NISKANEN CENTER

HEALTHCARE ABUNDANCE: AN AGENDA TO STRENGTHEN HEALTHCARE SUPPLY

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Introduction: What is healthcare abundance?

The American health system is in crisis – a crisis of both affordability and outcomes. Among OECD countries, the U.S. spends the most on healthcare but has the highest rate of treatable deaths. At the heart of this crisis is a fundamental imbalance between the ever-rising demand for patient care and our ability to supply it. As it stands, our health system is designed around scarcity, where access to care is limited by constraints on the supply of doctors, facilities, and vital innovations. To chart a way forward, we must embrace a vision of healthcare abundance — a world in which providers are plentiful, less inhibited by onerous regulations, and more responsive to patients' needs.

This is a framework that challenges conventions on both the left and the right. One set of reformers has traditionally focused on the demand side of healthcare by subsidizing insurance, and paired that work with efforts to control costs. But the aggregate effect is to boost demand for care without increasing the number of providers or their capacity to provide care, a condition my colleagues have labeled "cost disease socialism."[1] Another school of thought has tended to focus on market mechanisms, such as requiring price transparency for negotiated rates and encouraging shopping. What this approach overlooks is that healthcare is unlikely to ever operate like other markets, largely because the primary buyers of health services (government and private insurance companies) are not the consumers of those services. Moreover, better price intermediation will not have the intended effect if true market power is driven by policies that constrain entry or encourage consolidation.

The alternative we offer is driven by the imperative to increase the overall amount of healthcare on offer. As such, many of our recommendations emphasize the supply side, which deals with where and how health providers (both individual physicians and facilities like clinics and hospitals) begin servicing communities. But of course, market entry is also driven by demand, which is driven by payers — patients, insurers, and government — so this framework also recommends changes to how providers are compensated for the services they offer.

This agenda will diagnose our problems in trends that date back to the 1960s. Since that decade, the United States has been artificially restricting the supply of doctors and health care facilities. Meanwhile, various attempts at reform have created perverse incentives for providers to integrate, limiting competition in the provider market while increasing the market leverage of incumbent providers. The result is an expensive, inefficient, and concentrated provider market that fails to meet patient needs.

1. Steven Teles, et al. *Cost Disease and Socialism: How Subsidizing Costs While Restricting Supply Drives America's Fiscal Imbalance*, (Niskanen Center, September 9, 2021).

To visualize the power of this framework, consider that the U.S. stands as an outlier both in spending and in "treatable mortality" – deaths from conditions patients should survive if they were identified and treated in time. Such early detection and intervention is the special province of primary care physicians, who can flag chronic and life-threatening conditions in patients they see routinely. Unsurprisingly, the U.S. is significantly below the OECD average on both the number of primary care physicians per capita and the number of primary care visits, and these numbers are declining year over year as demand for care grows.[2]

But correcting healthcare market dynamics requires a principled, but not idealistic policy response. We can chart a new path where robust health insurance programs are paired with abundant low-cost care care options. An abundance approach to health policy can bridge ideological gaps by working to remove barriers to the supply of care while also addressing underlying incentive structures that prevent robust competition.

Healthcare abundance requires breaking through the "iron triangle"

The healthcare system's issues are not always separable. Often, reforms targeting one problem have unintended consequences for others. Healthcare economists sometimes refer to what they call the "iron triangle" of access, cost, and quality. Research reveals many examples in which a decision that improves one or potentially two of these will come at the expense of the third.[3] For example, increasing insurance coverage will increase access and may raise at least the perception of quality, but by raising costs.

Strictly speaking, however, such tradeoffs are iron only for a system that is already optimized or at least close to optimized. If the system is underperforming on all dimensions, it is possible to make improvements along one dimension of the triangle without harm to others. For example, suppose that misaligned incentives cause providers to choose a treatment for some condition that brings them higher revenue, but at the expense of less favorable outcomes for patients. Correcting the misaligned incentive would limit the iron triangle tradeoffs by simultaneously reducing costs and improving quality without any detriment to access.

Such flaws are all too common in the U.S. healthcare system. Some experts argue the U.S. system performs well on aspects of the care process, including prevention, safety, coordination, patient engagement, and sensitivity to patient preferences. However, a recent comparative report from the Commonwealth Foundation found that the U.S. system has by far the highest costs among the health systems of 10 high-income countries while coming in dead last in health outcomes and access to care.[4] By many metrics, America is widely missing the mark on all three elements of the iron triangle.

Our substandard performance provides numerous opportunities to break through what might other-

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2. For example, one approach to rebuilding the demand side of the healthcare system would be universal catastrophic coverage (UCC). UCC is a form of universal health insurance that would cover medical expenses in full for people below a low-income threshold and ask those who can afford it to pay their fair share through income-based deductibles and coinsurance. The cost-sharing features of UCC would provide ample scope for the use of market-based incentives to improve quality, transparency, and competition, while helping make the private health insurance market stable at affordable premiums.

3. Brad Beauvais and Clemens Scott Kruse et al., "Testing Kissick's Iron Triangle—Structural Equation Modeling Analysis of a Practical Theory," *International Journal of Environmental Research and Public Health* 18, no. 11 (2021): 5708.

4. "Mirror, Mirror 2024: Reflecting Poorly on U.S. Healthcare," The Commonwealth Fund, September 2024.

wise be iron triangle constraints. As a practical example, the limited supply of primary care doctors and dwindling of independent primary care clinics often force patients to choose between expensive hospital emergency room visits or impromptu urgent care stops to treat conditions that would be better attended to by a primary care physician who has a relationship with the patient and knows their history. The obvious remedy would be to remove constraints on the supply of primary care doctors and expand the selection of lower-cost providers outside of the hospital system. Doing so would not only improve access and lower costs by providing patients with more options, but would also improve quality by encouraging the right care for patients, depending on their needs. High-cost emergency rooms would be reserved for severe cases and less-costly urgent care centers for less critical emergencies. Physicians' offices would be used in a cost effective manner for routine and preventive care. Finding a better fit between various options on the supply side and individual patient needs on the demand side would be a win-win-win. Subsequent sections of this healthcare agenda will examine numerous other opportunities to limit iron triangle tradeoffs with appropriate supply-side reforms.

Healthcare abundance requires removing barriers to supply

The constraints on healthcare supply operate at both the state and federal levels. Many states maintain certificate of need (CON) laws which require new providers to request permission from the state — and, effectively, from their competitors — to open a new clinic. CON laws have made it difficult for smaller clinics and facilities to open due to challenges from incumbent health systems, leaving patients with fewer options.[5] States also at times restrict providers from offering services that they are fully trained to deliver. Qualified immigrant doctors are forced to re-do their residency training because the vast majority of states do not offer alternative pathways to licensure.[6] Licensing laws and requirements differ state to state, so providers licensed in one state are not able to provide services in another, a rigidity most felt by home-bound patients or those in rural areas who are denied telehealth access to out-of-state providers.[7]

At the federal level, policymakers have been limiting the supply of primary care doctors by restricting pathways to general practice and capping Medicare-funded residency slots. As a result, medical professionals have a strong incentive to pursue speciality training instead of primary care. Provisions included in the Affordable Care Act (ACA) have also restricted innovation in care delivery by preventing physicians from owning and operating hospitals, further limiting the options available to patients outside of the large hospital systems.

These barriers all contribute to rising health costs through the simple laws of supply and demand. A healthcare abundance agenda will expand the number and types of providers and free them up to deliver services for which they are trained. However, lowering prices also requires healthy competition among those providers, and current payment policies have tilted in the opposite direction.

5. Matthew Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws Across America," (Mercatus Center, January 2021).

6. Kristina Fiore, "More States Cut Training Requirements for Some International Medical Graduates," MedPage Today, March 14, 2024.

7. Robert Orr, "U.S. Healthcare Licensing: Pervasive, Expensive, and Restrictive," Niskanen Center, May 12, 2020.

Healthcare abundance requires robust competition and better incentives

In most industries, prices of products and services are ultimately a result of competitive negotiations between the consumer and seller. In healthcare, a third party steps in to negotiate those prices. As a result, the market on the demand side functions very differently than in other industries. The consequences of patients being separated from the negotiation are clearly seen in both the opacity of price information and the steady rise in prices for services. Out of view of patients, consolidating providers have increased their market power, and perverse incentives in government systems and the insurance framework lead to persistent overbilling.

Patients rely on robust competition in the healthcare marketplace to determine fair prices between providers and insurance companies. But as providers have consolidated more in recent years, they have gained more leverage in negotiations with insurance companies and have negotiated higher reimbursement rates.[8] These higher rates get funneled into higher out-of-pocket costs and higher premiums for patients. Providers have integrated not just horizontally by combining hospitals and physicians offices, but also vertically by acquiring insurance companies and pharmacy benefit managers (PBMs). This kind of consolidation further warps the incentives providers have to offer value to patients. Antitrust advocates hope to break up some of these mergers and restore some competition to the marketplace, but these actions do not address the root cause. Perverse payment incentives have enabled and encouraged provider consolidation, and little has been done to remove those underlying financial incentives.

An abundance approach to health policy can bridge ideological gaps by working to remove barriers to the supply of care while also addressing underlying incentive structures that prevent robust competition.

As a result, hospitals charge Medicare, commercial insurers, and patients more for routine services that can also be delivered at the same level of quality in a physician's office. Site-based payment policy in Medicare rewards hospitals that consolidated their services and acquired free-standing physicians offices, allowing them to charge more than double for services performed at those offices.[9] Hospitals routinely charge facility fees to patients even in off-campus outpatient departments not connected to the hospitals. Reducing constraints on care models outside of a hospital system will give patients more options and lower the financial burden on taxpayers.

