicare, and all entered bankruptcy within 5 years.[172] In recent years, the AMA has advocated for repealing the ban on POHs,[173] but the ban is still in place. The PHA has likewise sought repeal and unsuccessfully challenged the constitutionality of ACA restrictions on POHs.[174]

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operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.").

167. *Id.* § 1395nn(i)(3)(D) ("Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.").

168. PHYSICIAN HOSPITALS OF AMERICA, PHYSICIAN HOSPITAL: IMPACT OF IMPLEMENTATION OF SECTION 6001, at 1–2 (Feb. 17, 2011); *see also* Debra Shute, *Is it Time to Lift the Ban on Physician-Owned Hospitals?*, MED. ECON., May 25, 2018, at 36, 39, https://www.medicaleconomics.com/view/it-time-lift-ban-physician-owned-hospitals [https://perma.cc/ELV7-DGKL].

169. PHYSICIAN HOSPITALS OF AMERICA, *supra* note 168, at 3.

170. *Id.* at 4.

171. *Id.* at 1.

172. Plummer, *supra* note 156, at 1458.

173. Letter from James L. Madara, MD, Executive Vice President & CEO, Am. Medical Ass'n, to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., regarding File Code CMS–1736–P (Oct. 5, 2020), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-4-Letter-to-Verma-re-2021-OPPS-FINAL.pdf [https://perma.cc/J8JR-2UMZ] (noting "The AMA also strongly supports repealing the federal ban on physician-owned hospitals").

174. Physician Hospitals of America v. Sebelius, 691 F.3d 649 (5th Cir. 2012).

CMS (which is part of HHS) permitted some POHs to expand during this period, but the limited nature of those allowances demonstrates how POHs largely cannot exceed the 2010 status quo. For example, in updating its regulations after the POH ban, CMS noted that a POH would be permitted to reduce and subsequently increase the number of licensed beds, procedure rooms, and operating rooms, so long as the POH did not exceed the baselines that existed on March 23, 2010.[175] More recently, CMS has made small changes to its regulations on POHs (e.g., permitting POHs that qualify as high Medicaid facilities to apply for exemptions more frequently than once every two years), while affirming that CMS "continue[s] to believe that our current regulations . . . are consistent with the Congress' intent to prohibit expansion of physician-owned hospitals."[176] CMS has also permitted limited expansion through a handful of advisory opinions. For example, in a 2016 advisory opinion, CMS permitted a POH to add "observation beds" beyond the March 23, 2010 baseline so long as they are not used for inpatient stays, operating rooms, or procedure rooms.[177] In a 2019 advisory opinion, CMS permitted POH use of operating rooms that were fully operational and accredited on March 23, 2010, and could be up and running within a few days but happened to not be in use in 2010 or in subsequent years.[178] Similarly, in a 2021 advisory opinion, CMS concluded that the addition of outpatient observation beds not subject to state licensure or registration to an existing POH would not violate

175. *See* 75 Fed. Reg. 71800, 72245 (Nov. 24, 2010) ("We interpret section 1877(i)(1)(B) of the Act to impose restrictions only on the aggregate number of operating rooms, procedure rooms, and beds. Therefore, we will not impose any restrictions regarding the manner in which a physician-owned hospital uses its beds, operating rooms, or procedure rooms. In other words, if a hospital is authorized to operate 20 beds, 2 operating rooms, and 2 procedure rooms, the hospital may reduce or increase the number of beds, operating rooms, or procedure rooms as long as the resulting aggregate number of beds, operating rooms, and procedure rooms does not exceed 24 (assuming any applicable licensure requirements are satisfied).").

176. Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule, 85 Fed. Reg. 85866, 86256 (Dec. 29, 2020) (to be codified at 42 C.F.R. pts. 410, 411, 412, 414, 416, 419, 482, 485, and 512); *see also* Press Release, Ctrs. for Medicare & Medicaid Servs., CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC) (Dec. 2, 2020), https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 [https://perma.cc/H9TT-WMJF] (summarizing rule changes).

177. Advisory Opinion No. CMS-AO-2016-01 (CMS Mar. 2016), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/CMS-AO-2016-01.pdf [https://perma.cc/7TR3-VXCC].

178. Advisory Opinion No. CMS-AO-2019-01 (CMS Aug. 2019), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/CMS-AO-2019-01-Redacted.pdf [https://perma.cc/UMW5-M64M].

the prohibition on expansion.[179] These narrow exceptions simply do not facilitate meaningful entry or expansion by POHs in the vast majority of circumstances.

Despite these efforts to work around the ban or repeal it, the ACA's restrictions on POHs have halted the growth and expansion of POHs and thus eliminated competition from new or expanded POHs in multiple service markets, including ones involving specialty hospitals, general acute care hospitals, and/or vertically integrated care delivery.

III. A Competition Perspective: The Benefits of Physician Ownership Become More Important in the Face of Market Power

The nature of competition in healthcare provider markets explains why a removal of the POH ban will strengthen the competitive incentives of market participants.[180] This Part first describes the likely contours of markets in which POHs may participate. These market dynamics are important for understanding how hospitals compete both in markets where they are sellers of services (to patients and payors) and in markets where they are buyers of labor (from physicians and other healthcare workers). Market dynamics also show why POHs are well-situated to overcome entry barriers and defeat the market power of incumbents, which informs the competition discussion that follows in Part IV. This analysis draws on the market definition principles utilized in antitrust matters, while not purporting to rigorously define specific markets as would be necessary in antitrust litigation. It then explains how market power held by incumbent hospitals and health systems incentivizes physicians to act on market opportunities for entry and innovation, both of which can improve the welfare of consumers and physicians.

A. Healthcare Markets Where Physician-Owned Hospitals Compete

The Merger Guidelines lay out key principles of market definition.[181] A market is defined around "horizontal" competition in that it includes actual and potential competitors that offer substitute products

179. Advisory Opinion No. CMS-AO-2021-2 (CMS Dec. 2021), https://www.cms.gov/files/document/cms-ao-2021-02.pdf [https://perma.cc/4NQE-XYYF].

180. *Cf.* 2023 Merger Guidelines, *supra* note 22 § 4.3 ("The Agencies engage in a market definition inquiry in order to identify whether there is any line of commerce or section of the country in which the merger may substantially lessen competition or tend to create a monopoly.").

181. *Id.*

or services but not upstream providers or downstream customers.[182] The Guidelines explain: "Market definition focuses solely on demand substitution factors, that is, on customers' ability and willingness to substitute away from one product or location to another in response to a price increase or other worsening of terms."[183]

Substitution factors show that POHs may operate in at least three service markets: markets for providing hospital services to patients, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services. This comports with recent case law that characterizes hospital markets as a "two-stage model of competition": first, "insurers and hospitals negotiate to determine whether the hospitals will be in the insurers' networks and how much the insurers will pay them," and second, "hospitals compete to attract patients, based primarily on non-price factors like convenience and reputation for quality."[184] Markets for physician services are less often at issue in the case law, but they sometimes arise as potential markets that can be harmed and as critical input markets for entry.[185]

1. Markets to Provide Patients Hospital Services

Patients have demand for treatment of their medical needs and can seek medical treatment from a variety of providers, including both general acute care and specialty POHs. General acute care hospitals, regardless of ownership structure, must provide services across a wide range of specialties focused on inpatient care and associated ancillary services.[186] Since such facilities offer direct substitutes across a broad range of specialties with other general acute care hospitals in their

182. *Id.* § 4.3 ("A relevant antitrust market is an area of effective competition, comprising both product (or service) and geographic elements.").

183. *Id.* § 4.3.D.2.b.

184. FTC v. Hackensack Meridian Health, Inc., 30 F.4th 160, 168 (3d Cir. 2022) (quoting FTC v. Advoc. Health Care Network, 841 F.3d 460, 465 (7th Cir. 2016)).

185. *E.g.*, FTC v. ProMedica Health Sys., Inc., No. 3:11 CV 47, 2011 WL 1219281, at *31–34 (emphasizing the time new hospitals require to obtain the requisite staff and physician affiliates); Satisky, *supra* note 33; Seaman v. Duke Univ., No. 1:15-CV-462, 2019 WL 13193731 (M.D.N.C. Sept. 24, 2019) (order granting approval of proposed class action settlement involving physician no-poach agreements); United States v. Anthem, Inc., 236 F. Supp. 3d 171, 187 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017) (noting "plaintiffs allege . . . merger will result in harm to competition in the market for the purchase of healthcare services, or a monopsony" though not reaching this claim because the court found in plaintiff's favor on other grounds).

186. *Hospitals*, Ctrs. for Medicare and Medicaid Servs., https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals [https://perma.cc/FV4X-Q9QG] (last modified Feb. 13, 2024); *see also* Peter Reid Kongstvedt, Essentials of Managed Healthcare 157–58 (5th ed. 2007) (describing ancillary services, quoted *supra* note 100).

geographic market, it makes sense that patients see such institutions as alternatives across a range of patient medical needs. General acute care hospitals may also provide services that partially overlap with those offered by specialty hospitals. Consider a general acute care hospital and a cardiac specialty hospital. Both hospital types could offer and compete for interventional cardiology services. A cardiac specialty hospital's interventional cardiology service would not, however, compete with primary care services[187] offered at the general acute care hospital. The case law also recognizes this partial overlap in services between general acute care hospitals and specialty hospitals.[188]

Specialty POHs likewise present patients an alternative both to other specialty hospitals and to general acute care hospitals, but only for a narrower set of services and medical needs. Based upon a 2015 survey, 45% of POHs are specialty hospitals.[189] Of these specialty POHs, 30.1% are cardiac specialty hospitals, 16.8% are orthopedic surgical specialty hospitals, 35.0% are general surgical specialty hospitals, and 18.1% are hospitals for some other specialty.[190] So, for example, a cardiac specialty POH might compete in the market for cardiac services in a particular geography with general acute care hospitals (which have a cardiology unit) as well as other cardiac specialty hospitals. For example, if a patient needed to undergo cardiac treatment (such as a cardiac catheterization for a balloon angioplasty and coronary artery stent placement with the expectation of post-procedural inpatient care and monitoring), the patient would have only these options: relevant cardiac specialty hospitals (including physician-owned) and general acute care hospitals. A physician's outpatient clinic[191] could not address these

187. Primary care refers to "[h]ealth services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists." *Primary Care*, HEALTHCARE.GOV GLOSSARY, https://www.healthcare.gov/glossary/primary-care/ [https://perma.cc/L6WL-KN38].

188. *See, e.g.*, Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc., 527 F. Supp. 2d 1257, 1265 (D. Kan. 2007) ("Niche providers include . . . specialty hospitals providing a limited range of specialty procedures, often organized around a singular issue, such as surgery, cardiac care, or women's care . . . . The insureds can obtain their healthcare from any of the niche providers or the traditional general hospitals . . . .").

189. *See* Blumenthal, *supra* note 63, app. 6.

190. *Id.*

191. Outpatient care refers to care that does not require an overnight stay in a hospital. *See, e.g.*, *What is Inpatient vs. Outpatient Care?*, CIGNA KNOWLEDGE CTR., https://www.cigna.com/knowledge-center/what-is-inpatient-vs-outpatient-care [https://perma.cc/VR4N-ASG7] ("What is outpatient care? Outpatient care—the kind that you don't have to stay in a hospital for—can vary greatly. Other than an annual check-up or blood test, almost any other kind of care can be defined as outpatient. These may be diagnostic tests,

patient needs because they lack the specialized operating room and the inpatient beds for overnight care. Likewise, an ambulatory surgical center[192] could not address these patient needs—even if they have a specialized operating room, these facilities lack the inpatient beds[193] for needed overnight care. Again, to have those beds, they would have to be licensed *as a hospital*.[194] Of course, outside their specialization, specialty POHs are not market participants.

The geographic market is defined by patients' willingness to travel to reach medical services. For some commonplace or routine procedures or treatments, patients typically exhibit a lower willingness to travel beyond their local hospital or clinic.[195] By contrast, for complex surgical services patients are often willing to travel greater distances.[196] Government economists,[197] academics,[198] and state regulators[199] closely study

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treatments, or other types of procedures. Outpatient care may be provided in a hospital, as well as a walk-in clinic, an outpatient surgery center, and even your doctor's office.").

