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Physician-Owned Hospitals

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Key Points

- Texas POHs contributed approximately $2.9 billion in economic activity to the state per year, including the provision of 22,226 full time jobs.
- Within the top 100 U.S. hospitals in the fields of cancer, digestive disorders, and heart and heart surgery, the higher ranking hospitals were disproportionately managed by physicians.
- Several community hospitals in direct competition with physician-owned facilities responded to the marketplace pressure by attempting to improve their own performance.

Introduction

A competitive health care market is vital to ensure high quality, cost effective health care for Texas patients. Some of the most competitive participants in the health market in recent years have been physician-owned hospitals (POHs). These facilities provide broad consumer choice, cutting-edge innovation and equipment, high quality of care, and high patient satisfaction.

This added competition from POHs has been a wakeup call for some general hospitals, forcing them to innovate to stay competitive. However, provisions in the Patient Protection and Affordable Care Act (PPACA) have essentially eliminated future expansion of POHs. By effectively removing this competition from the marketplace, access to high quality health care for patients will be diminished.

The Patient Protection and Affordable Care Act

Strong opposition to physician ownership of hospitals resulted in provisions in the PPACA that significantly restrict the operations and future expansion of POHs. The opposition is generally based on two complaints.

1. That POHs intentionally draw less-complicated, more profitable patients away from general hospitals. This criticism is based on the premise that general hospitals often rely on profitable services and patients to subsidize the more unprofitable services and patients. But this is not the case. In fact, a Health and Human Services study on POHs revealed that,

   "Critics contend that the physician-owned hospitals have siphoned off profitable services from competitor community hospitals, and as a result, lower earnings are available to support uncompensated care. Our analysis shows that the 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."[1]

2. Physicians are interested only in becoming owners of specialty hospital for financial gain. The data, however, suggests that they do so because of their "dissatisfaction with the quality of care, efficiency, and bureaucracy of the community hospitals."[2] Quality and efficiency, the natural result of competition, are the primary motivators for surgeons who choose to practice in these hospitals. The entry of physician-owned hospitals into a community can be a powerful force for change and improvement in the health care delivery system.

Contrary to the complaints by critics, POHs actually make positive contributions to our health care system. A study administered by the Medicare Payment Advisory Commission (MedPAC) revealed that several community hospitals in direct competition with physician-owned facilities responded to the marketplace pressure by attempting to improve their own performance.[3] Specifically, MedPAC found that POHs tend to force the community hospitals to improve operations and tighten physician relationships. For example, several community hospitals in these markets made constructive

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improvements, including improved operating room scheduling and upgrades in equipment and supplies. This is clear evidence that many of the community hospitals are reacting to the competitive pressures from POHs in a way that benefits both patients and doctors.

Another recent study confirmed within the top 100 U.S. hospitals in the fields of cancer, digestive disorders, and heart health, the higher ranking hospitals were disproportionately managed by physicians. This study by Amanda H. Goodall Ph.D. confirms that "the better a hospital's performance the more likely it is that its CEO is a physician and not a manager."[4] Figures 1, 2, and 3 exhibit the findings of the study.

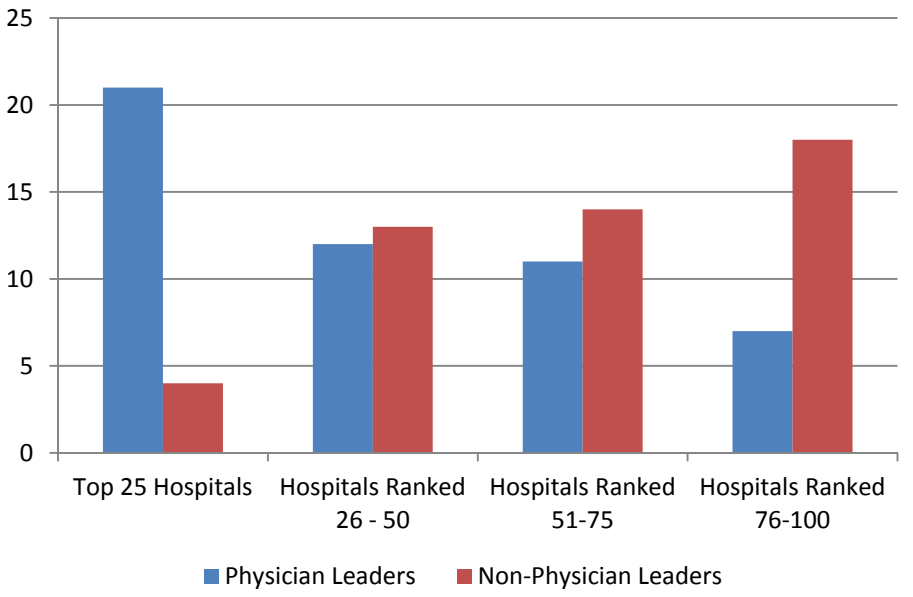
POHs also have proved that they provide higher quality care in a number of different situations. For instance, Mary Susan Littlepage, from the Heartland Institute, mentions:

