



Restoring Private Physician Practices in America: The Path to Increased Competition and Lower Healthcare Costs

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Executive Summary

Independent physician practices in the U.S. have been disappearing as hospitals and larger health systems acquire more and more of them, turning doctors into employees instead of owners of healthcare practices. For patients and the U.S. healthcare system as a whole, this has led to rising expenditures without commensurate improvements in the quality of care. Reforms should be undertaken to restore independent physician practices, which would provide a needed competitive boost to the health system, improve patient care, and lower expenses.

The objective of this report is to demonstrate the importance of restoring private physician practices in the United States. Private physician practices are well recognized for their positive health and economic benefits to patients and the healthcare system as a whole. However, private physician practice in the U.S. has been declining over the past decades due to market consolidation driven by physician fee reductions, government regulations, and unnecessary barriers to entry. Market consolidation takes two primary forms in the scope of this report: vertical consolidation, as hospital and healthcare systems acquire private physician practices, and horizontal consolidation, as hospital systems merge or combine into larger systems with greater market power.

Key findings of the report are:

- 1. Disappearing private physician practices and the growing market power of large hospital systems.**
 - a. There are less than half as many physician-owners of medical practices today as there were in the 1980s, and more doctors are now employees of hospitals (47%) than in private practice (42%).
 - b. Acquisition of independent physician practices and hospital mergers have created market-dominant health system organizations.
 - c. Where patients see a doctor matters – switching from private practitioners to hospital- or corporate-affiliated doctors increases costs and lowers the quality of care.

- 2. Driving the consolidation of physician practices into larger systems are inadequate payment rates, anti-competitive barriers to entry, and burdensome regulatory and administrative requirements.**
 - a. Medicare reimbursement rates for doctors have been declining relative to hospital reimbursement rates for decades.

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- b. Commercial insurance payments to physicians are lower than to hospitals, reflecting the greater market power hospital systems are able to exert.
 - c. Numerous regulations, such as the Stark law, Affordable Care Act, and state certificate-of-need (CON) laws provide a web of anti-competitive rules that impede the ability of private practitioners to offer better care.
- 3. Numerous studies and international data show that consolidation of physician practices has not necessarily led to improved health outcomes for patients, yet healthcare costs continue to rise.**
- a. Health insurance premiums in the U.S. continue to rise far exceeding inflation, and U.S. healthcare costs are the highest among OECD countries.
 - b. Multiple quality measurements have shown vertical physician integration and hospital market concentration to be associated with lower quality and patient satisfaction.
 - c. International comparisons of health outcomes across several disease conditions indicate gains in the U.S. have slowed or even reversed slightly in the years after approximately 2009, compared to greater and more persistent gains in peer OECD countries.
- 4. Levelling the playing field for private physician practices could inject sorely needed competition into the healthcare system, improve the quality of care, and lower expenditures.**
- a. Physician reimbursement rates should be adjusted and incentives aligned to reward quality through payment parity with larger health systems.
 - b. Reform barrier-to-entry laws to allow new physician-owned hospitals or expanded services, and referral regulations to allow independent physicians to provide better, integrated care.
 - c. Examine large health system practices for anti-competitive impacts and greater transparency.

The report is organized into four sections: (1) The shift in medical practice settings from private, independent practices to larger healthcare systems in the United States; (2) Major causes of the decline in private physician practice in the U.S. over the past two decades; (3) Negative health and economic impacts of the decline in private physician practice; and, (4) Policies to restore private physician practice.

I. The Shift in Medical Practice Setting in the United States

Independent physician practice in the U.S. has been in decline for several decades as doctors have moved from private practice to hospital-owned facilities. In 2012, over 60% of physicians were working in private practice while 29% of physicians were direct hospital employees or working in facilities that were owned by hospitals. Currently, only 42% of physicians are still working in private practice while 47% of physicians are employed or working in hospital-owned facilities.² (Figure 1)

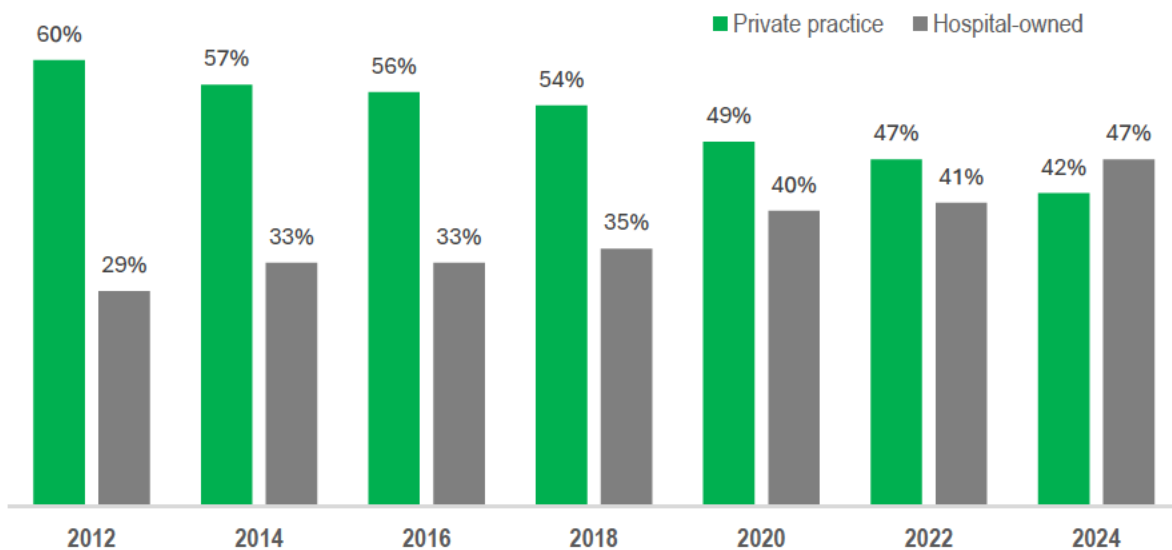
² [American Medical Association](#).

Data for physician-owned practices confirm this steep decline – the number of physician-owners is less than half of what it was several decades ago. While in the early 1980s an estimated 76% of physicians had an ownership stake in their practice, that figure declined to 53% in 2012, then to just 35% in 2024.³ The shift to larger health systems means doctors have increasingly become employees rather than entrepreneurial medical provider owners.

The shift from private practice to the hospital setting is due in part to acquisitions of independent physician organizations by larger healthcare systems. The U.S. Federal Trade Commission (FTC) found that 40% of just over 2,000 physician mergers across 15 states between 2015 and 2020 were associated with a healthcare system.⁴ Some health systems are “serial acquirers,” rolling-up multiple physician practices – 24 health systems in the FTC study made more than 10 acquisitions each in the study period.

Simultaneously with the vertical integration of independent practices, hospitals were consolidating horizontally, merging to create larger health systems. From 1998 to 2015, there were more than 1,400 hospital mergers, with more than 560 of them occurring in the last six years of that span.⁵ This gave larger healthcare systems increased market power.