192. As noted earlier, "[a]mbulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting." *Ambulatory Surgery Centers: A Positive Trend in Healthcare*, *supra* note 3.

193. As discussed *supra* note 161, hospitals are generally licensed at the for a certain capacity of beds for treating patients on an inpatient basis. *See, e.g.*, D.C. Mun. Regs. tit. 22, § 2002.2 (2008) ("The application for a hospital license shall state each service for which the applicant undertakes to furnish hospital care and the number of beds allocated to each service; and shall furnish other information as may be required.").

194. In contrast with outpatient providers, a "hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. " *Hospitals*, *supra* note 186.

195. Wei Yen, Wash. St. Health Servs. Rsch. Project Rsch. Brief No. 70, How Long and How Far Do Adults Travel and Will Adults Travel for Primary Care? (2013), https://ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2013/brief070.pdf [https://perma.cc/N4QG-GQ8B] ("For future routine care, adults are willing to spend 28.4 minutes and travel a distance of 20.4 miles; for future urgent care, they are willing to spend even more time (30 minutes) and go farther (22 miles).").

196. Jesse Chou et al., *The Volume-Outcome Relationship and Traveling for Hepatobiliary and Pancreatic Surgery: A Quantitative Analysis of Patient Perspectives*, 12 Cureus e11023 (Oct. 18, 2020) (finding "[m]any patients (80.2%) indicated that they would travel up to an hour to receive complex surgery. There were also a number of patients (28.9%) that were willing to travel more than two hours to undergo complex surgery"); *see also* Benjamin Resio et al., *Motivators, Barriers, and Facilitators to Traveling to the Safest Hospitals in the United States for Complex Cancer Surgery*, JAMA Network Open (Nov. 16, 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2714502 [https://perma.cc/ALL6-RNZJ] (finding U.S. public could be motivated to travel to safer hospitals for complex cancer surgery).

197. Devesh Raval & Ted Rosenbaum, *Why is Distance Important for Hospital Choice? Separating Home Bias from Transport Costs,* 69 J. Ind. Econ. 338 (2021).

198. Robin Haynes et al., *Potential Accessibility, Travel Time, and Consumer Choice: Geographical Variations in General Medical Practice Registrations in Eastern England*, 35 Env't & Plan. A: Econ. & Space 1733 (Oct. 2003).

199. Yen, *supra* note 195.

willingness to travel for healthcare and consumers' geographic preferences. Managed care market regulators recognize this market reality,[200] often implementing minimum, specific "time and distance" standards by medical specialty or type of care sought, a feature seen in ACA[201] and Medicare Advantage ("MA") markets,[202] amongst others.

Because of these consumer preferences, the geographic market for less complex, non-emergent services will typically be narrower, and hospitals outside that locality would not be in the same geographic market.[203] For rarer and higher stakes procedures or treatments such as complex cancer care or surgery, willingness to travel may increase and even providers in other states might be seen as serving the same geographic market. However, even where some patients willingly travel greater distances, many patients may be unwilling to travel, and so a local provider might nonetheless have market power to sustain a price increase, reflecting a narrower geographic market.[204] For most patients, the combination of cost-sharing with third party payors and limited price transparency means many patients have weaker incentives to seek out alternatives to an in-network provider based on cost.[205] Similarly for quality, patients have far from perfect information about how well healthcare providers diagnose patients or perform treatments and procedures, and this can dampen how far patients will consider traveling for alternatives.[206] Consequently,

200. Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/ [https://perma.cc/6HSD-BYKH].

201. Justin Giovannelli, Kevin Lucia, & Sabrina Corlette, *Regulation of Health Plan Provider Networks*, Health Affs. Health Pol'y Briefs (Jul. 28, 2016), https://www.healthaffairs.org/do/10.1377/hpb20160728.898461/full/healthpolicybrief_160.pdf.

202. *Medicare Advantage Network Adequacy Criteria Guidance*, Ctrs. for Medicare and Medicaid Servs., https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf [https://perma.cc/Z3TW-KXSG] (last updated Jan. 10, 2017). As discussed further *infra*, Medicare Advantage is a publicly-financed, privately-administered form of Medicare health benefits offered on a county-by-county basis.

203. *See* 2023 Merger Guidelines, *supra* note 22 § 4.3.D.2.a ("The Agencies sometimes define geographic markets as regions encompassing a group of supplier locations. When they do, the geographic market's scope is determined by customers' willingness to switch between suppliers.").

204. For antitrust market definition, the Agencies often look for the ability to sustain a price increase of at least five percent. 2023 Merger Guidelines, *supra* note 22 § 4.3.B.

205. *See, e.g.*, Ezekiel J. Emanuel & Amaya Diana, *Considering the Future of Price Transparency Initiatives—Information Alone Is Not Sufficient*, 4 JAMA Network Open (Dec. 13, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787076 [https://perma.cc/2VNQ-PWAB]; Ateev Mehrotra et al., *Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information*, 36 Health Affs. 1392 (2017).

206. *See* Logan Trenaman et al., *What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings*, 2 Health Affs. 1, 4 (2024)

the literature and case law generally find that these are local markets.[207] In these narrow geographic markets, another local provider such as a POH could be competitively significant for patients.

2. Markets for the Sale of Hospital Services to Payors

From the payors' perspective, POHs offer more ways to put together a network of providers they can offer to employers and other insurance customers.[208] General acute care POHs would compete to be in-network with other general acute care hospitals across the range of offered services.[209]

Even when POHs offer payors fewer services for their networks, they can provide valuable competition. First, consumers of those service lines benefit from the competition directly, and payors can benefit from low-cost, high-quality choices to weave into their networks. For example, payors have found that specialized service providers, such as

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("We found that, on average, Medicare beneficiaries would be willing to . . . travel 185 miles further (95% CI: 155 to 215 miles) for a hospital with a 1-star higher rating on clinical outcomes . . . ."); *cf.* Visa Pitkänen et al., *Choice, Quality and Patients' Experience: Evidence from a Finnish Physiotherapy Service*, 21 INT. J. HEALTH ECON. MGMT. 229, 243 (2021) ("Overall, information about providers' location and quality in an easily accessible form is a necessary condition for successful provider competition."); Stefanie Bühn et al., *Are Patients Willing to Accept Longer Travel Times to Decrease Their Risk Associated with Surgical Procedures? A Systematic Review*, 20 BMC PUB. HEALTH 253 (2020) ("The majority of the patients were willing to travel longer to lower their surgical risk. Older age and fewer years of formal education were associated with a higher risk tolerance in the local hospital.").

207. *See, e.g.*, Abraham et al., *supra* note 14, at 267 ("Hospital markets are local because consumers are not generally willing to travel far to obtain care."); Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 167–72 (3d Cir. 2022) (affirming proposed relevant geographic market in hospital merger challenge defined as all hospitals used by commercially insured patients who reside in Bergen County, New Jersey); FTC v. Advoc. Health Care Network, 841 F.3d 460, 470 (7th Cir. 2016) ("[B]ecause most patients prefer to go to nearby hospitals, there are often only a few hospitals in a geographic market."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284–85 (7th Cir. 1990) (approving six-hospital market in part because "for the most part hospital services are local").

208. *See, e.g.*, FTC v. Advoc. Health Care Network, 841 F.3d at 465 ("In the United States today, most hospital care is bought in two stages. In the first, which is highly price-sensitive, insurers and hospitals negotiate to determine whether the hospitals will be in the insurers' networks and how much the insurers will pay them."); *supra* Part II.A.2 (discussing example of Lincoln Surgical Hospital in Nebraska as an in-network provider with BlueCross BlueShield Nebraska).

209. For example, several insurers list general acute care POH Doctors Hospital at Renaissance, discussed *supra* in Part II.B, is an in-network provider. *See, e.g.*, *Table of Participating (In-Network) Hospitals for Calendar Year 2021*, AETNA, https://www.aetna.com/dsepublicContent/assets/pdf/en/tx_non_contracted_prvdr_rprt.pdf [https://perma.cc/3RJ5-5WYK]; *Provider Director 2023*, UNITEDHEALTHCARE, https://www.uhc.com/medicare/alphadog/UHTX23RP0078088_001 [https://perma.cc/MR4N-7YNY].

imaging centers and ambulatory surgical centers, can provide significant cost savings.[210] Payors could likewise benefit from additional provider choices in the form of specialty hospitals.[211] Second, specialized POHs could be well-positioned to enter additional service lines, and payors benefit as that happens.[212] Today, fifty-five percent of POHs are general acute care (or community) hospitals.[213]

Geographic markets from the payor perspective also tend to be local.[214] For market and regulatory reasons, health insurance plans need a minimum number of providers in a given geography.[215] This is true of plans sold directly to consumers like those on ACA exchanges. It is likewise true for the MA program, a publicly-financed, privately-administered form of Medicare health benefits offered on a county-by-county basis[216] that has become the dominant form of Medicare.[217] The breadth and quality of a payor's network is part of what it competes on and sells to consumers.[218] Moreover, network adequacy regulations ensure health insurance plans never drop below a minimum number of providers in a given geography.[219] For employer-provided health insurance, even national employers need to ensure networks meet *local* employee needs. And since an employer tends to want to be able to

210. *See, e.g.*, Morgan Haefner, *UnitedHealth: Move Routine Imaging out of Hospital, Lower Spending by 62%*, Becker's Payer Issues (Nov. 18, 2020), https://www.beckerspayer.com/payer/unitedhealth-move-routine-imaging-out-of-hospital-lower-spending-by-62.html [https://perma.cc/S4UD-8E2Q] (discussing potential for 62% cost savings shifting diagnostic imaging from hospitals to imaging centers); United-Health Group, Shifting Common Outpatient Procedures to ASCs Can Save Consumers More than $680 per Procedure (2021), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2021/Site-of-Service-Research-Brief.pdf [https://perma.cc/JAA6-9ZVL] (finding 59% cost reduction from shifting outpatient procedures from hospital outpatient departments to ambulatory surgical centers).

211. *See infra* Part V.C (discussing evidence of lower quality-adjusted prices from POH competition).

212. For example, as discussed *supra* in Part II.B, Doctors Hospital at Renaissance originated as a 2-room ambulatory surgery center in 1997 and has grown into a 530-bed general acute care POH.

213. Blumenthal, *supra* note 63, app. 6.

214. *See, e.g.*, FTC v. Hackensack Meridian Health, Inc., 30 F.4th 160, 167–72 (3d Cir. 2022) (affirming geographic market defined as hospitals used by commercially insured patients who reside in particular county).

215. *See, e.g.*, Pollitz, *supra* note 200.

216. *Id.*

217. Meredith Freed et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KFF (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/ [https://perma.cc/Z48D-HU88].

218. *See, e.g.*, United States v. Aetna Inc., 240 F. Supp. 3d 1, 45 (D.D.C. 2017) (noting insurers Aetna and Humana "compete on multiple dimensions of Medicare Advantage plan design, including network and cost").

219. *See, e.g.*, Pollitz, *supra* note 200.

hire employees who live across a local geography, the network must be able to serve employees throughout that area, whether they live on the east side of town, the west side, downtown, in the suburbs, or however the local labor market may be geographically divided.[220] As a result, employer-sponsored health insurance may enhance the market power of providers in local markets, since employer plans are less able to exclude hospitals in parts of local geographies with fewer alternatives.[221]

In this context, an additional local provider such as a POH could be a meaningful addition that helps payors create networks that are competitive and satisfy regulatory requirements.

3. Markets Where Hospitals Compete for Physician Services

POHs offer additional competition for physician services. Depending on their specialty, physicians can interact with hospitals in one of three ways: as salaried employees, as physicians with admitting privileges who either bill as part of their independent private practice or as part of a larger medical group (frequently owned and operated by the hospital), or as employers who share in a hospital's income (as is the case in POHs). Unlike in the other two previously discussed kinds of markets, here hospitals should be understood as the *purchaser* of the relevant services, not the seller. Despite that difference, the relevant principles of economics and competition policy still apply.[222] A POH will increase competition for a given physician's services if the physician's specialty is relevant to both a specialty POH and to a department within a general acute care POH. This can promote greater supply of physician services because increases to compensation or improved terms of employment may attract more physicians and incentivize physicians to work more.