> "Several studies by the federal government, independent researchers, and paid researchers have found specialty hospitals generally deliver care that is higher in quality than provided by general hospitals. A September 2005 CMS report, *Specialty Hospital Evaluation: Final Report* found '...the proportion of patients that died while hospitalized was significantly less for specialty hospitals ...' compared to general hospitals. For example, orthopedic specialty hospitals had a mortality rate of .03 percent compared to a 1.25 percent rate for general hospitals.
>
> Specialty hospitals also performed better than general hospitals in complication rates. The CMS study compared 14 areas, including complications of anesthesia, infections due to medical care, and post-op hip fracture. Specialty hospitals led in 13 of the 14 areas, in some cases by wide margins."[5]

The more relevant prices are to the actors involved in an economic exchange, the more quality will go up. It is not surprising that POHs deliver a better product since the doctors are more invested in creating a valuable product for their patients, namely quality treatment.

In addition to the high quality health services they provide, POHs have considerable community impact and contribute to local economies. Currently, there are approximately 260 of them throughout the United States, nearly 25 percent of them

Figure 1: Proportion of Physician and Non-Physician Managers as CEOs in the Top 100 U.S. Hospitals in the Field of Cancer: By Quartiles



Source: Amanda H. Goodall, Physician-Leaders and Hospital Performance: Is There an Association?, IZA Discussion Paper No. 5830 (Jan. 2010).

Figure 2: Proportion of Physician and Non-Physician Managers as CEOs in the Top 100 U.S. Hospitals in the Field of Digestive Disorders

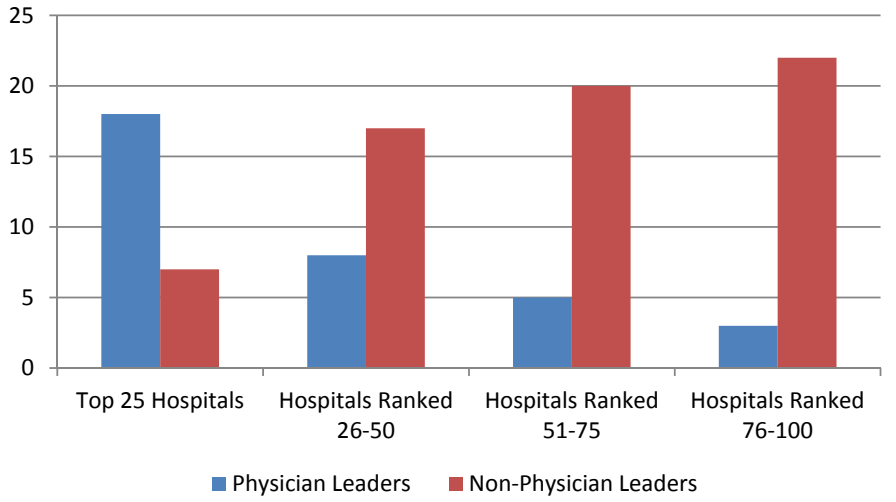
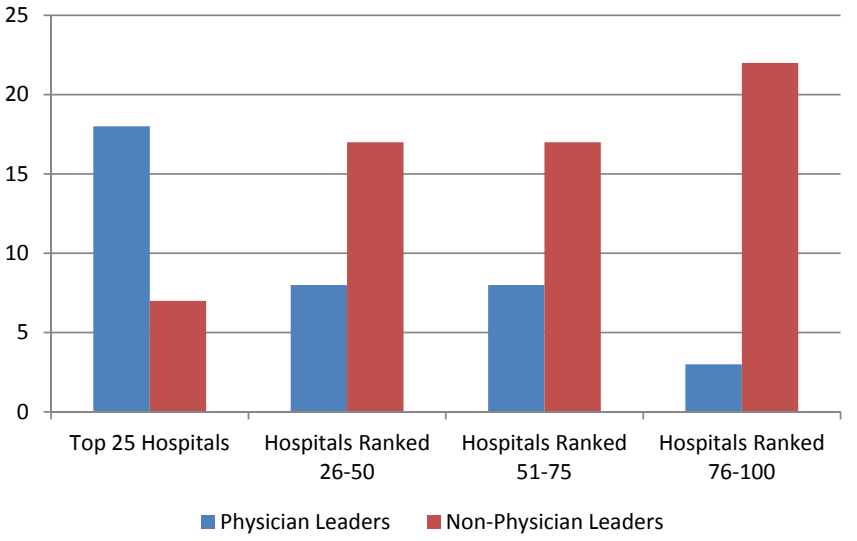