Figure 1.
The declining trend in private physicians in the U.S., 2012-2024



³ Payerchin, Richard. “AMA: Physician private practice ‘unraveling’ due to low payment, high costs, administrative burdens,” *Medical Economics*, May 29, 2025, <https://www.medicaleconomics.com/view/ama-physician-private-practice-unraveling-due-to-low-payment-high-costs-administrative-burdens>.

⁴ U.S. FTC, “Physician merger involve 38% of doctors, substantial health system participation, and frequent serial acquisition,” *Health Affairs Scholar*, 2025, 3(5), qxaf061, <https://doi.org/10.1093/haschl/qxaf061>.

⁵ Miller, Brian, et al., American Enterprise Institute, “Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation,” *New York Univ. Journal of Legislation & Public Policy*, July 8, 2024, <https://www.aei.org/research-products/report/reconsidering-the-ban-on-physician-owned-hospitals-to-combat-consolidation>.

Commensurately, patients in the U.S. are also increasingly seeking healthcare in the hospital setting, particularly emergency rooms (ER), rather than doctors' offices, more so than patients overseas. Approximately 16% of adults in the U.S., compared to 7% in Germany, 9% in France, or 11% in the UK, used hospital emergency departments for non-urgent conditions that could have been treated by primary care physicians.⁶ According to Peterson-KFF, ER visits may indicate poor access to outpatient care, reflecting in part the lack of or inability to find a regular provider. Fewer U.S. adults (87%, compared to over 90% in many other major OECD countries) had a regular doctor or place of care compared to many other OECD countries.⁷ According to Peterson-KFF, this impacts patient ability to receive continuous care, thus impacting health outcomes: "Continuous care is an important measure of health system quality as it facilitates better health outcomes."⁸

Exacerbating this problem, the U.S. has faced a growing physician shortage since the early 2000s. The most recent data show the U.S. has one of the lowest physician-to-population ratios among developed economies. For example, as of 2022 there were 27 general and specialist practitioners per 10,000 U.S. inhabitants compared to 46 in Germany, 45 in Austria, 33 in the UK, 32 in France, and so on.⁹ The same pressures driving the acquisition of independent practices are causing some independents to leave practice altogether, contributing to the doctor shortage.

Evidence suggests the decline of private physician-owned practices could lead to lower quality of care and higher per-patient expenditures. An article in *Health Affairs* stated that "physician-owned practices had fewer preventable admissions than hospital-owned practices."¹⁰ One *JAMA* study found that "hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than physician-owned organizations."¹¹ Adjusted for patient severity, hospital-owned physician organizations had 10.3% higher expenditures per patient than doctor-owned practices, and larger hospital systems had 19.8% higher expenditures. (Table 1)

Table 1.
Per patient expenditure by ownership of physician organization

Physician organization by ownership	Per patient average expenditure (2012)	Per patient expenditure adjusted for patient severity, indexed to physician owned
Physician owned	\$3,066	1.000
Hospital owned	\$4,312	1.103
Multihospital System owned	\$4,776	1.198

⁶ KFF.

⁷ The Commonwealth Fund; <https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries>; <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/>.

⁸ KFF, <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries>.

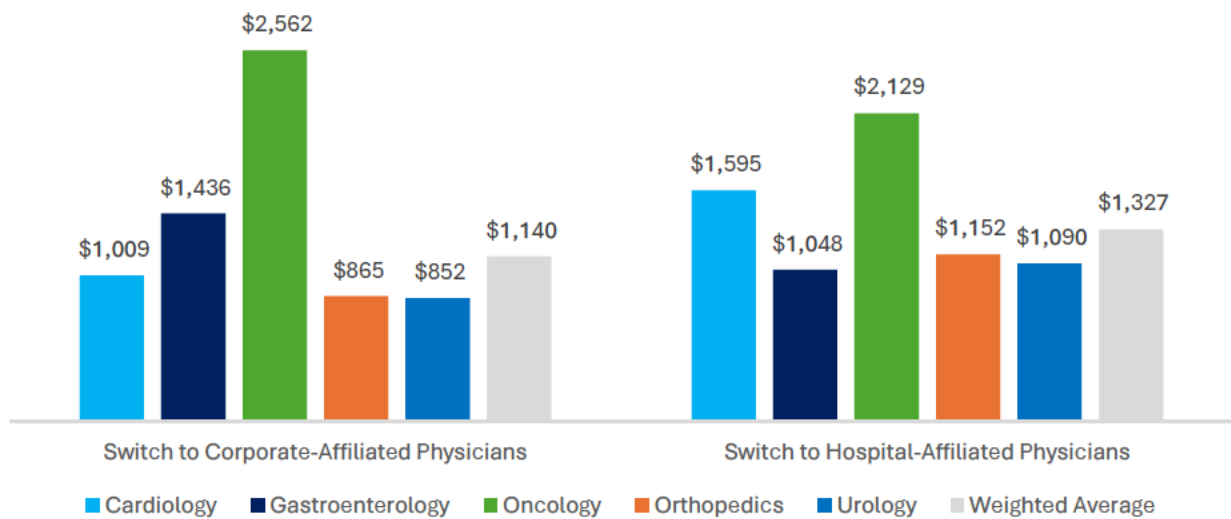
⁹ [Physicians by categories, OECD](#).

¹⁰ LP Casalino, et al., Small Primary Care Physician Practices Have Low Rates Of Preventable Hospital Admissions, *Health Affairs*, 33(9), September 2014, <https://doi.org/10.1377/hlthaff.2014.0434>.

¹¹ Robinson JC and Miller K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. *JAMA*. 2014;312(16):1663–1669. doi:10.1001/jama.2014.14072.

A broader study examining Medicare data revealed that patients who switched from unaffiliated physician practices to hospital or corporate-affiliated physicians saw an increase in expenditures across five specialty areas in the 12-month period after making the switch.¹² (Figure 2) On average, Medicare spending went up over \$1,100 per beneficiary within 12 months after patients switched from unaffiliated physicians to corporate-affiliated physicians, and went up over \$1,300 per beneficiary after patients switched to hospital-affiliated physicians.

Figure 2.
Increase in total Medicare expenditures per beneficiary, by specialty, 12 months after switching from unaffiliated physicians to corporate- or hospital-affiliated physicians



II. Contributing factors to the decline in private physician practice in the U.S.

The decline of private physician practice through the vertical integration of physician practices into larger health systems (and hospital consolidation) is driven by multiple factors.¹³ Survey data from the American Medical Association indicate that inadequate payment rates, high-cost resources, and burdensome regulatory and administrative requirements are driving the consolidation trend.¹⁴ As consolidation continues, the ability of independent practices to negotiate favorable contracts with insurers and to maintain referral streams from other physicians is increasingly eroded. Furthermore, as noted by the FTC, “research has found that, when doctors are acquired by health systems, reimbursement for commercial payers and Medicare increases, while not improving the health outcomes for the latter group.”¹⁵

¹² Avalere, *Medicare Service Use and Expenditures Across Physician Practice Affiliation Models*, September 2024, https://advisory.avalerehealth.com/wp-content/uploads/2024/09/Avalere_WP_20240917_Medicare-Cost-and-Utilization-Across-Physician-Affiliation-Models.pdf.