Geographically, labor markets tend to be local and that includes labor markets for physician services.[223] In some ways, physicians may be

220. *Cf.* KFF, 2020 Employer Health Benefits Survey 204 (2020), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf [https://perma.cc/Y76K-WNP3] (finding that only seven percent of all firms offer narrow network plans, and only four percent of all firms offer health plans that eliminate a hospital or health system).

221. *See, e.g.*, Cong. Budget Off., Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (2022), https://www.cbo.gov/publication/58541 [https://perma.cc/E3RP-VFZW] (noting "providers with market power can credibly threaten to stay out of an insurer's network and still maintain their market share, which strengthens their ability to negotiate higher prices with insurers").

222. *See* 2023 Merger Guidelines, *supra* note 22 § 2.10.

223. *See* Alan Manning & Barbara Petrongolo, *How Local Are Labor Markets? Evidence from a Spatial Job Search Model*, 107 Am. Econ. Rev. 2877, 2877 (2017) ("We

more mobile than the typical employee because, for example, they tend to be higher income, they are highly educated and so can better research opportunities in other locations, and their skills are in demand across the United States.[224] On the other hand, physicians face entry barriers: medical licenses are not easily transferred across state lines,[225] and physician practices can take a lot of time to rebuild, including referral relationships. Physicians also may have substantial personal roots in their current location. The economic evidence finds that the costs and frictions of relocating for a physician are sufficiently high that a hypothetical monopsonist could exercise market power.[226] As a result, the addition of a local POH could substantially strengthen competition for physician services.

4. Barriers to Entry in Hospital Markets

Barriers to hospital entry and expansion may strengthen incumbent hospitals' ability to exercise market power in these three kinds of markets. Evidence strongly suggests that such barriers are high for

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estimate that labor markets are quite local, as the attractiveness of jobs to applicants sharply decays with distance. Also, workers are discouraged from searching in areas with strong competition from other job-seekers."); Meredith B Rosenthal et al., *The Geographic Distribution of Physicians Revisited*, 40 HEALTH SERV. RES. 1931, 1932 (2005) ("While views on the adequacy of the national physician workforce vary widely and fluctuate over time . . . most seem to agree that physicians are geographically maldistributed, with too few in rural areas.") (citations omitted).

224. *See, e.g.*, Noah Schwartz & Alan Condon, *118 Statistics on Physician Compensation: 2023*, BECKER'S HOSP. REV. (May 12, 2023), https://www.beckershospitalreview.com/compensation-issues/118-statistics-on-physician-compensation-2023.html [https://perma.cc/8CSN-AEF2] (discussing compensation); Press Release, Am. Med. Ass'n, AMA President Sounds Alarm on National Physician Shortage (Oct. 25, 2023), https://www.ama-assn.org/press-center/press-releases/ama-president-sounds-alarm-national-physician-shortage [https://perma.cc/9LYK-PTEU] (discussing national physician shortage).

225. *See* Edward Timmons & Conor Norris, *Potential Licensing Reforms in Light of COVID-19*, 3 HEALTH POL'Y OPEN 100062 (2022) ("State licensing laws also reduce interstate mobility because of the added cost of obtaining a license in a new state after a move. . . . Although licensing standards for healthcare professionals are much more standardized than other professions, licensing laws continue to pose a barrier in the United States. Healthcare professionals are less able to respond to regional or local changes in demand for healthcare without facing delays due to the application process.") (citation omitted).

226. *See, e.g.*, United States v. Aetna, Inc., No. 3-99 CV 1398-H, 1999 WL 1419046, at *15 (N.D. Tex. Dec. 7, 1999) (approving consent decree in case alleging acquisition would "consolidate . . . purchasing power over physicians' services in Houston and Dallas, enabling the merged entity to unduly reduce the rates paid for those services") (citations omitted); *see also* A DOSE OF COMPETITION, *supra* note 59, at ch. 6, p. 16 (noting importance of evaluating switching costs in monopsony analysis and discussing reasons physicians may face high switching costs, including value of physician's time, difficulty quickly replacing lost patients, investment in specialized assets and training, and lack of geographic mobility); *cf.* United States v. Bertelsmann SE & Co. KGaA, 646 F. Supp. 3d 1, 34-35 (D.D.C. 2022) (applying hypothetical monopsonist test to assess whether a proposed publisher monopsonist could exercise market power over authors).

hospital markets. A new hospital generally must enter multiple service markets at once, such as emergency care, procedural care, ambulatory care (primary and specialty), and habilitative services.[227] Construction time is often measured in years, with technology-driven facilities frequently requiring as long as four years.[228] Building a new hospital or expanding an existing hospital is a tremendously expensive and time-consuming endeavor, as frequently both development and initial operating costs must be covered.[229] Direct costs include land acquisition, facility construction, and the acquisition of medical equipment to name a few, along with initial staffing—clinical (nursing, pharmacy, physician), ancillary (technicians, patient transporters, unit secretaries, environmental services, facilities maintenance), and managerial.[230]

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227. Because hospitals generally offer a collection of services, courts often view hospitals as competing in a "cluster market" of services. *See, e.g.*, FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1075–76 (N.D. Ill. 2012) ("The primary product market advanced by the FTC in this case is general acute care inpatient services ("GAC") sold to commercial health plans. This is a 'cluster market' of services that courts have consistently found in hospital merger cases, even though the different types of inpatient services are not strict substitutes for one another. In this case, the FTC defines the GAC market to 'encompass a broad cluster of medical and surgical diagnostic and treatment services that include an overnight hospital stay, including, but not limited to, many emergency services, internal medicine services, and surgical procedures.' The GAC market does not include outpatient services, rehabilitation services, psychiatric services, or complex tertiary and quaternary services, as these services are offered by a different set of competitors. In their post-hearing submissions, defendants do not dispute that GAC services, as defined by the FTC, is a relevant product market.") (citations omitted); California v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001) ("In the present case, the parties agree that the relevant product market consists of the cluster of services comprising acute inpatient care. While the treatments offered to patients within this cluster of services are not substitutes for one another (for example, one cannot substitute a tonsillectomy for heart bypass surgery), the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services. Accordingly, courts have consistently recognized the cluster of services comprising acute inpatient services as the appropriate product market in hospital merger cases."); FTC v. ProMedica Health Sys., Inc., No. 3:11 CV 47, 2011 WL 1219281, at *9 (N.D. Ohio Mar. 29, 2011) (finding "General acute-care ('GAC') inpatient hospital services sold to commercial health plans are a relevant product market in which to evaluate the effects of the Acquisition. . . . GAC services are a broad 'cluster market' of inpatient surgical, medical, and supporting services provided in a hospital setting to commercially-insured patients.") (citations omitted).

228. *See How Do You Build a Hospital That Balances Cutting Edge Technology and Affordable Healthcare?*, ARUP, https://www.arup.com/projects/kaiser-permanente-san-diego [https://perma.cc/HBJ2-32ED] (beginning hospital design bids in 2013 and finishing construction in 2017).

229. *See generally* John E. Millsap, Cal. HealthCare Found., Understanding the Hospital Planning, Design, and Construction Process (Feb. 2007), https://www.chcf.org/wp-content/uploads/2017/12/PDF-SB1953HospitalConstructionIB.pdf [https://perma.cc/P66R-UTD2].

230. *Id.* at 3 (noting "total project cost budget includes architects and engineers' fees, medical equipment, furnishings and fixtures, OSHPD [Office of Statewide Health

Even small micro hospitals,[231] which are typically around ten beds, can cost $25–50 million.[232] Hospital construction costs per square foot are significant, typically running $385 to $970 per square foot in a major city.[233] Measured differently, "cost per bed" can run $1–3 million depending upon the intended use, with recent examples of facility expansion including Rush University's new $654 million, 304-bed pavilion,[234] MedStar Georgetown University Hospital's new $567 million, 477,000 square foot surgical pavilion[235] that includes 156 new beds,[236] and the Mayo Clinic's $353 million La Crosse and Mankato projects with a new 70-bed hospital and a 121-bed expansion.[237]

Beyond these direct costs, new hospitals often must overcome significant regulatory hurdles such as zoning, building permits, and

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Planning and Development] building permit fees and project contingencies."); Alia Paavola, *12 US Cities Ranked by Cost per Square Foot to Build a Hospital*, BECKER'S HOSP. REV. (Jul. 21, 2017), https://www.beckershospitalreview.com/capital/12-us-cities-ranked-by-cost-per-square-foot-to-build-a-hospital.html [https://perma.cc/VRQ9-8PVW] (describing construction costs).

231. Michelle E. Andrews, *Microhospitals May Help Deliver Care In Underserved Areas*, NPR (Jul. 19, 2016), https://www.npr.org/sections/health-shots/2016/07/19/486500835/microhospitals-may-help-deliver-care-in-underserved-areas [https://perma.cc/9FJQ-K8UB]; *see also Micro-Hospitals*, USC PRICE EXEC. MASTERS OF HEALTH ADMIN. ONLINE (November 17, 2023), https://healthadministrationdegree.usc.edu/blog/micro-hospitals [https://perma.cc/TUY4-RMM3] ("Micro-hospitals are small-scale inpatient facilities on two to three-story buildings built on 20,000 to 50,000-square foot spaces that offer a wide range of medical services in a small, neighborhood setting. They run 24/7, all year long, and commonly have between eight and 10 beds where patients can be observed or admitted for a short stay.").

232. Beth Jones Sanborn, *Are Micro-Hospitals the Answer for Systems Looking for Low-Cost Expansions? They Might Be*, HEALTHCARE FIN. (Jul. 12, 2017), https://www.healthcarefinancenews.com/news/are-microhospitals-answer-systems-looking-low-cost-expansions-they-might-be [https://perma.cc/7AQZ-W7FK].

233. Noah Schwartz, *Hospital Construction Costs in 12 Large U.S. Cities*, BECKER'S HOSP. REV. (June 29, 2023), https://www.beckershospitalreview.com/capital/hospital-construction-costs-in-12-large-u-s-cities.html [https://perma.cc/7LZ9-W2QP].

234. *Rush's New Hospital is the Largest New Construction Health Care Facility in the World to Receive LEED Gold Certification*, RUSH UNIV. MED. CTR. (Jun. 25, 2014), https://www.rush.edu/news/rushs-new-hospital-largest-new-construction-health-care-facility-world-receive-leed-gold [https://perma.cc/8CQY-BUM9].

235. Tina Reed, *Medstar Georgetown University Hospital Prepares to Start Construction on New Tower*, WASH. BUS. J. (Feb. 23, 2018), https://www.bizjournals.com/washington/news/2018/02/23/medstar-georgetown-university-hospital-prepares-to.html.

236. *Building Medical Excellence: The Medical/Surgical Pavilion at MedStar Georgetown University Hospital*, MEDSTAR HEALTH, https://www.medstarhealth.org/philanthropy/get-involved/medstar-georgetown-medical-surgical-pavilion [https://perma.cc/J783-M8VU].

237. Karl Oestreich, *Mayo Clinic Invests in Facilities at Mayo Clinic Health System Locations and in Florida to Expand and Enhance Patient Care*, MAYO CLINIC (Feb. 22, 2022), https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-invests-in-facilities-at-mayo-clinic-health-system-locations-and-in-florida-to-expand-and-enhance-patient-care/ [https://perma.cc/9MUU-P6EJ].

state licensure.[238] In many markets, hospital facilities must obtain clearance for market entry through a certificate of need ("CON") process, a regulatory barrier present in 35 states and the District of Columbia.[239] Originating in the 1960s and intended to provide downward pressure on health care expenditures and avoid unnecessary facility duplication due to a medical arms race,[240] certificate of need laws can suppress market entry, especially when incumbents abuse the hearing, comment, and appeal processes.[241]

Additionally, new hospitals often must negotiate agreements with multiple public and private payor networks to be included in their insurance coverage. To participate in the Medicare and Medicaid programs, hospitals must meet the conditions of participation[242] and accept public payor fee schedules. As part of this process, hospitals typically undergo a survey process, or an inspection and review by a certifying agency.[243] Hospitals may also use those survey results for participation in private plan networks, with facilities facing the additional step of negotiating payment rates with each private plan or modifying pre-existing health system payor contracts to include the new or expanded facility. If a hospital is opened as a stand-alone facility rather than as part of a larger network, the hospital may lack leverage to negotiate higher rates with payers which may make it more difficult to recoup the significant

238. As discussed *supra* note 161, hospitals are generally licensed at the state level for a certain capacity of beds for treating patients on an inpatient basis. *See, e.g.*, D.C. Mun. Regs. tit. 22, § 2002.2 (2008) ("The application for a hospital license shall state each service for which the applicant undertakes to furnish hospital care and the number of beds allocated to each service; and shall furnish other information as may be required.").