Meanwhile, Medicare's fee-for-service payment system, which is also used in commercial insurance, rewards providers based on the volume, rather than the value of services. As prices rise on a service-by-service basis, this system contributes to unnecessarily inflated healthcare costs. Patients are at times overbilled and overtreated because providers are able to charge higher rates for particular services.[10] In Medicaid, due to 50 percent minimum federal matching rates across all states, wealthy states benefit at the expense of poorer states who have less fiscal capacity to administer their programs. States also game

8. Karyn Schwartz and Eric Lopez, et al., "What We Know About Provider Consolidation," KFF, September 2, 2020.

9. Site-based payment in Medicare is no longer offered for newly acquired physicians offices, but persists for previously acquired physicians offices and all on-campus hospital outpatient departments.

10. Rae Ellen Bichell, "A Hospital Charged More Than $700 for Each Push of Medicine Through Her IV," NPR, June 28, 2021.

the system to receive higher payouts.[11] Finally, the 60 percent of hospitals that operate as tax-exempt nonprofits see tens of billions in tax breaks from the federal government without providing commensurate levels of charity care.[12]

Diagnosis: What went wrong with healthcare supply in America

This section outlines the history of supply restrictions for hospitals and physicians as well as the current policies that give providers incentives to consolidate their services, particularly in higher-cost hospital settings, and that subsidize high prices.

The United States spends the most and has the worst outcomes

Health experts generally agree that we can measure the performance of a country's healthcare system by balancing patient access and outcomes with the cost that the system assesses for that care. Because the purpose of the healthcare system is to save lives and prevent unnecessary suffering from treatable conditions, comparing countries by combining measures of cost and outcomes can illuminate where the U.S. stands in comparison with similarly wealthy nations.

Reducing constraints on care models outside of a hospital system will give patients more options and lower the financial burden on taxpayers.

But how expenditures relate to outcomes is not straightforward. Each country has populations with unique health needs, and spending on care represents different types of interventions, care delivery models, and uses of technology.[13] In particular, a country whose population has a higher underlying prevalence of disease cannot readily be compared with a country where the population is healthier if our goal is to focus on the performance of the healthcare system *once people are sick*. To mitigate this problem, Figure 1 focuses on what the OECD calls "treatable deaths" — that is, deaths from conditions that would not be fatal if properly detected and treated. This measure, unlike life expectancy, does not include suicide deaths or traffic fatalities, which occur at higher rates in the U.S. than in other wealthy countries.[14] Nor does it include conditions such as, for example, lung cancer. The intuition is that if a fatal disease is generally preventable, a health system with higher incidence of that disease should not be "penalized" in this performance measure. Treatable causes of mortality do include some cancers, diabetes and other endocrine diseases, circulatory system diseases, and other conditions.

11. Brian Blase and Drew Gonshorowski, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States," (Paragon Institute, July 2024).

12. "Federal Tax Benefits for Nonprofit Hospitals," Committee for a Responsible Federal Budget (CRFB), June 12, 2024.

13. Munira Gunja, et al., "U.S. Healthcare from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes," (Commonwealth Fund, January 31, 2023).

14. "Estimated Road Traffic Death Rate," World Health Organization, accessed October 4, 2024.
"New International Report on Healthcare: U.S. Suicide Rate Highest Among Wealthy Nations," Commonwealth Fund, January 30, 2020.

Figure 1. The U.S. spends the most on healthcare and has the highest rate of treatable deaths among highest spending countries[15]

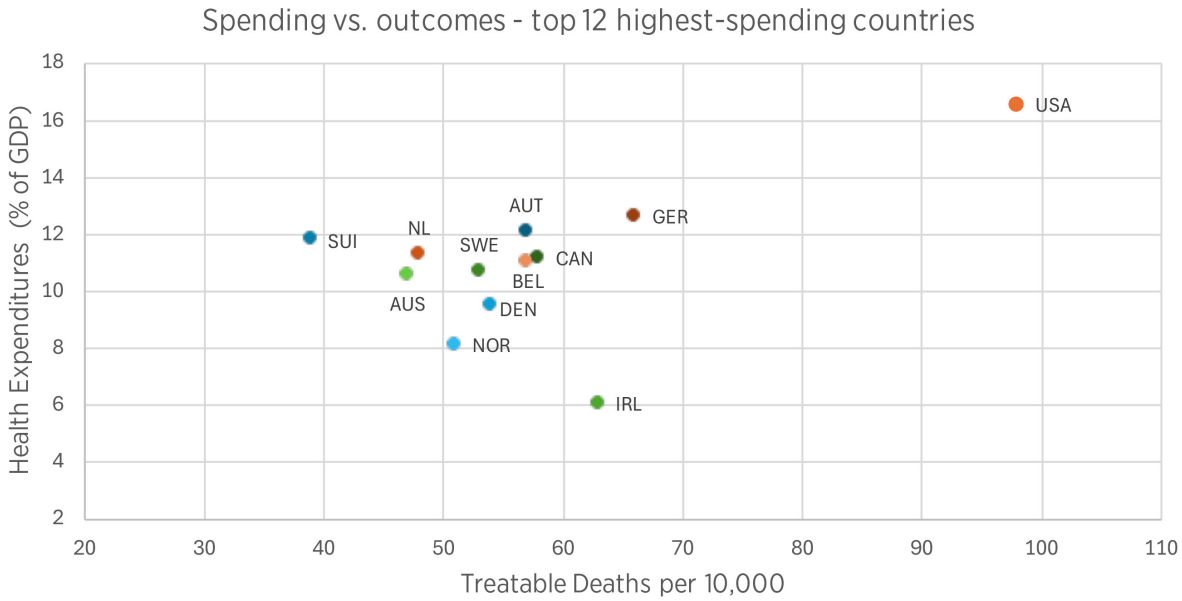


Figure 1 clearly shows that among high-spending countries, the U.S. is a remarkable outlier in terms of outcomes *and* spending. Among the top 12 highest-spending countries, healthcare makes up the largest portion of GDP in the United States, while the U.S. lags behind those same countries in deaths from treatable conditions.

The U.S. may spend a reasonable amount on healthcare considering its above-average population needs. However, the outcomes indicate that funding is not going towards the types of interventions or delivery models that work for patients. Patients report experiences with the health system that confirm the concerning statistics. A recent poll found that only 6 percent of Americans felt the health system offered them high value.[16] Addressing the issues plaguing health supply will require a focus on both improving value and incentivizing quality care delivery. This starts with identifying the causes of our high and ineffective health spending.

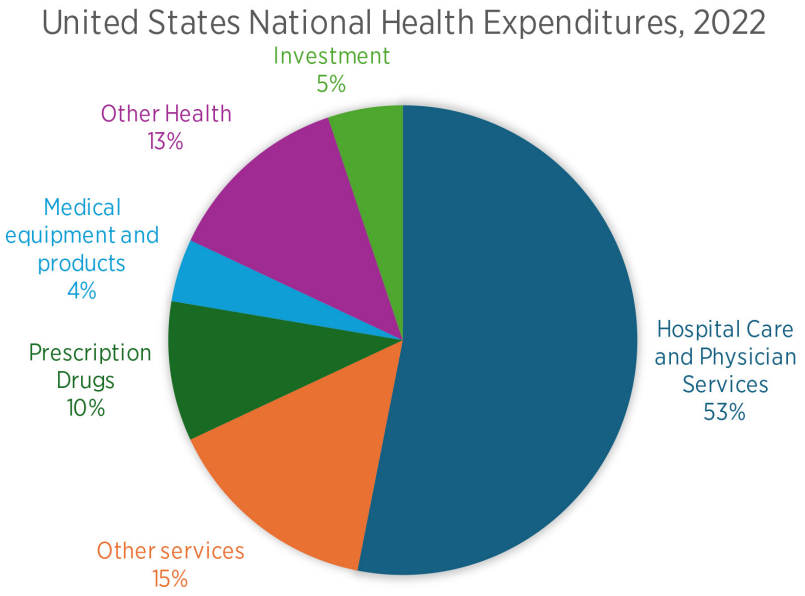
Negotiated service prices are driving ineffective health spending

To identify the key drivers of ineffective health spending, we must look no further than the prices providers charge for their services. To see why provider charges are so important, consider the breakdown of health spending in Figure 2.

15. Highest spending countries are determined by health expenditures per capita with a minimum population of 1 million (excludes Monaco, Luxembourg, and Iceland), data from World Health Organization Global Health Expenditure database. Health expenditures as percentage of GDP data from 2022, or 2021 if 2022 data was not available. Treatable deaths data from 2021 or nearest year, based on the WHO Mortality Database.

16. "West Health-Gallup Healthcare Affordability and Value Indexes 2021-2024," WestHealth-Gallup, 2024.