¹³ GAO Sep 2025.

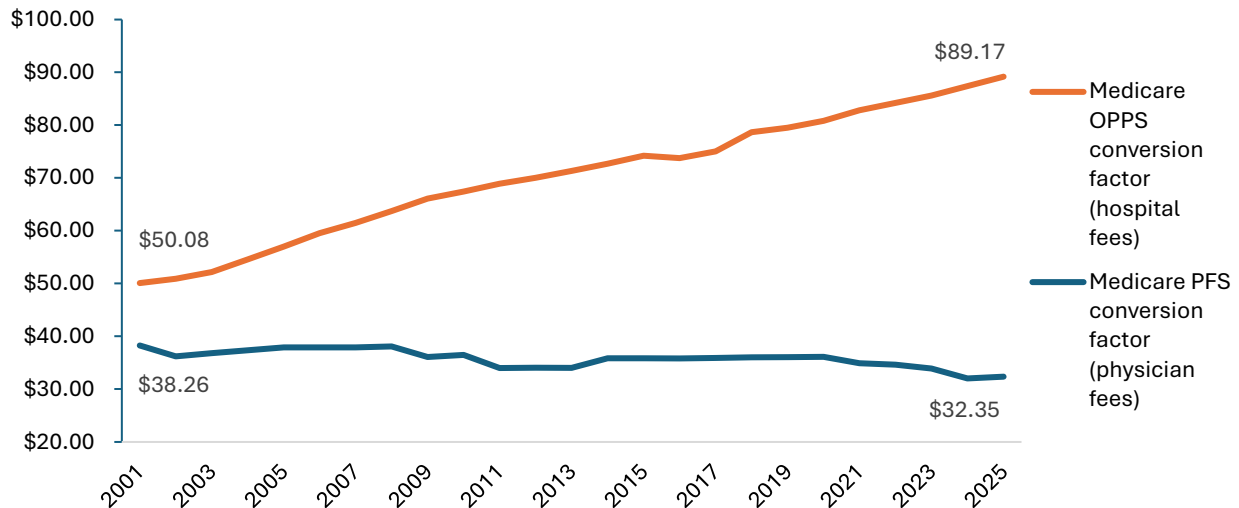
¹⁴ Kane, *Physician Practice Characteristics*.

¹⁵ FTC, *op cit*.

Over the past 20 years, there has been a noticeable divergence between the rates Medicare pays physicians and those it pays hospitals.^{16,17} (Figure 3) The ability to extract greater payments from Medicare gives hospital systems a tremendous competitive advantage over private practitioners, inducing the acquisition trend.

Figure 3.

Diverging trends in physician fees and hospital fees in the U.S.



It is also the case that commercial health insurance typically pays higher rates to doctors affiliated with hospital systems than to independent private physicians. This is evident in the differences between Medicare and commercial insurance reimbursement rates. Commercial insurance pays providers more than Medicare – 143% more for physician services and 199% more for hospital services, according to analysis by KFF.¹⁸ And the more concentrated the hospital market, the greater negotiating power hospital systems are able to exert with insurers, thus increasing payments. An independent analysis found that “hospital prices are higher in more concentrated hospital markets, while lower in more concentrated insurer markets.”¹⁹ Private practitioners are at a disadvantage as they exert less bargaining power than large health systems. KFF found that “private insurance rates for physician services are substantially closer to Medicare levels than private insurance rates for hospital services, which suggests that physician groups generally have less negotiating leverage relative to private insurers than hospital groups.”²⁰

Another major contributing factor to the decline of private physician practices is the increase in regulatory burdens at the federal and state levels over the past decade. (Table 2) Each of the provisions below tends to incentivize the push toward hospital system integration and consolidation and to discourage independent physician practices.

¹⁶ American Medical Association history of Medicare conversion factors.

¹⁷ Federal Register/CMS/AHA.

¹⁸ KFF, “How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature,” April 15, 2020, <https://www.kff.org/medicare/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature>.

¹⁹ Li SE, Jones D, Rich E, Lansdale A. How do hospitals exert market power? Evidence from health systems and commercial health plan prices. *Health Aff Sch.* 2025 Jan 16;3(1):qxae179. doi: 10.1093/haschl/qxae179. PMID: 39822238; PMCID: PMC11736714.

²⁰ KFF, April 15, 2020, op cit.

Table 2
Major recent regulations contributing to the decline in private physician practices

Regulation	Purpose	Effect
Requirements Related to Surprise Billing; Parts I and II	A series of interim and final rules issued July and October 2021 and August 2022 to implement certain provisions of the No Surprises Act (NSA). ²¹	These rules improperly favor health insurers by a.) allowing the inclusion of “ghost rates” in QPA methodology; b.) not imposing penalties on health insurers that do not pay IDR losses in the required timeframe; and c.) not imposing penalties on health insurers that falsely claim that particular IDR claims are ineligible.
Stark Law	Prohibits physicians from referring Medicare or Medicaid patients to places of care in which they have a financial interest. ²²	These restrictions on physician referrals create compliance risks and financial burdens for physicians, which may deter them from maintaining an independent practice and may incentivize them to join a hospital system.
Affordable Care Act (Section 6001) – Prohibition of physician-owned hospitals (POHs)	Effectively prohibits the establishment of new POHs and restricts the expansion of current POHs by barring them from accepting Medicare/Medicaid referrals. ²³	Reduces ownership and entrepreneurial opportunities for physicians.
CMS Rules (42 CFR § 413.65) – Requirements for a facility to obtain provider-based status	Establishes when a clinic or facility can be treated as a part of a hospital rather than as an independent practice, allowing it to bill Medicare at higher hospital rates. ²⁴	Allowing hospital-affiliated outpatient clinics to bill Medicare at higher hospital rates than lower physician-office rates may pressure private practices to merge with/be acquired by hospitals to remain financially viable.
Certificate-of-Need (CON) laws	Require that healthcare providers get state approval before opening new facilities, expanding services, or conducting major equipment purchases. ²⁵	Restricts physicians’ ability to establish or expand their practices due to additional bureaucratic requirements.

²¹ <https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i>;
<https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii>;
<https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing>.

²² <https://www.cms.gov/medicare/regulations-guidance/physician-self-referral>.

²³ <https://freopp.org/oppblog/reconsidering-the-acas-ban-on-physician-owned-hospitals>.

²⁴ <https://www.law.cornell.edu/cfr/text/42/413.65>.

²⁵ <https://www.ncsl.org/health/certificate-of-need-state-laws>.

