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Hospitals across the country are struggling to maintain coverage in key hospital-based specialties, including anesthesiology, radiology, emergency medicine, and certain surgical subspecialties. In many markets, hospitals are providing substantial financial support to physician groups simply to maintain required coverage.

At the same time, reimbursement pressures continue to widen the gap between professional collections and the cost of providing 24/7 hospital services.

The typical explanation for these shortages focuses on workforce pipeline constraints or payor reimbursement. Those factors matter. But there is a structural issue that receives far less attention: federal restrictions that effectively prohibit new or expanded physician ownership of hospitals.

With limited exceptions, the Stark Law prevents physicians from owning or expanding ownership interests in hospitals to which they refer patients. The policy justification historically offered for these restrictions has been prevention of overutilization driven by financial self-interest.

That justification deserves closer scrutiny, particularly in today's hospital employment environment.

The Internal Inconsistency

If the concern is that financial alignment between physicians and hospitals creates incentives for overutilization, it's difficult to reconcile that concern with the modern hospital employment model.

Hospitals today directly employ large numbers of physicians across multiple specialties. Employed physicians generate downstream revenue for the hospital, including admissions, procedures, imaging, and ancillary services. While there are compliance guardrails, e.g., fair market value compensation standards, quality metrics, and fraud and abuse enforcement, the financial alignment between hospital and physician is both real and intentional.

In other words, the system already permits powerful economic integration between hospitals and physicians. The prohibition applies specifically to ownership structures but not to employment structures.

That raises a legitimate policy question: if financial alignment itself is not categorically prohibited, why is ownership uniquely restricted?

It's impossible to ignore the fact that political horse trading between the Obama administration and the American Hospital Association to garner support for Obamacare was a significant and perhaps controlling factor.

However, to be complete, the answer might also lie in historical concerns about physician-owned specialty hospitals selecting profitable service lines and avoiding unprofitable ones. That was a legitimate policy debate in the early 2000s. But today's hospital-based specialist shortage presents a different problem: hospitals are struggling to sustain essential services, not to manage excessive profitable capacity.

The Current Economic Reality

In anesthesiology and radiology in particular, professional reimbursement has failed to keep pace with inflation and operating costs. Many hospital-based groups require substantial stipends or "coverage support" payments from hospitals to maintain staffing levels.

Hospitals are therefore already subsidizing these services.

The prevailing model is one in which:

Independent physician groups contract with hospitals.
Professional collections are insufficient to support required staffing.
Hospitals provide financial support to fill the gap.

This is not a market-based equilibrium. It is a patchwork subsidy structure.

Given that hospitals are already bearing financial risk to maintain coverage, it is worth asking whether ownership alignment might offer an alternative structure.

How Ownership Could Change the Equation

Allowing physicians to hold ownership interests in hospitals could create several potential effects:

> **1. Stronger Institutional Alignment**
> Ownership may foster longer-term commitment to a facility, particularly in competitive markets where physicians frequently change affiliations. Stability in hospital-based coverage has real operational value.
>
> **2. Capital Formation and Risk Sharing**
> Ownership structures allow physicians to share in facility-level financial performance. Instead of hospitals shouldering subsidy risk alone, risk and reward could be shared.
>
> **3. Entrepreneurial Incentives**
> Ownership can incentivize physicians to participate in operational efficiency initiatives, service line development, and throughput improvements.
>
> **4. Competitive Pressure**
> In markets dominated by large nonprofit systems, physician ownership could introduce additional competitive models.

None of these outcomes are guaranteed. But current federal restrictions prevent these models from even being tested at scale.

Addressing the Overutilization Argument

Critics will argue that physician ownership inherently increases the risk of overutilization. That risk cannot be dismissed. Financial incentives do influence behavior.

But several points deserve consideration:

- Overutilization concerns are not unique to ownership; they also exist under employment and productivity-based compensation models.
- Fraud and abuse statutes, civil and criminal litigation risk, payor oversight, quality reporting, and value-based reimbursement structures already exist to mitigate inappropriate utilization.
- Many hospital-based specialties, such as anesthesiology, have limited independent control over volume; they respond to surgical scheduling and patient demand rather than generating discretionary services.

