PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

ISSUE BRIEF

How Government Policy Is Consolidating the Practice of Medicine

Why tightening corporate practice of medicine laws weakens independent physicians, empowers hospitals, and raises healthcare costs

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Introduction

The U.S. physician market is consolidating at a rapid pace. As recently as 2012, fewer than one in three physicians were affiliated with hospital systems. Last year, roughly half were, according to the U.S. Government Accountability Office.[1] A Physicians Advocacy Institute study puts that figure at 55%.[2]

Consolidation consistently leads to higher prices. One recent study found that a 10-percentage point increase in hospital-physician vertical integration was associated with a 1% increase in prices for primary care, a 0.6% increase in the price of orthopedics, and a 0.5% increase in price for cardiology.[3]

A 2023 analysis published in JAMA concluded that prices for health system-affiliated physician services were 12% to 26% higher than prices for independent physicians.[4]

Competition is a prerequisite for affordable, high-quality care. Yet some states, alarmed by consolidation among healthcare providers, are responding in ways that risk accelerating market concentration to the detriment of patients and the healthcare system.

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In particular, efforts to strengthen bans on the “corporate practice of medicine”—often justified as a way to protect physician independence—are likely to do the opposite. By restricting the ability of independent practices to partner with entities called management services organizations for administrative, operational, and financial support, these policies tilt the playing field in favor of hospitals, undermining competition and driving further consolidation.

Government Policies Stack the Deck Against Independent Physicians

Physicians who wish to remain independent face several structural disadvantages. Chief among them is Medicare’s flawed payment system.

Medicare physician reimbursement lacks an automatic inflation adjustment and has steadily eroded in real terms. According to the Medicare Payment Advisory Commission, Medicare physician payments increased just 12% in nominal terms between 2000 and 2022.[5] The costs associated with operating a practice, meanwhile, have increased substantially—nearly 48% over that time frame.[6]

The American Medical Association estimates that, after adjusting for inflation, Medicare physician reimbursement declined 33% between 2001 and 2025.[7]

No business can reconcile declining revenue with higher costs indefinitely. For many physician practices, selling to a larger entity—typically a hospital or health system—has become a financial imperative rather than a strategic choice.

Medicare payment policy also systematically favors hospitals over independent physician practices. The entitlement pays substantially more for the same services when they are delivered in hospital outpatient departments than when they are furnished in physician offices or ambulatory surgical centers.

These payment differentials create powerful incentives for hospitals to acquire physician practices and reclassify services as hospital-based. As a June 2025 *Health Affairs* analysis explained, higher hospital outpatient payment rates have fueled vertical integration by making acquisition financially attractive.[8]

Because Medicare rates strongly influence commercial pricing, these distortions ripple throughout the healthcare system. A study from BlueCross BlueShield looked at prices for thousands of different outpatient services—from chest x-rays to back-pain injections—and found that prices were up to five times higher when performed in a hospital outpatient department than in an ambulatory surgery center or doctor's office.[9]

Those pay discrepancies have enabled hospitals to stockpile cash that they can use to bolster their competitive offerings over independent practices—or acquire their competitors.

Hospitals also benefit from the 340B Drug Pricing Program, which allows eligible providers to purchase prescription drugs at steep discounts. Although the program is intended to support care for vulnerable populations, many hospitals have transformed it into a significant source of unrestricted revenue.[10]

> "The American Medical Association estimates that, after adjusting for inflation, Medicare physician reimbursement declined 33% between 2001 and 2025."

Hospitals can purchase discounted drugs through the 340B program and bill insurers and Medicare at full price, retaining the spread. That revenue is increasingly used to subsidize acquisitions, including the purchase of physician practices.[11]

In many cases, hospitals designate acquired practices as 340B "child sites," expanding their access to discounted drugs and compounding the disparity. Independent physician practices, by contrast, are excluded from the program entirely. That puts them at a persistent competitive disadvantage.