Figure 2. Hospital care and physician services make up the majority of healthcare spending[17]



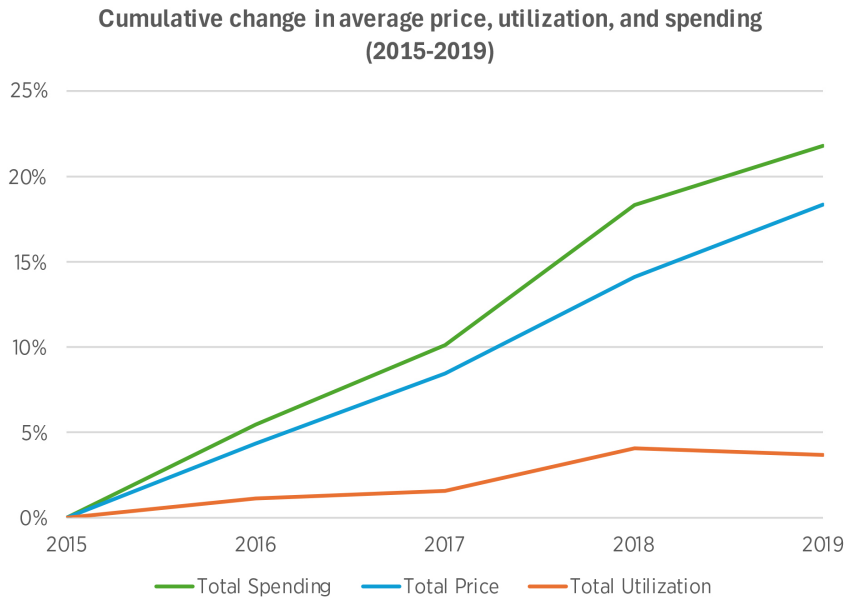
Prescription drugs consume an enormous amount of political energy because patients often pay for them out of pocket, making the expense visible to those who can afford it and putting medication out of reach for those who cannot. But they account for only 10 percent of the total $4.5 trillion in health spending in the United States. Spending on hospitals and physician offices accounts for over half, and this has been the case since at least 1960.[18]

Which payers are covering healthcare costs and what is driving the growth? Spending on health services is done primarily in three ways: out-of-pocket costs (11% of total spending), private health insurance (29%), and government programs like Medicare, Medicaid, CHIP, Veterans Affairs, etc. (43%). The remainder of government spending goes toward other third party programs, state and local programs, and public health and investment (17%). As with prescription drugs, patients are ultimately the only payer, though: They cover health insurance premiums in the private market and pay taxes to cover government insurance programs and any other health spending. Figure 3 illustrates that in the crucial arena of hospitals and physicians' services it is rising prices, not utilization, that are responsible for driving up health spending in recent years. Accounting for inflation, prices (stated in 2019 dollars) have increased at much higher rates than utilization in recent years, aligning closer to the cumulative rise in total spending on healthcare services. About two-thirds of the spending growth between 2015 and 2019 came from higher prices, which rose by 18 percent. Increased service utilization, which include visits and prescriptions per person, grew by only 3.6 percent. The gap was even more pronounced for inpatient care, which had a 30 percent cumulative rise in prices and a -12.5 percent decrease in utilization. Prices for care are rising faster than demand for care, an inefficiency that underlines an urgent need to specifically address prices as a driver of spending.

17. Other Services Includes: Other Professional Services, Dental Services, Home Healthcare, Nursing Care Facilities and Continuing Care Retirement Communities. Other Health Includes: Government Administration, Net Cost of Health Insurance and Government Public Health Activities. Source: Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary

18. Since 1960, hospital care and physician services have consistently accounted for between 52 and 60 percent of health expenditures. Hospital care and physician services incorporate all services provided by hospitals and physician offices, including office visits, imaging, and inpatient hospital stays. In 2022, hospital spending was 32 percent of total health spending; physician offices accounted for 21 percent. While hospital care and physician spending represent different spending categories based on different reimbursement rates, combining them provides a helpful perspective on where dollars are being spent in the system. Source: "National Health Expenditures 2022 Highlights," Center for Medicare and Medicaid Services Office of the Actuary, December 13, 2023.

Figure 3. Average prices increase at higher rates than utilization, alongside total spending[19]



International evidence also suggests negotiated service prices are driving spending. The U.S. offers relatively fewer healthcare resources to patients while maintaining relatively higher prices. The United States sits below the OECD average in several metrics related to healthcare supply: As of 2015, the U.S. had 19 percent fewer practicing physicians than the OECD median, 20 percent fewer practicing nurses, 26 percent fewer inpatient hospital beds, and the lowest percentage of generalist physicians in the OECD.[20] Meanwhile, as of 2017, price levels for health goods and services in the United States were 27 percent higher than the OECD average and 36 percent higher for hospital care.[21]

Due to relatively higher prices, the U.S. spends three times the OECD average but only consumes care at two times the OECD average.[22] This is why simply reducing overutilization of healthcare services is not an effective strategy to improve the American system's performance — instead, we must reduce prices to improve value. Scaling up higher-value care requires incentivizing and expanding care models with reduced prices (like independent physician offices and ambulatory surgery centers) and improving overall market dynamics to lower prices on hospital and physician care.

Although all transactions ultimately lead back to patients' wallets, it is primarily commercial insurers and the government that negotiate and pay physician and hospital bills. Patients are largely disconnected from the actual cost of care at physician offices and hospitals. Patient out-of-pocket spending only accounted for 2.6 percent of payments to hospitals in 2022 and around 7.6 percent of payments to physicians and clinics.[23] Medicare covers around 26 percent of hospital and physician services, while

19. "2019 Healthcare Cost and Utilization Report," (Healthcare Cost Institute, October 2021).

20. Gerard Anderson and Peter Hussey, et al., "It's Still the Prices, Stupid: Why the U.S. Spends so Much on Healthcare, and a Tribute to Uwe Reinhardt," *Health Affairs* 38 (1): 87–95, (January 2019).

21. Luca Lorenzoni and Sean Dougherty, "Understanding Differences in Healthcare Spending: A Comparative Study of Prices and Volumes Across OECD Countries," *Health Services Insights* 15 (June 2022).

22. "Prices in the Health Sector," OECD, *Health at a Glance,* Figure 7.7 (2021).

23. "Data Dashboard," Peterson-KFF Health System Tracker, accessed October 3, 2024.

commercial insurance takes on between 35 and 39 percent.[24] Patients rely on their insurance company and their government to negotiate fair rates for services. Medicare payments to physicians and hospitals are determined via federal rules and regulations, and the programs tend to pay less than commercial insurers do for the same services.[25] In the private market, those prices are decided via negotiation between the insurance company and provider.

Over the past few years, providers have been integrating both horizontally and vertically, consolidating ownership by buying up hospitals, physician offices, and even merging with insurance companies. Although some hospital consolidation provides benefits in the way of better coordination for care, which can reduce operating costs, research consistently shows that hospital mergers result in higher prices with no corresponding benefits in the way of quality.[26] A study of 1,164 hospital mergers from 2000 to 2020 found that prices increased by an average of 1.6 percent over two years, with a 5.2 percent increase in cases where mergers significantly boosted market power.[27] As providers consolidate, they gain bargaining leverage over insurance companies in price negotiations. Higher negotiated prices for insurers mean higher premiums for patients and higher costs for employers.

But higher premiums also create more revenue for insurance companies. Because of this, insurance carriers do not always have sufficient incentive to negotiate lower rates for the services they cover. This can be observed in the difference between cash pay rates and negotiated rates. For example, the cash price for a colonoscopy can be as much as 128 percent lower than the prices insurance companies negotiated for the same procedure.[28] Insurance companies can negotiate uncompetitive prices for routine services because paying higher prices does not necessarily mean they collect less revenue.[29] They only need to set premiums in such a way that covers their costs.

Policies to decrease health costs must focus on leveling the playing field in price negotiations and aligning incentives for payers. Preventing consolidation via antitrust enforcement requires a reactive whack-a-mole approach, and while addressing anticompetitive conduct in this way can help on a case-by-case basis, antitrust enforcement does not change the underlying incentive structure for providers.[30] Preventing future consolidation must start with reforming the foundational market incentives that encourage hospitals to consolidate.

Before we explore policies to correct the many perverse incentives that encourage hospitals to consolidate, an important question remains: Why does the U.S. offer fewer healthcare resources to patients?

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24. *Ibid*.

25. "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," (Congressional Budget Office, January 2022).

26. Jamie Goodwin and Zachary Levinson, et al., "Understanding Mergers Between Hospitals and Health Systems in Different Markets," KFF, August 23, 2023. Jonathan Hartley and Yevgeniy Feyman, "The Perils of Hospital Consolidation," (National Affairs, Summer 2016).

27. Zarek Brot-Goldberg and Zack Cooper, et al., "Is There Too Little Antitrust Enforcement in the U.S. Hospital Sector?," *American Economic Review: Insights*, Vol. 6, No. 3, (September 2024).

28. Josh Archambault and Tanner Aliff, "Patient's Right to Save: Colonoscopy Cash vs Average Insurer Rates in Nashville, Tennessee," Cicero Institute, June 6, 2023.

