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Prescription for Affordability: Restoring Patient Power

BY CHRIS JACOBS

Founder & CEO, Juniper Research Group

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How Big Government Made Life
Unaffordable and How to Fix It

INTRODUCTION

In last year's debate over enhanced Obamacare subsidies, many Members of Congress took the entirely wrong approach, beginning with the very language they employed. For instance, last June, Sen. Thom Tillis (R-NC) said that "with the ACA subsidies and other things, we should start thinking about a stream of bipartisan bills that we can work on."¹

Rather than challenging a failing law, Tillis and others like him reveal exactly how far the debate has shifted. Calling the 2010 healthcare law the "Affordable Care Act" represents more than a semantic concession; it endorses a thoroughly refuted premise. Obamacare has proven anything but affordable—for patients or taxpayers. The law singularly failed to deliver on candidate Obama's 2008 promise that his signature legislation would "bring down premiums by \$2,500 for the typical family."²

Indeed, within the first four years after Obamacare took full effect, premiums on the individual health insurance market more than doubled.³ And in the time since, premiums for individual health insurance have continued to rise at a faster pace than those for employer-provided health coverage.⁴

Proposed legislation to permanently extend the Biden-era COVID subsidies would have cost taxpayers \$350 billion, plus interest, at a time when the federal government faces \$39 trillion in debt.⁵ Democrats thought their plan such a political winner that they forced the longest government shutdown in history for 43 days, from October 1 to November 12, 2025. Their plan sought to double down on Obamacare's failed

1 Sahil Kapur, "Republicans Face New Pressure to Extend Expiring Obamacare Tax Credits," NBC News June 2, 2025, <https://www.nbcnews.com/politics/congress/republicans-face-new-pressure-extend-expiring-obamacare-tax-credits-rcna209281>.

2 Quoted in Kevin Sack, "Health Plan from Obama Spurs Debate," New York Times July 23, 2008, <https://www.nytimes.com/2008/07/23/us/23health.html>.

3 Department of Health and Human Services Office of Planning and Evaluation, "ASPE Data Point: Individual Market Premium Changes: 2013-2017," May 23, 2017, <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>.

4 Cited in Brian Blase, Testimony before Senate Homeland Security Permanent Subcommittee on Investigations in hearing on "Assessing the Damage Done by Obamacare," November 6, 2025, <https://www.hsgac.senate.gov/wp-content/uploads/Blase-Testimony-2.pdf>, Figure 7, p. 6.

5 Congressional Budget Office, Letter to Sen. Chuck Schumer, et al. regarding selected health coverage policies, September 18, 2025, <https://www.cbo.gov/system/files/2025-09/61734-Health.pdf>; Department of the Treasury, "Debt to the Penny," <https://fiscaldata.treasury.gov/datasets/debt-to-the-penny/debt-to-the-penny>.

approach—one that layers on costly mandates and regulations that raise the cost of health insurance—then attempts to make that coverage “affordable” by masking the damage with subsidies, perpetuating the underlying dysfunction.

Congress was right to let these enhanced subsidies expire. Now, they must build on that victory rather than simply defending the status quo—by advancing true reforms that focus on the most important concern most Americans have about healthcare—its high cost.

Healthcare’s rising costs have their roots in a system of twisted and perverse incentives. The tax-free treatment of employer-provided health coverage, which will reduce federal revenue by roughly \$6 trillion over the coming decade, has its roots in World War II-era wage and price controls.⁶ This historical anomaly means that most individuals do not select their own insurance policy so much as their employer selects it for them—which, by definition, places actors other than the patient in control of major healthcare decisions.

The tax treatment of health insurance also effectively subsidizes higher health costs. A dollar in employer-provided health coverage that federal law excludes from payroll, income, and (in many cases) state and local taxes has a greater value to an employee than a dollar in taxable cash wages. The distortionary incentive that government provides encourages workers to purchase additional health insurance, and additional healthcare, contributing to rising costs.

