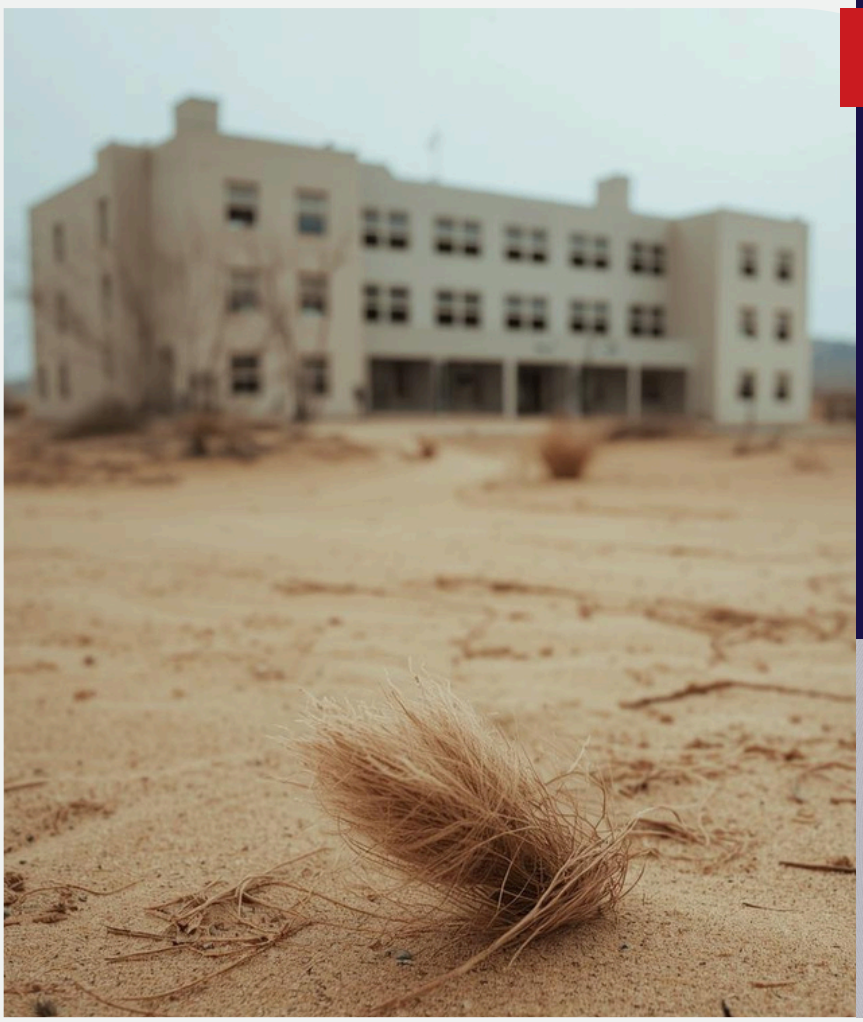
The Numbers Don't Lie
Physician-Led Hospitals Deliver Outstanding Quality, Lower Costs and Critical Competition

PHA
PHYSICIAN-LED HEALTHCARE FOR AMERICA



The Problem: A Ban Based on Politics, Not Evidence

In 2010, the Affordable Care Act imposed an arbitrary ban on physician-led hospitals – not to improve healthcare, but to eliminate competition at the behest of special interest lobbyists. Tucked away as Section 6001 of the ACA, the arbitrary provision prohibited new physician-led hospitals from opening and severely restricted grandfathered hospitals from expanding.

Fifteen years later, the consequences are clear:

- ✗ **Hospital consolidation has accelerated.**
- ✗ **Patient access to high-quality & low-cost care has diminished.**
- ✗ **Healthcare costs have soared as competition has been stifled.**
- ✗ **Patients lack choices.**

The Solution: *Let The Evidence Speak*

While Congress banned physician-led hospitals based on unsubstantiated concerns, **decades of independent research tells a completely different story.** Studies from Harvard, the British Medical Journal, JAMA, the American Enterprise Institute, the Mercatus Center and leading health economists consistently demonstrate that **Physician-Led Hospitals**

- ✓ **Increase Market Competition**
- ✓ **Lower Medicare Costs Per Beneficiary**
- ✓ **Have Greater Patient Satisfaction**
- ✓ **Make An Incredible Impact On The Market**

& Overall, Raise The Bar!