Health systems have capitalized on all these advantages to add physician practices to their portfolio. Between 2019 and 2024, hospitals acquired 7,600 practices and 74,500 physicians, according to research from the Physicians Advocacy Institute.[12]

Less competition translates into higher prices. A study in the journal *Health Affairs* examined the effect of consolidation in California's healthcare market. It found that

> The estimated impact of the increase in vertical integration from 2013 to 2016 in highly concentrated hospital markets was found to be associated with a 12 percent increase in Marketplace premiums. For physician outpatient services, the increase in vertical integration was also associated with a 9 percent increase in specialist prices and a 5 percent increase in primary care prices.[13]

Despite these challenges—all of which are driven by government policy, not market forces—some physician practices are finding ways to resist acquisition and remain independent. One strategy that practices have adopted is a partnership with an entity called a management services organization, or MSO.

Under these arrangements, physicians retain full control over clinical decision-making but delegate administrative, financial, and operational tasks to their MSO partners. For independent practices facing declining reimbursement, rising compliance costs, and competition from vertically integrated health systems, MSOs can provide capital, scale, and expertise without requiring physicians to sacrifice clinical autonomy.

Some MSOs are backed by private equity, a fact that has drawn political scrutiny, thanks in part to the high-profile bankruptcies of a few PE-owned hospitals and nursing homes.[14]

But it's important to remember that, as a matter of economics, private equity is simply a financing mechanism. Healthcare accounts for nearly one-sixth of our economy.[15] It's only natural that the sector would feature a multitude of business models and mechanisms for financing healthcare operations.

> "Because Medicare rates strongly influence commercial pricing, these distortions ripple throughout the healthcare system."

Physician practices increasingly need scale to compete effectively against large hospitals and health systems. Partnerships with management services organizations can give them that scale and sophisticated business support to compete.

How States Are Making Health Care Less Competitive

Many states have responded to healthcare consolidation by seeking to expand or more aggressively enforce bans on the corporate practice of medicine. Thirty-three states limit corporations from owning medical practices to "varying degrees."[16]

The goal is understandable—ensuring that medical decisions remain in the hands of physicians.

In practice, however, these laws target independent physician practices almost exclusively. Hospitals are typically exempt—even though their affiliated physicians may be subject to some of the same perverse incentives that corporate practice of medicine rules are supposed to address.[17] For example, hospital-affiliated physicians may be strongly encouraged, if not required, to refer their patients to other physicians within the hospital system.[18]

Recent efforts in several states to restrict independent practices' partnerships with MSOs exemplify this imbalance.

Consider Oregon Senate Bill 951, which became law in June 2025. The law:

> [p]rohibits a management services organization, an individual who works as an independent contractor with a management services organization or a shareholder, director, officer or employee of a management services organization from owning or controlling shares in,

> serving as a director or officer of, being an employee of, working as an independent contractor with or otherwise managing, directing the management of or participating in managing a professional medical entity with which the management services organization has a contract for management services.[19]

Lawmakers in Washington,[20] Vermont,[21] and North Carolina[22] have contemplated similar legislation.

By limiting the ability of physicians to partner with management services organizations, these policies make it far more difficult for independent practices to access capital, scale, and operational support.

Further, it makes little sense to bar physicians who care for patients in medical practices from investing in or serving as employees, officers or directors of their affiliated MSO—as Oregon's law does—if the goal is to ensure that physicians have clinical control of their practices and the ability to shape the direction and priorities of the MSO that supports them.

"By limiting the ability of physicians to partner with management services organizations, these policies make it far more difficult for independent practices to access capital, scale, and operational support."

Lawmakers concerned about corporate influence over medicine should want physicians to have the opportunity to exercise leadership and influence over the ways in which an MSO partners with its affiliated practices.

The effect of measures like Oregon's is not to prevent consolidation but to channel it. Independent practices lose a critical path to remaining autonomous. Hospitals face fewer constraints on expansion—and even gain an edge in potential buyout negotiations with physicians in independent practice, who have one less option for avoiding hospital and health system employment. The result is less competition, not more.

State efforts to fight consolidation in the healthcare market should not unwittingly exacerbate consolidation. But that's exactly what's happening.

Protecting Competition, Not Picking Winners

There are better ways for policymakers to fight consolidation among providers, preserve competition, and ensure that clinical decision-making remains solely the province of physicians and other licensed healthcare providers.