340B Drug Pricing Program	Mandates that there be significant discounts for outpatient drugs for eligible “covered entities”. ²⁶	Allowing eligible hospitals to buy drugs at large discounts while charging full/higher rates creates a profit margin advantage that independent practices cannot compete with, which may cause consolidation and reduce the financial viability of smaller private practices.
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These regulations limit reimbursement and create barriers for private practitioners to enter new markets, offer new services, or even acquire the most innovative equipment. Additionally, a functioning independent dispute resolution (IDR) process is critical for the survival of private medical practices. Policymakers and regulators should resist efforts by health insurers to manipulate and alter the IDR process. While dampening the ability of private practitioners to improve healthcare entrepreneurially, administrative burdens hit smaller medical practices from the cost side.

- In a meta-study of 114 tests that assessed the impact of CON laws, it was found that 46% of the tests associated the regulation with lower quality. States with CON laws had higher mortality rates for heart disease, diabetes, respiratory disease, influenza, and more.²⁷
- Due to complex billing processes, it is estimated that approximately one-quarter of U.S. healthcare spending is on administration functions, with doctors spending up to 20 hours per week on paperwork – as much time as providing actual care.²⁸ For example, insurer payment denials for opaque reasons now total about 12% of reimbursement requests, not counting those later approved after considerable administrative effort.
- The total regulatory and administrative burden disadvantages small practices more than larger organizations and is helping to drive private practitioners into the arms of larger health systems or out of practice altogether.

III. The negative health and economic impact of the decline in private physician practice

As physician practices have declined and hospital consolidation has continued, healthcare costs have also risen. Yet the quality of care has not improved, as numerous studies have shown:

²⁶ <https://www.340bhealth.org/members/340b-program/overview>.

²⁷ Mitchell MD. Certificate of Need Laws in Health Care: Past, Present, and Future. *Inquiry*. 2024 Jan-Dec;61:469580241251937. doi: 10.1177/00469580241251937. PMID: 38727175; PMCID: PMC11088301.

²⁸ M.Monger, “How doctors and practices can rein in administrative burden,” *Medical Economics*, August 2, 2023, <https://www.medicaleconomics.com/view/how-doctors-and-practices-can-rein-in-administrative-burden>.

- Beaulieu et al., using Medicare claims and Hospital Compare data from 2007 to 2016, found that hospital consolidation was associated with worse patient experiences and there were no changes in readmission or mortality rates.²⁹
- Ianni, Sinaiko, and Curto studied the quality-of-care outcomes in vertically integrated physician and hospital systems using data from the Massachusetts All-Payer Claims Database from 2013 to 2017, finding that these vertically integrated relationships were associated with increased healthcare prices but no improvements in patient outcomes.³⁰
- Setzler analyzed hospital mergers and found that they significantly reduce patient volume, increase healthcare costs, reduce employment, lower wages, and lower the quality of care, leading to higher patient mortality.³¹
- Using claims data from a large national insurer, Cooper et al. analyzed childbirth admissions, the most common procedure for those who are privately insured, and calculated that hospital and physician practice mergers led to price increases of 3.3% and 15.1% for hospitals and physicians respectively but did not lead to any increase in healthcare quality.³²
- Short and Ho also studied the effects of vertical integration and market concentration on hospital quality using 2008 to 2015 data from 4,438 hospitals in Medicare Hospital Compare. They found that increased market concentration is strongly associated with lower healthcare quality across all ten of their measured patient satisfaction measures.³³
- Lin, McCarthy, and Richards studied pricing after physician practices were acquired by hospitals using multiple samples of hospital system data from SK&A, a commercial research firm. The authors determined that after physician-hospital integration, hospital prices increased by 3% to 5% while the quality of care saw marginal improvement at best.³⁴

III.A. Rising healthcare costs in the U.S.

Health insurance premiums in the U.S. have been rising faster than inflation over the past decade. Since 2014, health insurance premiums have risen 82% compared to 36% inflation.³⁵ (Figure 4)

²⁹ <https://www.nejm.org/doi/full/10.1056/NEJMsa1901383>.

³⁰ <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2821687>.

³¹ https://www.nber.org/system/files/working_papers/w34180/w34180.pdf.

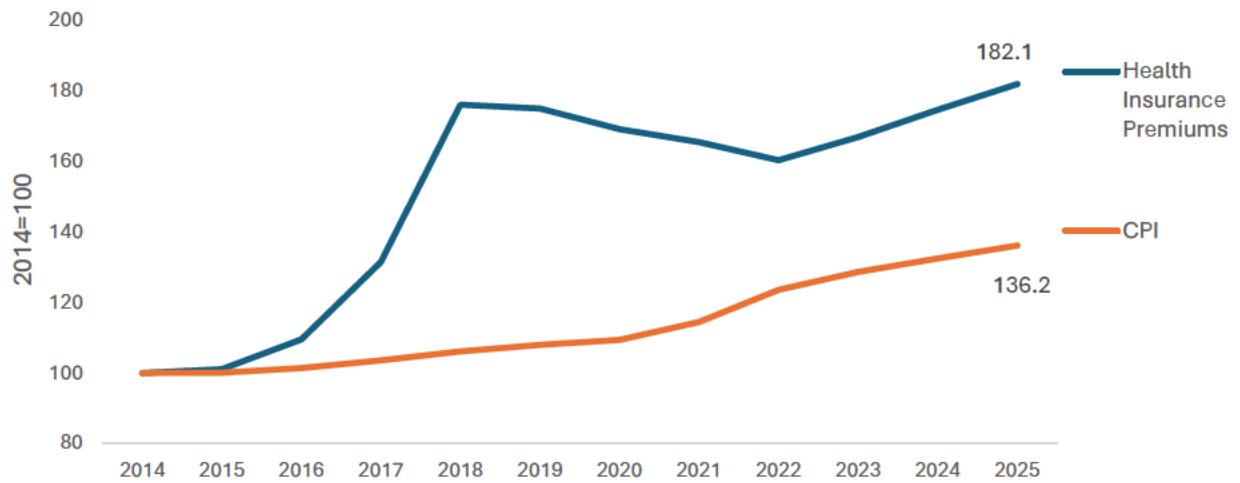
³² https://www.nber.org/system/files/working_papers/w34039/w34039.pdf.

³³ <https://pmc.ncbi.nlm.nih.gov/articles/PMC7536528>.

³⁴ <https://www.sciencedirect.com/science/article/abs/pii/S0167629621000291>.