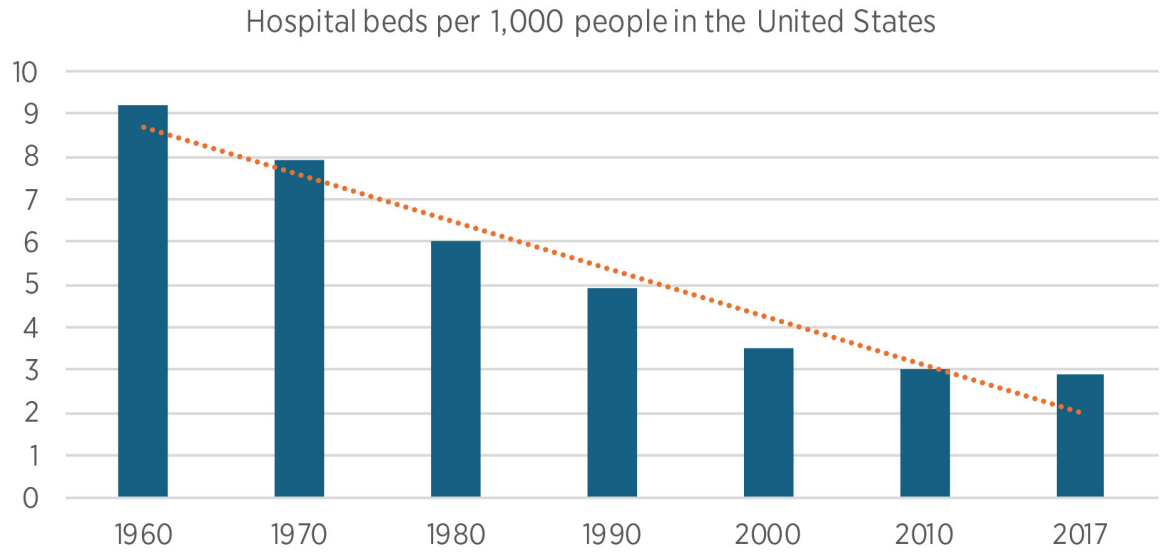
29. Marshall Allen, *"Why Your Health Insurer Doesn't Care About Your Big Bills," NPR, May 25, 2018*

30. Allan Sloan and Carson Kessler, "Is The FTC's Campaign Against Hospital Mergers Effective?" ProPublica, October 27, 2022.

History of hospital supply restrictions

In 1960, the United States had 9.2 hospital beds per 1,000 people. In 2017, that number was around 2.9 – 43 percent fewer beds than the OECD average.[31] Figure 4 illustrates the drastic drop in hospital bed availability over the years. The United States population has increased over 85 percent since 1960 and total hospital bed supply has *decreased* 68 percent in that same time period.[32]

Figure 4. Availability of hospital beds has decreased every decade since 1960[33]



There are numerous reasons for the drop in hospital bed availability, including a shift away from inpatient to more outpatient care due to technological advances and Medicare payment incentives for shorter hospital stays.[34] The drop in bed availability is also due to policy decisions spurred by concerns over excess hospital capacity and the effect it had on spending. At a time of rising demand for health services precipitated by the creation of Medicare and Medicaid in 1965, the U.S. passed the National Health Planning and Resources Development Act of 1974. The bill established a federal and state regulatory system to restrict the supply of hospitals. At the time, Congress believed that the increase in hospitals being built due to legislation like the Hill-Burton Act of 1946, which provided grant funding for hospital construction, was causing an unnecessary increase in spending on hospital care.[35] The intellectual foundation of the restrictive 1974 bill was "Roemer's Law," a theory from UCLA researcher Milton Roemer, who argued that in an insured population, "a bed built is a bed filled:" Providers would induce demand by offering beds to insured patients where payment was guaranteed.[36] By decreasing available hospital

31. "Hospital beds (per 1,000 people) - United States," The World Bank, accessed October 3, 2024.

32. *Ibid*.

33. *Ibid*.

34. Aaron Catlin and Cathy A. Cowan. "History of Health Spending in the United States, 1960-2013," (Center for Medicare and Medicaid Services, 2015).

35. The Hill-Burton Act of 1946 provided federal grants for hospital construction with the goal to increase the number of hospital beds to 4.5 per 1,000 population in the United States. Ken Wing and A. G. Schneider. "National Health Planning and Resources Development Act of 1974: Implications for the Poor," *Seattle University School of Law Digital Commons*, 1976.

36. M. Shain and M. Roemer, "Hospital Costs Relate to the Supply of Beds," *Journal of Occupational Medicine* 1(9):p 518, September 1959.

beds, the U.S. could theoretically decrease utilization, and the costs associated with it – essentially, a rationing of hospital care.

But we now know that while federal and state health spending did balloon following Medicare and Medicaid creation, increasing by 12 percent each year between 1966 and 1973, it was driven by increased demand for services rather than an oversupply of facilities for care.[37] While an increase in available services can prompt more utilization, the ratio is not 1:1. Later research found that a 10 percent increase in bed availability led to a 4 percent increase in utilization, a ratio of 5:2.[38]

Even when applying Roemer's Law to other types of services such as imaging, there is limited correlation between acquiring equipment and increased utilization.[39] Rather than restrict expansions and limit providers, we should give them the flexibility to expand services and capacity in response to an increase in demand for healthcare services.

Hospitals began reporting strained capacity in the early 2000s.[40] With per-enrollee spending continuing to rise year-over-year during this time, industry groups and the media began reporting increased interest in expanding hospital capacity to meet the demand for care. Yet, the regulatory barriers to increasing capacity and supply of healthcare centers remain.

Among the entry barriers are state laws known as Certificates of Need (CON). The National Health Planning and Resources Development Act required states to establish CON programs to ensure that additional hospital construction and equipment were needed or risk the loss of federal funding. CON programs are administered by state health authorities and require providers to request approval to build hospital facilities or acquire new equipment.[41] In 1964, New York became the first state to enact a CON law; 48 other states followed suit by 1982. Although the federal mandate and corresponding incentives were repealed in 1987, 38 states still have a CON or similar program.[42]

CON laws may establish a helpful incentive for hospitals to consider expanding capacity by becoming more efficient (rather than adding equipment/facilities), but the laws also allow existing providers to ward off competition. In most states, the approval process allows for competing hospital systems to challenge new market entrants and even sue to prevent the building of new facilities. As a result, current providers are able to exercise what amounts to a "competitor's veto" of new hospital construction.

To be sure, the relationship providers have with expanding capacity is complicated. Some research shows that strained capacity can improve a provider's bargaining leverage in negotiations with insurance

37. Catlin and Cowen, *History of Health*.

38. Paul Ginsburg and Daniel M. Koretz. 1983. "Bed Availability and Hospital Utilization: Estimates of the 'Roemer Effect'," *Healthcare Financing Review* 5(1):87–92, January 1, 1983.

39. Robert L. Ohsfeldt and Pengxiang Li, et al., "In-office Magnetic Resonance Imaging (MRI) Equipment Ownership and MRI Volume Among Medicare Patients in Orthopedic Practices," *Health Economics Review* 5 (1), 2015.

40. Gloria J. Bazzoli and Linda R. Brewster, et al., "The Transition From Excess Capacity to Strained Capacity in U.S. Hospitals." *Milbank Quarterly* 84 (2): 273–30, 2006.

41. Matthew Mitchell, "Certificate of Need Laws in Healthcare: Past, Present, and Future," *INQUIRY the Journal of Healthcare Organization Provision and Financing* 61 (January 2024).

42. "Certificate of Need State Laws," National Conference of State Legislators (NCSL), accessed October 4, 2024.

companies.[43] This opens the possibility that providers might deliberately restrict their own supply, a problem that repealing CON laws would not solve. But it also underscores their incentive to restrict new entrants into the market — a problem that CON law repeal would address. Research in the early 2000s found that hospital services did not adjust well to increases in demand, moving slowly and often lagging behind the need.[44] This was before further increases in demand for services spurred by the Affordable Care Act, which expanded Medicaid coverage to the previously uninsured in some states. Later research found the supply response to Medicaid expansion to be similarly inelastic, due to a combination of entry barriers, oligopolistic providers charging higher prices rather than increasing supply, and the lead time required to set up new care centers.[45]

It is difficult to estimate how many hospital construction plans were delayed, spiked, or never conceived due to CON programs, but research consistently finds that patients in CON states have access to fewer hospitals.[46] Following CON repeal in five states, researchers found a substantial increase in hospitals in both urban and rural settings.[47] CON repeal also has effects on health outcomes. Research shows that states with CON laws have higher mortality rates for pneumonia, heart failure, and post-surgery complications.[48] Ultimately, CON rationing methods were a tragically blunt attempt to mitigate the perverse provider incentives of the fee-for-service payment model, capping supply to limit "provider-induced demand" without regard to the value of the care subject to the cap.

Policies to decrease health costs must focus on leveling the playing field in price negotiations and aligning incentives for payers.

The efforts to limit hospital supply and bed availability in the 1960s and 70s have resulted in a provider market that is slow to respond to increases in demand for care. Providing patients more options for care and allowing existing hospitals the flexibility needed to meet demand will improve care delivery. But it is not just hospitals that experienced restrictive policies due to concerns about oversupply. Physicians now face a similar challenge.

History of physician supply restrictions and the primary care shortage

It is widely understood that the United States is approaching a physician supply crisis. The Association of American Medical Colleges (AAMC) estimates that by 2036 the U.S. will be short 20,000 to 40,000 primary care doctors and as many as 124,000 total doctors.[49] Figure 5 shows how the U.S. compares

43.Jack Zwanziger and Glenn A. Melnick, et al., "Costs and Price Competition in California Hospitals, 1980–1990," *Health Affairs* 13 (4): 118–26, 1994.

44. Bazzoli, *The Transition*.

45. Li Lin and Mico Mrkaic, et al. "U.S. Healthcare: A Story of Rising Market Power, Barriers to Entry, And Supply Constraints," *International Monetary Fund Volume* 2021: Issue 180, 2021.