239. *Brief: Certificate of Need Laws*, Nat'l Conf. of St. Legislatures (NCSL), https://www.ncsl.org/health/certificate-of-need-state-laws [https://perma.cc/R6NU-ZQMJ] (last updated Jan. 1, 2023).

240. Christopher J. Conover & James Bailey, *Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis*, 20 BMC Health Servs. Rsch. 748 (Aug. 14, 2020).

241. *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (Sep. 15, 2008), https://www.justice.gov/atr/competition-health-care-and-certificates-need-joint-statement-antitrust-division-us-department; U.S. Dep't of Justice & Fed. Trade Comm'n, *supra* note 145; Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 Antitrust 50 (2015); Matthew D. Mitchell et al., *CON Laws in 2020: About the Update*, Mercatus Ctr. (Feb. 19, 2021), https://www.mercatus.org/publications/healthcare/con-laws-2020-about-update [https://perma.cc/8XRY-5C4J].

242. *Critical Access Hospitals (CAHs)*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals [https://perma.cc/9NGM-KS9L] (last modified Sept. 6, 2023).

243. *See, e.g.*, 42 C.F.R. pts. 482, 485 ("In accordance with Section 1864 of the Act, State surveyors assess hospital compliance with the conditions as part of the process of determining whether a hospital qualifies for a provider agreement under Medicare.").

investments necessary to open the new hospital, further discouraging new entry.[244]

Thus, the barriers to hospital construction or expansion are significant, and this conclusion is echoed in the antitrust case law.[245]

B. Market Power by Incumbent Hospitals and Health Systems—How it Affects the Incentives and Importance of Physician-Owned Hospitals

Given the three kinds of markets identified in Part III.A, we can revisit the trends and concerns for consolidation discussed in Part I and investigate how each market is affected by this consolidation. When hospitals and health systems consolidate and develop market power, we expect negative effects in terms of price, quality, output, and innovation. For example, payors would have fewer ways to put together local provider networks. That may mean payors develop lower quality networks and consumers have fewer in-network alternatives. Hospitals and health systems may have more leverage to demand higher prices, as some providers become increasingly "must haves" for meeting network adequacy thresholds and for offering viable, commercially attractive plans. Similarly, quality and innovation may suffer as hospitals and health systems face less pressure to earn their in-network status or earn patient loyalty. Innovations in hospital management and care delivery may seem like unnecessary risks to revenue. Lastly, these institutional providers may have incentives to engage in anticompetitive conduct, like contracting practices that protect their market power.

As these hospitals and health systems (jointly owned or managed groups of hospitals and other facilities) exercise power upstream in the market for physician services, physicians would have fewer local alternatives for their services, and hospitals would have added leverage to move physicians to a salary model. As employees, physicians would not be negotiating independently with payors for compensation, so the health system may be able to demand more from payors for the same physician services. Additionally, physicians would no longer be

244. *Cf.* Kelly J. Devers et al., *Hospitals Negotiating Leverage with Health Plans: How and Why Has It Changed?*, 38 HEALTH SERVS. RES. 419, 435-37 (2003) (finding that horizontal integration, vertical integration, and brand name strengthen hospital leverage in payor negotiations—which an entrant would likely lack).

245. *E.g.*, FTC v. ProMedica Health System, No. 3:11-cv-47, 2011 WL 1219281, at *1, *31–34 (N.D. Oh. Mar. 29, 2011) (finding high entry barriers into the hospital market on a motion for a preliminary injunction); Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 788 (9th Cir. 2015) (noting the court made "uncontested finding of high entry barriers" in suit challenging merger of two Idaho healthcare providers).

negotiating as independent physicians for admitting privileges at the hospital, thus they can more effectively be asked to work longer hours for less pay and profit sharing. Moreover, physicians may be compelled to engage in referral patterns that are limited to their employer health system. Lastly, health systems may be less responsive to requests to design hospital operating rooms and other aspects of the hospital setting around optimizing specific physician practice areas, as discussed above in Part II.B. This is especially true if those physician requests do not conform to maximizing supracompetitive profits for the health system overall, for example, if a focused-factory model increases output in a way that reduces overall rents from market power.

These harms of market power can accentuate the potential value of physician entry and innovation identified in Part II and in some respects make POH entry more feasible. If market power increases the costs of hospital services downstream, that increases the importance of a POH to compete and defeat the price increases, and those high incumbent prices also create the space for a new entrant to win market share. The same is true of quality and innovation—POH entrants can earn their place in the market by making up for the deficit in high-quality, innovative care that can arise from the consolidation of market power in incumbents. Moreover, to the extent physicians are underpaid, overworked, or underutilized, the market power of incumbent hospitals in upstream labor markets gives physicians a greater incentive to form a POH and a greater ability to attract other physicians with enticing terms to join their new POH, including an ownership interest.

The FTC's 2012 investigation into the proposed acquisition of Surgical Institute of Reading L.P. (SIR) by Reading Health System (RHS) is illuminating, which the parties abandoned following the FTC's complaint.[246] As alleged in the complaint, RHS was the dominant incumbent health system in the Reading, Pennsylvania area.[247] RHS had 735 licensed hospital beds and is the largest local employer of physicians.[248] By contrast, SIR was a surgical specialty POH formed only five years earlier with a mere 15 licensed beds.[249] SIR provided a range of inpatient and outpatient surgical services.[250] The FTC identified only one other general acute care hospital in the local market.[251] The FTC determined

246. Complaint, Reading Health Sys., FTC Docket No. 9353 (Dec. 7, 2012), https://www.ftc.gov/legal-library/browse/cases-proceedings/1210155-reading-health-system-surgical-institute-reading-matter [https://perma.cc/PPF8-5T4T].
247. *Id.* ¶ 1.
248. *Id.* ¶ 11.
249. *Id.* ¶ 13.
250. *Id.*
251. *Id.* ¶ 9.

that the acquisition would give RHS control of two-thirds of the local market for inpatient orthopedic services, up from 42 percent.[252]

SIR's pending entry alarmed RHS, and the incumbent projected heavy losses on its revenue and volume on competing surgical procedures.[253] Once SIR entered the market, RHS began internally attributing "notable losses of volume" directly to SIR.[254] RHS executives complained of SIR as its "nemesis" and observed how "by service line" RHS was "even a harder hit."[255]

According to the FTC, SIR achieved its entry by outcompeting RHS. There were "wide differences" in the rates SIR charged health plans.[256] SIR also received higher patient satisfaction scores than RHS and the other local general acute care hospital.[257] SIR distinguished itself by offering 24-hour visitation, quick schedule times, private rooms, and lower infection rates.[258] RHS primarily responded to SIR with exclusionary tactics, such as offering health plans discounts contingent on them excluding SIR and using their network of primary care physicians to steer patients away from SIR.[259]

The FTC credited SIR's "physician-driven management" and "patient-focused" approach to care that was notably "less bureaucratic" than RHS in explaining SIR's successful entry despite high barriers.[260] Incumbent RHS was well-capitalized, dominant in the local market for primary care physicians, and had "already immense bargaining leverage" over health plans.[261] And yet, despite RHS internally recognizing the cost of losing "higher-reimbursed patients" to SIR and the importance of "improv[ing] our services so that patients will want to come," RHS "struggle[d] to provide the same level of service and amenities" as SIR.[262] Notably, a point of failure for both RHS and another local provider was the inability to recruit additional orthopedic surgeons to improve their departments and compete with SIR.[263] RHS ultimately offered to buy out SIR at a "considerable premium" compared to other bidders, seeking to protect its market position by removing SIR from competition.[264]

252. *Id.* ¶¶ 58–59.
253. *Id.* ¶ 2.
254. *Id.* ¶¶ 24.
255. *Id.* ¶ 25.
256. *Id.* ¶ 26.
257. *Id.*
258. *Id.* ¶ 37.
259. *Id.* ¶¶ 27–28.
260. *Id.* ¶¶ 39, 68–73.
261. *Id.* ¶ 7.
262. *Id.* ¶¶ 2, 40.
263. *Id.* ¶¶ 9, 70.
264. *Id.* ¶ 29.

The FTC also observed that "[b]ased on recent history, the most likely entrant into this market would be another physician-owned specialty hospital."[265] Unfortunately, the POH ban that is the subject of this article was already in place by 2012, so such entry would not be forthcoming. This might lead one to wonder why another specialty surgical hospital, not owned by physicians, could not have followed SIR's lead and had similar success by employing "physician-driven management" and taking a "patient-focused," "less bureaucratic" approach. The FTC's evidence here suggests physician-owned SIR had an edge over incumbents and non-physician-owned entrants alike, because the unique role of physicians in providing and directing care helps them identify opportunities for hospital market entry and innovation.[266] Physician ownership gives them the incentives and ability to seek out and act on those opportunities.[267] The combination of upstream and downstream market power amplifies these incentives.[268] Ownership also helps overcome challenges recruiting physicians.[269] By contrast, RHS used its dominance to become "one of the most expensive healthcare providers in central Pennsylvania," while also being dominant as a healthcare employer.[270] This exercise of upstream and downstream market power by RHS gave SIR an opening to outcompete RHS in contracting with health plans, which RHS failed to prevent with its exclusionary pricing, and in recruiting orthopedic surgeons, which SIR did successfully while RHS fell short. A non-physician-owned entrant would likely lack this competitive edge that physician ownership provided to SIR.

IV. A Competition Analysis on Curtailing the Physician-Owned Hospitals Ban

In this Part we examine the competitive impact of the POH ban on competition in the three kinds of healthcare markets described previously: markets to provide hospital services to patients, markets for the sale of hospital services to payors, and markets where hospitals compete for physician services. We begin by outlining a competition policy approach to analyzing these issues. We then consider the purported objectives of the ban—whether the purported market failures are well-founded and can justify how the ban harms competition in these markets. Lastly, we consider whether there are more narrowly tailored

265. *Id.* ¶ 72.
266. *See supra* Part II.A.1.
267. *See supra* Part II.A.2.
268. *See infra* Part IV.C.
269. *See supra* Part II.A.3.
270. Complaint ¶¶ 21 & 28, Reading Health Sys., *supra* note 246.

policy options that would preserve the benefits of POH competition while addressing potential concerns. We conclude that concerns regarding POHs are not sufficient to justify the competitive harms caused by the POH ban and are better addressed through more narrowly tailored policies.

A. Analytic Approach

A competition policy approach considers the competition offered by POHs in various markets and whether particular approaches to regulating POHs unnecessarily impede competition in those markets. The federal government has for decades assessed the competition effects of regulatory policies,[271] and indeed the White House recently updated its guidance to federal agencies on how best to do so.[272] That guidance parallels a history of competition advocacy by the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission.[273] Similar analytic frameworks are utilized to assess how regulations affect competition in other countries.[274] In the past, government bodies have provided at most a cursory assessment of the competition relating to POHs.[275]

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271. *See, e.g.*, Exec. Order No. 14036, 86 Fed. Reg. 36987 (July 9, 2021) ("Agencies can and should further the polices set forth in section 1 of this order by . . . rescinding regulations that create unnecessary barriers to entry that stifle competition."); Exec. Order 12866, 58 Fed. Reg. 190 § 3(f) (Oct. 4, 1993) (defining a "significant regulatory action" to include one that may "adversely affect in a material way . . . competition").

272. Off. of Info. & Reg. Affairs (OIRA), Guidance on Accounting for Competition Effects When Developing and Analyzing Regulatory Actions (2023), https://www.whitehouse.gov/wp-content/uploads/2023/10/RegulatoryCompetitionGuidance.pdf [https://perma.cc/5UQ4-XKST].

273. *See, e.g.*, *Comments to Federal Agencies*, U.S. Dep't of Just. Antitrust Div., https://www.justice.gov/atr/comments-federal-agencies [https://perma.cc/54BR-MT5V] (last updated Feb. 8, 2024) (recent Division comments sharing a competition perspective to other federal agencies); *Comments to States and Other Organizations*, U.S. Dep't of Just. Antitrust Div., https://www.justice.gov/atr/comments-states-and-other-organizations [https://perma.cc/M47Z-MJZE] (last updated Jan. 25, 2024 (recent Division comments sharing a competition perspective to states and other organizations); *Legal Library: Advocacy Filings*, FTC, https://www.ftc.gov/legal-library/browse/advocacy-filings [https://perma.cc/57GK-NPZX] (a database of FTC comments sharing a competition perspective to other federal agencies, states, and other organizations).