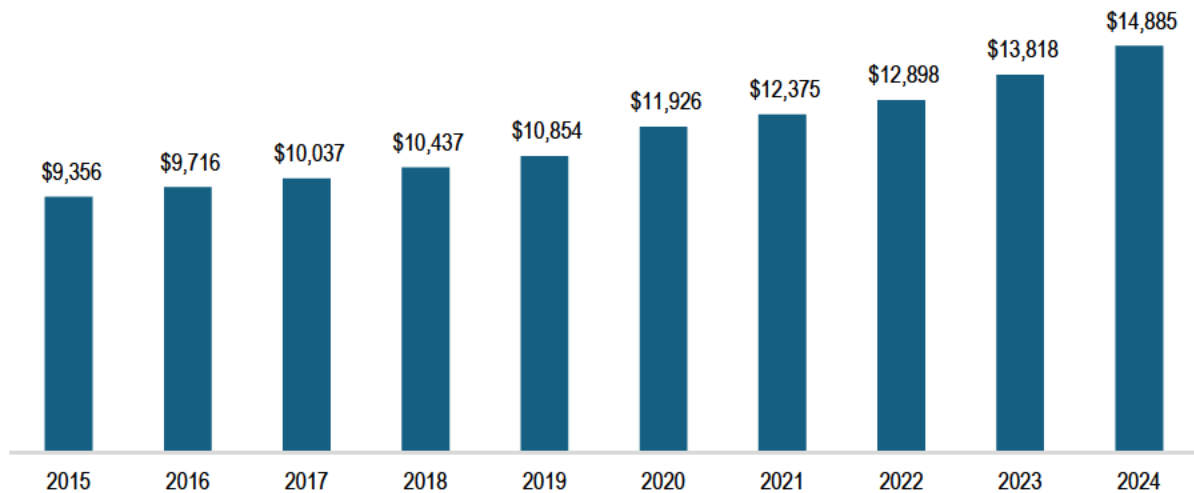
³⁵ Marketplace Average Monthly Benchmark Premiums, KFF. <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?activeTab=graph¤tTimeframe=1&startTimeframe=12&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> and Federal Reserve Bank of St Louis.

Figure 4.
The rising trend in health insurance premiums



Per capita healthcare spending in the U.S. keeps rising from \$9,356 in 2015 to \$14,885 in 2024, accounting for 20% of personal income.³⁶ (Figure 5)

Figure 5.
Healthcare spend per capita in the U.S. has been rising over the past decade

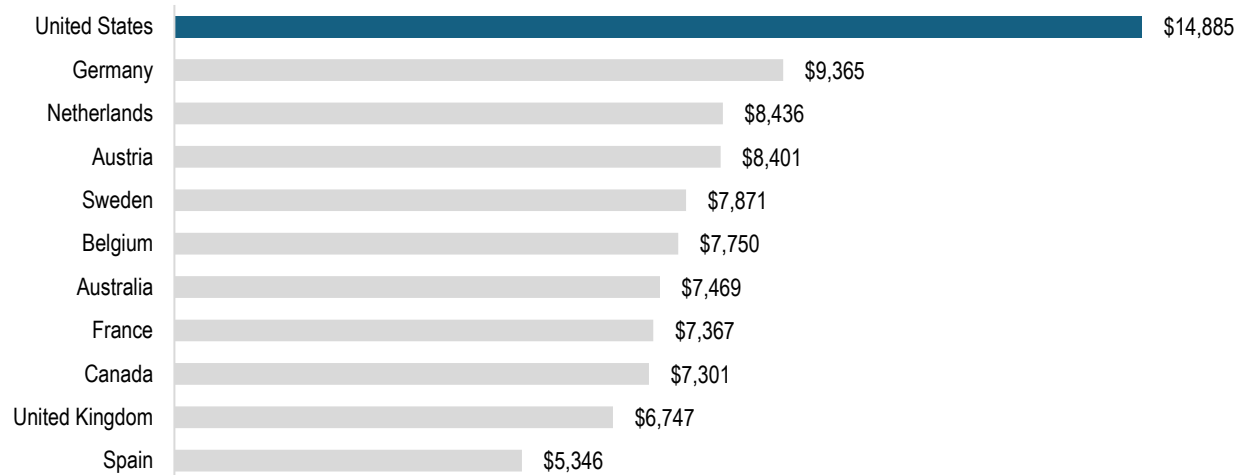


³⁶ OECD. [https://data-explorer.oecd.org/vis?utm_source=chatgpt.com&fs\[0\]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&pg=0&fc=Topic&bp=true&snb=4&vw=tb&df\[ds\]=dsDisseminateFinalDMZ&df\[id\]=DSD_SHA%40DF_SHA&df\[ag\]=OECD.ELS.HD&df\[vs\]=1.0&dg=USA.A.EXP_HEALTH.USD_PPP_PS_T..T..T...&pd=2015%2C2024&to\[TIME_PERIOD\]=false](https://data-explorer.oecd.org/vis?utm_source=chatgpt.com&fs[0]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&pg=0&fc=Topic&bp=true&snb=4&vw=tb&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_SHA%40DF_SHA&df[ag]=OECD.ELS.HD&df[vs]=1.0&dg=USA.A.EXP_HEALTH.USD_PPP_PS_T..T..T...&pd=2015%2C2024&to[TIME_PERIOD]=false)

U.S. healthcare expenditure per capita is the highest among OECD countries.³⁷ (Figure 6)

Figure 6.

Healthcare per capita in the U.S. is the highest among developed countries



III.B. Lagging health outcomes in the U.S.

Despite spending more on healthcare, U.S. health outcomes are not necessarily superior to those experienced by patients overseas. In fact, based on comparative data from the OECD, the U.S. has experienced something like a reversal of a steady improvement in health outcomes across several disease conditions in the years shortly after approximately 2009. Yet steady improvement in health outcomes in these same disease conditions in peer OECD countries continued or, in some cases, accelerated during this time, as the data show.

For example, while in 2004 the U.S. had one of the lowest rates of mortality due to acute myocardial infarction (AMI) compared to several peer OECD countries, by 2022-2023 other countries experienced more rapid improvement and several exceeded the U.S. rate of positive health outcomes. (Figure 7)

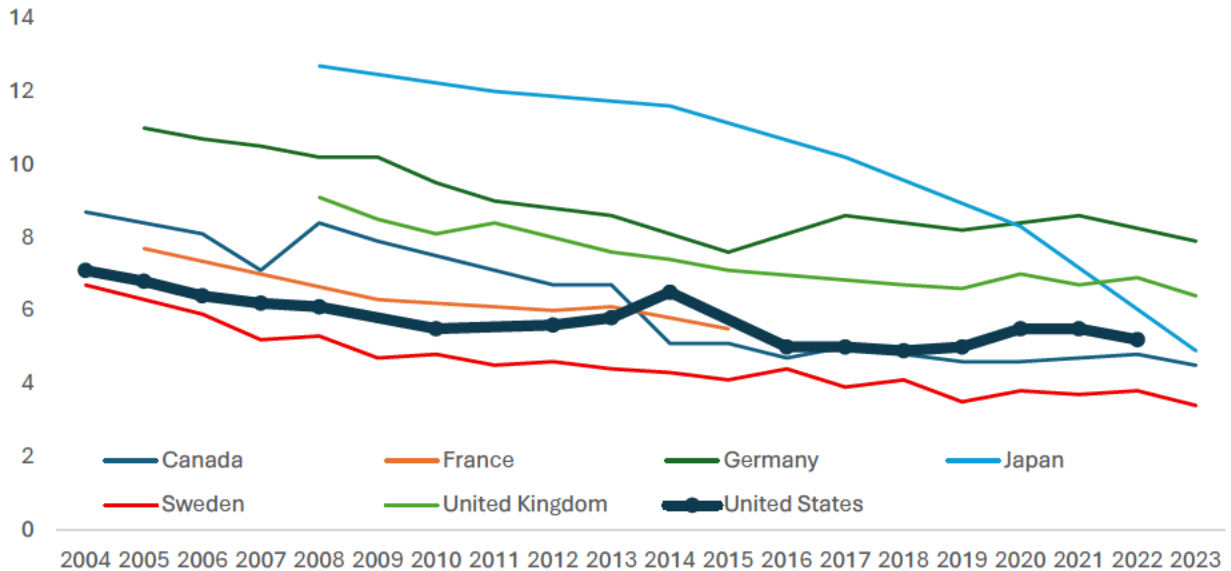
- From 2004-2022 (latest year available for U.S. data), U.S. patients benefited from an overall 27% decline in the 30-day mortality rate due to AMI, despite a spike in the mortality rate from 2010-2014.
- By comparison, Canadian patients benefited from a 48% decline in the AMI mortality rate and had a lower overall AMI mortality rate of 4.5% (2023), compared to the U.S. at 5.2%.
- Japan similarly experienced a much greater improvement than the U.S., with its AMI mortality rate declining 61%, to a rate of 4.9% in 2023.