46. Mitchell, *Certificate of Need Laws*.

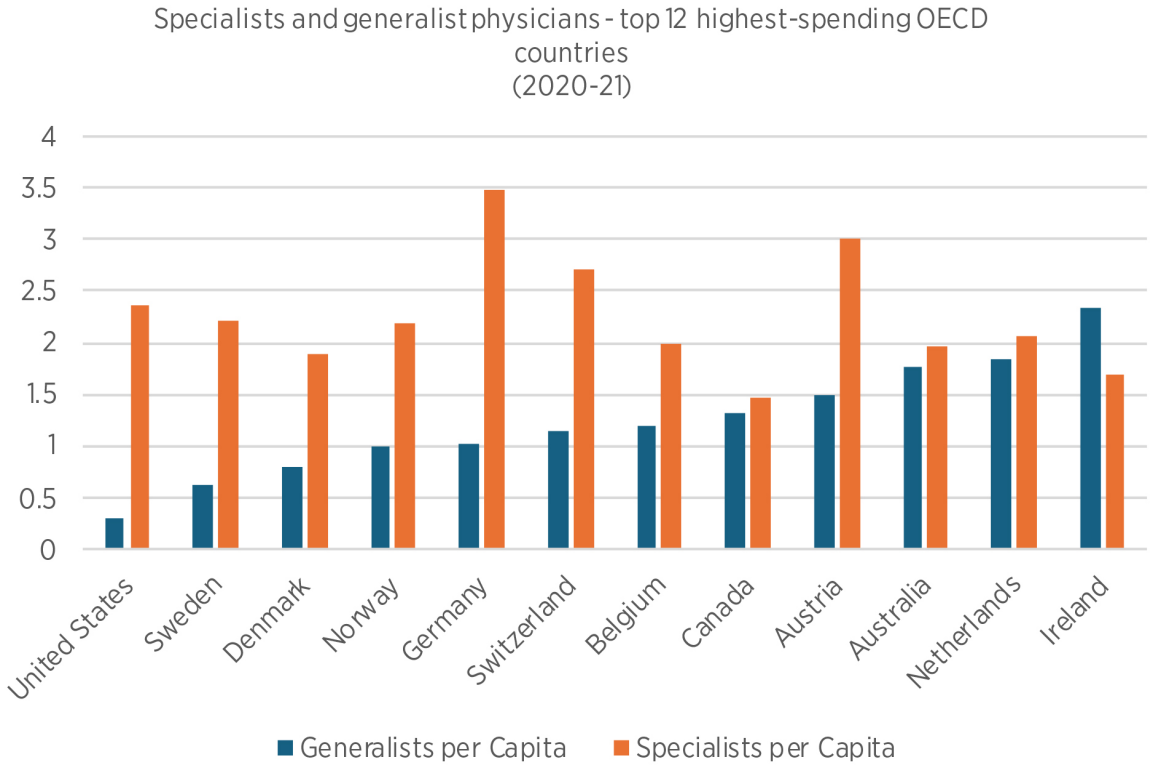
47. Vitor Melo and Liam Sigaud, et al., "Rural Healthcare Access and Supply Constraints: A Causal Analysis," *Southern Economic Journal*, April 2024.

48. Thomas Stratmann, "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services," *Journal of Risk and Financial Management* 15 (6): 272, June 2022.

49. "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036," Association of American Medical Colleges, 2024.

to the top 12 highest spending OECD countries when it comes to both generalists and specialists per capita. Generalist physicians under the OECD definition are similar to what the U.S. would refer to as primary care doctors. Specialists represent anyone who focuses on a patient group or medical field, including surgeons, psychiatrists, pediatricians, etc. While the U.S. is roughly in the middle of the pack with the number of specialists per capita compared to other high-spending countries, it has the smallest number of primary care physicians.

Figure 5. The U.S. lags behind high-spending countries in primary care physicians, but not specialists [50]



The dearth of primary care physicians and solid supply of specialists can be explained by bottlenecks and faulty incentives in the U.S. residency system's pipeline.[51] Becoming a doctor in the U.S. requires anywhere from 11 to 19 years of post-secondary education and training. U.S. doctors then graduate with over $200,000 in student debt on average with no guarantee of matching with a residency.[52] In contrast, medical students in Europe only go through a dedicated six-year medical program, which allows them to get placed into medical practices quickly.[53] Medical students in the U.S. have a larger incentive than those in Europe to go into more lucrative specialities as a result of the more expensive and arduous process.

The process became fatefully more arduous in the early 1970s, when previously separate accreditation organizations consolidated and created the Accreditation Council on Graduate Medical Education

50. Source: "Healthcare Resources," OECD, 2022.

51. Robert Orr, "Unmatched: Repairing the U.S. Medical Residency Pipeline," (Niskanen Center, September 2021).

52. Rebecca Safier, "Average Medical School Debt: What to Know About Loans and More," Wall Street Journal, September 2024.

53. Robert Orr, "America Can't Fix Its Doctor Shortage without Fixing Federal Financing," National Review, October 26, 2021.

(ACGME). Until this point, a physician seeking to work as a general practitioner would only need to finish a one-year rotating internship following medical school. The ACGME eliminated that pathway and replaced it with specialist residency training. From that point forward, the primary care workforce would have to go through three-year residency requirements via specialties like family and general internal medicine.[54] Enrollment in subspecialities exploded because medical students could make more money as a specialist than a primary care doctor without necessarily having to go through more years of training. The income gap between primary care doctors and specialists persists to this day.[55]

Around the same time that policymakers began fretting about overbuilding of hospitals, a report from the Graduate Medical Education National Advisory Committee (GMENAC) in 1981 sounded the alarm bells about a physician surplus.[56] Primed by the Reagan revolution's retrenchment orientation, policymakers became concerned that without any supply controls, too many physicians would needlessly increase utilization and spending. As we saw, federal support for the construction of hospitals (where medical residencies occur) was completely cut off. Meanwhile, medical schools voluntarily froze both new residency slots and the construction of additional medical schools between 1980 and 2005 upon the GMENAC's recommendation.[57] The number of annual MD-entrants into residency programs fell as a result, not reaching its 1980 high until after 2005.[58]

The efforts to limit hospital supply and bed availability in the 1960s and 70s have resulted in a provider market that is slow to respond to increases in demand for care.

Another important restriction came through the Balanced Budget Act of 1997, which capped Medicare-funded residency slots at 1996 levels – a cap that was increased by 1,000 in 2021.[59] Medical schools are able to increase slots above the cap, but cannot receive Medicare funding to cover the costs. This serves as a limiting factor to licensing physicians. In 2022, over 3,300 medical school graduates failed to match with a residency due to a lack of available slots.[60] Because medical residents often remain in the same area where they complete their training, the cap effectively froze the geographic distribution of slots as well, fueling the mismatch between local demand for medical services and physician supply.[61]

The purposeful downsizing of the 1980s and 90s was based on the idea that having too many physicians would lead to unnecessary increases in spending on healthcare. But as seen in the section above on

54. James Dalen and Kenneth J. Ryan, et al., "Where Have the Generalists Gone? They Became Specialists, Then Subspecialists,," *The American Journal of Medicine* 130 (7): 766–68, 2017.

55. Thomas Bodenheimer and Robert Berenson, et al., "The Primary Care–Specialty Income Gap: Why It Matters," *Annals of Internal Medicine* 146 (4): 301, February 2007. Note: Specialists get paid more largely because Medicare and private insurance pay more for services performed by specialists than services typically performed by primary care doctors.

56. "Volume 1: GMENAC Summary Report, Summary Report of the Graduate Medical Education National Advisory Committee," (Graduate Medical Education National Advisory Committee, August 1, 1982).

57. Robert Orr, *The Planning of U.S. Physician Shortages*

58. *Ibid.*

59. "CMS Funding 1,000 New Residency Slots for Hospitals Serving Rural & Underserved Communities," Center for Medicaid and Medicare Services, December 17, 2021.

60. "Fact Sheet: Increased Graduate Medical Education Needed to Preserve Access to Care," American Hospital Association, June 2023.

61. Robert Orr, "Federal policy misallocates American doctors," Niskanen Center, February 1, 2023.

hospital care and supply, the relationship between supply and spending is not straightforward. Healthcare spending has accelerated while the relative level of healthcare resources, both physicians and hospitals, has declined. Increasing the supply of primary care physicians would change how the US spends money on healthcare, directing spending towards the type of care Americans need most.

There is good news: In response to the projected shortage of primary care doctors and regional distribution challenges, physician supply has increased since the early 2000s. Since 2002, the number of MD graduates has increased by 58 percent - from 18,212 to 28,811 in 2022-23.[62] The number of doctors of osteopathic medicine (DOs), who undergo similar training to MDs and represent a quarter of U.S. medical students, has increased at a much faster rate in that time, nearly tripling between 2002 and 2021.[63] Because DO training emphasizes more holistic approaches and symptom treatment, more than half of them become primary care doctors, compared to only 28 percent of active MDs. DOs are in an advantageous position to respond to the primary care shortage.[64] Although DOs used to have a separate residency matching program, the consolidation of residency pathways continued in 2020 and now both MDs and DOs have to go through the same matching process under a single accreditor, the ACGME.[65] Even without Medicare expanding its residency funding to match the larger cohort of aspiring doctors, hospitals created new slots for many of them. But as noted, in 2022 more than 3,300 physicians still failed to match, and the proportion of graduates going into specialties rather than primary care remains imbalanced.[66]

A lack of primary care doctors has implications for health outcomes and access. Patients have to wait longer for primary care services and then have to choose between higher-cost hospital settings or urgent care centers for conditions that require consistent attention. It is worth considering the connection between access to primary care and treatable mortality. As noted earlier, the U.S. leads highest-spending countries in deaths due to treatable conditions even as we have the smallest number of primary care physicians — and these trends are probably not unrelated. Research shows that counties in the U.S. with better access to primary care experienced lower mortality rates from treatable conditions.[67] The U.S. will not be able to address its primary care physician shortage without meaningful reform to physician training and residency, including reducing the financial incentive students have to enter non-primary care specialties.