Figure 3: Proportion of Physician and Non-Physician Managers as CEOs in the Top 100 U.S. Hospitals in the Field of Heart & Heart Surgery



Source: Amanda H. Goodall, Physician-Leaders and Hospital Performance: Is There an Association?, IZA Discussion Paper No. 5830 (Jan. 2010).

in Texas. Nationwide, these facilities currently employ over 75,000 full- and part-time workers, with an average annual payroll of $13,000,000 per hospital.[6] Unlike their not-for-profit counterparts, the average POH pays more than $3 million in federal, state, and local taxes annually.

Despite the benefits of POHs, a series of new federal regulations targeting physician-owned hospitals became effective with the signing of the PPACA. This law contains several provisions that limit the ability of physicians to take an ownership interest in hospitals. Specifically, Section 6001 prevents any POH from becoming Medicare-certified after last year, bars any increase in the percentage of physician ownership in existing Medicare-certified hospitals, and limits expansion of existing Medicare-certified POHs. It is important to note that unlike many other provisions in the health care bill that will

not have an impact for years to come, these restrictions went into effect immediately. For existing physician-owned hospitals, these regulations are devastating.

As a result of these anti-competitive regulations, in June of 2010 the Physician Hospitals of America and Texas Spine & Joint Hospital jointly filed suit in U.S. Federal Court, Eastern District of Texas, challenging the constitutionality of Section 6001 of the Patient Protection and Affordable Health Care Act. The lawsuit asserts that Section 6001 is "exclusionary and unconstitutional, eliminates competition for non-physician owned hospitals, and will ultimately have a negative impact on patient choice and medical care affordability." The lawsuit claims further that the regulation is retroactive legislation that is arbitrary, vague, contradictory, and fails to provide due process and equal protection.