If the policy goal is to prevent abusive self-referral, enforcement mechanisms should target abusive conduct directly rather than categorically banning ownership structures

The Shortage Problem Is Structural

The shortage of hospital-based specialists is not solely a pipeline issue. It is also a structural financing issue.

- Maintaining 24/7 coverage.
- Supporting unprofitable service lines.
- Cross-subsidizing care with shrinking margins.

At the same time, physicians in certain specialties face declining real reimbursement and increasing lifestyle and liability pressures.

Ownership is not a cure-all. But prohibiting ownership removes one potential alignment tool from the policy toolbox.

A Related Question: Tax Neutrality

A separate but related issue is competitive neutrality.

Nonprofit hospitals benefit from tax exemptions while operating in many markets as large integrated health systems competing with for-profit entities. If physician ownership were permitted more broadly, policymakers would need to consider whether current tax structures create competitive imbalances.

That debate stands on its own and should be addressed separately. But it underscores a broader point: the regulatory and tax framework governing hospitals has evolved piecemeal over decades, often without revisiting underlying assumptions.

A Call for Reexamination, Not Deregulation by Default

This is not an argument for eliminating all guardrails. It is an argument for reexamining whether a categorical prohibition on new or expanded physician ownership remains justified in light of current market conditions.

Policymakers should ask:

- Does the prohibition meaningfully reduce inappropriate utilization in today's regulatory environment?
- Does it unintentionally prevent innovative alignment models that could stabilize hospital-based coverage?
- Would carefully structured ownership models with transparency and oversight help to address workforce shortages?

The hospital-based specialist shortage is unlikely to resolve through incremental adjustments alone. If the existing regulatory framework limits the range of permissible solutions, it deserves reconsideration.

At minimum, the issue warrants serious discussion rather than reflexive defense of policies rooted in a decades old healthcare landscape.

The question is not whether physician ownership is inherently good or bad. The question is whether prohibiting it remains sound policy in an era defined by workforce instability, reimbursement compression, and fragile hospital margins.

That is a debate worth having.

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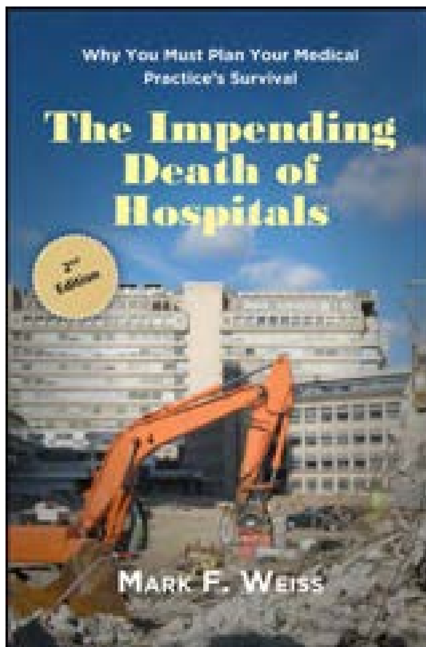

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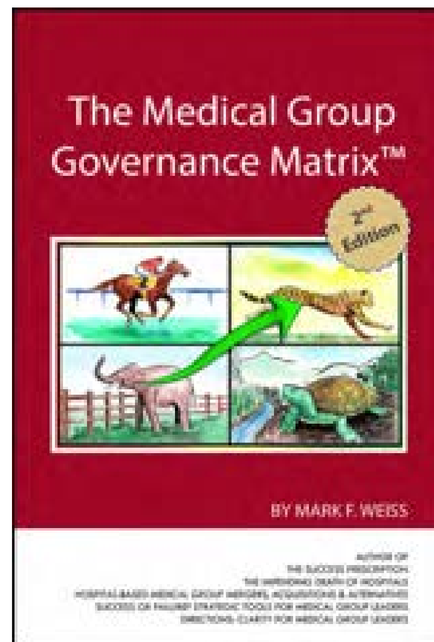

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