Other government policies also distort market principles. For instance, Medicare physician payment rates, which are set via a statutory formula, have declined by approximately one-third on an inflation-adjusted basis this century.⁷ However, in that same

time frame, physicians have performed more services in response, attempting to make up in volume what they lose from government-imposed price declines.⁸ Moreover, continued declines in Medicare payment levels “incentivize providers to increasingly favor commercial patients [i.e., those with private insurance] over Medicare patients.”⁹ These types of hidden cost shifts pervade the healthcare sector, due to disconnects between the payer of services (often the government) and the end user, along with opacity stemming from a lack of transparency.

Policies should realign incentives and empower consumers in ways that can drive down the underlying cost of care. Other changes should focus on making coverage personal and portable, such that people can purchase the insurance they want to buy, not what government dictates. Only fundamental reform—not incremental adjustments to a failed system—can deliver meaningful relief to American families.

Portability: Because most Americans currently obtain their health coverage through their employer, they often face a disconnect between the coverage that they want and what their employer offers. Individuals also have to change their coverage when they switch jobs—a particularly difficult problem when patients face a catastrophic medical situation—a cancer diagnosis, for instance—and risk losing their job and their health coverage simultaneously.

When talking about healthcare, the Left traditionally highlights individuals with pre-existing conditions to justify greater government control of the health system. By contrast, conservatives should emphasize changes that would make it easier for Americans to buy coverage before they develop a pre-existing condition—insurance that individuals can buy, hold,

6 William McBride and Alex Durante, “Federal Revenue and Distributional Impacts of Limiting the Tax Exclusion for Employer-Sponsored Health Insurance Premiums,” Tax Foundation, October 2, 2025, <https://taxfoundation.org/research/all/federal/employer-sponsored-health-insurance-premiums-tax-affordable-care-act/>.

7 American Medical Association, “Medicare Physician Payment Reform: The Urgent Need for Comprehensive Reform,” February 2025, <https://www.ama-assn.org/system/files/2025-mac-medicare-physician-payment-issue-brief.pdf>.

8 Eric Christensen, et al., “Medicare Volume Growth and Shift in Payments From Physicians to Non-Physician Practitioners Under Statutory Budget Neutrality,” Inquiry April 2024, <https://pmc.ncbi.nlm.nih.gov/articles/PMC11055487/>.

9 Ibid.

and keep themselves, without being tied to an employer or place of business.

The first Trump Administration made important progress on the portability front by finalizing rules regarding Health Reimbursement Arrangements (HRAs) for insurance coverage.¹⁰ These rules allow employers to subsidize insurance coverage that the individual, and not the employer, owns—enhancing portability by allowing workers to take that coverage from job to job while retaining their employer subsidy. Congress should codify these rules so that a future Administration cannot undo them.

Additional reforms to enhance portability could codify other alternatives to the failed Obamacare status quo, such as Association Health Plans, cross-state purchasing of health insurance, and short-term, limited-duration insurance. By making coverage portable, these concepts would increase the number of Americans owning their own health insurance policies.

Pre-Existing Conditions: In addition to improving portability, conservative solutions should also provide better policies for people with pre-existing conditions. While not insignificant, this “uninsurable” population is smaller than Obamacare supporters would have the public believe. Surveying the available data at the time of Obamacare’s passage, one study estimated the number of Americans who could not buy health insurance on the individual market due to an underlying health condition at approximately 2-4 million.¹¹

For this group, policymakers could explore restoring the high-risk pools that covered some patients

with high healthcare needs in the years leading up to Obamacare. Before the law’s major insurance regulations took effect, these pools provided coverage to people with pre-existing conditions who could not buy affordable coverage on the individual market. Most of the 35 state-based risk pools capped premiums at 125% to 150% of standard individual market insurance rates.¹²

At the time of Obamacare’s passage, the pools covered approximately 200,000 individuals.¹³ Because premiums paid by enrollees did not cover their sizable health costs, the pools required external sources of funding—assessments on insurers, state appropriations, federal grants, or a combination of the three—to offset their financial losses.¹⁴ Enrollment often varied by state based on the stability of external funding sources. More robust federal funding would allow high-risk pools to offer coverage to individuals who could not buy coverage on the private market—at a cost far cheaper than Obamacare.