Perverse incentives in federal policy lead to market consolidation and ineffective spending

The undersupply of hospitals and physicians was an intentional policy choice. Some of the remaining problems with healthcare supply are the result of government policies with good intentions and unintended side effects that created perverse incentives for providers to consolidate or payers to artificially increase spending, maximizing profits at the expense of patients and taxpayers. Among

62. "Total Number of Medical School Graduates," KFF, accessed October 4, 2024.

63. Jeffrey Flier and Jared Rhoads, "The U.S. Health Provider Workforce: Determinants and Potential Paths to Enhancement," (Mercatus Center, February 2018).

64. Brendan Murphy, "DO vs. MD: How much does the medical school degree type matter?," American Medical Association, April 2024.

65. *Ibid*.

66. Flier and Rhoads, *The U.S. Health Provider Workforce*.

67. Barbara Starfield and Leiyu Shi, et al., "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 83 (3): 457–502, October 2005.

individual payers, Medicare and Medicaid together cover 39 percent of all health expenditures, a larger proportion than what commercial insurance covers (29 percent).[68] The negotiated rates that commercial insurers pay for services are set by the market (although distorted by various federal mandates), but policymakers determine the reimbursement for services by Medicare and Medicaid.

How much the government pays for care and what services it covers create incentives for companies who seek to maximize their revenue. For private payers, the federal government extensively regulates both private insurance and providers through federal programs and patient protections. This section deals with the incentives baked into those policies and the implications for patients and taxpayer spending.

Fee-for-service: Quantity is not our biggest problem

Historically and through the present day, much of the health policy conversation revolves around the idea that overutilization of care is our biggest problem. In recent decades much opprobrium has been heaped on the fee-for-service model, in which providers get paid primarily on a service by service basis, both when billing Medicare and private insurance. Each service, from the least to most complicated, receives a specific code with a designated price. Naturally, this means that providers can charge more when they provide a higher volume of services, regardless of patient outcomes. The number of billable services has tripled since the 1960s, and with each new billable service, providers see more revenue.[69] This often comes at the expense of patients, who receive bills with line items such as an "IV push" which can result in a $700 charge each time a nurse provides an intravenous medication.[70]

Healthcare spending has accelerated while the relative level of healthcare resources, both physicians and hospitals, has declined.

To address the disconnect between hospital incentives and patient needs inherent to fee-for-service, providers and insurers have tried different models that either bundle services for one price or set fixed monthly fees for each beneficiary and provide rewards for better health outcomes. These models are broadly referred to as value-based care. Insurance groups like Health Maintenance Organizations (HMOs), Accountable Care Organizations (ACOs), and Managed Care Organizations (MCOs) use capitation payment models where payers pay a fixed, monthly rate for each patient regardless of the volume of care they receive and rewards like performance bonuses tied to service quality. The ACA incentivized the creation of value-based payment structures like ACOs in Medicare.[71]

But while there is room for value-based payment structures in a cost-reduction strategy, their track record is mixed.[72] More importantly, they do not attack the primary cost problem, which is less the rising quantity of services and more the rising *price*. Recall, for example, Figure 3, which showed that increases in the price of services have far outstripped increases in their utilization. Attacking prices, meanwhile,

68. Peterson-KFF Health System Tracker, *Data Dashboard*

69. Kaitlin Hunter and David Kendall, et al., "The Case Against Fee-for-Service Healthcare," Third Way, September 2021.

70. Bichell, *A Hospital Charged*.

71. Kieran Holzhauer, "Accountable Care Organizations: The First Two Years' Performance and Directions for the Future," *The AMA Journal of Ethic* 17 (7): 630–36, 2015.

72. "What is Value-Based Healthcare?," NEJM Catalyst, January 1, 2017.

requires that we tackle consolidation, and on this front, value-based care could even be contributing to the problem. Studies have found that the rise in ACOs has contributed to physician group consolidation, because larger, more integrated providers are better able to coordinate service delivery in an ACO model.[73] Efforts to move away from fee-for-service must ensure that incentives are aligned to prevent further market concentration and reward providers that offer lower-cost, higher-quality services.

Medicare

Reimbursement rates for providers who participate in the Medicare program are primarily determined by the Physician Fee Schedule (PFS), which covers reimbursement rates for services performed by physicians, and the Outpatient and Inpatient Prospective Payment Systems (OPPS & IPPS), which cover reimbursement to clinics and hospitals. Medicare has several other payment systems that calculate unique rates for certain types of facilities, such as skilled nursing, psychiatric, hospice, long-term care, and home health agencies.

Site-based billing

A contributing factor in the relative growth in Medicare outpatient spending is the increase in consolidation of hospital systems and site-based differential in payments.[74] Medicare has different reimbursement rates for different types of facilities. The original intention of such "site-based billing" was to compensate hospitals for higher overhead costs brought on by regulatory requirements to provide services at all hours, among other requirements. For some services, the higher rates of payment may be needed to keep up with expenses. But site-based billing also applies to routine services that are usually provided by physician offices as well in most cases.[75] Medicare pays hospital outpatient departments nearly double what it would pay a freestanding physician's office for the same service, and can rise to four times higher for routine services like x-rays.[76]

Policies like site-based payments created an incentive for hospital systems to acquire freestanding physician offices where they could immediately begin receiving higher reimbursements by simply labeling an off-campus facility as a hospital outpatient department (HOPD) without changing the care patients receive.

Site-based payments for new off-campus HOPDs were repealed in 2015, but existing off-campus HOPDs were grandfathered in. Meanwhile, site-based payments remain for all on-campus HOPDs, emergency departments, and ambulatory surgery centers, regardless of the service they are providing. Medicare could save $126.8 billion over 10 years if site-neutral payments were extended to all HOPDs just for routine services.[77] Correcting perverse payment incentives like site-based billing is a necessary step to stem the tide of rising hospital consolidation — and save taxpayers a great deal of money.

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73. Genevieve Kanter and Daniel Polsky, et al., "Changes in Physician Consolidation With the Spread of Accountable Care Organizations," *Health Affairs* 38 (11): 1936–43, 2019.

74. Lawson Mansell, "Addressing Medicare spending and hospital consolidation with site-neutral payments," Niskanen Center, March 2024.

75. Mansell, *Addressing Medicare Spending*.

76. "Equalizing Medicare Payments Regardless of Site-of-Care," Committee for a Responsible Federal Budget, February 2021. Brady Post and Edward C. Norton, et al., "Hospital-physician Integration and Medicare's Site-based Outpatient Payments," Health Services Research 56 (1): 7–15, 2021.

77. Bulat and Brake, *Site-Neutrality Proposals*.

Impacts of the ACA's Medical Loss Ratio

Site-based billing is not the only perverse incentive baked into Medicare's payment policies. A little-known provision in the ACA also has implications for spending in Medicare Advantage (MA), the program in which Medicare services are provided through private insurers. The medical loss ratio (MLR) is a regulation enacted as part of the ACA that requires insurers, including those in MA, to spend no less than 80 percent (individual and small-group markets) or 85 percent (large-group) on medical costs, or else pay back the difference to customers (usually employers providing retiree health benefits) in the form of a rebate. The remaining 15 or 20 percent can be spent on administration, setting a proportional, but not absolute, cap on administrative costs and profit. The MLR was intended to prevent runaway administrative costs and provide relief for employers who bear the brunt of rising premiums, but insurers have found a loophole. Because it is proportional, insurers have an incentive to spend more in total to increase the profit potential of their MLR.

The MLR was intended to prevent runaway administrative costs and provide relief for employers who bear the brunt of rising premiums, but insurers have found a loophole. Because payments to subsidiaries and sister companies are counted as a medical "cost", insurers are able to shift profits to their subsidiaries without having to rebate employers due to a lopsided MLR.

Efforts to move away from fee-for-service must ensure that incentives are aligned to prevent further market concentration and reward providers that offer lower-cost, higher-quality services.

This process has been well-documented with pharmacy benefit managers (PBMs), where UnitedHealth has managed to transfer 25 percent of its medical claim revenue to its own PBM and subsidiary Optum, which was formed a year after the MLR took effect.[78] Because UnitedHealth also owns or has influence over a tenth of physicians in the U.S., it is also able to shift profits to their own physician groups – a practice economists call "transfer pricing."[79] The MLR, which took effect in 2011, offered a perverse incentive for Medicare Advantage insurers to vertically integrate and side-step MLR rules to increase their bottom line.[80] This regulatory arbitrage ultimately hurts employers and patients who have to deal with higher premiums while large health conglomerates benefit from double margins. These reimbursement policies benefit large healthcare companies while providing no additional benefit for Medicare patients. Providing more scrutiny over MLR practices or even updating MLR requirements could reduce such gaming of the system.

Medicaid

Medicaid's payment policy is a partnership between the federal and state governments. The federal government provides states with guidance on how to deliver and pay for care, but state governments

78. "Elizabeth Warren Has an ObamaCare Epiphany," Wall Street Journal Editorial Board, November 2023.

79. "Profiting at the Expense of Seniors: The Financialization of Home Healthcare," (Center for Economic and Policy Research, September 28, 2023).

80. Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Healthcare," (American Economic Liberties Project, April 2024). Conrad Milhaupt and Richard G. Frank, "Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation," (Brookings Institution, March 24, 2023).

ultimately determine how much providers are reimbursed when serving Medicaid beneficiaries. Federal support for Medicaid is uncapped and provided via a matching grant reimbursement known as the Federal Medical Assistance Percentage (FMAP). The grant currently covers anywhere from 50 to 83 percent of costs depending on the per capita income of the state's residents. ACA expansion states receive a 90 percent matching rate for the expansion population (those with incomes up to 138 percent of the poverty level). As a result, there is significant variation in both Medicaid costs and coverage by state. As a whole, the federal government financed 73 percent of the total $805.7 billion spent on Medicaid in 2022. The FMAP program offers two key perverse incentives that both limit the capacity of poorer states and inflate already-rising healthcare spending.

Flawed FMAP formula

First, while there is no binding cap on the portion of funds covered by the federal government, there is an FMAP minimum of 50 percent – regardless of the fiscal capacity of each state. Because the FMAP is inversely correlated with per capita incomes, the statutory minimum percentage disproportionately benefits wealthier states, whose percentage of federal funding would otherwise be lower.[81] Per-capita income does not account for other fiscal capacities like corporate income or capital gains and thus underestimates the fiscal capacity of states like Wyoming, which would receive a 44 percent match without the floor.[82] It also does not reflect the health needs of the populations in each state. While Florida and Wisconsin receive the same FMAP due to similar per capita income levels, Florida has 22 percent higher poverty levels and a similarly higher proportion of adults reporting poor health status.[83] Rather than bring about a progressive distribution of federal funding, the 50 percent FMAP floor serves as a benefit to wealthier states and strains the fiscal capacity of poorer states.

Secondly, states take advantage of the FMAP through creative financing schemes. Because the federal government reimburses states based on their reported spend on Medicaid beneficiaries, when states increase their total payments to providers, they receive a higher effective matching rate. The primary way states do this is through levying provider taxes. In theory, provider taxes are a commonsense way for states to fund their portion of Medicaid spending. But in practice, states often tax and boost payments to the same provider simultaneously, allowing them to inflate their Medicaid spending without increasing their net spending.[84] This artificially increased the reported prices for Medicaid services and federal reimbursement. All states but one use provider taxes to fund Medicaid, an increase from 21 states in 2003. Between 2008 and 2018, states used revenue from provider taxes to fund more and more of their Medicaid spending — increasing by 270 percent to the tune of $37 billion, 17 percent of total Medicaid costs.[85]

Under current policy, Medicaid offers perverse incentives to states to inflate their spending, while not providing adequate reimbursement to poorer states that need additional fiscal capacity. As a result, it is no surprise that states are seeking to increase their effective matching rate, particularly for poorer states that receive the short end of the stick due to the flawed FMAP formula. Federal Medicaid policy

81. Joshua McCabe, "How the Medicaid Expansion Fuels the Politics of Austerity," Niskanen Center, October 2018.

82. Blase and Gonshorwoski, Medicaid Financing Reform.

83. Liam Sigaud, "Why Average Income Isn't a Good Way to Distribute Federal Medicaid Funds to States," Open Health Policy, August 4, 2023.

84. "Medicaid Provider Taxes Inflate Federal Matching Funds," Committee for a Responsible Federal Budget, September 2023.

85. *Ibid*.

should ensure that states are receiving fair payment to administer their Medicaid programs while also establishing guardrails to prevent financing schemes that artificially increase federal spending.

Private insurance and other provider payments

A number of federal policies create incentive structures that distort the private market and allow hospitals to receive higher payments than is commensurate with the level of care provided.

Federal tax policy plays a large role by offering advantages to hospitals and employer-sponsored insurance plans. Among those advantages are hospitals' status as tax-exempt nonprofit entities. 58 percent of America's community hospitals are nonprofit, nongovernmental entities and exempted from paying most taxes. Together, they drew around $28.1 billion in tax exemptions in 2020 – around half from federal tax exemptions and the other half from state and local.[86] This benefit was originally offered to hospitals at a time when they were largely run by religious organizations and provided extensive charity care to low-income patients. Today, hospitals must meet a vague standard of providing "community benefits" to earn this status.[87] If charity care is the benchmark, they are clearly not meeting it: Independent analysis has found that nonprofit hospitals spend 2.3 percent of their operating costs on charity care — well below the estimated 4.3 percent value of their tax exemption.[88] It is ultimately patients and taxpayers that have to pay higher taxes to accommodate the resulting drop in tax revenue, while experiencing little benefit in return.

Both these extensive tax benefits and site-based billing through Medicare are ostensibly designed to compensate hospitals for their complex patient mix and higher overhead costs. But hospitals also charge patients facility fees — to cover operational expenses.[89] These fees can be levied against patients who receive care in hospital outpatient settings with more routine care and less overhead costs than the hospital itself. Facility fees unnecessarily increase patient out-of-pocket costs and inflate the price of care in a hospital setting relative to an independent physician's office. For patients receiving chemotherapy treatment, a one-hour infusion can cost nearly three times more in a "hospital" setting compared to an independent physician's office.[90]

In recent years, policymakers have made major strides in protecting patients from other billing practices that unnecessarily cost patients, including surprise billing. In December 2020, Congress enacted the No Surprises Act (NSA) to shield patients from surprise bills that were often the result of a patient receiving a service from an out-of-network provider without their prior knowledge. Patients have mostly been protected from those bills since its implementation — but much of the costs seem to be funneling into premiums. That is because the legislation sent such bills into arbitration between providers and insurers, and the process is so biased toward providers that it allows them to receive even higher payments

86. "The Federal Tax Benefits for Nonprofit Hospitals," Committee for a Responsible Federal Budget, June 2024.

87. "Tax Administration Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status," United States Government Accountability Office, 2020.

88. Hossein Zare and Matthew D. Eisenberg, et al., "Comparing the Value of Community Benefit and Tax-Exemption in Non-profit Hospitals," *Health Services Research* 57 (2): 270–84, 2021.

89. "Facility Fees and How They Affect Healthcare Prices," (Healthcare Cost Institute, June 2023).

90. Darbin Wofford, "Same Service, Same Price: Tackling Hospitals' Add-On Facility Fees," (Third Way, March 2024).

than they were receiving before.[91] Providers are winning 75 percent of disputes in the new arbitration process for payment disagreements and receive payments three times the median in-network rates.[92] Essentially, the bill has passed on the costs to insurance premiums, which will result in higher costs for patients. The No Surprises Act is one example of how patient-centered policy changes need to take into account provider market dynamics to prevent negative externalities.

Another well-intentioned effort was the 1992 340B Drug Pricing Program, which was enacted to subsidize safety-net hospitals for prescription drugs. Qualifying hospitals that treat low-income patients can buy prescription drugs at a discount of 25 to 50 percent.[93] The program started out with around 500 qualifying providers but has increased substantially, to 50,000 by 2020. It is now the second largest drug pricing program in the U.S. — second only to Medicare part D.[94] Because providers in the 340B program are able to buy drugs at a discount and then charge insurers a much higher price, there is an incentive to purchase more expensive, brand-name drugs to increase their revenue through the program.[95] But qualifying hospitals are not required to use profits from the discounted drugs to provide care to underserved populations or to disclose their profit margins from the program. There is also evidence that qualifying providers are incentivized to consolidate hospital systems and clinics to expand the number of clinics that qualify for the program. Reporting shows that hospitals were purchasing clinics in wealthier neighborhoods but remaining in the program because they list newly acquired clinics as an extension of the qualifying "poorer" facility.[96]

Well-intentioned programs meant to protect patients from hospital closures or overly high bills for services often include loopholes and distort market dynamics to the advantage of providers. It is critical that policymakers identify these incentive structures and reshape them to avoid further consolidation and even higher prices.

Treatment: Policy recommendations

Now that we have identified the policies that restrict healthcare abundance and their impacts on the underperforming and uncompetitive provider market, it is time to look at solutions. Three overarching ideas provide the policy foundation for moving forward. First, lawmakers must **expand access to primary care physicians** by rolling back restrictive policies. Second, lawmakers should **expand provider capacity** by removing restrictions on the construction and growth of existing care centers and encouraging innovation in treatments and care models. Third, to put downward pressure on prices, lawmakers must **correct programs and policies that incentivize providers to consolidate** and raise prices at the expense of patients and taxpayers.

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91. Loren Adler and Matthew Fiedler, "Outcomes Under the No Surprises Act Arbitration Process: A Brief Update," Brookings Institution, July 31, 2024.

92. Lawson Mansell, "The No Surprises Act Is Protecting Patients, but Not Containing Healthcare Costs," Niskanen Center, March 26, 2024.

93. Bobby Clark and Marlene Sneha Puthiyath, "The Federal 340B Drug Pricing Program: What It Is, and Why It's Facing Legal Challenges," Commonwealth Fund, September 2022.

94. Jackson Hammond, "340B 101," Paragon Institute, September 2024.

95. Laura Hobbs, "Does the 340B Drug Pricing Program Encourage High-cost Prescriptions? A Case Study of Preventative HIV Treatments," American Action Forum, August 30, 2023.

96. Katie Thomas and Jessica Silver-Greenberg, "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits," The New York Times, September 2022.

Expand and improve the supply of physicians

Fix residency financing and incentivize more careers in primary care medicine. As explained above, the rate at which the U.S. produces physicians is limited by the 1997 Balanced Budget Act, which capped Medicare-funded graduate medical education (GME) residency slots at 1996 levels. Policymakers must reform the residency pathway if we are to increase physician supply. This includes removing obstacles to practice for DOs, who are more likely to become primary care doctors. While there are efforts underway to increase the Medicare-capped rate, reformers should think even bigger. Because Medicare funding is based solely on the number of Medicare patients a hospital sees, the underlying funding structure benefits wealthier hospitals and areas at the expense of poorer and more competitive markets. New York trains three-and-a-half times more medical residents than Georgia but receives six times more Medicare funding per resident for residency training. This fuels the imbalance between patient demand and where doctors are trained.