274. *See, e.g.*, OECD, Competition Assessment Toolkit, Version 4.0 (2019), https://www.oecd.org/competition/assessment-toolkit.htm.

275. *E.g.*, U.S. Dep't of Health & Hum. Servs., U.S. Dep't of Treasury, & U.S. Dep't of Lab., Reforming America's Healthcare System Through Choice and Competition, at 73–74 (2018) (discussing how reason for passing the ban of POHs in the ACA may have been overstated and that the ban reduces competition) [hereinafter 2018 HHS Report]; A Dose of Competition, *supra* note 59, at ch. 3 pp. 17–23 (2004) (summarizing the contemporaneous debate from a competition perspective over

This is not simply a matter of comparing the value proposition of one service provider over another; consumers typically benefit when such decisions are left to the marketplace absent a market failure. Higher-cost providers with a foothold in the market may deter lower-cost providers from raising prices beyond the level of the higher cost provider so that the lower-cost provider can maintain market share. Similarly, high-quality providers can be induced to maintain or increase investments in the quality of their services to continue proving their value over alternatives. When new entrants do offer lower cost or higher quality products or services, the marketplace provides them the opportunity to expand, and it induces incumbent competitors to improve their offerings or lose their market share. When patients, payors, or physicians have choices in their respective markets it creates an incentive for all market participants to make their offerings better.

Rather, a competition assessment asks: (1) "how competitive are markets in the baseline"; (2) whether a policy would "change the number or range of competitors in a market"; (3) whether it would "limit or enhance the ability of firms to compete"; (4) whether the change would "weaken or strengthen the incentives for firms to compete vigorously"; and (5) how that relates to other parts of the supply chain, including labor markets.[276]

This Article has identified many reasons to think POHs offer competitive services and may be particularly well-positioned to take advantage of market entry opportunities in consolidated hospital markets. Therefore, the potential benefits offered by their competition can be especially important to protect. This is exemplified by the five examples of antitrust litigation identified in this Article where local incumbents were alleged to address POH entry with anticompetitive conduct, rather than competition on the merits.[277] It is likewise reflected in a systematic review of the cost and quality research of POHs, where evidence suggests that surgical specialty POHs exhibit higher quality and lower or comparable cost compared to non-POHs, while general acute care POHs were similar in terms of cost and quality performance when compared to their non-profit and investor-owned hospital counterparts.[278]

A competition policy approach is especially concerned with policies that affect barriers to entry and expansion and consequently the

"single specialty hospitals" owned by physicians); *id.* at Executive Summary, p. 26 ("The Agencies encourage further research into the competitive significance of SSHs . . . .").

276. *See generally* OIRA, *supra* note 272, at 7.

277. *See supra* Part II.B, Part III.B.

278. CHO ET AL., *supra* note 1.

accumulation or exercise of market power. If barriers to entry or expansion are very low, a large incumbent likely cannot exercise market power because the moment it raises prices, reduces output or quality, or ignores innovation, new entrants will see the market opportunity and push price, output, quality, and innovation back towards a competitive equilibrium.[279] However, when policies unnecessarily raise barriers to entry or expansion, a powerful incumbent may be able to raise prices, reduce output or quality, or ignore innovation with reduced fear of a competitive response.[280] By contrast, when policies do not affect entry or expansion generally, they may not harm competition outcomes even if a policy harms a subset of competitors.[281] In the case of POHs, if a loss of POH entry was easily replaced with entry by investor-owned or nonprofit hospitals, then the competitive significance would be minimal. However, POH entry is not easily replaced,[282] and there has been a trend towards more consolidation and less new entry.[283]

Even when there are important market failures (e.g., externalities, fraud, substandard care) that merit a policy response, a competition policy approach asks whether policy alternatives can achieve the same policy objectives while preserving more benefits from competition. On balance, the benefits of addressing a market failure should exceed the harms to competition arising from the policy response.[284] By focusing on markets where a policy impinges on competition and by considering policy alternatives that preserve benefits of that competition, a competition policy approach can lead to better policies and welfare outcomes. There are strong reasons to believe a POH ban is an overly broad restriction that fails to narrowly address any of its purported justifications.

B. Purported Objectives of the Ban on Physician-Owned Hospitals

POH critics have generally argued that specialty POHs cherry-pick highly profitable patients, and that the ownership structure of POHs give their physician owners an incentive to order unnecessary medical treatments.[285] Below we lay out these arguments and responses to assess

279. OECD, *supra* note 275, Vol. 2, at 23.
280. *Id.*
281. *Cf.* Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977) ("The antitrust laws . . . were enacted for 'the protection of competition not competitors.'" (quoting Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962).
282. *See infra* Part IV.C.
283. *See supra* Part I.
284. OIRA, *supra* note 273, at 26–28 (providing an overview of how to incorporate competition effects into a cost-benefit analysis).
285. *E.g.*, Charles N. Kahn III, Perspective, *Intolerable Risk, Irreparable Harm: The Legacy Of Physician-Owned Specialty Hospitals*, 25 HEALTH AFFS. 130, 132 (2006)

the merits of these policy concerns. The weight of the evidence suggests that to the extent there are any such perverse incentives, they are not unique to POHs.

According to the first argument, specialty POHs focus on highly profitable procedures such as elective total hip or knee replacement for healthier patients with fewer comorbidities, while leaving community general acute care hospitals to treat less profitable patients needing the same procedure.[286] In addition to cherry-picking the healthiest patients and most profitable procedures, specialty POHs can avoid less profitable patients, by selecting for patients with better insurance coverage for example, or by having few Emergency Department (ED) beds. The critics argue that the patient with multiple comorbidities would either not be dispatched to the specialty POH due to the limited supply of ED beds or the limited services offered. In other words, critics allege that the owners of POHs essentially free ride off of nearby general acute care hospitals that treat the sickest and most complex patients, while profiting off the healthiest ones.[287] Any apparent decrease in price, so the argument goes, is not the result of increased efficiency, but rather a matter of avoiding the costs associated with treating less profitable patients. This argument would not appear to extend as well to general acute care POHs.

The second argument traditionally made against POHs is that they have an incentive at the margins to refer more patients for a higher volume and intensity of care because they own the surgical facilities, driving up costs.[288] Economists refer to this as "provider-induced demand,"[289] which may arise where more than one diagnostic or treatment strategy may be appropriate and a provider's choice tends to reflect financial incentives.[290] In support of this argument, critics point to evidence that POHs have been associated with a statistical increase in

(describing specialty POHs as subject to an "underlying conflict-of-interest issue that leads to patient selection and potential overuse").

286. Patients with fewer comorbidities are less likely to experience complications or have an extended length of stay. As hospitalization is paid as an episode bundle, complications and extended length of stay reduce profitability.

287. *See, e.g.*, A DOSE OF COMPETITION, *supra* note 59, at ch. 3, pp. 20–21 (summarizing various critics articulating this perspective on specialty POHs at a DOJ-FTC event).

288. *Id.* (summarizing various critics articulating this perspective on specialty POHs at a DOJ-FTC event).

289. Louis L. Nguyen et al., *Provider-Induced Demand in the Treatment of Carotid Artery Stenosis*, 152 JAMA SURGERY 565 (2017).

290. Memorandum from the Volume-and-Intensity Response Team, Office of the Actuary, HCFA, CMS to Richard S. Foster, Chief Actuary, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Aug. 13, 1998), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/physicianresponse.pdf [https://perma.cc/SD69-JWD6]; *see also, e.g.*, Nguyen et al., *supra* note 289.

surgical procedures, which they argue are due to the impact of financial incentives on individual clinician decisions.[291]

Supporters of POHs have raised several arguments in responses to these arguments. First, either a cherry-picking theory or a provider-induced-demand theory presumes that physician owners have perverse incentives that nonprofit and investor-owned hospitals lack. Any such incentives likely reflect vertical integration—that the referring provider and the surgical site have shared ownership, and so the referring practice profits from either (a) steering low-cost patients to the owned surgical site and complex and high-cost patients elsewhere or (b) inducing demand that otherwise would not exist. But vertical integration is not unique to physician owners. Indeed, because of the consolidation trends explored in Part I, integrated health systems increasingly dominate local markets, and those systems often encompass a meaningful share of local physician practices (along with emergency departments) that can be essential sources for referrals. These vertically integrated health systems would also profit from cherry-picking or inducing demand. Both non- and for-profit hospitals face similar incentives to encourage their doctors to perform more treatments to increase billings and the volume of care in the pursuit of greater revenue.[292]

Second, a cherry-picking theory or a provider-induced-demand theory presumes that physician owners have a distinct ability to act on those perverse incentives that other providers lack, such as physician owners earning a portion of the return from perverse referral patterns. But nonprofit and investor-owned hospitals also have many tools to affect the referral practices of their employed physicians, from setting policies to conditioning employment on following those policies. According to a 2016 Nielsen Strategic Health Perspectives survey of hospital executives, 55% were actively managing, or planning to manage, referrals to keep them within their hospital systems,[293] so to the extent these incentives exist, investor-owned and nonprofit hospitals can act

291. *See* 2006 MedPac Report, *supra* note 102, at vii ("Taken together these findings—an increase in overall surgeries, but no material shift in the ratio of high-severity to low-severity surgeries—are consistent with more than one hypothesis. One hypothesis is that physicians have a financial incentive to invest in cardiac hospitals, and these new specialty hospitals result in more surgical capacity and hence more surgeries per capita. Alternatively, individual physicians' clinical decision making is directly affected by financial incentives, but the change is a broad shift toward more surgeries rather than a precise shift toward the most profitable surgeries.").

292. Rachel O. Reid et al., *Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems*, 3 JAMA Health F. e214634 (2022) (finding that "health system physician compensation . . . was dominated by volume-oriented incentives" that maximize health system revenue).

293. Mathews & Evans, *supra* note 92 (describing the survey).

on them. As the FTC found in its complaint against the Reading Health System discussed in Part III.B *supra*, POHs can be victims of such conduct as health systems have used control over primary care providers in attempts to deny referrals to POHs. And health systems have been the subject of litigation for steering high-cost patients to other facilities.[294] Moreover, research suggests that larger health systems are the ones associated with more overuse.[295]

Third, physician referral patterns are not unconstrained. Rather, physician referrals are constrained by factors such as payors, patient preferences, specialty hospital location, and taking emergency department "call"[296] from local competitor hospitals.[297] If POHs were just cherry-picking low-cost patients or ordering unnecessary services, economic theory suggests that payors acting rationally would negotiate for lower rates to account for lower cost patients and for greater oversight, increase the rate of claim denials, or remove providers from their network to ensure wasteful treatment was not ordered. Indeed, payors increasingly rely on narrow, tiered, and managed care networks that make tradeoffs and manage the quality, cost, and breadth of their provider networks.[298] In recent decades, as physicians have been pushed to provide more data and information to justify tests and treatments, payors have employed increasingly sophisticated tools to adjust payments for the

294. *See, e.g.*, NorthBay Healthcare Grp., Inc. v. Kaiser Found. Health Plan, Inc., 838 Fed. Appx. 231, 234 (9th Cir. 2020) (finding plaintiff's allegations sufficiently plausible, alleging defendant health system directed emergency personnel to steer "uninsured and indigent" (high-cost) patients to plaintiff's facility and insured patients to defendant's facilities).

295. *E.g.*, Jodi B. Segal et al., *Factors Associated with Overuse of Healthcare Within US Health Systems*, 3 JAMA Health F. e214532, at 6 (2022).

296. Procedural specialty physicians frequently remain "on call" for a hospital. Functionally they are either on-site or frequently off-site within a pre-specified time or distance, available to return to the hospital.

