

## Trump Administration's 2026 Economic Report Targets Physician Markets

On April 13, 2026, the Council of Economic Advisers (CEA) transmitted the *2026 Economic Report of the President* to Congress, including a 10-page chapter that recasts the long-running national conversation about physician access as a problem of competition rather than reimbursement.<sup>1</sup> Chapter 11, titled “Making America Healthy by Unleashing Competition in Physicians’ Markets,” argues that the U.S. has more physicians per capita than at any point in its history but that federal regulations, outdated workforce-shortage maps, and payment rules favoring hospital-based care have misdirected where those physicians practice and how they are paid.<sup>2</sup> This Health Capital Topics article reviews the CEA’s central argument, the regulatory agenda it is designed to justify, the competing views from organized medicine and hospital stakeholders, and the political context in which the chapter was released.

Chapter 11 is organized into five substantive sections that address rural access, regulatory and payment distortions, administrative burden, physician payment methods, and transparency and technology.<sup>3</sup> The chapter’s thesis is that government rules, not a shortage of clinicians, account for the access problems Americans experience. In the CEA’s diagnosis, the U.S. does not have too few physicians; rather, federal payment rules push physicians toward hospital employment, and federal workforce-shortage designations direct training subsidies and loan-repayment programs to the wrong places. The policy implication is that healthcare affordability and access can be improved through competition and deregulation rather than through higher Medicare physician payment rates.

Notably, the CEA leans on research from the Paragon Health Institute, founded by former Trump first-term economic adviser Brian Blase. Paragon’s analysis observes that the Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) designations still rely on methodologies that reflect the workforce composition of the mid-1970s and largely ignore the nearly 600,000 nurse practitioners (NPs) and physician assistants (PAs) now in practice across the U.S.<sup>4</sup> Paragon also reports that the combined primary care workforce of physicians, NPs, and PAs has more than doubled per capita since 1980, growing from 21.4 to 44.4 per 10,000 population, with most of that growth attributable to the rise of NPs and PAs as clinician categories.<sup>5</sup>

On competition, the chapter cites academic research showing that commercially insured patients pay approximately 20% lower prices in the least-concentrated physician markets than in the most concentrated markets, and that a 10% decrease in physician market concentration is associated with a 0.5% to 1% decrease in prices.<sup>6</sup>

The chapter ties the CEA’s diagnosis to a concrete agenda of regulatory actions already issued or proposed. The Calendar Year (CY) 2026 Medicare Physician Fee Schedule final rule, released October 31, 2025, cut indirect practice-expense payments for facility-based services by half relative to non-facility services, with the stated goal of equalizing Medicare payment regardless of ownership setting.<sup>7</sup> The chapter further notes administration steps to phase out the Medicare inpatient-only list, expand the ambulatory surgery center (ASC) covered procedures list, and collect Medicare Advantage (MA) price data to inform fee-for-service rates.<sup>8</sup>

The chapter also highlights provisions of the *One Big Beautiful Bill Act* (OBBBA) that constrained Medicaid State-Directed Payments (SDPs), which had previously allowed states to direct managed care plans to pay hospitals above standard Medicaid rates.<sup>9</sup> The CEA frames these reforms as pro-competition, although the Kaiser Family Foundation (KFF) and other analysts have estimated that OBBBA’s overall Medicaid changes will reduce federal spending by approximately \$1 trillion over a decade and result in over 10 million people losing coverage by 2034.<sup>10</sup> Other elements of the chapter’s agenda include flat-rate payment for skin substitutes, a 340B Drug Pricing Program hospital-acquisition-cost survey, scrutiny of restrictive covenants in employed-physician contracts, permanent telehealth flexibilities, and reform of prior authorization through artificial intelligence (AI)-enabled processes.

The CEA’s diagnosis stands in tension with the testimony delivered just weeks earlier at the House Energy and Commerce Health Subcommittee hearing on healthcare affordability discussed in a previous Health Capital Topics article.<sup>11</sup> The American Medical Association (AMA) testified during the hearing that Medicare physician reimbursement has fallen by over 33% in inflation-adjusted dollars since 2001, even as practice costs have risen by approximately 63%, and argued for tying annual Medicare physician updates to the full Medicare Economic Index (MEI).<sup>12</sup> The AMA’s

prescription, in other words, is a payment-rate fix, while the CEA’s prescription is a market-structure fix. Hospital industry stakeholders frame the same data differently, contending that hospital acquisition of physician practices is driven by the need to subsidize money-losing community specialties and that site-neutral payment cuts could accelerate, rather than reverse, the closure of independent practices. Independent physicians who testified at the hearing offered a third view aligned more closely with the CEA’s, arguing that the existing system starves independent practices of revenue while burying them in paperwork, leaving sale to a hospital as the only viable exit.<sup>13</sup> The chapter implicitly endorses portions of that third critique, particularly through its emphasis on transparency, competition, and reduction of administrative burden.

The chapter’s release comes at a moment when healthcare costs have become the leading economic concern across the U.S.<sup>14</sup> The January 2026 KFF Health Tracking Poll found that 32% of adults are “very worried” about affording healthcare for their families, a higher proportion than those who report the same level of concern about food, rent, utilities, or gasoline.<sup>15</sup> Over four in 10 voters said healthcare costs would have a “major impact” on their midterm vote.<sup>16</sup> Against that backdrop, both political coalitions have moved to stake out healthcare positions: the Center for American Progress (CAP) released a “Patients’ Bill of Rights” framework in April 2026 calling for caps on premium increases and a ban on prior authorization,<sup>17</sup> while Paragon Health Institute has continued to advance its 2026 Medicare reform agenda, emphasizing site-neutral payments, MA reform, and changes to how Medicare sets spending benchmarks for MA plans and accountable care organizations (ACOs).<sup>18</sup> Some independent observers

have credited the administration’s CMS payment-reform work, including the site-neutral proposals, prior authorization initiatives, and Center for Medicare and Medicaid Innovation (CMMI) physician-focused pilot models, even while criticizing other aspects of the administration’s health agenda; CMS has been described by some commentators as the “shining light” of the second Trump administration’s domestic policy work, particularly with respect to payment reform.<sup>19</sup> That assessment has been offered alongside continued criticism of OBBBA’s Medicaid reductions and the lapse of the enhanced *Affordable Care Act* premium tax credits at the end of 2025.<sup>20</sup>

Chapter 11 of the 2026 Economic Report of the President offers the clearest articulation to date of the second Trump administration’s supply-side, deregulatory approach to healthcare, and it provides the economic justification for a series of CMS rules that healthcare counsel and executives are already navigating in 2026. The chapter identifies real distortions in physician markets, including obsolete shortage-designation methodologies and payment differentials between hospital outpatient departments and independent physician practices. It is also strategically silent on the questions raised by the AMA and hospital stakeholders about whether site-neutral and consolidation-focused reforms can succeed without a corresponding update to physician payment rates. Whether the executive branch’s competition-first framing and the legislative branch’s reimbursement-and-transparency framing will converge into a coherent national policy, or whether each will pull the physician-market debate in opposing directions through the 2026 election cycle and beyond, is the question now in front of the industry.

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3 Council of Economic Advisers, Executive Office of the President, April 2026.

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5 Merkel and Drew Keyes, Paragon Health Institute, July 2025.

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