Healthcare Abundance: Building Supply-Side Reform

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The American healthcare crisis is not simply about coverage—it is about *capacity*. The United States spends more on healthcare than any other wealthy nation yet ranks last in access and outcomes. That failure stems from decades of policies that subsidized demand while constraining supply. *Healthcare abundance* is a new framework that aims to reverse this imbalance by expanding the availability of doctors, facilities, and innovative care models while reforming perverse incentives that reward consolidation and high prices.

1. From Scarcity to Abundance

U.S. healthcare operates under a scarcity regime. Demand is inflated by insurance subsidies and public spending, while the ability to deliver care is throttled by restrictions on entry, outdated licensing, and perverse payment rules. These distortions drive up costs without improving outcomes. Reformers on the left have tried to make care more affordable by expanding insurance; those on the right have focused on price transparency and consumer choice. Both approaches overlook the structural barriers that limit the supply of affordable care. The abundance agenda seeks to expand the number and diversity of providers and facilities while fostering competition and innovation.

It is sometimes said that there is an “iron triangle” within which no reform can reduce more than two of cost, access, and quality. But when the system is underperforming on all three—as it is in the U.S.—it does become possible to make simultaneous improvements. Expanding supply, especially of primary care, can raise quality, improve access, and lower costs all at once.

2. Barriers to Supply

State-level barriers include certificate-of-need (CON) laws that allow incumbent hospitals to veto new competitors; restrictive scope-of-practice rules that prevent nurse practitioners and physician assistants from working to the full extent of their training; and licensing systems that block telehealth across state lines or require foreign-trained doctors to repeat residencies.

Federal barriers stem from deliberate policy choices. Caps on residency slots, introduced in 1997, artificially limit the number of new physicians, particularly in primary care. The Affordable Care Act’s ban on physician-owned hospitals constrains

competition. Together, these rules restrict capacity, especially in rural and underserved regions.

3. The Price Problem

The central driver of America's high healthcare spending is not overuse but *price inflation*. Between 2015 and 2019, prices for hospital and physician services rose nearly five times faster than utilization. Hospitals and physician groups have consolidated, gaining bargaining leverage to demand higher reimbursement from insurers. Because insurers can pass these costs along in premiums, they have weak incentives to resist. Patients, insulated by third-party payment, rarely see true prices. The result is a self-reinforcing cycle of consolidation, opaque pricing, and cost escalation.

Government programs have contributed to the problem. Medicare's site-based billing pays hospitals nearly twice as much as independent offices for identical services, encouraging hospital acquisition of clinics. The ACA's *medical loss ratio* rule, meant to cap insurers' administrative costs, inadvertently encourages them to expand total spending—since profits are allowed as a percentage of costs—fueling vertical integration among insurers, pharmacy benefit managers, and provider networks. Medicaid's matching formula (FMAP) rewards states that inflate payments through provider taxes, favoring wealthy states while straining poor ones. And nonprofit hospitals enjoy billions in tax exemptions despite providing limited charity care.

4. How We Got Here

Starting in the 1970s, policymakers sought to restrain costs by limiting capacity. The 1974 National Health Planning Act, guided by "Roemer's Law" ("a bed built is a bed filled"), required states to control hospital expansion. Nearly all states adopted CON laws, many of which still exist. Simultaneously, the U.S. curtailed physician training. Medical schools froze enrollments, and Medicare capped residency funding. The result was predictable: a dwindling number of hospital beds and primary care doctors even as population and demand grew. Today, the U.S. has less than one-third the hospital beds per capita it had in 1960 and faces a projected shortage of up to 120,000 physicians by 2036.

5. Policy Prescriptions

The abundance agenda focuses on *expanding supply* and *realigning incentives*:

Expand physician supply.

- Lift Medicare's cap on residency slots and create a uniform per-resident payment to correct geographic imbalances.

- Redirect graduate medical education funds to favor primary care specialties.
- Ease relicensing for international medical graduates (an untapped pool of over 150,000 potential practitioners).
- Streamline interstate licensing and enable cross-state telehealth.
- Broaden scope-of-practice laws so nurse practitioners and physician assistants can deliver routine care independently.

Expand facility capacity and innovation.

- Repeal certificate-of-need laws and the ACA's ban on physician-owned hospitals.
- Encourage lower-cost delivery models such as direct primary care (fixed monthly fees instead of fee-for-service) and telemedicine partnerships for Medicaid patients.
- Reform the drug-patent system to prevent "patent thickets" that delay generics and biosimilars.

Reform payment and tax incentives.

- Adopt *site-neutral payments* in Medicare—same pay for the same service regardless of location—to curb hospital consolidation and save an estimated $127 billion over 10 years.
- Fix Medicaid's FMAP formula to eliminate the 50 percent floor for wealthy states and limit provider-tax gaming.
- Tighten oversight of nonprofit hospital tax exemptions and the 340B drug-discount program to ensure benefits flow to patients, not hospital margins.

6. Toward Abundance

America's healthcare system is failing because scarcity has been baked into its design. By expanding the number of doctors, breaking down barriers to competition, and aligning financial incentives with patient value, policymakers can achieve abundance—an environment where providers are plentiful, prices fall under competitive pressure, and access improves.

Healthcare abundance is not about deregulation for its own sake or about endless spending. It is about rebalancing the system: pairing robust insurance protection with an ample, dynamic supply of care. Only when policymakers address the supply bottlenecks alongside demand-side reforms can Americans enjoy healthcare that is affordable, equitable, and sustainable.