297. 2005 CMS Report, *supra* note 101, at ii–iii. The study also noted that the referral rates varied by the type of specialty POH. At cardia POHs, the percentage of Medicare cardiac referrals by owners ranged from 61% to 82%, at orthopedic POHs owner referrals ranged from 48% to 98%, and at the surgical POH, owner referrals were 90%. *Id.*

298. *See* Aditi P. Sen et al., *Physician Network Breadth and Plan Quality Ratings in Medicare Advantage*, 2 JAMA Health F. 2, July 30, 2021 ("Narrow physician networks were positively associated with star ratings. Plans may use narrow networks to achieve a higher star rating by selectively contracting with physicians and/or actively managing the quality of physicians in their network."); Leemore S. Dafny et al., *Narrow Networks on The Health Insurance Marketplaces: Prevalence, Pricing, and the Cost Of Network Breadth*, 36 Health Affs. 1606, 1607 (2017) (narrow-networks plans may be associated with lower premiums because they only select providers "that agree to low reimbursement rates or that generate medical savings by performing only necessary services and using the lowest-cost appropriate sites of care for those services").

risk and complexity of diagnosing and treating a particular patient.[299] Many such payors utilize prior authorization as well.[300] That is not to say that these tools are without their limitations, especially in an environment of imperfect, asymmetric information. Nevertheless, this bargaining, oversight, and network selection process by payors, who are sophisticated third parties and repeat players, should reduce excess profits from cherry-picking and deter referrals for unnecessary services, resulting in lower prices for downstream consumers.

Moreover, it is possible that POHs might be more subject to constraint by payors than integrated health systems. To the extent an integrated health system has incentives to cherry-pick or induce demand for certain services, it may be able to use its market power to shield that practice from a payor in negotiations, similar to how they might shield unreasonably high prices from competition. Indeed, one study found that private payor contracts less often incorporate prospective payment systems for hospital reimbursements (which payors use to "lower[] relatively unproductive health spending") in markets with less hospital competition.[301] As another example, DOJ spent several years challenging Atrium, the dominant health system in the Charlotte, North Carolina area, for imposing restrictions on payors that prevented them from steering patients towards lower cost alternative providers.[302] Because insurers in the Charlotte area could not offer financial incentives or information to steer subscribers, local rivals lacked the ability or incentive to win business by competing with Atrium on price.[303] As POHs tend to be smaller and offer fewer service lines, they likely lack such leverage to shield unjustified referral patterns and practices from negotiations with payors.[304] Therefore, it is not obvious that a physician owner would

299. Laurence Baker et al., *Why Don't Commercial Health Plans Use Prospective Payment?*, 5 Am. J. Health Econ. 407 (2019) (Medicare and most private payor contracts use prospective payment systems that account for complexity and intensity of care when reimbursing for a wide range of services).

300. *See generally* Angelo P. Giardino & Roopma Wadhwa, *Utilization Management*, StatPearls, July 10, 2023, https://www.ncbi.nlm.nih.gov/books/NBK560806/ [https://perma.cc/4BPL-2398].

301. Baker et al., *supra* note 299, at 477 (finding that such contract terms may be "a channel other than price through which hospital market power may affect social welfare").

302. Press Release, U.S. Dep't of Just., Off. of Pub. Affairs, Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions (Nov. 15, 2018), https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering [https://perma.cc/G5UU-7KZR].

303. Competitive Impact Statement at 2–3, United States v. Charlotte-Mecklenburg Hosp. Auth., No. 3:16-cv-00311 (W.D.N.C. Dec. 4, 2018), ECF No. 89.

304. *See, e.g.*, Kate Ho & Robin S. Lee, *Equilibrium Provider Networks: Bargaining and Exclusion in Health Care Markets*, 109 Am. Econ. Rev. 473, 477 (2019)

be more effective at pursuing such a strategy with payors than a non-physician owner.

Fourth, while ban proponents may argue that POHs are structured to avoid complex patients (e.g., by having fewer ED beds), evidence suggests POH facilities are designed based on the services they provide rather than their ownership structure. As one study author explained, the majority of POHs "are generally larger acute care hospitals with several hundred beds. They have big EDs. They look just like community hospitals."[305] Similarly, another report found that cardiac hospitals resemble full-service hospitals with emergency departments, whereas orthopedic hospitals and general surgical specialty hospitals more closely resemble Ambulatory Surgery Centers (ASCs),[306] frequently lacking active emergency departments and instead focusing on outpatient services or cases with a reasonable expectation of limited hospitalizations. That is, cardiac hospitals that make greater use of emergency departments have EDs more similar to general acute care hospitals, whereas more outpatient, procedure-focused specialty POHs are more akin to ASCs with a smaller "hospital" component. In each of these cases, the facility design is driven by the services that the facility provides, independent of whether it is a POH or a non-POH. Prior research cited in support of the ban compared specialty POHs to non-physician-owned general acute care hospitals, yet this improperly conflates two variables: physician ownership and hospital type.[307] The ban and the criticisms are directed at physician ownership, not hospital type, and yet such studies could not properly estimate the key treatment effect of interest (physician ownership) and so also reflected differences in specialization and the service mix provided.[308]

(presenting a model which finds that the ability to replace a hospital with an alternative in its network allows the payor to bargain for better terms).

305. Shute, *supra* note 168, at 39.

306. 2005 CMS Report, *supra* note 101, at ii. Ambulatory Surgical Centers (ASCs) are entities that exclusively perform outpatient surgery, that is, surgeries with an expected duration of less than 24 hours that do not require hospitalization. *See* 42 C.F.R. § 416.2 (2022). Such centers generally may not mix functions and operations in a common space with another entity, such as a physician's office. *See Ambulatory Surgery Centers*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs [https://perma.cc/NKH2-X4CD] (last modified Sep. 6, 2022).

307. *See generally* Arthur Lewbel, *The Identification Zoo*, 57 J. Econ. Lit. 835, 851–54 (2019) (incompleteness, simultaneity, and failure to properly control for confounding variables can lead to failure of identification and causal analysis).

308. *E.g.*, Blumenthal, *supra* note 63, at 6 ("[T]he populations of specialty POHs included in previous studies are not representative of POHs more broadly."). One study published after the Cho et al. systematic review, *supra* note 1, made a similar error when it purported to find that California POHs "cherry-picked" their patients because

Fifth, a recent systematic review found that claims of cherry-picking lacks consistent support in the research.[309] Instead, the review found that the individual studies controlled for a variety of factors, such as case mix, disease severity, and volume of procedures, with no clear evidence consistent with cherry-picking. The review found that research results on quality metrics were highly favorable for specialty POHs and neutral for general acute care POHs.[310] In contrast, cost evidence suggested that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in costs.[311] Indeed, several studies looking at the effect of hospital ownership on healthcare utilization have concluded that physician ownership does not lead to an increased volume of surgeries being performed, suggesting that any evidence of increased utilization is at best mixed.[312] These limited, mixed findings show that cherry-picking by POHs is not a well-established fact in the empirical literature, and that the empirical data shows benefits for POHs.

Sixth, the argument that the POH model will lead to cherry-picking or unnecessary procedures seems to assume that business ethics will somehow protect the public better than medical ethics. But why would one make that assumption? Medical specialty societies have responded to the problem of unnecessary or low-value care with criteria to help identify and avoid such services.[313] Moreover, comparing the medi-

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they had an "advantageous payor mix" for 3 out of 6 years studied. *See* Jim Pinder et al., *Profitability and Cherry Picking of California Physician-Owned Hospitals*, 8 Int'l J. Health & Econ. Dev. 1, 11 (2022). But the Pinder study cannot support its cherry-picked conclusion. This purported advantage in payor mix was brief, did not yield higher profits for the POHs, *id.* at 12, and may have simply reflected that the hospitals were treating patients for different conditions, because the study could not control for specialty hospital, case mix, or diagnosis severity. *Id.* at 14.

309. Cho et al., *supra* note 1, at 15.

310. *Id.* at 14.

311. *Id.*

312. Gregory D. Schroeder et al., *The Effect of Hospital Ownership on Health Care Utilization in Orthopedic Surgery*, 31 Clinical Spine Surgery 73, 73 (2018) (concluding that "In a well-established large orthopedic practice, surgeon ownership of a hospital or ASC does not lead to an increase in surgical volume."); G. William Woods et al., *Orthopaedic Surgeons Do Not Increase Surgical Volume After Investing in a Specialty Hospital*, 87 J. Bone & Joint Surgery Am. 1185, 1185 (2005) (concluding "The opening of an orthopaedic surgery specialty hospital did not increase the surgical volume or the surgical rate for ten orthopaedic surgeons who held a financial interest in the facility."). *But see* Jean M. Mitchell, *Effect of Physician Ownership of Specialty Hospitals and Ambulatory Surgery Centers on Frequency of Use of Outpatient Orthopedic Surgery*, 145 Arch Surgery 732, 732 (2010) (concluding that "[t]he consistent finding of higher use rates by physician owners across time clearly suggests that financial incentives linked to ownership of either specialty hospitals or ambulatory surgery centers influence physicians' practice patterns.").

313. *E.g.*, *Five Things Patients and Providers Should Question*, Choosing Wisely (Nov. 15, 2017), https://web.archive.org/web/20230509194923/https://www.choosingwisely.org/

cal profession with the legal profession suggests the POH model may actually *mitigate* the incentive to cherry-pick or perform unnecessary procedures.

Physicians are bound by principles of medical ethics that prioritize patient needs, and they can risk their medical license when they violate medical ethics. Similarly, lawyers are bound by detailed ethical obligations, including duties of competence, diligence, loyalty, and confidentiality.[314] As such, the legal profession not only allows lawyers to own law firms, but actually prohibits non-lawyers from having an ownership stake, or even taking a share of the revenue or otherwise exercising control over legal judgment.[315] The rationale for this rule is that it preserves the ability of lawyers to exercise their legal judgment on behalf of their clients.[316] This is driven at least in part by a concern that non-lawyer owners might encourage their lawyer employees to perform unnecessary work on behalf of their clients to increase revenues.[317] As a group of corporate general counsel explained:

> [N]on-lawyer investment cannot help but inject outside concerns into a partnership's calculations. It changes a firm from a group of like-minded attorneys zealously pursuing their clients' interests, into a group with inherently mixed motives and responsibilities, where some partners have a professional duty to the client's interests and others do not. It is not hard to imagine that non-lawyer partners might place considerations of economic gain ahead of a client's interests. That is not a criticism of those who seek profit. It is simply a recognition of the reality that our profession often mandates conduct and practices that are not profit maximizing or optimizing. Investors operate under a different code.[318]

By limiting law firm ownership to lawyers, the owners are bound by the same legal ethics rules as the other attorneys at the firm, which

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wp-content/uploads/2015/01/Choosing-Wisely-Recommendations.pdf [https://perma.cc/H23J-7CT8].

314. *E.g.*, MODEL RULES OF PRO. CONDUCT r. 1.1, 1.3, 1.6, 1.7 (AM. BAR ASS'N 2020).

315. *See, e.g.*, *id.* r. 5.4 (generally prohibiting fee sharing, partnership, ownership, or control of law practices with or by non-lawyers).

316. *Id.*, r. 5.4 cmt. 1 ("The provisions of this Rule express traditional limitations on sharing fees. These limitations are to protect the lawyer's professional independence of judgment.").

317. *See, e.g.*, Letter from Mark Chandler et al. to Natalie Vera, Sen. Rsch. Paralegal, Am. Bar Ass'n Ctr. For Pro. Resp., Comments of Nine General Counsel on the ABA Commission on Ethics 20/20's Discussion Paper on Alternative Law Practice Structures 5 (Feb. 29, 2012), https://www.americanbar.org/content/dam/aba/administrative/ethics_2020/ethics_20_20_comments/ninegeneralcounselcomments_alpschoiceoflawinitialdraftproposal.authcheckdam.pdf.

318. *Id.*

prohibits them from performing unnecessary legal work and to act in the best interests of their clients.[319]

Doctors have similar ethical obligations to their patients.[320] The American Medical Association Code of Medical Ethics (the "Code") has a number of opinions on professional self-regulation that deal with competition, financial incentives, economic incentives tied to care levels, as well as self-referral and fee-splitting.[321] The Code explicitly states that "[t]reatment or hospitalization that is willfully excessive . . . constitutes unethical practice" and says that providing "unnecessary treatment" is prohibited.[322] The Code further states that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients."[323] With respect to hospital practice, the Code indicates that physicians on a medical staff have an obligation to avoid wasteful practices and unnecessary treatment and that patient welfare always takes priority over the economic interests of the hospital.[324] These ethical requirements present one way that the POH model could resist incentives to perform unnecessary procedures better than either non-profit or for profit hospitals (i.e. non-POHs), where the owners are not bound by the same medical ethics rules as the doctors they employ. The physicians employed in non-physician-owned hospitals are similarly bound by the ethics codes, but they may risk their jobs by violating a hospital policy that induces demand, whereas the physician hospital owner would only forego the marginal increase in income gained by inducing demand.