³⁷ OECD. [https://data-explorer.oecd.org/vis?utm_source=chatgpt.com&fs\[0\]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&pg=0&fc=Topic&bp=true&snb=4&vw=tb&df\[ds\]=dsDisseminateFinalDMZ&df\[id\]=DSD_SHA%40DF_SHA&df\[ag\]=OECD.ELS.HD&df\[vs\]=1.0&dq=AUS%2BAUT%2BBEL%2BCAN%2BFRA%2BDEU%2BNLD%2BESP%2BSE%2BGBR%2BUS.A.EXP_HEALTH.USD_PPP_PS.T..T..T...&pd=2024%2C&to\[TIME_PERIOD\]=false](https://data-explorer.oecd.org/vis?utm_source=chatgpt.com&fs[0]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&pg=0&fc=Topic&bp=true&snb=4&vw=tb&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_SHA%40DF_SHA&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=AUS%2BAUT%2BBEL%2BCAN%2BFRA%2BDEU%2BNLD%2BESP%2BSE%2BGBR%2BUS.A.EXP_HEALTH.USD_PPP_PS.T..T..T...&pd=2024%2C&to[TIME_PERIOD]=false)

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- The gap between the U.S. and Sweden increased as well, as the AMI mortality rate dropped in Sweden from 6.7% in 2004 to 3.8% in 2022, compared to the respective U.S. figures of 7.1% and 5.2%.

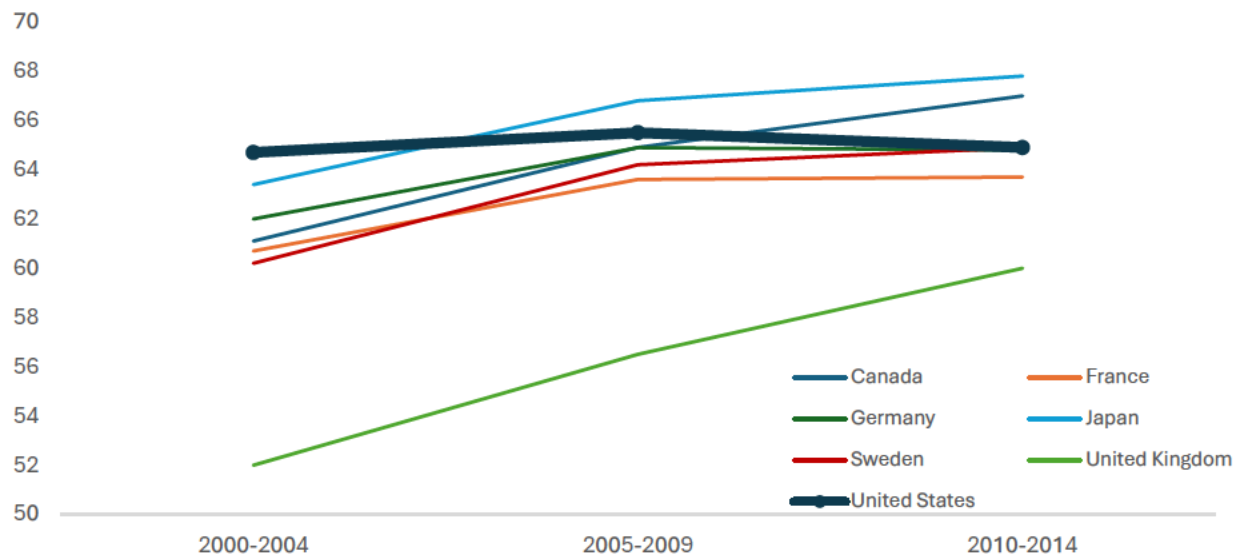
Figure 7.
Acute myocardial infarction 30-day mortality (during same hospital admission, unlinked data)



Further, in 2004, the U.S. had better outcomes in colon cancer treatment than other OECD countries. Yet here, too, peer nations have closed the gap since then, or have even surpassed the U.S. (Figure 9)

- In 2004, the U.S. had a leading 5-year colon cancer survival rate of 64.7%, improving to 65.5% in 2009, but then falling back to 64.9% by 2014.
- Peer OECD countries' improvements in colon cancer survival were of greater magnitude and notably did not see a reversal in this positive trend post-2009.
- Lagging in 2004, by 2014 (latest year available) Sweden (64.9%) and Germany (64.8%) matched and Canada (67%) and Japan (67.8%) exceeded the U.S. in colon cancer 5-year survival rates.

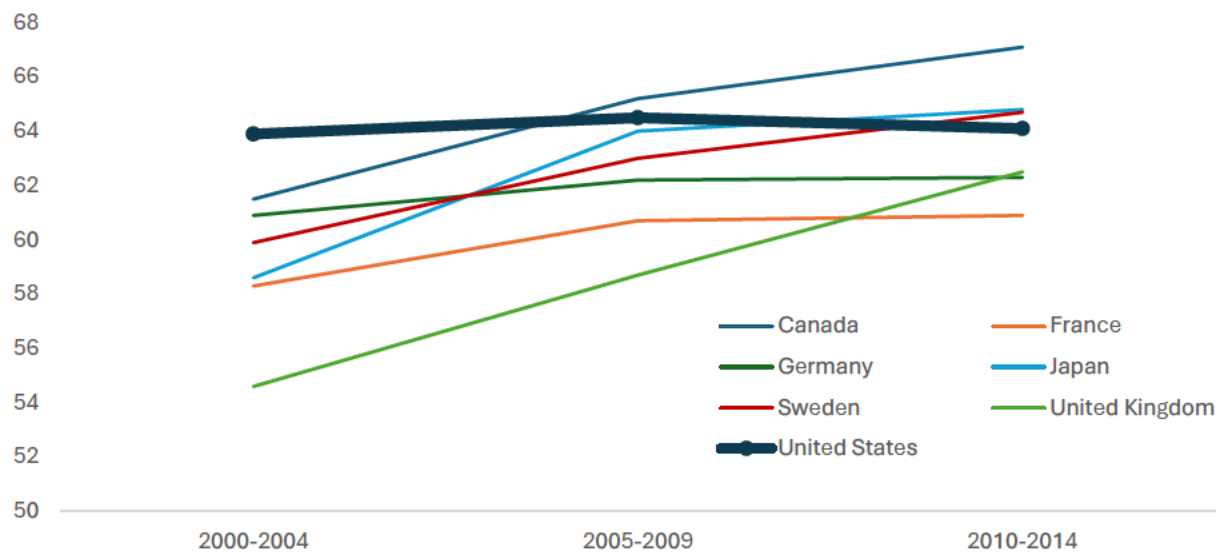
Figure 9.
Colon cancer 5-year survival rates (data cover 5-year periods)