New Research Shows Significantly Lower Costs in Physician-Owned Hospitals, Signaling Potential Savings to Medicare - Physicians Advocacy Institute (2024)

Study Year: 2019

Context:

- Study commissioned to support legislative efforts to overturn POH ban.
- Data presented to lawmakers considering lifting restrictions.
- Analysis focused on **20 of Medicare's most expensive conditions.**

Hospital Characteristics:

- 186 POHs analyzed across 92 hospital referral regions.
- **Comparison group:** 1,230 non-POHs in the same hospital referral regions.
- Patient demographics and comorbidities were statistically similar between hospital types.

Cost Performance:

- For all 20 high-cost DRGs, **POHs delivered care at lower Medicare payment rates** than non-POHs in the same market.
- **Average cost difference:** 8–15% lower per patient episode at POHs.
- **Per-episode savings:** ranged from $726 (Sepsis without mechanical ventilation) to $5,925 (Spinal fusion with complications).
- If all cases for those DRGs had been treated in POHs, **Medicare could have saved approximately $1.1 billion in 2019.**
- Cost differences persisted after adjusting for patient characteristics, **supporting the conclusion that POHs are more efficient, not selective.**

Quality Metrics:

- **No evidence of "cherry-picking"**: POHs treated comparable patients in terms of age, race, and health status.
- Study references earlier literature showing **equal or better quality outcomes** at POHs vs non-POHs.
- Patient-level similarities reinforce that **savings stem from operational efficiency.**

Benefits & Impact:

- Highlights physician-led hospitals as **effective catalysts for competition and system efficiency.**
- Emphasizes POHs role in **advancing affordable, patient-centered, and quality-driven care.**

This 2024 study commissioned by the Physicians Advocacy Institute and Physicians Foundation **found no evidence of cherry-picking** — researchers analyzing nearly 740,000 Medicare patients across 186 physician-owned hospitals found that **patient age, race, ethnicity, and comorbid medical conditions were virtually identical between physician-owned and traditional hospitals in the same geographic areas.**

Sources: Physicians Advocacy Institute, "New Research Shows Significantly Lower Costs in Physician-Owned Hospitals, Signaling Potential Savings to Medicare" (2024)

Economic Impact Report (2022) - ndp | analytics

Study Period: 2018-2021
Sample: 250+ physician-led hospitals across the United States

Hospital Characteristics:

- **Type:** 96% acute care facilities; 4% other (critical access, psychiatric, long-term).
- **Geographic Distribution:** 55% South, 24% Midwest, 16% West, 5% Northeast.
- **Location:** 87% urban, 13% rural.
- **Beds:** Nearly 14,700 staffed beds nationally.

Market Competition & Access:

- Markets with physician-led hospitals have **16.7% lower concentration scores** (2,776 vs. 3,334).
- **Only 4%** of areas with POHs are "very highly concentrated" vs. 13% without POHs.
- POHs provide **increased patient access to care and drive healthy competition.**

Cost Performance:

- 59% of physician-led hospitals have **lower Medicare costs per beneficiary** than national median.
- Compared to only 51% of all hospitals.
- **Pennsylvania Example:** 71% of physician-led hospitals vs. 65% of all hospitals had lower Medicare costs than national median.

Quality Metrics:

- **Average patient experience rating:** 3.9 for POHs vs. 3.2 for all hospitals.
- 41% of POHs received highest patient experience rating (5) vs. 6% of all hospitals.
- POHs received 14% of **Healthgrades Outstanding Patient Experience Awards** despite representing only 5% of hospitals with ratings.
- **Texas Example:** POHs were 74% of hospitals with top patient experience ratings while representing only 20% of rated hospitals.

Economic Impact (2021):

- 166,365 **total jobs** supported (72,512 direct + 93,853 indirect/induced).
- $10.3 billion in **wages** ($5.4B direct + $4.9B indirect/induced).
- $43.1 billion in **economic output** ($19.8B direct + $23.3B indirect/induced).
- $1.25 billion in **federal and state taxes** ($685M income taxes + $564M payroll taxes).

Government Savings & Community Support:

- $217.1 million in Medicare cost savings (2019).
  - **Average savings:** $1,500 per patient.
  - **Highest savings in Northeast:** $3,639 per patient.
- $240.1 million in **charity care** reported to CMS (2018).
- $546.2 million in total **uncompensated care** (2018).

Key Cost Saving Procedures:

- Orthopedic surgery (hip and knee replacements).
- Cardiovascular surgeries (coronary bypass, cardiac valve replacement).