The study at the time of Obamacare’s passage estimated that a robust system of high-risk pools would require approximately \$15-20 billion annually in federal funding.¹⁵ Inflation since 2010 would likely push those costs higher, to the tune of several hundred billion dollars over the course of a decade.

But consider that the Congressional Budget Office estimates that spending on Obamacare’s entitlements—Exchange subsidies and Medicaid expansion to able-bodied adults—will total more than \$2.5 trillion over the coming decade.¹⁶ This sizable sum

10 Departments of the Treasury, Labor, and Health and Human Services, Final Rule regarding “Health Reimbursement Arrangements and Other Account-Based Group Health Plans,” Federal Register June 20, 2019, <https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf>, pp. 28888-29027.

11 Jim Capretta and Tom Miller, “How to Cover Pre-Existing Conditions,” National Affairs Spring 2010, <https://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions>.

12 Ibid.

13 Ibid.

14 Ibid.

15 Ibid.

16 Congressional Budget Office, “Federal Subsidies for Health Insurance,” February 2026, <https://www.cbo.gov/system/files/2026-02/51298-2026-02-healthinsurance.pdf>, Table 2: CBO and JCT’s Projections of Net Subsidies for Health Insurance, p. 4; Congressional Budget Office, “Medicaid Baseline,” February 2026, <https://www.cbo.gov/system/files/2026-02/51301-2026-02-medicaid.pdf>.

does not even include the \$350 billion that Democrats tried, and failed, to get Congress to approve last fall to extend the Biden-era COVID enhanced subsidies.¹⁷

The CBO estimates show how conservative health policies could address the pre-existing condition problem, while saving trillions of dollars compared to Obamacare’s costly mandates and regulations. In addition, conservative policies that enhance portability would, by providing more ways for Americans to buy coverage before they develop a pre-existing condition, dramatically reduce the pre-existing condition problem over time.

Health Savings Accounts: President Trump’s recent “Great Health Care Plan” contained a key principle to increase competition, expand consumer choice, and ultimately lower costs: “Stop sending big insurance companies billions in extra taxpayer-funded subsidy payments and instead send that money directly to eligible Americans.”¹⁸

Health Savings Accounts, first established in 2003, provide the best vehicle to achieve the President’s vision. HSAs permit individuals to save money for routine medical expenses on a pre-tax basis, allowing them to accumulate savings that they can use in the event of a major emergency. HSAs encourage families to become smart consumers of healthcare.

Major reforms to Health Savings Accounts should include increasing the maximum contribution limit, expanding eligibility, and allowing individuals to use HSA dollars to purchase health insurance.¹⁹ As the President suggested, Congress can use HSAs to redirect existing program dollars from subsidizing

insurers to subsidizing patients directly. When allocating public funds directly to HSAs, Congress should include appropriate restrictions to ensure that subsidy recipients spend these taxpayer dollars only on qualified medical expenses, and that taxpayer dollars do not fund abortions, consistent with the Hyde Amendment’s 50-year-old precedent. Allowing all individuals to contribute to an account, rather than just those with high-deductible health insurance plans, would dramatically expand HSA eligibility.

Price and Quality Transparency: HSAs and empowering patients can only help bring down costs if Americans have the information they need to serve as smart consumers of healthcare. At a recent congressional hearing, multiple witnesses provided examples of how transparency is already working to reduce prices, lower costs, and make the healthcare system more efficient:

- A representative of a healthcare data and analytics firm testified that, thanks to transparency, prices converged in nearly five in six (82.8%) markets between December 2021 and June 2024, suggesting more rational pricing behavior by hospitals;²⁰
- The CEO of an employer coalition noted that “employers with complete claims data access are far more likely to deploy high-value hospital strategies” like direct contracting with providers and designating high-quality hospitals as centers of excellence, illustrating that purchasers can put transparency to work to lower costs and improve care quality;²¹ and
- A researcher cited multiple examples of how policies like reference-based pricing—where an employer

17 CBO, Letter to Sen. Schumer.

18 President Donald J. Trump, “The Great Health Care Plan,” January 15, 2026, <https://www.whitehouse.gov/wp-content/uploads/2026/01/The-Great-Healthcare-Plan.pdf>.