Cherry-picking and induced demand may be present in healthcare markets, but the evidence and arguments do not clearly establish that POHs should be singled out. Rather, these concerns are more general

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319. *See, e.g.*, MODEL RULES OF PRO. CONDUCT r. 1.5 (AM. BAR ASS'N 2020) ("A lawyer shall not . . . charge . . . an unreasonable fee. . . . The factors to be considered in determining the reasonableness of a fee include . . . the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly . . . ."); *id.* r. 1.3 ("A lawyer shall act with reasonable diligence and promptness in representing a client.").

320. *See* CODE OF MED. ETHICS (AM. MED. ASS'N), https://code-medical-ethics.ama-assn.org [https://perma.cc/A4XC-XCJR].

321. *See, e.g.*, AMA Council on Ethical & Judicial Affairs, *AMA Code of Medical Ethics' Opinions on the Physician as Businessperson*, 15 AMA J. ETHICS 136 (2013), https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinions-physician-businessperson/2013-02 [https://perma.cc/G86C-8LWD].

322. AMA CODE OF MEDICAL ETHICS, Op. 11.2.2 on Conflicts of Interest in Patient Care, (2007), https://code-medical-ethics.ama-assn.org/sites/default/files/2022-09/11.2.2%20Conflicts%20of%20interest%20in%20patient%20care%20--%20background%20reports.pdf [https://perma.cc/A4XC-XCJR].

323. *Id.*

324. *Id.*

problems that can arise with vertical relationships and integration. Of course, vertical integration also may offer the opportunity for some efficiencies.[325] For example, a trend in value-based healthcare (a model where providers are paid based on patient outcomes or risk-adjusted capitation for population-based payment) is greater reliance on coordination across providers, which may be facilitated in some cases by vertical integration.[326]

C. The Competition Costs of Banning Physician-Owned Hospitals

In any policy proposal, the purported benefits should exceed the costs. Here, the sweeping POH ban would need to justify the substantial harm it causes to competition in the markets for physician services, payor markets, and consumer markets. Given that the literature has not established that POHs engage in cherry-picking or tactics to induce demand—let alone that POHs are at distinct risk of engaging in such behavior—the POH ban cannot justify these competition costs.

Evidence shows that these markets have been subject to the acquisition and exercise of market power. As discussed in Part I *supra*, the general trend in healthcare markets has been towards increased consolidation, and this lack of competition is associated with higher prices for health services,[327] higher health insurance premiums,[328] lower quality in the form of decrements in patient experience,[329] and less choice. In the patient market for healthcare services and the payor market for provider networks, patients and payors have fewer providers to choose from and those providers face less competitive pressure to keep prices low and quality high, in addition to decreased market pressure to innovate. Likewise, in the employer market for physician services, physicians have fewer local employment opportunities and less bargaining power, which can affect employment conditions, not just wages, as reflected in the growing share of salaried physicians. These deteriorations of physician's terms of employment are consistent with an increase in physician

325. Brian J. Miller & George L. Wolfe, *Managed Care Marketplaces: Growing Drivers of Payer-Provider Vertical Integration*, Antitrust Source, Apr. 2017, https://www.akingump.com/a/web/57128/aoiok/wolfe-article.pdf [https://perma.cc/G2GE-ERQR].

326. *See, e.g.*, *What Is Value-Based Healthcare?*, NEJM Catalyst (Jan 1, 2017), https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558.

327. Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q. J. Econ. 51, 55 (2019); Schwartz et al., *supra* note 10; Gaynor & Town, *supra* note 12.

328. Andrew Boozary et al., *The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces*. 38 Health Affairs 668 (2019); Erin Trish, Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health insurance Premiums?*, 42 J. Health Econ. 104 (2015).

329. Beaulieu et al., *supra* note 13, at 56.

burnout from high job demands, low job resources, externalization of the locus of control over clinical practice, and other factors under the control of health care organizations.[330]

As explored in Subpart III.A.4 *supra*, this market power cannot be easily addressed with new entry because there are significant costs and other barriers to building new hospitals and expanding existing ones. The POH ban exacerbates these barriers by directly restricting entry or expansion by a category of new entrants, and the ban has been unfortunately effective. As described in Parts IV.A and IV.C *supra*, POH entry was growing quickly from 2000–2010, a unique countertrend to the story of consolidation, and that entry story ended after the POH ban. The authors have not identified other providers in the literature that might fill the gap of POH entry.

Some early criticism of POHs is that they were only found to be comparable in price rather than cheaper than non-POHs.[331] Even if this criticism were true, the loss of such entrants would be costly from a competition perspective. Putting aside potential benefits that are specific to POHs discussed here and even identified in some of that early research,[332] and instead assuming POHs are no better than non-POHs or only serve a portion of the market, the potential entry of additional providers reduces the ability of incumbents to exercise market power and applies competitive pressure on price, quality, and innovation. Even the threat of such entry can improve market outcomes as incumbent hospitals keep prices and quality more competitive to deter new entry. Consequently, the ban exacerbates the accumulation and exercise of market power in markets where incumbents could otherwise have faced actual or potential POH entry.

As explored in depth in Part II *supra*, POHs likely present a model with unique competitive potential, so their continued ban is likely to have an outsized, negative effect on the marketplace. Physicians, given their operational expertise directing care, are particularly well-positioned to identify opportunities for entry and innovation. They may have insights

330. National Acads. of Scis., Eng'g, & Med. et al., Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being 1, 81 (2019).

331. *E.g.*, 2006 MedPac Report, *supra* note 102, at vi. ("Specialty hospitals' inpatient services are not less costly than community hospitals' services, as might be expected from a 'focused factory' hypothesis").

332. *E.g.*, 2005 CMS Report, *supra* note 101, at iii ("Patient satisfaction was very high in both cardiac and orthopedic/surgery hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for their family members if needed, easy parking, and good food."); 2018 HHS Report, *supra* note 275, at 73–74 (noting that more than 40% of POHs received a top 5-star rating, whereas only 5% of general hospitals received such a rating).

into how the science and business of their practice area can be improved, as well as ways that local markets are underserved.[333] Ownership gives them incentives to seek those opportunities out.[334] Moreover, hospital market power is being exercised not just downstream against payors and consumers, but upstream against the very physicians who might start their own hospital and become competitors. These physicians are likely to know whether wages or other local market conditions, like lack of control over patient care, might be making local physicians dissatisfied, and they may also know the identities of fellow physicians ready to join a POH.[335] This upstream and downstream market power provides space to attract and retain physicians—a critical labor input—by paying them more competitive rates (including by sharing in hospital profits) and granting them more control of patient care, while also creating space to offer payors and consumers more competitive rates and higher quality service.[336]

A POH's ability to distinguish itself in the market both upstream and downstream is more important to the newly established facility that must build business quickly than it is to an established incumbent.[337] This POH value proposition must be clear from the outset, when a POH begins to raise capital from future physician owners and outside investors.[338] Moreover, ownership provides physicians with more "skin in the game," better aligning the incentives of the physician-owners with outside investors, as compared with a model where the hospital is owned exclusively by non-physician outside investors.[339]

Specialty hospitals may be a distinct and underutilized path to market entry that physician owners are particularly well-suited to identify and seize upon. This may explain why a disproportionate share of POHs (nearly half) are specialized hospitals.[340] These specialty POHs are often built around the practices of the surgeon owners who may have distinct ideas on how to better tailor their pre-operative care, operating room design and setup, clinical staffing, and post-operative care to the specific set of procedures they perform. As described in Part II *supra*, physicians may be deeply attuned to when specialization rather than generalization can more efficiently address patient needs. This pathway provides a potential avenue for entry into one or a small handful of service markets in a local geography, rather than needing to overcome

333. *See supra* Part II.A.1.
334. *See supra* Part II.A.2.
335. *See supra* Part II.A.3, III.B.
336. *Id.*
337. *See supra* Part III.A.4.
338. *Id.*
339. *See supra* Part II.A.2.
340. Blumenthal, *supra* note 63, at app. 6.

the challenges of entering all the service lines of a general acute care hospital.[341] This explains why the FTC's investigation of RHS and SIR found that "the most likely entrant into [the Reading] market would be another physician-owned specialty hospital."[342]

Once in the market, specialty POHs are well-positioned to expand into other service lines or other locations. This is well-illustrated by DHR, a POH discussed in Part II *supra*, that grew from a 2-room ambulatory surgery center in 1997 to a substantial health system, all the while treating a high-need patient population and addressing unmet local needs, such as kidney transplants and beds to treat COVID-19.[343] Other specialty POHs have also evolved into health systems, with the Oklahoma Heart Hospital, a cardiac POH, growing into a system with two heart hospitals and 60 clinics, including other specialties such as family medicine.[344]

Specialty POHs have also promoted competition in downstream payor markets, primarily by helping payors develop more robust, competitive networks but also occasionally by entering the markets directly. For example, Lincoln Surgical Hospital in Nebraska partnered with independent physicians to form an Independent Physicians Association ("IPA"),[345] which sells a benefits package to self-insured employers.

Both statistical evidence and examples illustrate how POHs can be potent competitors, especially specialty POHs. As mentioned in Part V.B *supra*, research results on quality metrics were highly favorable for specialty POHs and neutral for general acute care POHs, and cost metrics were neutral to favorable, suggesting that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in cost.[346] Specialty POHs also demonstrated a positive volume-quality relationship,[347] supporting the "focused factory" model and the benefits of clinician-driven procedural focus and operational design. For example, cardiac POHs had lower 30-day mortality in the setting of treatment and hospitalization for congestive heart failure and acute myocardial infarction,[348] while orthopedic specialty POHs earned supe-

341. *Contra supra* Part III.A.4.
342. Complaint ¶ 72, Reading Health Sys., *supra* note 246.
343. *See supra* Part II.A.2.
344. *See Hospital Facilities*, Okla. Heart Hosp. https://www.okheart.com/about-us/hospital-facilities [https://perma.cc/3JX8-XFFE]; OHH Outpatient Clinics, Okla. Heart Hosp., https://www.okheart.com/find-a-clinic [https://perma.cc/8AJV-SBTW].
345. *See supra* Part II.A.2 (discussing Lincoln IPA partnership).
346. Cho et al., *supra* note 1, at 14.
347. *Id.*
348. Brahmajee K. Nallamothu et al., *Acute Myocardial Infarction and Congestive Heart Failure Outcomes at Specialty Cardiac Hospitals*, 116 Circulation 2280 (2007).

rior patient satisfaction,[349] were more likely to try a more conservative therapy (prescribing oral inflammatory medication) before offering surgical intervention,[350] exhibited lower average length of stay[351] and lower ratios of actual to expected length of stay,[352] and demonstrated lower readmission rates in the setting of total knee and total hip arthroplasty.[353]

International models also support the "focused factory" thesis in producing meaningful quality benefits for patients. For example, the Shouldice Hernia hospital in Canada[354] has a lower re-operation rate for hernia repair compared to general hospitals.[355] Dr. Previ Prasad Shetty founded Nayrana Health in Bangalore, India to focus on tertiary care, particularly cardiac care, and achieved quality outcomes for open-heart surgery that compare favorably with international benchmarks and U.S. patient outcomes at one-fiftieth of the cost.[356] Focused factories positively exploit the well-researched quality-volume relationship present in much of procedural medicine, from lower mortality in percutaneous coronary intervention (cardiac catheterization)[357] to lower complication rates in total knee arthroplasty[358] and even lower *mortality* in total hip arthroplasty.[359]

In the antitrust context, a "maverick" is a "firm with a disruptive presence in a market."[360] They may have a new business model or technology, or they may have an ability and incentive to expand capacity or resist prevailing norms on price or other forms of competition. Such mavericks may be identifiable if they are disproportionately responsible

349. As measured by recommending the hospital, communication of both doctors and nurses, staff responsiveness, overall hospital rating, and HCAHPS summary star rating. *See* P. Maxwell Courtney et al., *Reconsidering the Affordable Care Act's Restrictions on Physician-Owned Hospitals: Analysis of CMS Data on Total Hip and Knee Arthroplasty*, 99 J. Bone Joint Surg. Am. 1888, 1892 (2017).