At the state level, lawmakers should consider what California has done to restrict the corporate practice of medicine. In October 2025, Gov. Gavin Newsom signed SB 351 into law, which bars private equity groups from interfering with the professional judgement of physicians in healthcare decisions or exercising ultimate control over clinically related matters like coding, the content of medical records, and hiring and firing physicians.[23]

The measure preserves clinical autonomy for physicians without regulating the structure of the business affiliation between a physician practice and an MSO. Practices are free to remain unaffiliated or affiliate with

an MSO, hospital, or insurance company. All practice models compete for patients—and negotiate with payers—on equal terms.

Creating a more competitive healthcare provider market—one where patients can choose to receive care in the site of care most appropriate for them and providers have strong incentives to improve quality to attract patients—will also require action from federal policymakers.

To start, Congress should reform Medicare's flawed reimbursement system. Indexing Medicare physician reimbursement to inflation is critical to preserving the viability of independent practice. The entitlement already adjusts payments to hospitals, hospices, and skilled nursing centers for inflation. There's no reason that physician practices should be outliers.

The primary obstacle to this reform has been budgetary politics. Indexing physician reimbursement to inflation would increase Medicare spending in the near term. Historically, Congress has raised physician reimbursement under Medicare through repeated temporary fixes rather than durable reform. Even with those fixes, physician reimbursement declined 33% between 2001 and 2025 after adjusting for inflation.

"Implementing site-neutral payment reforms in Medicare—through which hospital outpatient departments and medical practices would be paid the same amount for furnishing identical services—would also foster competition among healthcare providers."

Congress enacted a one-time 2.5% increase in Medicare physician reimbursement for 2026.[24] That increase follows a 2.8% cut in Medicare physician reimbursement in 2025.[25]

In late 2025, a bipartisan group of Congressmen introduced the Strengthening Medicare for Patients and Providers Act, which would permanently index Medicare physician reimbursement to inflation. Its prospects for passage are uncertain.[26]

Implementing site-neutral payment reforms in Medicare—through which hospital outpatient departments and medical practices would be paid the same amount for furnishing identical services—would also foster competition among healthcare providers. This change would deprive hospitals of the revenue premium they're using to buy up competing independent practices.

It would make our healthcare system more efficient, too. Site-of-care optimization, wherein healthcare services are delivered in the lowest-cost setting that can safely and effectively provide them, should be our guiding principle. Medicare should not reward hospitals for engaging in regulatory arbitrage by using their revenue premium to acquire physician practices and then billing for the same services at higher hospital rates.

The Medicare Payment Advisory Commission and other experts have repeatedly endorsed site-neutral payment as a means of improving efficiency and competition.[27] But progress has been slow due to opposition from hospital systems.

Hospitals argue that higher outpatient payment rates are necessary to subsidize emergency services and uncompensated care, even when those higher rates are applied to routine services delivered in physician offices that hospitals have acquired.

The reality is that hospitals benefit greatly from the current reimbursement imbalance. The savings from site-neutral payments, meanwhile, would be dispersed across taxpayers, payers, and patients. Changing the status quo is difficult politically when benefits are concentrated and costs are diffuse.

Finally, cracking down on abuses within the 340B program would enable independent physician practices to compete more effectively—and deliver savings throughout the rest of the healthcare system. By one estimate, only 35% of participating hospitals are in underserved areas.[28]

The Trump administration can begin that effort by conducting a hospital drug cost acquisition survey, as required under Medicare law and clarified by the U.S. Supreme Court in a 2022 decision.[29] Collecting data on how hospitals use 340B savings would allow regulators and taxpayers to assess whether the program is fulfilling its statutory purpose.

What little data we have on 340B suggests that it's not—and is simply subsidizing consolidation.

Potential long-term reforms for 340B could include tightening eligibility requirements to ensure participating hospitals meaningfully serve low-income and uninsured patients; requiring hospitals to demonstrate that 340B revenue is used directly to expand access to care rather than to finance acquisitions; and limiting the ability to designate acquired physician practices as 340B child sites absent clear evidence of community benefit.

Conclusion

Policymakers seeking to preserve competition in healthcare must confront the true drivers of consolidation. Payment distortions, regulatory favoritism, and uneven enforcement—not physician ownership structures—are pushing independent practices out of the market. And when independent physicians lose the ability to compete, patients lose choices, prices rise, and quality suffers.

"First, do no harm" is a fitting maxim not just for physicians but for policymakers as well. Efforts to restrict the corporate practice of medicine should strengthen competition—not unintentionally extinguish it.

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