In rectal cancer outcomes, the U.S. has seen little improvement over the period 2004-2014 (the latest year for which data are available), while other OECD countries have seen more rapid improvement, surpassing the U.S. in several regions. (Figure 10)

- Overall, the U.S. has seen little improvement in rectal cancer 5-year survival from 2004-2014, but post-2009 saw a negative inflection again. A best-among-peers survival rate of 63.9% in 2004 improved to 64.5% by 2009 but then reversed course to 64.1% in 2014.
- No peer OECD country experienced this negative inflection in 2009. All six peer OECD countries examined showed positive improvements over the period 2004-2014, and three of the six surpassed the U.S. by 2014.
- The 5-year rectal cancer survival rate in Canada (67.1%), Sweden (64.7%), and Japan (64.8%) exceeded that of the U.S. in 2014, whereas these countries had lagged the U.S. in 2004.

Figure 10.
Rectal cancer 5-year survival rates (data cover 5-year periods)



Reasons behind these health outcome divergences over time and between countries are multi-variate, but as the studies and data outlined in this section indicate, there is evidence that the quality of healthcare services in the U.S. has not necessarily improved through health system consolidation and acquisition of independent doctor practices (and despite the putative savings such consolidation was said to obtain).

IV. Policies to restore private physician practice

There are many ideas for policy changes that could strengthen private physician practices to increase competition and improve patient care in the U.S. For example:

1. **Adjust Medicare reimbursement rates to doctors:** Doctors are the only providers in Medicare without an annual inflation-adjustment for reimbursements.³⁸ Medicare reimbursement for other services, such as hospitals, has outpaced inflation since 2001. Indexing payments to doctors could be a cost-effective way to make independent practices more financially viable and increase the quality of patient care, since physician-owned practices tend to have lower per-patient costs, fewer preventable hospital admissions and fewer readmissions than hospital employee doctors.
2. **Reward quality through reimbursement/payment parity:** Payment differentials between hospital-owned doctors' offices and independent doctors do not adequately account for the improvements in patient care that independent doctors have been demonstrated to obtain. In keeping with the concept of rewarding quality, primary care rates for independent doctors could be set to parity with those paid

³⁸ Berggreen, Paul. "Independent doctors like me are becoming an endangered species," *STAT*, February 15, 2024, <https://www.statnews.com/2024/02/15/independent-doctors-physician-owned-practices-congress-reimbursement>.

to doctors in larger health systems.³⁹ Site-neutral payment policies like this could help maintain independent practices and achieve the attendant patient benefits of better, continuous care.

3. **Improve the No Surprises Act's IDR process:** After a turbulent regulatory period, the No Surprises Act's IDR process is now working relatively well and as intended. However, the process can be strengthened. First, real penalties are needed for health insurers that a.) fail to pay IDR determinations within the 30-day time period per the statute; b.) falsely claim that cases initiated in the IDR process are ineligible. Second, "cooling off" periods should be reduced. This would eliminate process confusion and reduce administrative burden. Third, revising batching rules to permit easier batching of related claims would lower the cost of IDR participation—this is advantageous to both private practices and health insurers. Finally, policymakers should advance efforts to incorporate a focused private right to action for private physician practices to collect in court payments owed to them that health insurers have failed to pay.
4. **Allow new or expanded physician-owned hospitals:** The Affordable Care Act (ACA) banned new or expanded physician-owned hospitals in 2010 (included to reduce incumbent hospital systems' opposition to the bill, e.g. Federation of American Hospitals), removing a powerful incentive for innovation in healthcare delivery. As discussed extensively by American Enterprise Institute policy experts,⁴⁰ physicians are the most medically expert of all entities in the healthcare delivery chain, work most closely with patients on treatment regimens, and are best positioned to identify opportunities to innovate and improve patient care. Physician-owners can act as entrepreneurs and are most incentivized to do so, whereas hospital-employed doctors may have to go through hospital administrators to implement improvements or obtain management or investment decisions. Ownership also provides strong incentives to attract and retain doctors in practice, which might help mitigate the ongoing doctor shortage. Repealing this section (S.6001) of the ACA could introduce entrepreneurship and competition into markets with consolidated health system power, helping reduce costs and improve the quality of care.
5. **Repeal barrier-to-entry CON laws that protect incumbent health systems and lower the quality of care:** Regulations requiring providers that wish to offer new or expanded healthcare services must prove to regulators that the offerings are needed. In addition to demonstrating lower-quality care, studies have found that this protects incumbent health systems from competition. In fact, incumbent providers are sometimes allowed to oppose would-be provider applications through the CON review process.⁴¹ Some states disallow this practice, and that policy should extend to other states as well, short of repeal.
6. **Reform Stark law to level the playing field between independent doctors and larger health systems and align incentives to bring more value to care:** Stark law prohibits doctors from referring patients to healthcare entities with which the doctor has a financial relationship – ignoring

³⁹ F. Mostashari, The Paradox of Size: How Small, Independent Practices Can Thrive in Value-Based Care, *The Annals of Family Medicine*, January 2016, 14(1)5-7; DOI: <https://doi.org/10.1370/afm.1899>.

⁴⁰ M. Mandelberg et al., American Enterprise Institute, "Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation," *New York Univ. Journal of Legislation & Public Policy*, July 8, 2024, <https://www.aei.org/research-products/report/reconsidering-the-ban-on-physician-owned-hospitals-to-combat-consolidation>.

⁴¹ Mitchell MD. Certificate of Need Laws in Health Care: Past, Present, and Future. *Inquiry*. 2024 Jan-Dec;61:469580241251937. doi: 10.1177/00469580241251937. PMID: 38727175; PMCID: PMC11088301.

the financial interests that large hospital systems might also have. This makes it more difficult for independent, physician-owned practices to provide integrated, “one-stop shopping” for patients.⁴² The playing field should be levelled between independent physicians and larger institutions.