Source: ndp | analytics, "The Economic and Social Benefits of Physician-Led Hospitals" (September 2022)

Hospital Competition and Restrictions on POHs - AEI Report (2023)

Authors: Federal Trade Commission and U.S. Department of Justice staff (views are authors' own)
Context: 1,412 hospital mergers between 1998-2015

Market Consolidation Crisis:

- Hospital markets increasingly consolidated over recent decades.
- Consolidation results in:
  - **Increased prices.**
  - **Decreased patient options.**
  - **Lesser patient experience.**
  - **Upstream market power affecting nurses, physicians, pharmacists.**

Historical Context of POH Ban:

- ACA 2010 imposed functional ban on new or expanded POHs.
- Ban prevents POHs from billing Medicare.
- **Not related to main ACA provisions**—result of legislative horse-trading.
- Industry groups freely admitted their lobbying success.
- POH growth before 2010 was **rare counterpoint to consolidation trends.**

Benefits of Removing POH Ban:

1. Care Delivery Innovation:

- Physicians well-positioned to redesign care around specific areas of medicine.
- Development of specialized care models.

2. Increased Hospital Supply Flexibility:

- **COVID-19 Example:** Doctors Hospital at Renaissance converted rehabilitation hospital into **102-bed COVID hospital in 10 days.**
- Speed of innovation facilitated by physician leadership.

3. Workforce Recruiting & Retention:

- Ownership stake similar to employee stock ownership plans.
- Improves recruiting and retention.

4. Combating Labor Market Monopsony:

- Counterweight to rising physician corporate employment.
- Counterweight to hospital monopsony power in labor markets.
- Increases competition for physician services.

5. Increased Patient Choices:

- More community hospitals.
- Development of specialty hospitals.
- Competition drives down prices, raises quality.

6. Enhanced Hospital Service Competition:

- Price, quality, and innovation improvements.
- Benefits patients and payers constructing networks.

Recommendation: Congress should consider removing the POH ban.

Source: American Enterprise Institute, "Hospital Competition and Restrictions on Physician-Owned Hospitals" (February 2023)

Commercial Pricing Study - JAMA Network Open (2023)

Study Period: January 2023 price transparency data
Sample: 156 POHs and 1,116 non-POHs across 78 hospital referral regions
Procedures Analyzed: 8 CMS-designated shoppable services

Hospital Characteristics Comparison:

Characteristic	POHs	Non-POHs
Mean beds	55	162
Profit margin	15.20%	7.10%
For-profit status	99%	24%
Non-teaching	88%	72%
Metropolitan location	94%	63%
Medicaid discharges	3.00%	7.10%
Charity care ratio	1.30%	3.20%

Pricing Findings:

Nationwide Median Prices:
- POHs had 4-33% lower commercial negotiated prices for 7 of 8 services.
- POHs had 5-36% lower cash prices for 7 of 8 services.

Hospital Referral Region Analysis:
- POHs had 33.7% lower median commercial negotiated prices.
- POHs had 32.7% lower median cash prices.
- For same procedure in same geographic market.

Hospital-Plan Level Analysis:
- POH status associated with 17.5% lower negotiated prices.
- POH status associated with 46.7% lower cash prices.
- For same procedure in same market.

Procedures Studied:

1. Spinal injection
2. Physical therapy–therapeutic exercise
3. MRI scan of lower spinal canal
4. CT scan of abdomen and pelvis
5. Comprehensive metabolic panel
6. Blood test–clotting time
7. Emergency department visit level 3
8. Emergency department visit level 4

"A 2023 study published in JAMA Network Open by researchers at Johns Hopkins University found that physician-owned hospitals charge 17.5% lower commercial negotiated prices and 46.7% lower cash prices than competing hospitals in the same market for the same procedures — the opposite of what the researchers expected to find."

Source: JAMA Network Open, "Commercial Negotiated Price vs Cash Price in Physician-Owned and Other Hospitals in the Same HRR" (2023)

BMJ Study (2015)

Sample: 219 POHs and 1,967 non-POHs across 95 hospital referral regions

Patient Demographics - NO CHERRY-PICKING:

Population	POHs	Non-POHs	Statistical Significance
Medicare patients	47.10%	47.20%	p=0.97
Medicaid patients	14.90%	15.40%	p=0.75
Black patients	5.10%	5.50%	p=0.85
Hispanic patients	1.40%	1.00%	p=0.58
Mean age	77.4	78.4	p<0.001 (1 year)

Quality Metrics - EQUIVALENT PERFORMANCE:

Measure	POHs	Non-POHs	P-value
Patient experience	74.30%	74.90%	p=0.49
30-day mortality	13.90%	13.90%	p=0.91
Risk-adjusted cost	$10,113	$10,024	p=0.82
Medicare payments	$7,217	$7,033	p=0.52
Length of stay	4.6 days	5.2 days	p<0.001

Market Share:

- POHs: **6.3% of Medicare admissions** in their markets.
- Non-POHs: **93.7% of Medicare admissions.**
- **Minimal impact** on financial viability of competing hospitals.