Larger reform of the residency pathway should include lifting the per-hospital residency cap and consolidating funding streams into a uniform per-resident payment.[97] Additionally, simply expanding the number of residency slots Medicare funds will not affect the concerning proportion of graduates going into other specialties and subspecialties instead of primary care, which has the largest shortage. Federal policymakers should consider using GME funds to address this imbalance and incentivize a more robust primary care workforce.

Expedite state licenses for international medical graduates (IMGs). In all states but four, graduates of international residency programs have to repeat their residency in the United States to become a licensed physician. Because of the undersupply of residency slots and a preference for domestically-trained graduates, immigrant physicians struggle to match with a residency program. In recent years, some states have begun waiving U.S.-based residency as a requirement for IMGs, creating alternative pathways to licensure.[98] Immigrants have been a critical force in addressing staffing shortages in all other healthcare fields, but increased restrictions on prospective physicians have hindered their ability to meet the demand for primary care services.

Estimates show that there are currently around 165,000 unemployed or underemployed IMGs in the United States.[99] We are barreling toward a shortage of anywhere from 42,600 to 121,300 physicians by 2030. Allowing IMGs to perform jobs they are qualified for would significantly cut into that deficit without threatening the jobs of domestically-trained physicians.[100] In fact, without reforms to the Medicare residency cap, this is one of the only remaining federal options for increasing the rate at which the U.S. produces doctors. Policymakers should remove duplicative residency requirements for IMGs and build the infrastructure at each level to smooth the pathway for IMGs to begin treating patients.

Improve licensing portability for all physicians. Fragmented and restrictive licensing rules at the state level are one of the reasons healthcare supply is slow to respond to demand for care. Compared to our European counterparts, healthcare occupational licensing in the U.S. is more pervasive and burden-

97. Robert Orr, *America Can't Fix It's Doctor Shortage*

98. Kristina Fiore, *More States Cut Training Requirements*.

99. Jeanne Batalova and Michael Fix, "As U.S. Health-Care System Buckles under Pandemic, Immigrant & Refugee Professionals Could Represent a Critical Resource," Migration Policy Institute, April 2020.

100. AAMC, *The Complexities of Physician Supply*.

some.[101] Because licensing occurs at the state level, physicians face barriers in providing care to out-of-state patients and when moving to a new state. Physicians are stymied in providing telehealth services in particular due to the lack of portability between states. Policymakers are attempting to address this problem via interstate compacts like the Interstate Medical Licensure Compact (IMLC), but it is limited by a lack of state adoption. Policymakers at the state level should streamline licensing processes and enter into interstate compacts to improve access. Federal policymakers should consider allowing exceptions to state licensure requirements so that doctors with established relationships with out-of-state patients can continue providing care without restrictions.[102]

Expand scope-of-practice (SOP) so qualified medical professionals can offer more services. It is no surprise that medical students are choosing more lucrative specialties given the high cost of obtaining a medical degree and the corresponding certifications. One proven method to address this imbalance is to expand the type of services nurse practitioners (NPs), physicians assistants (PAs), pharmacists, and other professionals are able to provide patients.[103] For example, only 22 states and the District of Columbia allow NPs a full practice environment where they can diagnose, interpret tests, and prescribe medication without a physician's oversight — all of which are routine primary care offerings.[104] Expanding SOP will not only give patients more and better access to care, it will also allow overworked physicians to focus on treatments that require their high levels of training.[105] There has been a trend towards increasing SOP for NPs and PAs in recent years. Policymakers should continue to pursue SOP reform where there is clear evidence that other professionals can perform services just as effectively as physicians.

Increase capacity and foster innovative, affordable care delivery models

Eliminate remaining Certificate of Need (CON) restrictions. CON laws are one of the primary barriers to building and expanding care centers. The laws, different in each state, require new providers to request permission from the state to open or expand new facilities. Many states allow existing hospitals to challenge new healthcare facilities during the approval process, potentially blocking market entry for competitors. Twelve states have now either fully repealed their CON program or allowed it to expire. Policymakers in the remaining states should remove their own restrictions to allow for more provider supply and competition.

Allow physicians to own hospitals. Included in the Affordable Care Act package passed in 2010 was a little-known provision that prevents physicians from owning or operating hospitals. Existing physician owned hospitals (POHs) were grandfathered in by the law. The ban came in the wake of concerns over the performance of POHs, but extensive research shows that POHs actually outperform other hospitals on quality.[106] Allowing physicians to own hospitals will increase provider competition and better align care incentives across ownership and treatment. Research also shows that POHs have the potential to

101. Robert Orr, *U.S. Healthcare Licensing*.

102. Lawson Mansell, "Addressing concerns about permanent telehealth expansion in Medicare," Niskanen Center, May 2024.

103. Flier and Rhoads, *The U.S. Health Provider Workforce*.

104. Jessica Flanigan, "Scope of Practice Reform: Cost Savings and Patient Empowerment," The Center for Growth and Opportunity at Utah State University, April 2021.

105. Robert Orr, *U.S. Healthcare Licensing*.

106. Brian Miller and Jesse Ehrenfeld, et al., "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review," (Mercatus Center, September 2021).

lower Medicare costs by charging less than traditional hospitals.[107] Congress should act on this commonsense solution.

Incentivize use of innovative, lower-cost care models like Direct Primary Care (DPC). Addressing the scarcity of primary care providers requires innovative approaches to healthcare delivery and state funding mechanisms to ensure access to family doctors. Among those innovative models is DPC, which offers patients virtually unlimited access to a primary care doctor for an affordable, fixed monthly fee, usually between $40-$85 a month. Because DPC practices do not accept traditional insurance, DPC doctors spend less time and resources on paperwork and more time with patients. Recent efforts to encourage Medicaid partnerships with DPC clinics are a ripe opportunity for improving access to primary care for those in most need through innovative, lower-cost models.[108]

Reform the patent process to increase access to more affordable medicine. Although most of this agenda focuses on physician and hospital care, Americans spend more out-of-pocket on prescription drugs than on hospital care. Ensuring reliable access to lower-cost generic medications is critical to lower the financial burden and ensure that patients are not delaying or forgoing needed care due to the cost. Generic and biosimilar drugs are often delayed by anticompetitive practices from brand name drug manufacturers. For example, they build overlapping patents to block generic and biosimilar competitors, who then face tough litigation to challenge these patent claims and enter the market with their lower-cost versions.[109] Regulators and lawmakers should prevent these practices and allow for better competition in drug manufacturing.

Realign incentives to improve competition and reduce ineffective spending

Prioritize site-neutral payments in Medicare. Site-based billing is one of the key drivers of Medicare spending and provider market consolidation. A site-neutral payments policy would require Medicare to pay hospitals and physician offices the same rate for the same services. Currently, services that regular clinics can provide cost Medicare part B nearly double in hospital outpatient departments.[110] Because there is little quality variation for routine treatments between settings, the additional costs are just passed on to patients through higher out-of-pocket costs and ineffective Medicare spending.[111] Reining in this practice should also prove appealing as Congress looks for cost-saving opportunities in light of a ballooning debt crisis and looming Medicare insolvency.

Repair Medicaid's flawed formula for payments to states. The existing Medicaid funding formula creates perverse incentives for states to increase their spending and does not adequately compensate states with less fiscal capacity.[112] Lawmakers should remove the 50 percent FMAP floor for wealthy states to correct the imbalance in payments. Policymakers should also confront state gimmicks to receive

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107. Robert H. Aseltine, Jr. and Gregory J. Matthews, "A Study of the Cost of Care Provided in Physician-Owned Hospitals Compared to Traditional Hospitals," Physicians Advocacy Institute and The Physicians Foundation, October 2023.

108. Lawson Mansell and Daphne Hansell, "Innovations in care delivery can improve access to primary care for Medicaid beneficiaries," Niskanen Center, September 2024.

109. Lawson Mansell, "Reforms targeting "patent thickets" would speed up the arrival of lower-cost drugs," Niskanen Center, July 2024.

110. CRFB, *Equalizing Medicare Payments*.

111. Mansell, *Addressing Medicare Spending*.

112. McCabe, *The Politics of Austerity.*

artificially higher effective matching rates by requiring more transparency over provider taxes and closing loopholes.

Roll back federal tax and payment policies that distort market dynamics. Federal tax and payment policies, such as tax exemptions for nonprofit hospitals, inflated facility fees, and the 340B program, skew the competitive landscape and allow providers and insurers to charge higher prices and shift costs onto patients and taxpayers. Rolling back each of these policies would reduce inflationary spending and align financial incentives with the actual value of care provided.

Conclusion

The healthcare system is not delivering performance commensurate with the high costs Americans pay. Healthcare abundance offers a framework for improving performance while lowering the relative cost. By expanding the availability of basic care, we keep chronic or potentially dangerous conditions from spinning out of control. By adding more providers, ensuring diversity of ownership, and tackling perverse pricing incentives, we reduce the power of oligopolistic stakeholders to negotiate high prices and exploit payment systems. This is a path forward that challenges conventional approaches on both left and right that operate from a scarcity mindset and emphasize either subsidies or price transparency without prioritizing underlying supply. By targeting areas where the system is far from having optimized tradeoffs, the abundance approach breaks free from the traditional trade-offs between cost, access, and quality. It is up to policymakers to enact reforms that dismantle supply barriers and promote a competitive healthcare marketplace that delivers for all Americans.

About the Author

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