19 Under current law, HSA dollars cannot be used to purchase health insurance, with limited exceptions. See 26 U.S.C. 223(d)(2).

20 Carol Skenes, Testimony before the House Energy and Commerce Subcommittee on Health at a Hearing on “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency,” June 10, 2026, <https://docs.house.gov/meetings/IF/IF14/20260610/119378/HHRG-119-IF14-Wstate-SkenesC-20260610.pdf>, pp. 4-5.

21 Shawn Gremminger, Testimony before the House Energy and Commerce Subcommittee on Health at a Hearing on “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency,” June 10, 2026, <https://docs.house.gov/meetings/IF/IF14/20260610/119378/HHRG-119-IF14-Wstate-GremmingerS-20260610.pdf>, Figure 3, p. 6.

sets a maximum price it will reimburse a hospital for a procedure (e.g., hip replacement)—have lowered the costs of care by double-digit percentages and millions of dollars.²²

These efforts would have even more impact if patients could get full transparency into the cost and quality of care. Although the first Trump Administration acted to make pricing information more transparent for consumers, special interests continue to thwart public disclosure. For instance, hospitals have added special codes to their websites to prevent patients who search on sites like Google from finding their pricing information.²³

Healthcare interests continually resist price disclosure—a fact of life in virtually every other sector of the economy—suggesting the need for legislative action. While lawmakers should take a skeptical view of government mandates, they should consider passing bills such as the Patients Deserve Price Tags Act, which would expand and clarify existing transparency requirements.²⁴

Fighting Waste, Fraud, and Abuse: The industrial-scale fraud unearthed in Minnesota beginning in 2022—in which federal funds meant to feed children during COVID were diverted to luxury cars, overseas real estate, and shell companies—offers a cautionary example of the pervasive fraud endemic to the modern welfare state. A December 2025 Government Accountability

Office report also noted rampant fraud on Obamacare's Exchanges. For instance, one Social Security number was linked to “over 26,000 days (over 71 years of [taxpayer-subsidized] coverage) across 125 insurance policies in 2023.”²⁵

The One Big Beautiful Bill Act (OBBBA), which President Trump signed into law last year, contains several policies that address this problem. For instance, more frequent and rigorous eligibility checks should help alleviate the fraud involving millions of individuals who have improperly claimed tens of billions in Obamacare subsidies each year by falsifying their income.²⁶

However, Congress and states can and should do more to fight waste, fraud, and abuse in government healthcare programs. Congress should codify the common-sense program integrity provisions the Trump Administration finalized in a rule published last year, many of which have been blocked by a federal judge due to a lawsuit by several Democrat cities and interest groups.²⁷ States can do more to fight fraud, from fully staffing their program integrity offices to checking that beneficiaries are not simultaneously enrolled in multiple Medicaid programs.²⁸ States should also cease to expand Medicaid services, which drives up spending on an unsustainable program.²⁹

The ways in which states perpetually expand populations and services to receive more “free”

22 Christopher Whaley, Testimony before the House Energy and Commerce Subcommittee on Health at a Hearing on “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency,” June 10, 2026, <https://docs.house.gov/meetings/IF/IF14/20260610/119378/HHRG-119-IF14-Wstate-WhaleyC-20260610.pdf>, pp. 12-14.

23 Tom McGinty, Anna Wilde Mathews, and Melanie Evans, “Hospitals Hide Pricing Data from Search Results,” The Wall Street Journal March 22, 2021, <https://www.wsj.com/health/healthcare/hospitals-hide-pricing-data-from-search-results-11616405402>.