General vs. Specialty POHs:

- General POHs served **greater proportions of Medicaid patients** (18.4%) than specialty POHs (7.6%).
- General POHs had patients with **more comorbidities** and **higher predicted mortality.**

Conclusion:

"Policies that penalize all US hospitals with physician owners need to be re-evaluated."

Source: BMJ, "Access, quality, and costs of care at physician owned hospitals in the United States: observational study" (2015)

Journal of General Internal Medicine (2020)

Study: Texas Blue Cross Blue Shield PPO Claims, 2014-2016
Focus: Hospital-owned vs. Physician-owned practices

Cost Comparison (Hospital-Owned Practices):

- **5.8% higher annual spending** ($280 more per patient).
- **13.0% higher imaging costs.**
- **12.9% higher DME costs.**
- **21.4% higher unclassified services spending.**
- **21.7% higher outpatient facility expenditures.**
- **47.9% vs. 39.1%** paid outpatient facility fee.

Source of Higher Costs:

- Driven by **utilization rather than prices.**
- Hospital-owned practices **more likely to bill in higher-reimbursement outpatient settings.**

Quality Comparison:

- **No consistent difference in care quality.**
- Mixed results on specific measures (some better, some worse).
- No difference in 30-day readmissions.

Key Finding:

"Financial integration between physicians and hospitals raises patient spending but not care quality."

Policy Implication:

"Policy makers should carefully consider policies that limit consolidation of hospitals and physicians."

Source: Journal of General Internal Medicine (2020)

Summary of Evidence by Category

QUALITY OF CARE

✓ POHs match or exceed non-POHs on mortality rates.
✓ POHs match or exceed non-POHs on readmission rates.
✓ POHs score significantly higher on patient experience (3.9 vs 3.2).
✓ 41% of POHs receive highest patient rating vs. 6% of all hospitals.
✓ No service market where quality data disfavors POHs.
✓ Shorter lengths of stay without increased complications.

ACCESS & EQUITY

✓ Serve identical proportions of Medicare patients (47.1% vs 47.2%).
✓ Serve similar proportions of Medicaid patients (14.9% vs 15.4%).
✓ Serve similar proportions of minority patients.
✓ General POHs serve higher proportions of Medicaid than specialty POHs.
✓ NO EVIDENCE OF SYSTEMATIC CHERRY-PICKING.

COST & PRICING

✓ 59% of POHs have lower Medicare costs than national median.
✓ Commercial prices 17.5-33.7% lower than non-POHs.
✓ Cash prices 32.7-46.7% lower than non-POHs.
✓ $217 million in Medicare savings (2019).
✓ Potential $1.1 billion in additional Medicare savings.
✓ Average $1,500 savings per Medicare patient.

MARKET COMPETITION

✓ Markets with POHs have 16.7% lower concentration scores.
✓ Only 4% of POH markets "very highly concentrated" vs 13% without.
✓ POHs represent only 6.3% of market—not a threat to competitors.
✓ Historical POH growth was rare counterpoint to consolidation.
✓ Provide critical competition alternative.

Summary of Evidence by Category

ECONOMIC IMPACT

✓ 166,365 jobs supported (2021).
✓ $10.3 billion in wages.
✓ $43.1 billion in economic output.
✓ $1.25 billion in taxes paid.
✓ $240 million in charity care.
✓ $546 million in total uncompensated care.

INNOVATION & FLEXIBILITY

✓ Physician-led governance enables rapid innovation.
✓ COVID example: 102-bed hospital converted in 10 days.
✓ Specialized care model development.
✓ More conservative treatment approaches.
✓ Greater efficiency in resource utilization.

LABOR MARKETS

✓ Counterweight to hospital monopsony power.
✓ Increased competition for physician services.
✓ Improved workforce recruiting and retention.
✓ Ownership stake model benefits.