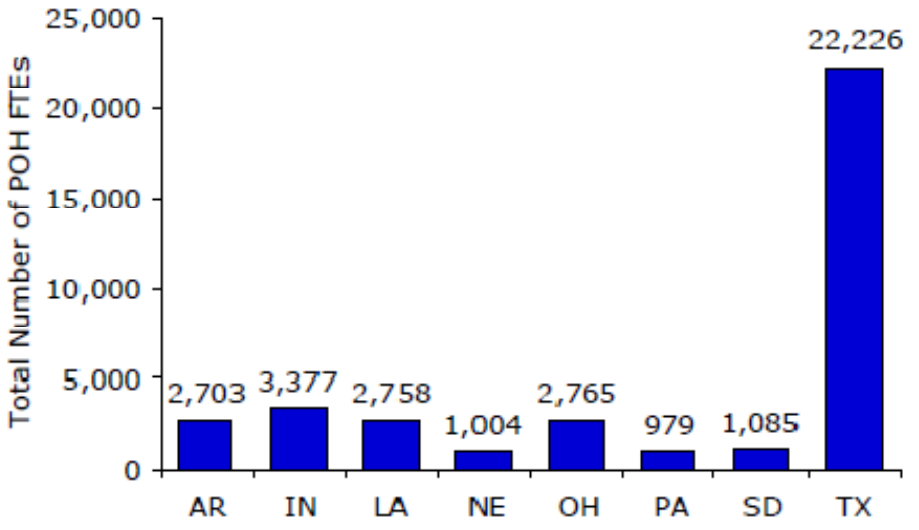
Impact on Texas

Texas, with more POHs than any other state, is hit harder by the new regulations than any other state. According to a 2009 study by the Health Economics Consulting Group, Texas POHs contributed approximately $2.9 billion in economic activity to the state per year, including the provision of 22,226 full time jobs. Figures 4 and 5 show the comparison with seven other states.[7]

The impact of the PPACA is not just economic; it also affects the quality of care delivered to Texans. A report by the Center for Medicare Services shows physician-owned hospitals in the Dallas, Houston, Austin, San Antonio, and Rio Grande areas ranked higher than general hospitals in every area and every category, including facility cleanliness, staff attentiveness, and promptness of service.[8] POHs are vital to Texas' economy and ability to deliver quality health care to our citizens, but the new Health Care Law puts all of that in jeopardy.

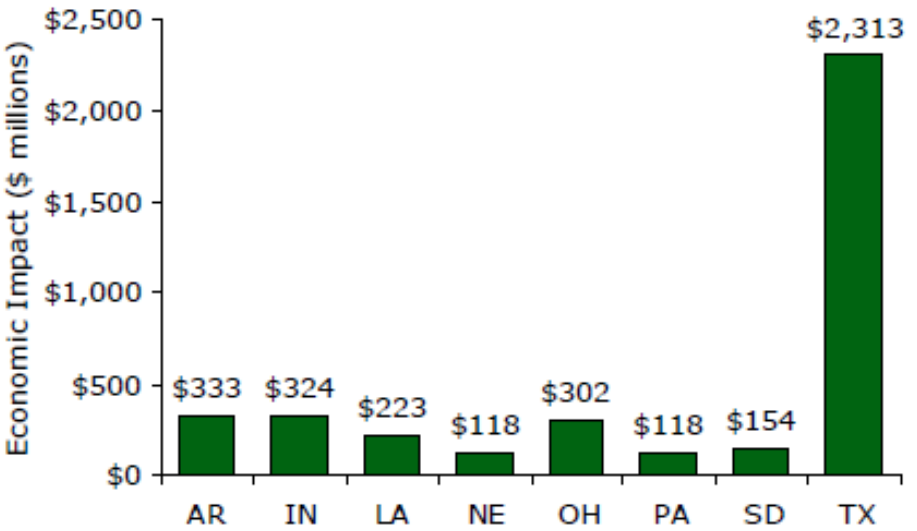
Such is the case with the Texas Spine and Joint Hospital (TSJH), a Tyler-based POH that specializes in diseases and injuries that affect the spine and joints. The level of care received at TSJH has been recognized on multiple occasions as among the highest in the nation. In late 2009, the Department of Justice announced that an investigation into violations of the False Claims Act, the Anti-Kickback Statute, and the Stark Statute by McAllen area hospitals was ending with a $27.5 million dollar settlement with Universal Health Services Inc. Contrary to the rest of the McAllen area, it was noted that TSJH was never part of the investigation, nor has the hospital ever had an allegation levied against it.[9] TSJH has been honored numerous times for spine surgery by HealthGrades, including being ranked first in Texas and in the top 5 percent in the nation for spine surgery. Commendable results such as these raise the standard of care for all.

Figure 4: Total POH FTEs by State, 2009



Source: John Schneider & Christopher Decker, "The Economic Impact of Physician-Owned Hospitals in Eight States" (12 Jan. 2009).

Figure 5: Total POH Economic Impact by State, 2009



Source: John Schneider & Christopher Decker, "The Economic Impact of Physician-Owned Hospitals in Eight States" (12 Jan. 2009).