24 Patients Deserve Price Tags Act, S. 2355 (119th Congress).

25 Government Accountability Office, “Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist,” Report GAO-26-108742, December 3, 2025, <https://www.gao.gov/assets/gao-26-108742.pdf>.

26 Congressional Budget Office, Letter to Rep. Jodey Arrington, et al. regarding clarifications of Marketplace coverage and eligibility, August 25, 2025, <https://www.cbo.gov/system/files/2025-08/61506-marketplace.pdf>, p. 7; Brian Blase, et al., “The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025,” Paragon Health Institute, June 2025, https://paragoninstitute.org/wp-content/uploads/2025/06/The-Greater-Obamacare-Enrollment-Fraud_RELEASE_V4.pdf.

27 Department of Health and Human Services, Final Rule regarding “Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability,” Federal Register June 25, 2025, <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf>, pp.27074-27224; City of Columbus v. Cochran, 523 F. Supp. 3d 731, 761-763 (D. Md. 2021).

28 Christopher Weaver et al., “Taxpayers Spent Billions Covering the Same Medicaid Patients Twice,” The Wall Street Journal March 26, 2025, <https://www.wsj.com/health/healthcare/mcicaid-double-payments-insurers-states-1c091b41>. Beginning in October 2029, Section 71103 of the One Big Beautiful Bill Act requires states to submit beneficiary names and addresses to a database intended to prevent simultaneous enrollment in multiple state Medicaid programs.

29 Club for Growth Foundation, “The Hidden Medicaid Expansion,” Policy Report No. 9, June 2025, <https://clubforgrowthfoundation.org/policy-reports/the-hidden-medicaid-expansion/>.

federal matching funds illustrate why Congress must change Medicaid’s incentives. For starters, lawmakers should equalize federal Medicaid match rates so that states do not receive a higher match for covering able-bodied adults than for covering seniors and individuals with disabilities, as a first step toward phasing out Obamacare’s Medicaid expansion to able-bodied adults entirely. In addition, reducing or eliminating the minimum 50% federal match for all states would end the system that encourages wealthier states like California and New York to unduly benefit from federal dollars via continual program expansions. Ideally, transforming Medicaid into a block grant or per capita cap would give the federal government funding certainty, reform its incentives, and give states additional regulatory flexibility to innovate.

Telehealth: Since 2020, seniors have increasingly used pandemic-era telehealth options to access care remotely. Particularly in rural areas with limited access to specialist providers, or for individuals with mobility and transportation issues who may have difficulty traveling to the doctor, telehealth provides an important means for patients to receive the personalized care they need.

In recent appropriations legislation, Congress extended these pandemic-era flexibilities through the end of calendar year 2027.³⁰ Lawmakers should go further by examining opportunities to make these flexibilities permanent and considering additional ways medical providers can deliver care remotely, benefitting patients and reducing overall costs. Although this policy change occurred during the government overreaches of the COVID era, preserving telehealth expands choice and competition in the marketplace to give consumers more options, which will help drive costs down.

Antitrust Enforcement: Obamacare led to rising costs in part because it gave insurers, hospitals, and physician practices greater incentives to merge to increase their clout when negotiating rates. For instance, the percentage of physicians employed by hospitals rose from one in four (25.8%) in 2012 to more than half (55.1%) by 2024, with another 22.5% employed by corporate entities such as insurers.³¹

Even Sen. Elizabeth Warren (D-MA) has acknowledged that Obamacare’s medical loss ratio provisions have encouraged consolidation within the sector. Warren has argued that by acquiring physician practices and pharmaceutical benefit managers, big insurance companies can offload revenue from their insurance business—where Obamacare capped their profits—onto other healthcare entities that lack such restrictions.³²

Greater resources devoted to antitrust enforcement may help make healthcare markets more competitive. In addition, empowering patients by redirecting subsidy funds to them will also encourage competition, as innovators will develop new methods to deliver health insurance and healthcare in response to consumer demand.