350. Gregory D. Schroeder et al., *Are Patients Undergoing an Anterior Cervical Discectomy and Fusion Treated Differently at a Physician-Owned Hospital?*, 31 Clin. Spine Surgery 211, 214 (2018).

351. Antonia F. Chen et al., *Utilization of Total Joint Arthroplasty in Physician-Owned Specialty Hospitals vs Acute Care Facilities*, 32 J. Arthroplasty 2060 (2017).

352. 2005 MedPac Report, *supra* note 105, at 16.

353. Alexander J. Rondon et al., *A Novel, Synergistic Model in Total Joint Arthroplasty: A Report of 2 Specialty Hospitals with Joint Ownership Between Physicians and Healthcare Systems*, 34 J. Arthroplasty 1867 (2019).

354. Heskett & Hallowell, *supra* note 76; Atul Gawande, *No Mistake*, New Yorker, Mar. 22, 1998, at 74.

355. *See* Malik et al., *supra* note 78.

356. Andrea Taylor et al., *Expanding Access to Low-Cost, High-Quality Tertiary Care*, Commonwealth Fund (Nov. 9, 2017), https://www.commonwealthfund.org/publications/case-study/2017/nov/expanding-access-low-cost-high-quality-tertiary-care [https://perma.cc/23KM-FYKN].

357. Fanaroff (2017), *supra* note 81; Fanaroff (2019), *supra* note 81.

358. Lau et al., *supra* note 79.

359. Katz, *supra* note 80.

360. 2023 Merger Guidelines, *supra* note 22 § 2.3.A.

for fluctuations in market share.[361] Removing mavericks from a market can adversely affect competition more than removing run-of-the-mill competitors. POHs are more likely to function as mavericks, given their unique role as a countertrend to consolidation, their greater use of specialty surgical hospitals, and their unique incentives for entry and innovation. Indeed, their disruptive role is very likely animating resistance from incumbents, both in the policy space and in the five antitrust cases discussed earlier in Parts III.B and IV.A–.B *supra*. Consequently, the POH ban may be distinctly harmful in preserving the market power of incumbent health systems over physicians, payors, and physicians.

D. There are Narrowly Tailored Policies to Addressed Perceived Market Failures

To the extent there are valid policy concerns related to cherry-picking patients and inducing demand by vertically linked healthcare institutions, more narrowly tailored policies are available that directly address these concerns. It is difficult to see why such alternatives are not preferable from a public welfare perspective to a POH ban, especially given that it is not well-established that such concerns are unique to POHs and, moreover, that banning POHs harms competition. When the policy concerns are properly stated, one can already imagine better tailored policies.

For example, policymakers can make greater use of payment and other policy tools to address these concerns. First, by accurately adjusting payments for the complexity and cost of caring for a given patient, payors reduce a provider's incentive to cherry pick because easy-to-treat and hard-to-treat patients will be comparably profitable. For example, in a 2007 response to hospital industry complaints, CMS pursued more granular adjustments for patient acuity.[362] Of course, a payor will never have perfect visibility to adjust for a given patient's condition or the best course of treatment or the likely costs of care. Collecting more information from providers is not costless and can exhibit diminishing returns.

Second, policymakers can make further use of risk-adjusted, capitated managed care programs such as Medicare Advantage[363] (51% of

361. 2010 HMG, *supra* note 22 § 5.3.

362. In 2007, as part of the rulemaking process, CMS added a complicating condition and case-mix index adjustment to Diagnosis Related Groups (DRGs) for the fiscal year 2008. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 Fed. Reg. 47130 (Aug. 22, 2007).

363. Ctrs. for Medicare & Medicaid Servs., What's a Medicare Advantage Plan? (2015), https://www.medicare.gov/sites/default/files/2018-07/11474.pdf [https://perma.cc/Z47S-STD5].

Medicare enrollees)[364] and Medicaid managed care[365] (72% of Medicaid enrollees)[366] that cover over 80 million Americans. These publicly financed, privately managed health plans are functionally paid an annual, upfront global budget to cover the predicted healthcare costs for a population.[367] This incentivizes health plans in these markets to attract subscribers and deploy utilization review tools to ensure appropriate use and combat induced demand.

Third, to directly address induced demand, policymakers can promote research, development, and appropriate use of oversight of a provider's referral patterns and billing practices, especially for outliers that reflect their financial incentives instead of the best evidence on clinical practice. Health plan tools such as pre-payment claims editing, neural network-driven fraud detection, and other advanced analytic tools can operationalize fraud identification and prevention research. Slow, costly oversight can have its own health implications for patients. Nevertheless, these tools have often been validated by the literature in their use by managed care networks and in prospective payment systems, and their use could be further refined and expanded. These policies do not have to be perfect—just good enough to disincentivize cherry-picking and induced demand by increasing the time, effort, and cost to the provider of acting on a perverse incentive.

Fourth, policymakers can work to reduce the control or influence of vertically-integrated providers over where patients receive follow-on care by promoting information sharing and transparency of the price and quality of services. To the extent they have less control or influence, providers would be less able to act on such perverse incentives. Current policy efforts encourage patients to learn about their options for follow-up and to consider alternative, competing providers. Ongoing price transparency efforts that span administrations seek to facilitate price transparency for shoppable services,[368] including the recent

364. Freed, *supra* note 215.

365. Elizabeth Hinton & Jada Raphael, *10 Things to Know About Medicaid Managed Care*, KFF (Mar. 1, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ [https://perma.cc/SW35-QQKG].

366. *Id.*

367. *Capitation and Pre-payment*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/priorities/innovation/key-concepts/capitation-and-pre-payment [https://perma.cc/YR8Q-MAWM] (defining capitation and risk score).

368. Miller et al., *Price Transparency: Empowering Patient Choice and Promoting Provider Competition*, *supra* note 47, at 80; Nisha M. Patel, Jesse M. Ehrenfeld, & Brian J. Miller, *What Should "Shopping" Look Like in Actual Practice?*, 24 AMA J. Ethics, Nov. 2022, https://journalofethics.ama-assn.org/article/what-should-shopping-look-actual-practice/2022-11 [https://perma.cc/P3FY-MCPH].

increase in penalties for non-compliance.[369] Still other policy efforts focus on quality comparisons for providers, such as CMS star ratings for dialysis facilities (launched in 2001),[370] nursing homes (launched in 2008),[371] and hospitals (launched in 2016).[372] While imperfect and a source of controversy,[373] star ratings and recent early efforts at price transparency seek to advance patient choice and competition by endeavoring to reduce vertically-linked organizations' ability to capture patients. Policymakers should look to enhance and strengthen these various policy interventions by increasing price transparency in the context of quality, particularly at the clinical point of service.[374] Policymakers also should be mindful of conduct counter to these efforts. For example, DOJ successfully challenged a dominant health system that it alleged "insulate[d] itself from competition" by preventing transparency and steering of its patients to lower cost providers.[375]

Finally, both public and private payers could encourage second opinions through specific operational and regulatory actions, where a patient seeks advice from a rival provider on appropriate follow-up. For example, CMS and state insurance commissioners could audit provider directories, and health plans could increase the accuracy and transparency of information available in these directories,[376] helping to create

369. Press Release, Ctrs. for Medicare & Medicaid Servs., CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care (Nov. 2, 2021), https://www.cms.gov/newsroom/press-releases/cms-oppsasc-final-rule-increases-price-transparency-patient-safety-and-access-quality-care [https://perma.cc/VJ5H-DLGY].

370. Alyssa Pozniak & Jeffrey Pearson, *The Dialysis Facility Compare Five-Star Rating System at 2 Years*, 13 Clin. J. Am. Soc. Nephrology 474 (2018).

371. In 2002, detailed nursing home quality information was made public, followed by the implementation of star ratings in 2008. *See* R. Tamara Konetzka et al., *Two Decades of Nursing Home Compare: What Have We Learned?*, 78 Med. Care Rsch. & Rev. 295, 296 (2021).

372. Press Release, Ctrs. for Medicare & Medicaid Servs., First Release of the Overall Hospital Quality Star Rating on Hospital Compare (July 27, 2016), https://www.cms.gov/newsroom/fact-sheets/first-release-overall-hospital-quality-star-rating-hospital-compare [https://perma.cc/Z7MX-ZGEQ].

373. Elizabeth Whitman & Gregg Blesch, *Hospitals Keep Pushing Back as CMS Releases Overall Star Ratings*, Modern Healthcare (Aug. 1, 2016), https://www.modernhealthcare.com/article/20160730/MAGAZINE/307309967/hospitals-keep-pushing-back-as-cms-releases-overall-star-ratings; Karl Y. Bilimoria et al., *The New CMS Hospital Quality Star Ratings: The Stars Are Not Aligned*, 316 JAMA 1761 (2016).

374. Miller et al., *Redefining the Physician's Role in Cost-Conscious Care: The Potential Role of the Electronic Health Record*, *supra* note 47, at 722.

375. *See* Competitive Impact Statement at 9–11, United States v. The Charlotte-Mecklenburg Hosp. Auth., No. 3:16-cv-00311 (W.D.N.C. Dec. 4, 2018), ECF No. 89 (describing how Atrium Health's anti-steering and anti-transparency provisions in its payor contracts allegedly foreclosed competition).

376. Michael Adelberg et al., *Improving Provider Directory Accuracy: Can Machine-Readable Directories Help?*, 25 Am. J. Managed Care 241 (2019); *cf.* Jack S. Resneck

shopping tools for patients to obtain information about the availability of providers of specific services. This could include, for example, a list of all the local providers for a given surgery or expensive diagnostic procedure. Similarly, health plans could require disclosures of financial relationships between the referring provider and the follow-on site of care agnostic of ownership model, promoting competition between care delivery sites.

By contrast, the POH ban is very poorly targeted at these policy concerns. It is dramatically under-inclusive because investor-owned and nonprofit hospitals and health systems also have the incentive and ability to cherry pick and induce demand, and a POH ban does nothing to address any problematic conduct by such institutions. A POH ban is also dramatically over-inclusive because it bans all new or expanded POHs without any regard to whether a specific POH has engaged in such practices or is likely to do so. This poorly tailored policy is especially egregious because it is not well-established in the literature that POHs disproportionately engage in cherry picking or induced demand and because it sacrifices all the competition and consumer welfare benefits POHs offer their patients.

Conclusion

Leaders across administrations have noted the importance of increasing competition in health care markets.[377] With decades of research demonstrating that competition results in lower costs, improved quality, and greater innovation—and recent healthcare cost and quality research questioning the merits of the POH ban—Congress should consider the competition policy perspective provided by this Article. Ongoing hospital consolidation and high entry barriers put at risk upstream competition for physician services and downstream competition to meet the network needs of payors and the healthcare needs of patients. POH market entry offers one of the few paths to challenge this trend. The article provides

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Jr. et al., *The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks*, 150 JAMA Dermatol. 1290, 1290 (2014) (using telephone calls to audit Medicare advantage plans which revealed directories "substantially overestimate the number of in-network physicians available . . . ."); Abigail Burman & Simon F. Haeder, *Potemkin Protections: Assessing Provider Directory Accuracy and Timely Access for Four Specialties in California*, 47 J. Health Pol., Pol'y & L. 319, 319, 326 (2022) (using three-step survey protocol involving email or fax and telephone calls to audit California Department of Managed Health Care directories which revealed "deep shortcomings in both provider directory accuracy and timely access").

377. *E.g.*, Exec. Order No. 14036, 86 C.F.R. § 36987 (2021); 2018 HHS Report, *supra* note 275.

many reasons to invite POH market entrants to improve healthcare competition and outcomes. Policy concerns like cherry picking and induced demand are not unique to POHs and do not justify the competitive harm of the POH ban, particularly since policymakers have better, more appropriately targeted options that can reduce any provider's incentive to engage in such conduct. Physicians are directly affected by hospital consolidation and are uniquely positioned to challenge it. By removing the POH ban, Congress would free physicians to invest and innovate in the hospitals where they apply their expertise every day. Congress should unleash their potential to inject much-needed competition into healthcare markets.