Conclusion

The prohibition in the PPACA against physician-ownership of hospitals removes a clear source of competition to non-physician owned hospitals. This law "irrationally and arbitrarily singles out physicians and their families for a prohibition from owning a legal and necessary business—a hospital—that anyone else in […] the country can own."[10] As a result, the law constricts the economic effectiveness of the physician-owned facilities. This is akin to an unconstitutional taking under the Fifth Amendment of the United States Constitution. The government purpose employed by Congress "does not constitutionally justify the retroactive financial deprivation that will be sustained by physicians, many of whom have lawfully and responsibly committed significant funds to acquire, build, or expand upon a hospital."[11] Physicians will not be compensated for their lost investments.

It is not the POHs that cause the community hospitals to lose their most profitable cases and physician ownership does not induce overutilization of services. Rather, the real problem is the complex and confusing health care payment system. Managed care has resulted in a financial disconnect between the consumer (the patient) and the provider (hospital or physician), the same as government health care does. This has so severely distorted the reimbursement for medical services that most consumers are completely unaware of their true cost. Without reforming the third-party payment system there is little hope for a solution to the growing costs and overutilization.

Physician-owned hospitals provide for greater competition and inject innovation into the American health care system. Just as the free market has served us well in so many other sectors of the American economy, so free-market solutions should remain a major force for more effective delivery of health care services as well. The rapid growth of POHs is a prime example of how new and innovative entrants to an existing market fuel competition for cost, quality, and access. The final result is often a higher rate of productivity and efficiency. This translates to lower costs and much better quality to the patient.

Thus, the real losers in the restrictions against physician-owned hospitals are the patients who need health care and the taxpayers who are increasingly footing the cost of health care in America. ✯

Endnotes

[1] Center for Medicare and Medicaid Services, "Study of Physician-Owned Specialty Hospitals".
[2] U.S. Congress, House Committee on Ways and Means, Subcommittee on Health, *Hearing on Physician Owned Specialty Hospitals*, 109th Cong., 1st sess. (Washington: GPO, 2005) Print.
[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Physician-Owned Specialty Hospitals*, Washington, D.C. (Mar. 2005).
[4] Amanda H. Goodall, *Physician-Leaders and Hospital Performance: Is There an Association?*, IZA Discussion Paper No. 5830.
[5] Mary Susan Littlepage, "CMS Lifts Ban on Physician-Owned Specialty Facilities," The Heartland Institute (1 Oct. 2006).
[6] Molly Sandvig, Federal Lawsuit and Injunction Filed Challenging Limitations On Physician-Owned Hospitals in Healthcare Reform: *Constitutionality of Section 6001 Questioned in Plaintiffs' Filing*, Physicians Hospitals of America (3 June 2010) http://www.physicianshospital.org.
[7] John Schneider & Christopher Decker, "The Economic Impact of Physician-Owned Hospitals in Eight States" (12 Jan. 2009).
[8] Bobby Hillert, "TPHAC Reaction to CMS Hospital Compare Results" (10 June 2009) TPHAC. Print.
[9] Molly Sandvig, "U.S. Department of Justice Confirms Large Corporate Owned Hospitals Involved in Illegal Contracting Schemes in McAllen Texas, Not Physician Owned Hospitals" (2 Nov. 2009) Web.
[10] Complaint for Declaratory and Injunctive Relief at 5, *Physician Hosps. of Am. v. Sebelius*, Case 6:10-cv-00277 (E.D. Tex. June 3, 2010).
[11] Complaint for Declaratory and Injunctive Relief at 16, *Physician Hosps. of Am. v. Sebelius*, Case 6:10-cv-00277 (E.D. Tex. June 3, 2010).

About the Authors

Spencer Harris joined the Texas Public Policy Foundation in 2010 as a Health Care Policy Analyst. His research focuses on identifying patient-centered, free market solutions for our state's health care challenges.

No stranger to Texas public policy, Harris worked in the House of Representatives for Rep. Warren Chisum where he covered health care issues, immigration issues, and the Licensing and Administrative Committee.

Harris is a native Texan, born and raised in Houston. He graduated from Texas A&M University with a degree in History and Anthropology.

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Texas Public Policy Foundation

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