Drug Prices: Four separate reforms initiated in recent months should, both individually and collectively, help to bring down drug prices. First, President Trump’s proposal to “make more verified safe pharmaceutical drugs available for over-the-counter purchase” should reduce costs, especially if patients can avoid the cost of a doctor visit to obtain medicine.³³ Particularly if accompanied by swifter Food and Drug Administration (FDA) approval of generic alternatives, this reform would increase competition and drive down prices.

30 Section 6209 of the Consolidated Appropriations Act, 2026, P.L. 119-75.

31 Avalere Health, “Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023,” Report for Physicians Advocacy Institute, April 2024, <https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf>

32 Sens. Elizabeth Warren and Mike Braun, Letter to Department of Health and Human Services Inspector General Christi Grimm, November 21, 2023, <https://www.warren.senate.gov/imo/media/doc/2023.11.21%20Letter%20to%20HHS%20OIG%20regarding%20MLR%20evasion.pdf>.

33 President Trump, “Great Health Care Plan.”

Second, the FDA has taken action to streamline the often bureaucratic drug approval process. In February, the agency announced that its “default position is that one adequate and well-controlled study, combined with confirmatory evidence, will serve as the basis of marketing authorization of novel products.”³⁴ This move will provide regulatory certainty for pharmaceutical companies, who previously did not know whether the FDA would demand a second clinical trial to approve a new drug. Just as important, it will lower the time and costs associated with obtaining FDA approval, which will give manufacturers incentive to moderate their prices—and conduct clinical trials in the United States rather than China.

Third, selling pharmaceuticals directly to patients has the potential to take out costly middlemen, in the form of pharmaceutical benefit managers (PBMs).³⁵ Direct sales to consumers will eliminate one potential source of friction within the healthcare system, while also making patients more cost-conscious about the prices of the medicines they consume.

Congress has already enacted reforms that expand transparency regarding PBM business practices in the appropriations bill passed earlier this year.³⁶ As with efforts regarding transparency for hospital prices outlined above, more sunlight into pharmaceutical pricing will prevent PBMs from withholding rebates and price discounts from employers and patients, leading to lower costs on prescription drugs.

Fourth, trade agreements like the one President Trump negotiated with the United Kingdom will result in that country increasing what it pays for pharmaceuticals purchased by its National Health Service (NHS).³⁷ Such agreements would reduce or

eliminate the arbitrary price controls that socialized medicine systems place on prescription drugs, potentially allowing drug manufacturers to lower their prices for American patients.

Direct Primary Care: In recent years, many families and medical practices alike have discovered the benefits of a direct primary care (DPC) relationship. In exchange for a modest retainer of \$100-150 per month, individuals receive unlimited visits with a medical practice for their primary care needs; many practices also help coordinate specialist care when necessary. Patients benefit from greater contact and a deeper relationship with their physician, while providers benefit from a sharp reduction in the paperwork and bureaucracy generated by health insurers and government programs.

The One Big Beautiful Bill Act contained several important reforms improving coordination between DPC arrangements and Health Savings Accounts. Specifically, individuals with a DPC can now make contributions to HSAs, provided the monthly cost of such an arrangement does not exceed \$150 for an individual (or \$300 for a family).³⁸ Households can also have the cost of their DPC arrangement reimbursed using pre-tax dollars from their HSA.³⁹

These reforms will expand access to a form of care that does not rely on insurance company middlemen, or indeed any middlemen at all. Direct primary care and Health Savings Accounts will, like the other elements of President Trump’s health plan, empower patients rather than insurance companies.

Scope of Practice: While most of the above reforms involve Congress and federal agencies, states also play an important part in helping to alleviate rising

34 Quoted in Julia Bonavitacola, “FDA Will Require Only One Study to Approve New Drugs, Speeding Up Process,” AJMC February 19, 2026, <https://www.ajmc.com/view/fda-will-require-only-1-study-to-approve-new-drugs-speeding-up-process>.