7. **Reform 340B program, which drives prescribing toward hospitals and away from independent doctors:** Intended to help safety-net providers care for uninsured and underinsured patients by giving them steep discounts on prescription drugs to offset other uncompensated care, hospitals have abused the program to turn it into a cash cow. Hospitals keep the spread between the rebated price they pay for 340B medicines, and the higher undiscounted list price they are reimbursed from Medicare. This incentivizes drug administration away from doctors’ offices to the more expensive hospital outpatient setting, driving up healthcare costs and lowering the quality of care.⁴³ 340B rules should be changed to ensure hospitals use the program to serve only the truly needy, and Medicare should reimburse hospitals only for the actual acquisition cost (after rebates) of the medicines they provide under the program.
8. **Promote competition by investigating large health systems acting as credentialing gatekeepers:** The FTC should investigate larger health systems using their leverage from greater market power to block competition from independent providers. According to some observers,⁴⁴ health systems may be using hospital privileges to prevent independent practices from being able to admit patients to the hospital owned by the system, perform procedures, or access labs or other resources. “Some hospitals use closed-staff models, limiting privileges to their own employees or affiliated physicians, further narrowing options for independent doctors and the patients they serve.”⁴⁵ This tactic “keep[s] referrals and revenue in-house,” and might be the basis for an anti-competition investigation. At the very least, this sort of “economic credentialing,”⁴⁶ based not on patient safety but on the economic interests of large hospital systems, could be addressed through legislative reforms.
9. **Investigate insurers’ network policies:** Starting January 1, 2026, Anthem (Elevance Health) has implemented a policy⁴⁷ that punishes hospitals and outpatient facilities for using out-of-network physicians. In 11 states from coast to coast, this policy intends to cut payments to these facilities by 10% and potentially terminate them from Anthem’s networks. Anthem also recently announced that it intends to expand this policy to a 12th state, California, starting June 1, 2026. Other health insurers have started to adopt similar policies that would force facilities to expel all non-participating physicians. This administrative weapon is a clear effort to undermine the No Surprises Act, an abdication of Anthem’s network adequacy obligations, and a threat to patients’ continuity of care. Congress and federal regulators should initiate investigations into insurers that penalize or reward

⁴² Miller BJ, Ehrenfeld JM, Wu AW. Competition or Conflict of Interest—Stark Choices. *JAMA Health Forum*.2021;2(2):e210150. doi:10.1001/jamahealthforum.2021.0150.

⁴³ DiGiorgio AM, Winegarden W. Reforming 340B to Serve the Interests of Patients, Not Institutions. *JAMA Health Forum*. 2024;5(7):e241356. doi:10.1001/jamahealthforum.2024.1356.

⁴⁴ E.g. Mostashari, *op cit*.

⁴⁵ “Hospital privileges or barriers? How health systems quietly control access from credentials to real estate,” *ICRE Newsletter*, August 8, 2025, <https://investingincre.com/2025/08/08/hospital-privileges-or-barriers-how-health-systems-quietly-control-access-from-credentials-to-real-estate>.

⁴⁶ *ICRE, op cit*.

⁴⁷ “Facility Administrative Policy: Use of a Nonparticipating Care Provider,” https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy_FINAL.pdf.

hospitals and ambulatory surgery centers (ASCs) based on the network status of the physicians who have privileges at these facilities.

- 10. Ease administrative burden:** To help alleviate the administrative burden, process automation may help, but also greater transparency into payer pricing and reimbursement denials could help independent practices properly price their services and avoid denials upfront rather than after the fact with additional paperwork.⁴⁸

Table 3 below includes recent legislative proposals offered to address the policy options outlined above to strengthen independent physician practices.

Table 3.
Proposed legislation to restore private physician practices in the United States

Proposed Legislation	Purpose of Legislation	Impact on Private Physician Practice
No Surprises Enforcement Act	Would close enforcement gaps through increased penalties for health insurers' non-compliance of statutory payment deadlines and increase transparency in reporting requirements.	Would provide parity for penalties in the law and strengthen private physicians' ability to receive timely payment for claims awarded to them by neutral arbitrators in the IDR process.
Patient Access to Higher Quality Healthcare Act of 2025 ⁴⁹	Would fully repeal the federal ban/limits on physician-owned hospitals (POHs) that was enacted by the Affordable Care Act.	Would restore ownership paths for private physicians, increase negotiation leverage versus hospitals and insurers, and improve financial margins for private physician groups.
Same Care, Lower Cost Act ⁵⁰	Would apply site-neutral Medicare payments for a large number of outpatient services and close a major loophole in the current site-neutral law.	Would shrink the payment gap between hospital-employed and independent physicians and would reduce incentives for hospitals to buy private practices, cutting the extra advantage hospital systems receive under current law.

⁴⁸ M. Monger, "How doctors and practices can rein in administrative burden," *Medical Economics*, August 2, 2023, <https://www.medicaleconomics.com/view/how-doctors-and-practices-can-rein-in-administrative-burden>.

⁴⁹ <https://vandyne.house.gov/2025/6/van-duyne-leads-bipartisan-legislation-to-expand-patient-access-to-high-quality-health-care>.

⁵⁰ <https://www.kennedy.senate.gov/public/press-releases?id=9372387F-4662-4519-B244-DBDD87534CF7#:~:text=My%20Same%20Care%2C%20Lower%20Cost,the%202015%20Bipartisan%20Budget%20Act>.

Strengthening Medicare for Patients and Providers Act ⁵¹	Would amend Medicare so that the PFS conversion factor receives an annual inflation update tied to the Medicare Economic Index (MEI).	Would halt the steady inflation-adjusted erosion of physician fees, making it more feasible for independent practices to remain financially viable and competitive.
Addressing Anti-Competitive Healthcare Contract Clauses Act ⁵²	Would require a GAO study and review of anti-competitive clauses in healthcare contracts.	Would create a path for limits on anti-competitive insurer-hospital contract clauses which would make it easier for independent physician practices to get fair network access, bring in new patients, and compete on a more level playing field with large hospitals.

Additionally, at least 34 laws related to health system consolidation and competition were enacted across 22 states in 2024, aiming to strengthen oversight of health system mergers and acquisitions, reform health system contracting, modify certificate-of-need (CON) review, and more.⁵³

V. Conclusion

Specific federal laws and regulations have severely reduced the private practice of medicine in the United States. In turn, patients have lost the benefits of having access to private practices in their communities. These government actions have fueled healthcare consolidation, which has resulted in higher prices and lower quality care. The 10 policy reforms provided in this report should be undertaken to restore private physician practices. If enacted, they would foster competition in the healthcare system, reduce healthcare costs, and, most importantly, improve patients' quality of care.

⁵¹ <https://www.congress.gov/bill/118th-congress/house-bill/2474>.

⁵² <https://www.congress.gov/bill/119th-congress/house-bill/3020/text>.

⁵³ <https://www.ncsl.org/health/2024-legislative-recap-health-care-consolidation-and-competition>.

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