35 Ibid.

36 See for instance Sections 6701 and 6702 of the Consolidated Appropriations Act, 2026, P.L. 119-75.

37 Nathaniel Weixel, “New Trade Deal Pushes U.K. to Increase Drug Spending to Avoid Trump Tariffs,” The Hill December 1, 2025, <https://thehill.com/policy/health-care/5628347-trump-tariffs-uk-trade-deal-drugs/>.

38 Section 71308 of the One Big Beautiful Bill Act, P.L. 119-21.

39 Ibid.

healthcare costs. In recent years, states have taken an active role on medical licensing and workforce issues, with 34 states and the District of Columbia passing more than 120 bills concerning the licensing of healthcare professionals in 2024 alone.⁴⁰

States can and should continue to reform their licensing laws in ways that allow medical professionals to practice to the fullest scope of their license and training. They should also join interstate compacts that create reciprocity, and in some cases allow health professionals' licenses to cross state lines.⁴¹ Expanding opportunities for professionals like nurse anesthetists, physician assistants, and nurse practitioners will increase the supply of clinicians, particularly in rural areas that face the most acute shortages.

Certificate of Need: Most Americans would be surprised to discover that some types of businesses require a “permission slip” from the government simply to open. Yet many states impose such a requirement for healthcare facilities, in the form of certificate of need laws.

These anti-competitive and archaic laws allow incumbent hospitals or clinics to block the introduction of new competitors by objecting to the issuance of new certificates of need. Unsurprisingly, research demonstrates that these laws reduce the quality of care provided, increase costs, and impede healthcare access.⁴² As with scope-of-practice reforms, states should repeal these unnecessary laws to foster competition in healthcare.

A Better Approach Resulting in Lower Costs

The policies in this paper focus on reducing healthcare costs by harnessing “patient power”—the idea that individuals, not third-party payers or government programs, should control and direct their own care.

While Obamacare's failed policies have expanded big insurers, big government, and big bureaucracy, free-market reforms will place power where it belongs—with the people themselves. When patients are in control, providers must compete for their business on price and quality—the same dynamic that has driven down costs and expanded choice in virtually every other sector of the American economy.

For more than a decade, the American people have suffered from the havoc caused by Obamacare—higher costs for poorer coverage. A better vision for healthcare can deliver the cost relief Americans need and the quality care they deserve.

40 Razan Badr, “In Review: Trends in Scope of Practice Legislation for 2024,” National Council of State Legislatures, February 10, 2025, <https://www.ncsl.org/state-legislatures-news/details/in-review-trends-in-scope-of-practice-legislation-for-2024>.

41 Kelsie George, “Licensure and Interstate Compacts,” National Council of State Legislatures Telehealth Explainer Series, July 2021, https://documents.ncsl.org/www-ncsl/Health/Licensure-and-interstate-compacts_36242.pdf.

42 Matthew Mitchell, “It's Time for States to Ditch Certificate of Need Laws,” U.S. News and World Report July 9, 2021, <https://www.usnews.com/news/best-states/articles/2021-07-09/on-the-heels-of-the-pandemic-states-should-get-rid-of-certificate-of-need-laws>.



About the Author

Chris Jacobs, the Founder and CEO of Juniper Research Group and author of *The Case Against Single Payer*, has over a decade of experience in a variety of policy roles on and off Capitol Hill. He previously worked as Policy Director for America Next, a start-up think tank, and as a Senior Policy Analyst for the Heritage Foundation and the Joint Economic Committee's Senate Republican staff. Before that, Chris worked as a Policy Advisor for the House Republican Conference under then-Chairman Mike Pence during the debate surrounding the Patient Protection and Affordable Care Act, and as a Health Policy Analyst for the Senate Republican Policy Committee during the first two years of the law's implementation. He got his start on Capitol Hill as an intern for then-Congressman Pat Toomey of Pennsylvania.

While serving as Policy Director for America Next, Chris contributed to the *Wall Street Journal's Think Tank policy blog*. He has taught part-time on health policy at The American University, where he received his Bachelor's Degree in Political Science and History, Phi Beta Kappa.
